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Rheumatoid Arthritis, a New Focus on Cardiovascular Risk*



Artritis reumatoide, un nuevo enfoque del riesgo cardiovascular

Dear Editor,

Patients with rheumatoid arthritis (RA) have a greater prevalence of traditional risk factors and 68% more risk of developing a myocardial infarction¹ than the general population, with this risk persisting even when the analysis is adjusted for traditional coronary risk factors.^{1,2} EULAR³ recommendations for the evaluation of cardiovascular risk in subjects with RA propose the application of risk evaluation methods such as, for example, the Framingham type. On the other hand, EULAR recommends special attention to subjects with long-standing RA (over 10 years), rheumatoid factor or anti-CCP antibody positivity as well as those with extra articular manifestations.³

Rheumatologists, in their daily clinical practice, must perform different indices: diagnostic, classification, disease activity, radiological progression, risk for fracture due to frailty (FRAX and others), patient quality of life, etc., to which we add the evaluation of coronary risk.

The 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines⁴ were recently published, which propose “extensive and consistent” evidence on the benefit of the use of statins in order to reduce the cardiovascular risk in subjects with LDLc over 70 mg/dL. Four groups of patients are identified in subjects who would benefit from the use of statins: (1) subjects with clinical cardiovascular disease; (2) subjects with LDLc ≥ 190 mg/dL; (3) diabetics between 40 and 75 years of age with LDLc between 70 and 189 mg/dL and no clinical cardiovascular disease, and (4) subjects with no clinical cardiovascular disease or diabetes, with LDLc between 70 and 189 mg/dL and a 10 year estimated risk of ≥ 7.5%.⁴

Because RA has a cardiovascular risk similar to diabetes mellitus,⁵ that the use of statins provide a modest but significant anti-inflammatory effect,⁶ and that the use of anti-inflammatory drugs (coxibs or non-coxibs) is associated to a greater coronary risk,⁷ we propose that subjects with RA and no clinical cardiovascular disease, with LDLc between 70 and 189 mg/dL and no upper limit for age be considered in group 3 of the four above-mentioned groups, which implies the use of statins in “moderate intensity”⁴ for most of the patients with RA; however, in subjects

with long-standing RA who are rheumatoid factor/anti-CCP positive or have extra articular manifestations who comply with two or more of these criteria, the clinician might consider the use of “high intensity” statin treatment.⁴ These recommendations might be extended to subjects with spondyloarthritis, including psoriatic arthritis.⁸

The use of statins modifies the plasma lipid profile and the cardiovascular risk of subjects with inflammatory arthritis in a similar way than in patients without inflammatory arthropathy and this reduction of extended to RA, spondylitis and psoriatic arthritis⁹; even in subjects with RA who are using statins, the interruption in treatment is associated to an increase in the risk of cardiovascular mortality.¹⁰

In spite of the benefits in cardiovascular risk that, in our judgment, would be provided by statins in subjects with inflammatory arthritides, the clinician must always take into account the possibility of myopathy and especially liver toxicity that may occur in subjects who frequently take other hepatotoxic drugs.

In conclusion, we recommend that all patients with inflammatory arthritis, especially RA, over 40 years of age, with LDLc between 70 and 189 mg/dL and no cardiovascular disease receive statins at a moderate dose and those patients with a particularly high risk (two or more of these conditions: long-standing RA, rheumatoid factor/anti-CCP positivity, extra articular manifestations) receive statins in a high intensity regimen.

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