

Childhood Trauma Raises Risk Of Adult CHD and Depression

BY MITCHEL L. ZOLER
Philadelphia Bureau

VIENNA — Childhood trauma was an independent predictor of coronary heart disease and major depression later in life in a study with 360 men.

“Childhood trauma can have important consequences, but it is a risk factor that physicians don’t usually think about,” Dr. Viola Vaccarino said while presenting a poster at the annual congress of the European Society of Cardiology.

“Once a person is identified with a history of childhood trauma, that person needs to be monitored very closely. Our data [suggest] that childhood trauma may be a key history to ask about,” said Dr. Vaccarino, a professor of medicine and epidemiology at Emory University, Atlanta.

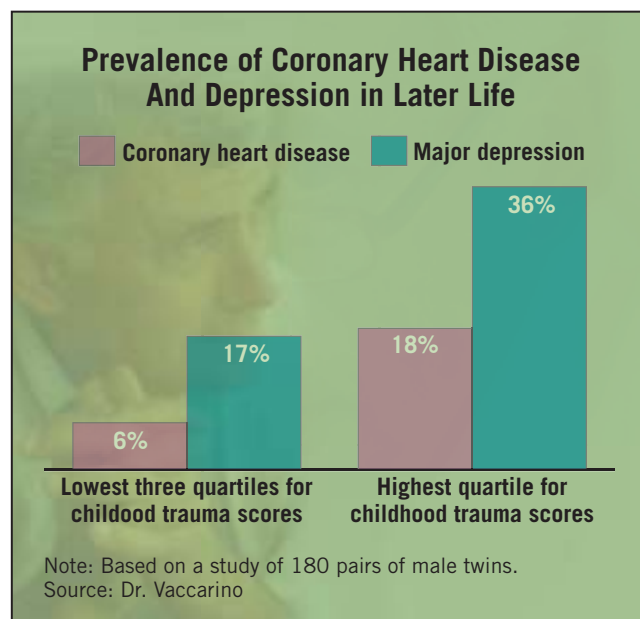
The study by Dr. Vaccarino and her associates used 360 male twins (180 pairs, either mono- or dizygotic) who were born in 1946-1956 and were enrolled in the Vietnam Era Twin Registry. The participants were interviewed at Emory University. They were assessed using the Early Trauma Inventory (ETI), a measure of traumatic events occurring before age 18 years, and the Late Trauma Inventory (LTI), a measure of traumatic events that occur when a person is aged 18 years or older. Physical health was assessed by examination, and mental health was assessed with the Structured Clinical Interview for Psychiatric Disorders. In all, 33 participants were diagnosed with coronary heart disease (CHD), 82 were diagnosed with major depressive disorder, and 23 had posttraumatic stress disorder. The participants were divided into quartiles based on their ETI scores.

The analysis showed that the men in the three lowest ETI quartiles had a 6% prevalence of CHD compared with an 18% rate in the quartile with the highest ETI score. When adjusted for age and smoking history, the men in the highest quartile for childhood trauma had about a twofold increased rate of CHD, compared with men with lower ETI scores, a statistically significant difference. (See box.)

A second analysis showed that men in the quartile with the greatest childhood trauma were also about twice as likely to have major depression, compared with men with lower ETI scores, also a significant difference, said Dr. Vaccarino, who is also director of EPICORE (Emory Program in Cardiovascular Outcomes Research and Epidemiology).

Initially, an excess of CHD and depression was also seen in men who had high scores on the LTI. But when the LTI analysis was adjusted for the prevalence of early trauma, the link between the LTI score and CHD and depression disappeared. In contrast, a strong link was also seen between high LTI scores and posttraumatic stress disorder, but this link was not affected by adjustment for ETI scores. Childhood trauma can occur in the form of physical abuse, emotional abuse, sexual abuse, or general trauma, which is caused by events such as earthquakes and car accidents.

These findings suggest primary care physicians should routinely ask patients about trauma exposures as children. They may even want to administer the ETI, which has recently been streamlined to a single-page questionnaire, Dr. Vaccarino said in an interview. ■



CVD Affects About 6 Million U.S. Diabetics

BY MIRIAM E. TUCKER
Senior Writer

Cardiovascular disease affected approximately 6 million diabetic adults aged 35 years and older in the United States in 2005, according to the Centers for Disease Control and Prevention.

Researchers at the CDC analyzed data from the National Health Interview Survey on the prevalence of heart disease, stroke, and other cardiovascular diseases among persons with diabetes during 1997-2005. In that period, the age-adjusted prevalence of diagnosed diabetes in the United States increased 43%, from 3.7% in 1997 to 5.3% in 2005, according to the report (MMWR 2007;56:1129-32).

