Multifactorial risk factor modification and control, especially interventions designed to reduce total cholesterol, systolic blood pressure, smoking prevalence, overweight/obesity, diabetes mellitus, and physical inactivity, can have a profound and favorable impact on decreasing the incidence of initial and recurrent cardiovascular events. Between 1980 and 2000, mortality rates from coronary heart disease (CHD) fell by >40%. Using a previously validated statistical model (IMPACT), researchers attempted to determine how much of this decrease could be explained by the use of medical and surgical treatments as opposed to changes in risk factors among US adults aged 25 to 84 years. Approximately half of the decline in cardiovascular deaths was attributed to reductions in major risk factors (obesity and diabetes mellitus were notable exceptions), and approximately half was attributed to evidence-based medical therapies (eg, secondary prevention medications, rehabilitation, and initial treatments for acute myocardial infarction [AMI]). In contrast, emergent and elective revascularization accounted for only 7% of the overall decline in deaths from CHD. Recently, similar results were reported in a Canadian study that evaluated the decrease in CHD mortality between 1994 and 2005.

Over the past decade, mortality rates from CHD and stroke in the United States decreased by >25% (Figure 1). Although there were also impressive reductions in the prevalence of uncontrolled high blood pressure, elevated blood cholesterol, and, to a lesser extent, cigarette smoking, there was only limited impact on other risk factors, including increases in the prevalence of obesity and diabetes mellitus, and a small reduction in those not engaged in moderate or vigorous physical activity. These indicators represent major challenges to achieving future goals for cardiovascular health promotion and disease reduction.

In 2009, a task force representing numerous professional organizations/associations developed a Competence and Training Statement on the Prevention of Cardiovascular Disease. More recently, the American Heart Association (AHA) released its bold new impact goal for the next 10 years, the 2020 Impact Goal: “to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.” This 2020 goal has an innovative new element to improve clinically relevant health and behavioral factors. Cardiovascular health is defined in 3 categories of ideal, intermediate, and poor on the basis of 7 simple health factors and modifiable behaviors, as detailed in the My Life Check assessment tool at http://www.mylifecheck.heart.org.

This review provides a compendium of important advances in preventive and lifestyle medicine during the past decade, including discussion of some emerging but unproven interventions (ie, the polypill) as well as the value of conducting large-scale randomized clinical trials rather than relying on biological hypotheses and observational data (ie, the homocysteine story). We also provide a call to action to support the AHA’s 2020 goals, summarize the impact of preventive interventions as a first-line strategy to combat stable cardiovascular disease (CVD), and discuss the potential impact of behavioral and complementary interventions in reducing the burden of CVD. Finally, we detail the goals of a new Circulation series of publications on Preventive Cardiology and Lifestyle Medicine.

A Decade of Discovery: Implications for Primordial, Primary, and Secondary Prevention

Prevention can be divided into 3 types: primordial (prevention of risk factors); primary (treatment of risk factors); and secondary (prevention of recurrent cardiovascular events) (Figure 2). Much of the success in reducing CVD in recent years has been through the latter 2 methods; however, additional emphasis on primordial prevention is needed to meet the AHA 2020 Impact Goal of improving cardiovascular health and achieving an additional 20% reduction in death from CVD and stroke.
The importance of risk factors in the development of CVD has received increased attention over the past decade. In addition, along with cardioprotective medications, the roles of lifestyle interventions, psychosocial factors, air pollution, dietary patterns, physical inactivity, low cardiorespiratory fitness, obesity, cardiac rehabilitation, and inflammation have been better elucidated as modulators of CVD and as targets for education, behavioral interventions, and policy approaches to improving health. Newer statin drugs, in particular, which markedly decrease and increase low-density lipoprotein and high-density lipoprotein cholesterol, respectively, have been heralded as a potential breakthrough to prevent initial and recurrent atherosclerotic events.

Consider the following key reports of the 2000s.

