ASK THE EXPERT

Rheumatologists Should Monitor Lipids in RA

Cardiovascular disease is the leading contributor to excess mortality in patients with established rheumatoid arthritis. While the risks of both premature and accelerated atherosclerotic cardiovascular disease in rheumatoid arthritis are not completely explained by traditional risk factors, the increased prevalence of hypertension, dyslipidemia, obesity, smoking, and inactivity are clearly contributing factors.

YUSUF YAZICI, M.D.

Dyslipidemia has been identified as a major culprit. For example, in the QUEST-RA (Quantitative Patient Questionnaires in Standard Monitoring of Patients With Rheumatoid Arthritis) project, disordered lipoprotein metabolism was independently associated with the occurrence of cardiovascular events in the study's 4,363 patients (Arthritis Res. Ther. 2008 March 6 [doi: 10.1186/ar2383]).

Dyslipidemia in rheumatoid arthritis often presents with normal or decreased low-density lipoprotein (LDL) cholesterol, low high-density lipoprotein (HDL) cholesterol, and high triglycerides, similar to that observed in inflammatory and infectious diseases in general, according to Dr. Yusuf Yazici, a rheumatologist at New York University Hospital for Joint Diseases. Additionally, the condition appears to be directly associated with disease activity, whereby higher disease activity is linked to lower total cholesterol levels and further reduced HDL levels, leading to an unfavorable atherogenic index.

Although disease suppression via disease-modifying antirheumatic drugs as well as tumor necrosis factor–blocking agents has been shown to have moderately favorable effects on the lipid profiles of RA patients, additional lifestyle and drug interventions are often warranted to minimize the risk of cardiovascular events, said Dr. Yazici. Unfortunately, cardiovascular screening in patients with rheumatic diseases is not performed routinely, and when it is performed, identified risk factors often remain untreated, leaving patients vulnerable to cardiovascular morbidity and, potentially, mortality. EULAR recently called on rheumatologists to aggressively manage cardiovascular risk factors in patients with RA, AS, and PsA (RHEUMATOLOGY NEWS, December 2008, p. 6).

In this month's column, Dr. Yazici stresses the role of the rheumatologist in the management of dyslipidemia in RA.

RHEUMATOLOGY NEWS: What are the underlying mechanisms for dyslipidemia in rheumatoid arthritis?

Dr. Yazici: The literature is not clear on exactly what happens to the lipid levels in RA patients before, during, or after treatment, yet we know that untreated RA and the associated inflammation leads to increased cardiovascular events and death. As such, every effort should be made to control the conventional risk factors for cardiac events, including dyslipidemia. And the first step to controlling lipid levels is to monitor them.

RN: Who should be monitoring lipid status in rheumatoid arthritis patients?

Dr. Yazici: Rheumatologists should routinely assess their rheumatoid arthritis patients for dyslipidemia and try to correct it through diet, exercise, and, if necessary, medication, working together with the patient's primary care physician and cardiologist.

RN: With respect to treatment of dyslipidemia, should rheumatologists manage the condition or should they refer patients back to their primary care physicians or to preventive cardiologists?

Dr. Yazici: Rheumatologists should take an active role in the treatment of dyslipidemia, working in concert with primary care physicians or cardiologists. As rheumatologists, we also are internists and it is well within our domain to treat this condition, not only in RA but also in systemic lupus erythematosus, where there are also data to suggest increased risk of cardiovascular events and the need to minimize risk factors.

RN: Are statins contraindicated in RA?

Dr. Yazici: Statins have well-defined risk profiles, which of course is need to be taken into account, along with the fact that most RA patients are on DMARDs, which pose potential—though rare—liver problems. The possibility of further increased risk of liver problems with multiple medications has to be considered. Additionally, muscle damage that can be seen with statins has to be considered when RA patients present with muscle pains and weakness. These are all well-recognized risks that can be monitored routinely by rheumatologists. Overall, the benefit of treating hyperlipidemia/dyslipidemia very likely outweighs the small risks associated with treatment.

RN: Are the statin treatment protocols (timing/dosing/monitoring) different for RA patients than the general population?

