Editorial

James V. Felicetta, MD
Editor-in-Chief

What's Wrong With My Wife?

Once again, with my long-suffering spouse's permission, I'm going to use her medical history as a jumping-off point for a broader discussion, this time of medical compliance (or noncompliance). You may recall that my poor wife has long suffered from a panoply of ailments ranging from the dermatologic (vitiligo) to the rheumatologic (Sjögren's syndrome) and the infectious (recurrent refractory pulmonary coccidioidomycosis, a true Arizona delight). But among her very most serious diagnoses was an iced-tea induced myocardial infarction (MI) that occurred as a result of very thin, spidery coronary vessels that went into spasm after she consumed an excessive amount of ice-cold tea at a restaurant serving spicy New Mexican cuisine.

I'm an endocrinologist, well-versed in the important role of lipid abnormalities in contributing to vascular disorders, such as an acute MI. And I'm also an administrator, well aware of the increasingly common practice standard that low-density lipoprotein (LDL) cholesterol levels should be driven below 100 mg/dL in patients with known coronary artery disease.

My dear wife has an excellent high-density lipoprotein (HDL) cholesterol level, well over 80 mg/dL and feels that she is completely justified in ignoring her LDL level, which is in the mid-120s. From her perspective, her MI was entirely due to her dietary indiscretion in overdosing on iced tea. She is certain that had she followed the lead of her dining companion (me) in ordering wine instead, she never would have experienced her inferior wall MI.

Perhaps that is true but, from my more cynical medical perspective, she did have an MI, and she needs to do everything possible to reduce the chances of having a recurrent episode.

HDL BUMP

The bone of contention that then arises between us relates to her refusal to take any sort of statin, in any dose, to reduce her cardiac risk. From her perspective, her high HDL level affords more than enough protection, sufficient reason to forgo looking for risk reduction through any lipid manipulation. But, the HDL religion took a big hit recently when the AIM HIGH (Atherothrombosis Intervention in Metabolic Syndrome with Low HDL/High Triglycerides: Impact on Global Health) trial was terminated prematurely because of futility—meaning that the HDL bump produced by adding niacin to statins afforded no additional reduction in vascular risk. That, to me, raises anew the question of whether a raised HDL is really any better than a lower one—even as it confirms that statins are "good stuff" that are hard to improve upon, as we showed in the ACCORD (Action to Control Cardiovascular Risk in Diabetes) trial, when fenofibrate added no additional benefit to statins.

So deep down, my every fiber tells me that every patient with a history of coronary artery disease, who could possibly tolerate a statin, should be on a statin, no ifs, ands, or buts. And, that statin dose should be a generous one to get the LDL level at a minimum, to below 100 mg/dL, and perhaps to under 70 mg/dL in high-risk patients.

REASON TO BE WARY?

There's an additional little fact I should throw into the mix before you conclude that my wife is strictly a nihilistic anti-scientific sort. In 1998, she had an episode of fulminant hepatic necrosis as an idiosyncratic reaction to a leukotriene antagonist, zileuton, prescribed off label for refractory urticaria. She managed to get her bilirubin up to 50 mg/dL and her aminotransferases well above 5,000 U/L.

She first turned yellow, then green, as the bilirubin was converted to biliverdin. She and I also learned about the phenomenon of hepatic frost, wherein bilirubin breakdown products are excreted through the skin to produce a gooey mess, especially in the hair. She was very close to being placed on an emergency liver transplant list before the necrosis stopped and her liver slowly began to heal.

That's why my wife is wary of potentially hepatotoxic drugs, such as statins. But I maintain that serious liver damage from statins is very uncommon—and idiosyncratic. Just because zileuton proved to be a bad actor doesn't mean that a statin would also cause trouble.

MISSING OUT ON THE BENEFITS OF STATINS

A part of me understands my wife's reasoning for refusing to partake in the many wonderful benefits of statins, but my more scientific side decries her self-denial of a potentially life-saving medication. But what about the thousands, if not millions, of patients out there who don't even bother to get their statin prescriptions filled? Or those who tell their providers they have read really bad things about statins on the Internet and won't take them under any circumstances? Or those who take statins for just a short period of time, perhaps just long enough to obtain a

repeat lab test showing that the LDL has dropped significantly? Don't these people get it? They're depriving themselves of a huge opportunity to reduce their risk of nasty cardiac and other vascular outcomes and, perhaps, to avoid a visit from the ever-crouched Grim Reaper, waiting to harvest yet another soul with vascular issues.

THE ART OF MEDICINE

One of the many frustrations of practicing medicine is knowing that we could be obtaining much better outcomes in so many of our patients, if only they would follow our recommendations. Perhaps it reflects a failure on our part to master the art of medicine as opposed to the science of medicine. An important part of our job is not just to prescribe an appropriate medication regimen for our patients, but also to motivate them to actually take the drugs as prescribed. We all could probably do better—certainly the patients, but also we caregivers. I'll keep trying to find ways to convince my wife, and you keep trying to motivate your patients to take the drugs you recommend for them. ●

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this editorial.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom Inc., the U.S. Government, or any of its agencies. The article may discuss unlabeled or investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*