**Risk Factors as Antecedents of Cardiovascular Disease: Debunking the Only 50% Myth**

The INTERHEART study examined the risk factors associated with first AMI in 52 countries, including 15,152 cases and 14,820 controls. Collectively, 9 risk factors (abnormal lipids, smoking, hypertension, diabetes mellitus, abdominal obesity, psychosocial variables, consumption of fruits and vegetables, regular alcohol consumption, regular physical activity) accounted for 90% of the population attributable risk in men and 94% in women. Similarly, Khot et al. and Greenland et al. examined data from 14 randomized clinical trials (n = 122,458) and 3 prospective cohort studies (n = 386,915), reporting that >80% of patients who developed CHD and ≥87% of patients who experienced a fatal coronary event had antecedent exposure to ≥1 of the 4 conventional cardiovascular risk factors (cigarette smoking, dyslipidemia, hypertension, diabetes mellitus). People with optimal levels of cardiovascular risk factors and lifestyle behaviors at 50 years of age demonstrate a marked survival advantage and only a 5% and 8% lifetime risk of developing CVD for men and women, respectively. Collectively, these data and other recent reports discount the longstanding claim that only 50% of CHD is attributable to conventional risk factors, and suggest that a more rigorous focus on these and the lifestyle behaviors that promote them has great potential to reduce the burden of atherosclerotic heart disease.

**Lifestyle and Mortality in Coronary Patients**

One review of prospective cohort studies and randomized, controlled trials among patients with established CHD sought to provide evidence for a prognostic benefit of lifestyle and dietary recommendations. Effect estimates for smoking cessation, higher levels of physical activity, and moderate alcohol consumption varied from a 20% to 35% lower risk of all-cause mortality. For individual dietary goals, data were too limited to provide reliable effect size estimates. If these estimates reflect the true value, they compare favorably with mortality reductions reported for low-dose aspirin, statins, β-blockers, and angiotensin-converting enzyme inhibitors after AMI. On the other hand, there are no randomized trials showing that alcohol consumption improves health, and the overall harms are well known: addiction, social dysfunction, and motor vehicle accidents. One large-scale study showed that low to moderate alcohol consumption may be associated with an increased risk of cancer in women.

**Cigarette Smoking, Mortality, and Effects of Secondhand Smoke**

A landmark study of 50 years of observation of 34,439 male British physicians found that, on average, cigarette smokers die...
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Similarly, the overweight subjects with impaired glucose tolerance compared an increase in exercise to 30 min/d resulted in a 58% reduction with metformin (850 mg twice daily) compared with placebo. The Diabetes Prevention Program (http://www.ClinicalTrials.gov; NCT00004992) and its long-term outcome study (NCT0038727) will determine whether the lifestyle-induced reduction in diabetes mellitus translates into a reduction in major coronary events.

Impact of Psychosocial Risk Factors on Cardiovascular Disease

An escalating body of research provides compelling evidence for an association of psychosocial factors with risk of CVD and prognosis of patients with CHD. Psychological risk factors such as depressive symptoms, anxiety, and vital exhaustion may worsen or exacerbate the development of CVD through associated unhealthy behaviors and physiological responses (Table) that may lead to clinical consequences, including myocardial ischemia, threatening ventricular arrhythmias, vulnerable plaque, and increased thrombosis potential and inflammation.

Patients with clinical depression are at least 3 times more likely to die during the first year after AMI than are patients without depression. Although the reasons for this are unclear, it appears that patients with depression after AMI are less likely to take prescribed medications and adhere to recommended behavior and lifestyle changes intended to reduce the risk of recurrent cardiovascular events. Moreover, investigators recently reported that depression is associated with a decrement in composite health score that is significantly greater than that associated with other chronic ill effects.
diseases, including angina, arthritis, asthma, and diabetes mellitus. When depression occurred in conjunction with other chronic diseases, it was associated with significantly greater decrements in overall health than the medical condition alone, particularly in persons with diabetes mellitus. Although a recent AHA Science Advisory recommended screening for depression in patients with CVD, there have been no large-scale randomized trials showing that screening prevents major cardiovascular events.

