CVD Risk in Arthritis Warrants Better Screening

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EXPERT ANALYSIS FROM A RHEUMATOLOGY SEMINAR

SANTA MONICA, CALIF. – The fact that many patients with rheumatoid arthritis are not smokers, have normal lipid levels, are not overweight, and do not have a family history of heart disease belies their elevated risk for cardiovascular disease.

Rheumatoid arthritis (RA) is an inflammatory disease, and physicians need to screen patients with RA more closely for cardiovascular disease (CVD) risks. Unfortunately, practitioners currently lack a screening tool since the Framingham Heart Study risk score falls woefully short of accurately predicting CVD risk in patients with RA, Dr. Sherine E. Gabriel said at a meeting sponsored by Skin Disease Education Foundation (SDEF) and the University of Louisville.

With colleagues at the Mayo Clinic, Dr. Gabriel is developing just such a tool for screening RA patients. In an interview, Dr. Gabriel didn't divulge details of the tool, because it is still being tested. She advised physicians, for now, to screen their RA patients for CVD risks using standard laboratory tests and to intervene earlier than in other populations.

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A new score is needed to predict CVD risk in RA, said Dr. Sherine E. Gabriel.

Severe, intractable RA often goes hand-in-hand with elevated risk for CVD. The patient who is positive for rheumatoid factor and always has an elevated level of C-reactive protein and a high erythrocyte sedimentation rate needs early intervention. Some physicians may want to consider using echocardiogram to screen for early signs of heart failure while it may be still treatable, said Dr. Gabriel, professor of medicine and epidemiology at the Mayo Clinic, Rochester, Minn.

Many of the insights into CVD risk in RA come from studies that Dr. Gabriel and other Mayo Clinic investigators have conducted over several years. The Mayo Clinic has followed a cohort of 1,179 residents of Olmsted County, Minn., who were diagnosed with RA between 1955 and 2007. The researchers compared the patients' rates of heart disease and survival with those of three other cohorts: 1,179 people without RA, 852 people with congestive heart failure, and 3,256 people with acute myocardial infarctions. Overall, survival among the RA patients was significantly shorter than would have been expected, particularly in women (Arthritis Rheum. 2003;48:54-8).

A second longitudinal study of residents of the city of Rochester, Minn., which is in Olmsted County, followed 603 patients with RA beginning when they were an average of 58 years old. During a mean follow-up of 15 years, 354 patients died, and CVD was the primary cause of death in 176 patients. The increased risk for CVD was associated with three markers of systemic inflammation: erythrocyte sedimentation rate above 60 mm/hour on three consecutive measurements, the presence of RA vasculitis, and the presence of RA lung disease (Arthritis Rheum. 2005;52:722-32).

In another study, 603 residents who were diagnosed with RA were significantly more likely to have been hospitalized for acute MI or to have experienced unrecognized MIs in the 2 years before diagnosis than were controls during a corresponding 2-year period. After diagnosis, RA patients were twice as likely to experience unrecognized MIs and sudden deaths and less likely to undergo coronary artery bypass grafting compared with non-RA subjects (Arthritis Rheum. 2005;52:402-11).

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