

# Heart Disease Plus Arthritis Increase Inactivity

BY SHERRY BOSCHERT

More than half of adults with heart disease also had arthritis, and they were 30% more likely to be physically inactive than were those with heart disease alone, judging from the findings of a survey of 757,959 Americans.

The Centers for Disease Control and Prevention analyzed data from all 50 states in the 2005 and 2007 Behavioral Risk Factor Surveillance System. In telephone interviews, 3% of respondents said they had been diagnosed with heart disease alone, 23% reported a diagnosis of arthritis alone, 4% said they had both, and 70% had neither.

Arthritis—defined as arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia—was present in 57% of the respondents with heart disease, compared with 27% of the total population (MMWR 2009;58:165-9).

In an interview, rheumatologist John A. Goldman, who was not involved with this study, said that getting patients with

joint pain to increase activity is a priority for his colleagues who treat arthritis. “The CDC’s recent slogan is ‘Exercise, the Arthritis Pain Reliever.’ Exercise is necessary. Working with physical therapists—especially trainers—on weight reduction; nonimpact, loading exercises; [and] bracing” can all help, said Dr. Goldman, who has a private rheumatology practice in Atlanta.

The investigators asked six questions about the frequency and duration of nonoccupational activities of moderate and vigorous activity; respondents who reported no participation in such activities were considered to be inactive.

People with heart disease and arthritis had the highest rate of inactivity (29%) compared with rates of 21% in people with heart disease alone, 18% in people with arthritis alone, and 11% in those who had neither heart disease nor arthritis, according to the MMWR report.

After adjustment for the effects of age, sex, education level, body mass index, and race or ethnicity, inactivity was 30% more likely in those with heart disease

and arthritis, compared with people who had heart disease alone.

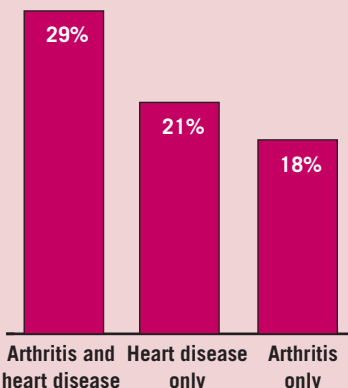
The risk of having one or both conditions increased with age. Men had a higher prevalence of heart disease alone (4%) or heart disease plus arthritis (4%) compared with women (2% and 3.5%, respectively). Women were more likely to have arthritis alone (27%) compared with men (19%). Whites were more likely than blacks to have one or both conditions. Each of these comparisons between subgroups was statistically significant.

According to Dr. Goldman, treating arthritis patients who are at risk for heart disease requires coordination with the patient’s cardiologist and/or primary care physician. The use of anti-inflammatory disease-modifying antirheumatic drugs and also biologic therapies like methotrexate and tumor necrosis factor- $\alpha$  inhibitors decrease the risk of vascular disease, as do traditional cardiovascular drugs like statins, he said. Thus, treatment of both the RA and other inflammatory diseases, and also treatment for lipids, blood pressure, and

diabetes mellitus need to be done in concert, he noted. ■

Associate Editor Denise Napoli contributed to this article.

## Physical Inactivity by Disease Status



Note: Based on a telephone survey of 757,959 adults.  
Source: MMWR

ELSEVIER GLOBAL MEDICAL NEWS

## Screening at Health Fairs Could Identify Early RA

BY DENISE NAPOLI

The combination of the connective tissue diseases questionnaire plus rheumatoid factor and anti-cyclic citrullinated peptide antibody positivity had a 95% sensitivity and 32% specificity for identifying people with at least one swollen joint at free community health fairs.

The study, presented at the Western regional meeting of the American Federation for Medical Research, is one of few to examine rheumatoid arthritis screening techniques in the community health fair setting, where more prevalent conditions, such as diabetes and hypertension, receive more attention. The nonprofit 9Health administers volunteer-driven health fairs in Colorado that offer a variety of free or low-cost screenings to more than 90,000 people per year.

In all, 601 participants (16% of total attendees) were screened at five sites in the Denver area. The researchers administered the 30-item questionnaire (Ann. Epidemiol. 1995;5:297-302) as well as blood tests for rheumatoid factor (RF) and anti-cyclic citrullinated peptide antibody (anti-CCP). The patients’ joints were examined by a rheumatologist who was unaware of the assay and questionnaire results.