Ineffectiveness of Homocysteine Lowering on the Incidence of Cardiovascular Events

Although homocysteine levels have been directly associated with cardiovascular risk in many observational studies, several randomized, double-blind, placebo-controlled clinical trials have discounted the hypothesis that supplementation with folic acid and other B vitamins that lower homocysteine would prevent acute cardiovascular events. After 7.3 years of treatment and follow-up, Albert and associates found that a combination pill of folic acid, vitamin $B_6$, and vitamin $B_{12}$ did not reduce the incidence of cardiovascular events among 5442 women with prior CVD or $\geq$3 coronary risk factors, despite significant homocysteine lowering. In the Heart Outcomes Prevention Evaluation Trial (HOPE 2), the same homocysteine-lowering treatment did not reduce the risk of major cardiovascular events among 5522 patients aged $\geq$55 years with vascular disease or diabetes mellitus over an average of 5 years. These results are consistent with a prior meta-analysis of randomized, controlled trials performed primarily among men with known vascular disease and do not support the use of B vitamins as preventive interventions for CVD in at-risk populations. The homocysteine story is an excellent example of why prevention enthusiasts must insist on large-scale randomized trials and not rely on biological hypotheses and observational data.

A Cardioprotective Polypill: Need for a Fully Powered Trial?

Wald and Law proposed a theoretical cardioprotective polypill, on the basis of a review of the scientific literature (including $>750$ trials with $\approx 400,000$ participants), as a population strategy to combat CVD. The daily formulation would include a statin, 3 blood pressure–lowering drugs, folic acid, and aspirin, and could theoretically reduce coronary events by 88% and stroke by 80%. Others have reported that a similar polypill (Polycap formulation) effectively reduced multiple risk factors and estimated cardiovascular risk in middle-aged individuals; however, the combined projected risk reductions for coronary events and stroke were lower than the aforementioned estimates, at 62% and 48%, respectively. The investigators emphasized that the effects of the polypill cannot be assumed to equal the combined effects of its individual components. On the basis of the homocysteine report, the expected benefit of including folic acid could also be questioned. More recently, a small, double-blind, randomized, placebo-controlled trial of a polypill reported more modest reductions in lipid levels and blood pressure than anticipated. Because of the independent and additive benefits of lifestyle modification on cardioprotective pharmacotherapies, it has been suggested that treatment with the polypill, or treatment with its components, be accompanied by the following user directions: “Take medication each day in the prescribed dosage, followed or preceded by $\geq 30$ minutes of moderate to vigorous physical activity, in combination with a low-fat, low-cholesterol diet, weight management, and the avoidance or cessation of cigarette smoking.”

Lifestyle Factors Associated With Lower Cardiovascular Risk

According to 2 recent studies, favorable lifestyle factors are associated with dramatically reduced risks of hypertension and heart failure. In the first study, an analysis of data from the longitudinal Nurses’ Health Study II, adherence to 6 lifestyle factors—normal body mass index ($<25$ kg/m$^2$); a low-sodium diet high in fruits, vegetables, and low-fat dairy products; a daily average of 30 minutes of vigorous exercise; modest alcohol intake (up to 10 g/d); infrequent use of nonnarcotic analgesics (less than once per week); and folic acid supplementation (1400 g/d)—was associated with a significantly lower incidence of self-reported hypertension. The authors acknowledged that if these associations were causal and independent, then lifestyle modification could have the potential to prevent a large proportion of new-onset hypertension occurring in young women. Similarly, the PREMIER randomized clinical trial reported that individuals with above optimal blood pressure, including stage 1 hypertension (120 to 159 mm Hg systolic and 80 to 95 mm Hg diastolic), who were not taking antihypertensive medications, can make multiple lifestyle changes that lower blood pressure and reduce cardiovascular risk. In another report, data were analyzed from 20,900 apparently healthy men (mean age at baseline, 53.6 years) in the Physicians’ Health Study who were followed for 22.4 years, during which time 1200 developed heart failure. Men who adhered to $\geq 4$ of 6 healthy lifestyle habits (normal body weight, not smoking, regular exercise, moderate alcohol intake, consumption of breakfast cereals, and a diet high in fruits and vegetables) had a 10% risk of developing heart failure. Men who did not adhere to any of these factors had a 21% risk of developing heart failure.