During 1997-2005, the annual number of survey respondents aged 35 and older who reported having both diabetes and CVD ranged from approximately 3,700 to 6,800 (out of a total of 31,000-36,000). Although the prevalence of individuals with both disorders did increase overall by 36% during the study period, the age-adjusted overall prevalence actually decreased by 11%, from 37% to 32.5%. The drop indicates that the number of people diagnosed with diabetes during that time exceeded the number with both diabetes and CVD, the report explained. ■

Broken down by age group, the age-specific prevalence of self-reported CVD among those aged 35-64 years with diabetes decreased by 14%, from 31% in 1997 to 27% in 2005, while the prevalence did not change significantly over time in older groups (from 46% to 51% in individuals aged 65-74 and from 53%-57% among those aged 75 and older).

Overall during the study period, the age-adjusted prevalence of CVD was higher among men than women, higher among whites than blacks, and higher among non-Hispanics than Hispanics. The age-adjusted prevalence decreased significantly in women (by 11%) but not in men, and in blacks (by 25%) but not in whites. It also decreased significantly among non-Hispanics (by 12%), while there was no clear trend among Hispanics, according to the CDC.

The decrease in self-reported CVD prevalence among diagnosed diabetic patients may relate to the fact that the median duration of diabetes has declined significantly overall. Also, decreases in risk factors such as total cholesterol level, blood pressure, and smoking may contribute, along with the increased use of preventive medications such as statins and aspirin, the report noted. ■

No Clear Benefit From Rosuvastatin for Heart Failure Patients

BY JEFF EVANS
Senior Writer

Treatment with rosuvastatin in older patients with moderate to severe chronic ischemic heart failure due to left ventricular systolic dysfunction did not reduce the risk of death from cardiovascular causes or the rate of nonfatal myocardial infarctions and stroke in the randomized Controlled Rosuvastatin Multinational Trial in Heart Failure (CORONA) presented at the annual scientific sessions of the American Heart Association.

Data from studies of statin use in patients with ischemic or nonischemic heart failure have suggested the use of statins is associated with better outcomes and beneficial effects on left ventricular function and clinical status, said the CORONA investigators.

“Doctors took for granted that statins should work in everyone with coronary artery disease,” including those with heart failure, even though there had been no placebo-controlled trial of statins in heart

failure patients, said Dr. Åke Hjalmarson, at a news conference at the meeting. The results were published concurrently with the news conference in the *New England Journal of Medicine* (N. Engl. J. Med. 2007 Nov. 5 [Epub doi:10.1056/NEJMoa0706201]).

But the reportedly low rates of myocardial infarctions in patients with ischemic heart failure (despite having high rates of coronary artery disease), as well as possible adverse effects of the drugs, have called the use of statins in these patients into question, reported Dr. Hjalmarson of the University of Oslo, and his coinvestigators.

They were concerned with possible adverse effects of rosuvastatin on the function of skeletal and cardiac muscle, the kidneys, and the liver, but found muscle-related symptoms and elevations in creatine kinase and alanine aminotransferase levels occurred at similar rates between the rosuvastatin and placebo groups. The drug also did not further reduce LDL cholesterol in patients with already low levels.

These factors suggest “clinicians should

continue [prescribing] statins for patients with ischemic heart failure and left ventricular systolic dysfunction,” said Dr. Masoudi.

The patients had a mean age of 73 years and for entry into the study, had to be at least 60 years old, have chronic heart failure due to ischemia with a New York Heart Association class of II-IV, and an ejection fraction no more than 40% (no more than 35% in class II patients); the investigators also had to think that a patient did not need treatment with a cholesterol-lowering drug.

At the end of the trial’s median follow-up time of nearly 33 months, there was an 8% relative reduction in the primary outcome—a composite of death from cardiovascular causes, nonfatal myocardial infarction, and nonfatal stroke—in the treated patients, a nonsignificant difference. In the 2,514 patients treated with 10 mg/day rosuvastatin, 692 reached the primary end point, compared with 732 of the 2,497 patients who received placebo. The event rates (number of events per 100 patient-years of follow-up) were 11.4 and 12.3 for the treated and placebo patients, respec-

tively. This effect was consistent across a range of different subgroups of patients.

In a post hoc analysis, rosuvastatin significantly reduced the total number of fatal and nonfatal myocardial infarction and stroke events, compared with placebo (227 vs. 264). For rosuvastatin-treated patients, this translated into a 16% lower relative risk than placebo-treated patients. The drug had no significant effect on cardiovascular mortality, which accounted for 68% of all events in the primary composite outcome, said Dr. Hjalmarson, professor of cardiology at the Wallenberg Laboratory for Cardiovascular Research at Sahlgrenska University Hospital, Göteborg, Sweden. “The major etiology of cardiovascular deaths ... may be a primary electrical event relating more to ventricular dilatation and scarring and not to a new atherothrombotic event.” Many of the researchers reported getting consulting, advisory board, and/or lecture fees from AstraZeneca, which funded the study and makes rosuvastatin. ■