Of those screened, 84 people (14%) had one or more swollen joints that would be consistent with possible inflammatory arthritis, said Dr. Kevin Deane of the division of rheumatology of the University of Colorado,

Denver. “Nine met at least four ACR criteria for RA but never had a prior diagnosis,” he said in an interview.

“An additional 15 people had a swollen joint and RF or CCP positivity, but met fewer than four ACR RA criteria. They may have early RA,” he added. And another 41 people had either RF or anti-CCP positivity but didn’t have any arthritis. “So something is going on immunologically, but no arthritis yet,” he said.

“The importance of identifying RA early is growing,” Dr. Deane said, but finding people with early disease remains difficult. “We thought we would try to utilize the health fair to screen a pretty large population.”

The cost of the screening effort is \$42 per person screened, which does not include salaries because the study relied on volunteers. “If you count person-hours into this, this health fair screen cost about \$2,000 to identify each person with RA or inflammatory arthritis,” said Dr. Deane.

“What we don’t know is, is that worth it? We think so; if you identify and treat RA early, you should reduce disability and lost work time. More study is needed to find out the true cost/benefit of this approach,” he said.

A follow-up study aiming to screen 5,000 health fair attendees is planned for later this year. Abbott Laboratories supported the cost of screening and assays, and was a cosponsor of the 9Health Fair, along with Quest Diagnostics Inc. and GE Healthcare. The authors disclosed no relevant conflicts of interest. ■

## Statins May Benefit Arthritis Patients With High CRP

BY SALLY KOCH KUBETIN

NEW YORK — Patients with rheumatoid arthritis and elevated C-reactive protein levels may benefit from treatment with a statin to lower their CRP levels and consequently their risk for a cardiovascular event, regardless of their cholesterol levels, according to Dr. Jeffrey Greenberg.

This insight comes from a review of data from the 2008 JUPITER (Justification for the Use of Statins in Prevention: an Intervention Trial Evaluating Rosuvastatin) study of almost 18,000 people, all of whom had high-sensitivity CRP (hs-CRP) levels above 2 mg/L, but relatively normal LDL cholesterol levels of less than 130 mg/dL. They were randomized to either 20 mg rosuvastatin or placebo.

The trial planned to run 5 years; however, it was stopped after 2 years when the statin dropped LDL cholesterol levels by 50% on average, while CRP levels dropped by 37%. Of clinical note, the patients on the statin had significantly fewer episodes of nonfatal myocardial infarction, any MI, nonfatal stroke, and any stroke (N. Engl. J. Med. 2008;359:2195-207).

Although strictly speaking one might say that the findings from JUPITER cannot be extrapolated to rheumatoid arthritis patients, “clinical trials of this magnitude are rarely conducted in RA populations,” noted Dr. Greenberg. Rheumatologists need to extrapolate what they can from such large and potentially applicable trials, as well as from available and relevant observational studies.

Another compelling finding concerning the role of hs-CRP in increasing heart disease risk emerged after Dr. Greenberg’s

presentation: It was reported from the American College of Cardiology’s annual meeting that JUPITER investigators doing subset analysis said that the effect of the statin on lowering the risk for cardiac events stemmed from its hs-CRP-lowering properties, rather than from its effect on cholesterol.

During his presentation, Dr. Greenberg, a rheumatologist at New York University Medical Center, reviewed an earlier trial’s findings suggesting that statins can act like a disease-modifying antirheumatic drug in RA. TARA (Trial of Atorvastatin in Rheumatoid Arthritis) involved 116 patients, randomized to placebo or 40 mg atorvastatin for 6 months. All patients were on DMARD therapy and some were taking a corticosteroid. Use of a statin reduced all components of their disease activity score, including erythrocyte sedimentation rate, hs-CRP level, swollen joint count, and plasma viscosity. About 30% of patients had a 50% reduction in their CRP (Lancet 2004;363:2015-21).

Findings from recent studies suggest that RA patients are more likely than other patients with cardiovascular disease to have silent myocardial infarctions and sudden death (Arthritis Rheum. 2005;52:402-11). Another study found that RA patients who present with acute coronary syndrome may be more likely than other patients to have a second event and not to survive it (Ann. Rheum. Dis. 2006;65:348-53).

Given their patients’ increased risk for CVD and its propensity for atypical presentation, rheumatologists must increase their vigilance to identify risk factors and intervene to lower them, he said. ■