Because the healthy adherer effect is well known, these reports from observational studies should be interpreted with caution. The Coronary Drug Project showed that individuals who adhere to placebo therapy generally have better health outcomes. Accordingly, people who adhere to healthy lifestyle practices often do better, but it remains unclear whether it is due to the intervention per se.

Air Pollution and Cardiovascular Risk

Numerous epidemiological studies have demonstrated consistent associations between short-term elevations in particulate matter (air pollution) and increases in nonfatal and fatal cardiovascular events, including myocardial ischemia and infarction, ventricular arrhythmia, heart failure exacerbation, and stroke. The pathways linking air pollution exposure to the onset of acute cardiovascular events may be explained by the direct effects from agents that cross the pulmonary epithelium into the circulation, including gases and the soluble constituents of particles (eg, transition metals). Al-
Dietary Pattern and Risk of Cardiovascular Disease

A substantial and expanding body of evidence has now associated a healthy dietary pattern with lower rates of major coronary events and diabetes mellitus. One systematic review found strong evidence of a causal relationship for cardioprotective dietary practices, including vegetables, nuts, and Mediterranean eating patterns, as well as associations for harmful factors, including intake of trans fatty acids and foods with a high glycemic index or load, and CHD. Modest reductions in dietary salt may also substantially reduce cardiovascular events and associated medical costs. Epidemiological and controlled interventional studies have consistently demonstrated the beneficial effects of omega-3 fatty acid consumption, especially the longer-chain fatty acids (≥20 carbons) from marine sources, on cardiovascular endpoints. Moreover, a 2-year study of weight loss diets, using either low-fat, Mediterranean, or low-carbohydrate strategies, reported a significant regression of carotid atherosclerosis, irrespective of the dietary intervention. On the other hand, the Women’s Health Initiative Dietary Modification Trial, the largest long-term randomized, controlled trial of a dietary intervention conducted to date, including 48 835 postmenopausal women aged 50 to 79 years who were followed over a mean of 8.1 years, showed that a dietary intervention that reduced total fat intake and increased intakes of vegetables, fruits, and grains did not significantly reduce the risk of CHD, stroke, or CVD, and achieved only modest effects on CVD risk factors. Nevertheless, subgroup analyses showed positive trends toward greater reductions in low-density lipoprotein cholesterol levels and rates of CHD in women with the lowest intakes of saturated fat or trans fat or highest intakes of vegetables/fruits. Because the trial was designed to test the hypothesis that a dietary intervention could lower rates of breast and colorectal cancer rather than CVD, the investigators suggested that more focused diet and lifestyle interventions may be needed to reduce CVD risk.

Mortality Benefits of Cardiac Rehabilitation in Modern Cardiology

Among older patients with documented CHD who undergo cardiac rehabilitation, mortality rates are generally 21% to 34% lower than among nonusers, and a significant dose-response relationship exists between the number of cardiac rehabilitation sessions attended and cardiovascular outcomes at 4 years. It has been suggested that contemporary thrombolytic and emergent revascularization procedures, which markedly diminish early postinfarction mortality, and newer cardioprotective drug therapies may serve to attenuate the impact of adjunctive exercise-based cardiac rehabilitation. Although a recent review of 48 randomized trials concluded that the mortality benefits of cardiac rehabilitation persist in modern cardiology, meta-analyses like these are suggestive but cannot be considered definitive. Despite the potential survival advantage and related beneficial outcomes, cardiac rehabilitation services remain vastly underutilized among Medicare beneficiaries.

