



EDITORIAL

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Take Your Statins, for Heaven's Sake

It's an extremely common scenario. A patient's screening tests return, showing a significant elevation of the calculated low-density lipoprotein cholesterol (LDL-C), known to the lay public as bad cholesterol. To a physician like myself, someone who prides himself on a modest bit of expertise in lipids, it's an absolute no-brainer. The patient should be placed on statin therapy pronto to reduce the major risks of heart attack, stroke, and other vascular misfortunes that are clearly associated with an elevated LDL-C level.

The tremendous ability of statins to reduce cardiovascular risk is among the best-demonstrated therapeutic effects of any class of medication in any branch of medical practice. The first major trial to show definitive benefits with the use of statins was the Scandinavian Simvastatin Survival Study, which came out in 1994 and showed a 30% relative reduction in cardiovascular events in a high-risk secondary prevention population, meaning that the subjects already had documented vascular disease before entering the trial.

Similar results were reported soon after in primary prevention populations in the WOSCOPS study in the United Kingdom (UK), and from the AFCAPS/TexCAPS studies in the U.S. Then the large UK-based Heart Protection Study showed that statins reduce cardiovascular risk regardless of the initial LDL-C level. Some experts suspected that many of the protective effects of statins were due not only to the LDL-C reduction per se, but also the so-called pleio-

tropic benefits, which included vasodilation, antithrombotic effects, and improved function of the endothelial cells that line the walls of blood vessels.

A number of additional studies have since markedly expanded the role of statins. The CARDS study showed that patients with diabetes had fewer events on statins. The ASCOT study suggested that statins reduce risk in patients with hypertension. And the SPARCL study revealed fewer recurrent events in patients on statins who had experienced a stroke or transient ischemic attack. Perhaps an even greater advance came with the JUPITER study, which showed that patients with elevated C-reactive protein levels—a marker of systemic inflammation—had fewer cardiovascular events when treated with statins than with placebo.

As you can imagine, there are plenty of times when I reach for my prescription pad (actually, my mouse) with the intention of ordering a statin to reduce a patient's cardiovascular risk. But unfortunately, many times the patient catches me up short by objecting to such a plan. I can't tell you how many times a patient responds by asking rather pointedly about the adverse effects (AEs) of statins. Now, I'll readily admit that a small number of patients ask about AEs with any medication, but I would submit that the question comes up far more commonly with statins than it does with almost any other class of medication. Why?

I firmly believe that a huge driver of my patients' irrational suspicions of statins is the drivel that is found on

countless unreliable and unscientific websites. Antistatin nonsense is readily available, and many patients have thoroughly marinated themselves in a toxic slurry of misinformation and medical fantasy. Most of these sites emphasize known statin AEs, such as myalgias and myopathies, liver damage, and rhabdomyolysis, but then grossly exaggerate the severity and frequency. Other sites hammer on the modest number of patients who are nudged from prediabetes to full-fledged diabetes by the statins or rant about medically unsubstantiated AEs of statins, such as worsened mentation and depression.

That's all bad enough, but what's even worse is when patients attack the very medical foundation for prescribing statins, claiming that their online "research" causes them to doubt the reported association between LDL-C levels and cardiovascular risk. They also hint darkly at a vast medical-industrial conspiracy to inflate the true importance of LDL-C, thus allowing for more sales of the highly questionable statins and increased drug company profits. No patient has directly accused me of personally benefitting financially by overprescribing statins, but some have certainly hinted at it.

Another large group of patients declines to take the proffered statins by insisting that they would much rather pursue diet and exercise to bring down their high levels of LDL-C. They are invariably surprised when I tell them that even the most aggressive approaches are unlikely to reduce LDL-C by more than a negligible amount. I suspect that they think that their tired

old doctor has bought into a reflexive pills-cure-all mentality and does not appreciate the wondrous benefits of a holistic approach.

The most annoying patients tell me they will instead take red yeast rice to bring down their LDL-C, because they prefer a “natural” remedy to some monstrous artificial chemical produced in a pharmaceutical company laboratory. When I try to tell them that red yeast rice contains a varying but unknown amount of a natural inhibitor of hMG-coA reductase, the same enzyme targeted with precisely dosed statins, they gape at me with unhidden disgust for completely missing the point: The naturally occurring remedy is inherently superior, precisely because it is naturally occurring!

Of course, I have to remind myself that a good number of patients simply do not want to take statins because it is a reminder of their vulnerability, status as a cardiac patient, or as

a potential future victim of a heart attack or stroke. Some patients find that concept so upsetting that they would rather ignore it altogether.

Reluctantly, I admit that statins are not perfect drugs. But I would still submit that they’re the closest things we have to wonder drugs today. Yes, a fair number of patients do develop myalgias, but these are often mild and transient and can be managed. Very infrequently, patients may manifest some degree of hepatotoxicity, and very rarely rhabdomyolysis can rear its ugly head. Statins can sometimes nudge prediabetes into diabetes, just as thiazide diuretics and beta-blockers will sometimes do. However, on balance, the risk-benefit analysis of taking statins in both primary and secondary prevention settings is very much in favor of taking the drugs.

So my message to my patients (and to your patients as well) is a very simple one. Take advantage of the phenomenal life-saving benefits of these

near-wonder drugs, ignore the unscientific online nonsense authored by individuals practicing medicine without a license, and do what your tired but well-meaning doctor urges: take your statins, for Heaven’s sake! ●

Author disclosures

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