COX-2 Drugs, Other NSAIDs Pose Cardiac Risks

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Physicians need a stronger message about the cardiac risks of treating chronic pain with anti-inflammatory drugs, both traditional NSAIDs and cyclooxygenase-2 inhibitors, according to Dr. Elliott M. Antman and his colleagues.

"We believe that some physicians have been prescribing COX-2 inhibitors as the first line of treatment. …For chronic pain in patients with known heart disease or who are at risk for heart disease, these drugs should be the last line of treatment," they said in a statement.

"I wish I could say to you that everybody has got the message correctly and is now modifying the way they practice, but unfortunately we don't believe that is the case," Dr. Antman, lead author of the statement, said in an interview. He added that this approach should be adopted even for patients with no known heart risks, and that caution should be extended to all NSAIDs. "The regulatory authorities have now put black box warnings on all NSAIDs, except aspirin, and even today many physicians are not aware [the warnings] exist."

The American Heart Association statement updates the 2005 statement and reflects this new information, said Dr. Antman, professor of medicine at Harvard Medical School, Boston. But the document, coauthored by six cardiologists, might not sit so comfortably with physicians who treat chronic pain on a regular basis.

"The point they're making, which I agree with, is that you have to be cautious. But that doesn't mean we can't use these medications judiciously and appropriately. They're looking at it from the cardiologist's view when it's the rheumatologists who are sitting with the patient who is in pain," said Dr. Roland Moskowitz, a rheumatologist and professor of medicine at Case Western Reserve University, Cleveland, in an interview.

The AHA document outlines a stepped-care approach to the pharmacologic treatment of musculoskeletal pain in patients with known cardiovascular disease or risk factors, starting with agents with the lowest cardiac risk. "When acetaminophen, aspirin, and perhaps even narcotic medications (for acute pain) are not effective, tolerated, or appropriate, it may be reasonable to consider an NSAID as the next step; however, this should be coupled with the realization that effective pain relief may come at the cost of a small but real increase in risk for cardiovascular or cerebrovascular complications," wrote Dr. Antman and his colleagues (Circulation 2007 Feb. 26 [Epub doi:10.1161/CIRCULATIONAHA.106.181424]).

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They noted that "if symptoms are not adequately controlled by a nonselective NSAID, subsequent steps involve prescription of drugs with increasing degrees of COX-2 inhibitory activity, ultimately concluding with the COX-2 selective NSAIDs."

Dr. Moskowitz said that most rheumatologists are already well aware of NSAIDs' cardiac risks, but they must also consider gastrointestinal risks and pain control: "You could be very nihilistic and say to the patient 'there's nothing I can give you that's safe' and let them walk out with pain, but that doesn't make sense. [Physicians] are frightening people away from using these things when they need to use them."

The American College of Rheumatology's NSAID guidelines have not yet been updated to reflect recent concerns about cardiovascular risk (Arthritis Rheum. 2000;43:1905-15). But the Osteoarthritis Research Society International's guidelines committee, of which Dr. Moskowitz is cochair, is expected to release its recommendations on osteoarthritis management soon. Dr. Moskowitz doesn't expect these guidelines to be as targeted as the AHA statement: "There are no absolute algorithms. … At low doses, some COX-2 selective inhibitors may have no greater cardiovascular risk than other NSAIDs."

Dr. Antman and his colleagues disclosed no potential conflicts of interest. Dr. Moskowitz has served as a consultant for Pfizer Inc., Novartis, Merck & Co., GlaxoSmithKline Inc., and Sanofi Aventis. ■