Pharmacotherapies and Lifestyle Modification in Patients With Acute Coronary Syndrome

Although individual drug therapies, such as antiplatelet medications, β-blockers, angiotensin-converting enzyme inhibitors, and lipid-lowering agents, are effective in reducing mortality in patients with acute coronary syndrome, it appears that the combination of these agents may have incremental and even synergistic benefits. Researchers created a composite appropriateness score for 6-month mortality based on the number of drugs used divided by the number of drugs potentially indicated for each patient, as follows: 0, none of the indicated medications used; I, 1 medication used if 3 or 4 medications indicated; II, 2 medications used if 3 or 4 medications indicated or 1 medication used if 2 medications indicated; III, 3 medications used if 4 medications indicated; and IV, all indicated medications used. The odds ratio for death for appropriate levels IV, III, II, and I were 0.10, 0.17, 0.18, and 0.36, respectively. A more recent study reported that adherence to behavioral advice (modify diet, exercise, and quit smoking) after acute coronary syndrome was associated with a substantially lower risk of recurrent cardiovascular events. Collectively, these data suggest that a combination of evidence-based medical therapies and behavioral recommendations in the immediate postevent care of patients with acute coronary syndrome should be given a high priority by physicians and adjunctive healthcare providers.

Physical Activity, Cardiorespiratory Fitness, and Mortality

A recent systematic review and meta-analysis of 33 physical activity studies (n=883 372 participants) reported risk reductions of 30% to 50% for cardiovascular mortality and of 20% to 50% for all-cause mortality, with pooled risk reductions of 35% and 33%, respectively. There are multiple mechanisms by which moderate to vigorous physical activity may decrease mortality rates associated with CVD (Figure 3), including antiatherosclerotic, antithrombotic, anti-ischemic, antiarrhythmic, and psychological effects. Numerous studies also suggest that cardiorespiratory fitness, expressed as metabolic equivalents (1 metabolic equivalent=3.5 mL O₂ per kilogram per minute) is 1 of the strongest prognostic markers in persons with and without CHD. In healthy men and women, each 1-metabolic equivalent increase in exercise capacity confers a 13% and 15% reduction in all-cause mortality and cardiovascular events, respectively. Participants with an aerobic capacity ≥7.9 metabolic equivalents had the most favorable health outcomes. Dutcher et al reported that cardiorespiratory fitness more accurately predicts 5-year mortality than left ventricular ejection fraction in patients with ST-segment elevation MI treated with percutaneous coronary intervention (PCI). On the other hand, a
increased morbidity. Other recent studies emphasize the protective benefits and risks of this widely recommended intervention. Despite several well-designed trials of moderate to vigorous physical activity, in varied populations, would be helpful in further clarifying the occurrence of AMI. Although some obese patients with CVD have lower adverse events and mortality than their metabolically leaner counterparts (ie, the “obesity paradox”), numerous studies now support purposeful weight reduction in this escalating patient subset. With the use of serial data and appropriate follow-up from the National Health and Nutrition Examination Surveys (I, II, III), the Centers for Disease Control and Prevention found that overweight and obesity, particularly high levels of adiposity, were associated with increased mortality relative to the normal weight category. On the other hand, overweight (body mass index 25 to <30 kg/m²) was not associated with increased mortality, a finding recently echoed in patients with CHD. A normal or desirable body mass index is classified between 19.0 and 24.9 kg/m²; however, this is primarily because body mass indexes ≥25 kg/m² are associated with increased morbidity. Other recent studies emphasize the importance of waist circumference as a risk factor for mortality in older adults, regardless of body mass index.