Dr. Yazici: The treatment protocols are not different. Current guidelines for patients with only elevated levels, or a history of cardiovascular events and elevated levels, and the various other subgroups, should be used when deciding on drug choice and monitoring. ■

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By Diana Mahoney

Tailor Ankylosing Spondylitis Therapy to Patient's Priorities

BY NANCY WALSH

FORT LAUDERDALE, FLA. — The treatment of ankylosing spondylitis should include both pharmacologic and nonpharmacologic modalities tailored to the current manifestations of the disease, and should reflect the wishes and expectations of the patient, according to Dr. Tore K. Kvien.

All domains of health status are affected by the disease, from bodily pain to social functioning, according to findings from a survey of patients with ankylosing spondylitis (AS). Interrupted sleep was the most frequently reported problem, surpassing difficulties in climbing stairs and getting out of bed.

"A way of addressing the complexity of this disease and prioritizing our treatment is by asking not only how the patient feels and is doing, but also asking about their priorities in treatment and what issues are most important to them," said Dr. Kvien, professor of rheumatology, University of Oslo, and past president of EULAR as well as editor of the Annals of the Rheumatic Diseases.

"The optimal management of AS requires a combination of nonpharmacologic and pharmacologic modalities, with nonpharmacologic strategies possibly being more important than in many of the other diseases we treat," Dr. Kvien said at a meeting sponsored by RHEUMATOLOGY NEWS and Skin Disease Education Foundation.

Exercise is crucial for these patients and is most beneficial in a formalized program. An updated Cochrane review of physiotherapy in AS recently concluded that individual home-based exercise is better than no exercise, that supervised group physiotherapy is preferable to home exercise, and that pool exercise followed by group physiotherapy is better than group exercise alone (Cochrane Database Syst. Rev. 2008 Jan. 23;CD002822).

The most effective medical treatments in AS differ from those for rheumatoid arthritis (RA), clinicians have learned. For example, the Assessment in Ankylosing Spondylitis International Working Group recommends nonsteroidal anti-inflammatory drugs as first-line treatment for pain and stiffness, and, as such, NSAIDs represent a more prominent component of treatment in AS than in RA. Corticosteroid injections also are recommended, but evidence does not support the use of systemic steroids for axial disease, said Dr. Kvien, also head of rheumatology, Diakonhjemmet Hospital, Oslo.

Conventional disease-modifying antirheumatic drugs (DMARDs) play a less prominent role in AS, with evidence of their efficacy being much weaker than in RA. Some recent studies, however, have suggested that sulfasalazine or methotrexate may be useful for patients with peripheral arthritis, Dr. Kvien said.

A further difference in treatment strategy compared with RA is that there is no requirement for a prior trial of DMARDs before initiating anti–tumor necrosis factor (TNF) therapy in the patient with a persistently high level of AS disease activity. There also is no evidence that combination therapy with a TNF inhibitor and a DMARD is better than the biologic alone.

All three of the available TNF inhibitors have demonstrated efficacy, and there has been no suggestion from the clinical trials that there are any differences in efficacy among them. One special circumstance is for the patient with acute anterior uveitis, however. "Some data suggest that in a patient with ongoing uveitis, the antibodies [infliximab and adalimumab] may be more effective than etanercept, but if the patient just has a history of one attack, you can use whatever you like," Dr. Kvien said. The same general safety concerns exist for the use of these drugs in AS as in RA, he added.

Increasing experience with TNF inhibitors in AS also has shown that they are associated with greater improvements in health-related quality of life than in RA. "Our data from observational studies have shown that the improvements on all dimensions of the [Short Form Health Survey] SF-36 were greater in patients with AS than in those with RA," he said. Differences were most notable on scores for emotional role, physical functioning, physical role, and vitality (Arthritis Rheum. 2005;52:2506-12).

Drug retention rates for the TNF inhibitors also are better for AS than for either RA or psoriatic arthritis, said Dr. Kvien. In another observational study, unadjusted 1-year retention rates were 77.5%, 77.3%, and 65.4%, in the AS, psoriatic arthritis, and RA groups, respectively, while adjusted hazard ratios for treatment termination were 0.76 for psoriatic arthritis versus RA and 0.66 for AS versus RA (Arthritis Rheum. 2008;59:234-40).

Dr. Kvien disclosed that he receives grant research support from, and acts as a consultant to, several companies, including Abbott Laboratories, Hoffmann-La Roche Inc., and Wyeth.

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