Inflammation, Low-Density Lipoprotein Cholesterol, and Statin Therapy: Implications for Primary Prevention?
Although numerous studies have highlighted the potential role of inflammation in the genesis of CVD and atherothrombosis and there is mounting evidence supported by guidelines of the clinical utility of inflammation assessment with biomarkers such as C-reactive protein, some investigators remain unconvinced that measurement of inflammation markers in practice is useful in risk prediction. The Justification for the Use of Statins in Primary Prevention: An Intervention Trial Evaluating Rosuvastatin (JUPITER) trial enrolled 17,802 men and women without documented CVD or diabetes mellitus with low-density lipoprotein cholesterol levels ≤130 mg/dL, and C-reactive protein levels ≥2 mg/L. The trial was stopped prematurely after a median follow-up of 1.9 years, demonstrating a 44% reduction in incident cardiovascular events and a 20% reduction in all-cause mortality. These data have potential implications for primary prevention by providing treatment to a large segment of the population that would not normally be prescribed a statin. Others contend that a significant proportion of the JUPITER subjects were not healthy, and warranted aggressive management, regardless of the concentration of C-reactive protein. Their analyses suggested that failure to adhere to currently accepted guidelines for care probably resulted in a spuriously high event rate that was conducive to the demonstration of benefit from statin therapy. Optimally designed trials to test the hypothesis of risk reduction with inflammation lowering would require a trial of a specific inflammation-lowering agent or a trial randomizing participants to usual care or to C-reactive protein testing as a guide to treatment.

Value of Percutaneous Coronary Intervention in Stable Coronary Heart Disease? Prevention as a First-Line Strategy to Combat Cardiovascular Disease
Primary PCI, with mechanical revascularization, reduces mortality in patients presenting with AMI. However, in patients with symptomatic or asymptomatic myocardial ischemia, the benefits of elective PCI are not as robust. In 2003, investigators evaluated the 7-year outcome of angioplasty versus medical therapy as the initial treatment strategy for chronic angina. Although symptoms were improved and use of antianginal medications decreased, the incidence of death or MI was slightly higher in the angioplasty cohort than in the medically treated patients, at 7.3% versus 4.1%, respectively.

The Atorvastatin Versus Revascularization Treatment (AVERT) study rekindled the debate concerning the pre-
ferred therapeutic strategy in patients with stable single- or double-vessel coronary artery disease. After 18 months’ follow-up, 22 of the 164 patients (13%) receiving atorvastatin had an ischemic event compared with 37 of 177 (21%) assigned to angioplasty and usual care, signifying a 36% reduction (P<0.05) in the group that received aggressive lipid-lowering therapy. In another clinical trial, men with single-vessel coronary disease were randomized to PCI versus a 12-month exercise program. Significantly higher event-free survival occurred with exercise training (88% versus 70%). Increased exercise capacity, reduced need for hospitalization, and decreased numbers of repeat revascularizations were also noted in patients randomized to the exercise intervention. Accordingly, Green et al suggested the following: “Coronary interventions treat a very short segment of the diseased coronary tree, whereas exercise exerts beneficial effects on endothelial function and disease progression in the entire arterial bed.”

In 2005, Katritsis and Ioannidis performed a meta-analysis of 11 randomized trials, including a total of 2950 patients, comparing PCI with conservative medical management in patients with stable coronary artery disease. In the absence of a recent MI, there was no significant difference between the 2 treatment strategies in terms of death, MI, or the need for subsequent revascularization. The COURAGE trial randomized 2287 patients with objective evidence of myocardial ischemia and stable coronary disease to PCI with optimal medical therapy versus optimal medical therapy alone. Again, lack of mortality benefit from PCI was observed. Similarly, the Bypass Angioplasty Revascularization Investigation 2 Diabetes (BARI 2D) Study Group reported no significant difference in the rates of death and major cardiovascular events among patients with type 2 diabetes mellitus and stable ischemic heart disease undergoing prompt revascularization versus medical therapy alone.

Despite these sobering reports, in 2006, 1.3 million coronary angioplasty procedures were performed at a cost approximating $60 billion, and 448 000 coronary bypass operations were performed the same year throughout the United States, at an estimated cost of $44 billion. Total healthcare spending in 2006 exceeded $2 trillion or $6700 per person, representing 16% of the gross domestic product. This trend is expected to increase at similar levels over the next few years, reaching $4 trillion in 2015 or 20% of the gross domestic product. Thus, in the near future, according to current projections, healthcare will account for $1 of every $5 spent in the United States. Currently, costs associated with chronic diseases (eg, obesity, diabetes mellitus, hypertension, coronary artery disease) account for ~75% of the nation’s annual healthcare costs. Accordingly, we must find ways to implement effective preventive interventions (eg, medications, weight reduction, healthier eating practices, regular physical activity) as a first-line strategy to combat CVD.

Behavioral Interventions and Complementary Preventive Strategies

Behavioral patterns represent the No. 1 factor contributing to premature death, exceeding genetic predisposition, social circumstances, environmental exposure, and access to health-care. Given the estimated number of preventable deaths associated with the health factors comprising the AHA’s Life’s Simple 7, which are cigarette smoking (465 000 per year), hypertension (395 000), obesity (216 000), physical inactivity (191 000), elevated blood glucose levels (190 000), high levels of low-density lipoprotein cholesterol (113 000), and other dietary risk factors, the AHA 2020 Strategic Plan offers an enormous opportunity to improve health system performance and public health. Nevertheless, disparities in health are large in the United States and globally, and strategies to increase national health rankings must focus on the poor and less fortunate.

Unfortunately, the prevalence of optimal levels of risk factors and health behaviors is very low in the US population. The Behavioral Risk Factor Surveillance System reported in 2000 that only 3% of 153 805 adults had 4 of 4 healthy lifestyle characteristics of current nonsmoking, body mass index 18.5 to 24.9 kg/m², consumption of 5 fruits and vegetables per day, and regular physical activity. The rate was lower in blacks than in whites, at 1.4% and 3.3%, respectively. These percentages were even lower in preliminary findings from the Reasons for Geographic and Racial Differences in Stroke (REGARDS) cohort, a national cohort of blacks and whites recruited in 2003–2007. Among 17 326 participants, only 0.5% of blacks and 2.1% of whites met all 4 lifestyle characteristics.

Despite these sobering statistics, behavioral interventions must be complemented by other strategies to further reduce the burden of CVD. Clearly, we have prevented many cardiovascular events by widely prescribing antihypertensive drugs, aspirin, and statins. Intriguing data exist that bariatric surgery may favorably modify risk factors, induce remission of diabetes mellitus, and reduce death rates. In other cases, public laws or policies may lead to better outcomes; examples include taxes on sugary beverages, bans on trans fats, smoking bans, and regulated decrements in salt content of processed foods. The impact of these interventions can be examined by quasi-experimental methods.

Goals of the Prevention Series

The science volunteers of the AHA have become energized early toward the achievement of the AHA 2020 Impact Goal and the role that prevention will have in improving cardiovascular health. Accordingly, this special Prevention series will review new insights in preventive cardiology, lifestyle interventions, and cardiac rehabilitation, with a focus on emerging clinical and psychosocial risk factors, cardioprotective drug and dietary recommendations, smoking cessation, cardiorespiratory fitness/physical activity, and counseling of patients regarding cardioprotective lifestyle changes. The series will explore the independent and additive benefits that may result when aggressive lifestyle modification is superimposed on optimal medical therapy (eg, cardioprotective medications). Interest in this area spans multiple dimensions involving traditional prevention strategies, improving compliance, lifestyle medicine, methods of education of healthcare providers, the built environment (where people live), strategies for health promotion in underserved ethnic groups, including the economically disadvantaged, childhood inter-
ventions, complementary and alternative therapies, and public policy interventions. Figure 2 illustrates a general framework for integration of these activities.

In summary, we hope that the new Circulation series will serve as a stimulus for leaders in preventive cardiology and lifestyle medicine to reflect on current knowledge and propose concepts for well-designed, large-scale randomized clinical trials and quasi-experimental studies that are needed to prove or disprove the many hypotheses listed herein. Equally, we hope that the reader will be stimulated to pursue changing paradigms and perceptions of these important topics. New studies should serve to complement the armamentarium of clinical, public health, and advocacy initiatives that will be needed to achieve further reductions in death from CVD and stroke. The challenge is yours!

Disclosures

None.

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