Atorvastatin reduces arterial stiffness in patients with rheumatoid arthritis

S Van Doornum, G McColl, I P Wicks

Background: Chronic systemic inflammation may contribute to accelerated atherosclerosis and increased arterial stiffness in patients with rheumatoid arthritis (RA). In addition to lowering cholesterol, statins have immunomodulatory effects which may be especially beneficial in patients with RA who have systemic immune activation.

Objective: To investigate the effect of atorvastatin on the augmentation index (AIx; a measure of arterial stiffness) and systemic inflammation in RA.

Methods: 29 patients with RA (mean (SD) age 55 (13) years) with moderately active disease of long duration were studied. AIx, lipid levels, serum inflammatory markers, and disease activity score were measured before and after 12 weeks of atorvastatin 20 mg daily.

Results: AIx improved significantly from 34.1 (11.6)% to 29.9 (11)% (p = 0.0002), with the greatest improvements in AIx occurring in those subjects with the highest disease activity scores (r = −0.5, p = 0.007). Total and LDL cholesterol were reduced from 5.5 (0.9) to 3.9 (0.7) mmol/l and 3.3 (0.8) to 1.9 (0.6) mmol/l, respectively (p = 0.0001). Serum inflammatory markers remained unchanged during the study.

Conclusions: Atorvastatin significantly reduced arterial stiffness in patients with RA. The greatest improvements were seen in patients with more active disease, suggesting that, in addition to the beneficial effects of cholesterol reduction, immune modulation may contribute to the cardioprotective effect of statins.

PATIENTS AND METHODS

Patients

Twenty nine subjects (9 male, 20 female) with RA according to criteria of the American College of Rheumatology were recruited from the Royal Melbourne Hospital Rheumatology clinic. Exclusion criteria were age <18 years, current treatment with lipid lowering drugs, contraindication to statins, renal or liver failure, pregnancy, and cancer. The study was approved by the institutional ethics committee and written informed consent was obtained from all subjects.

Study protocol

Subjects took atorvastatin 20 mg daily for 12 weeks and attended for assessment on three occasions: week 0 (before starting atorvastatin), week 6, and week 12. Arterial stiffness was measured at each visit by pulse wave analysis (PWA) as described below. Fasting venous blood was drawn after PWA for measurement of erythrocyte sedimentation rate (ESR), CRP, lipid levels (total, high density lipoprotein, low density lipoprotein (LDL) cholesterol, and triglycerides), liver function, and creatine kinase. Disease activity was measured with the 28 joint disease activity score (DAS28), a validated composite score incorporating tender and swollen joint count, ESR, and a patient global assessment of disease activity (100 mm visual analogue scale). A DAS28 <1.6 indicates remission, whereas a value ≥4.3 suggests active disease.

Abbreviations: AIx, augmentation index; CRP, C reactive protein; DAS28, 28 joint disease activity score; ESR, erythrocyte sedimentation rate; LDL, low density lipoprotein; NNT, number needed to treat; NO, nitric oxide; PWA, pulse wave analysis; RA, rheumatoid arthritis
Pulse wave analysis

PWA was performed using the SphygmoCor apparatus (Atcor Medical, Sydney, Australia) by a single trained investigator (SV) using the standard technique. Subjects attended in the morning after an overnight fast. Blood pressure was recorded in the supine position after several minutes of rest. Radial artery waveforms were recorded from the wrist of the dominant arm using a high fidelity tonometer (Millar SPT-301, Millar Instruments, Houston, Texas). Data were collected directly into a portable computer and when 20 sequential waveforms were acquired the integral software generated an averaged peripheral and corresponding central waveform using a validated transfer function. An augmentation index (AIx), a measure of systemic arterial stiffness, was calculated by the integral software as the difference between the second and first systolic peaks, expressed as a percentage of the pulse pressure. The mean of three measurements of the AIx was used in data analysis.

Reproducibility of same-day measurement of AIx as performed by SV was evaluated in 29 people (not the study subjects) before the start of the present study. The mean (SD) AIx for this group was 23.7 (12.5)% and the within observer difference (mean (SD)) was 1.1 (3.0)%.

These results compare favourably with data reported by other investigators. Wilkinson et al evaluated the same-day reproducibility of AIx in 33 subjects. The mean AIx for the study group was 19.6 (12)% and the within observer difference (mean (SD)) was 0.49 (5.4)%.

In a reproducibility study of AIx in 100 healthy subjects by Rietzschel et al the correlation coefficient between first and second measurements of AIx was 0.95.

Statistics

Results are expressed as mean (SD) unless otherwise indicated. Differences in variables before and after atorvastatin treatment were examined by the two tailed, paired t test. Correlation between AIx and reported variables was calculated using regression analysis. Statistical significance was inferred at p<0.05.

Table 1 summarises the results obtained.

Table 1: Demographic details of the 29 patients with RA

| Age (years) | 55 (13) |
| Sex (F:M) | 20:9 |
| Disease duration (years) | 13.5 (9.6) |
| Rheumatoid factor positive, No (%) | 23 (79) |
| Erosions present, No (%) | 23 (79) |
| Nodules present, No (%) | 12 (41) |
| Current smoking, No (%) | 5 (17) |
| Hypertension, No (%) | 12 (41) |
| Diabetes mellitus, No (%) | 1 (3) |
| Known coronary artery disease, No (%) | 1 (3) |
| Body mass index (kg/m²) | 29 (5) |

Current drugs

| NSAI D, No (%) | 19 (66) |
| Cyclooxygenase-2 inhibitor | 13 |
| Non-selective | 6 |
| Prednisolone treatment, No (%) | 13 (45) |
| Mean dose (mg/day) | 7.0 |
| D AWARD, No (%) | 27 (93) |
| Methotrexate | 20 |
| Leflunomide | 8 |
| Hydroxychloroquine | 5 |
| Sulfasalazine | 3 |
| Intramuscular gold | 4 |
| Azathioprine | 1 |

*Data are mean (SD) unless otherwise stated.

RESULTS

Table 1 shows the baseline demographic and clinical characteristics of the subjects with RA. All subjects enrolled in the study attended for the week 6 visit. Three subjects discontinued the study drug between weeks 6 and 12 and did not provide week 12 data. The reasons for withdrawal were rash, a flare of RA requiring high dose prednisolone, and an elective total hip replacement. For these subjects week 6 data were used in the final analysis; however, analysis of the data excluding these three subjects did not alter the findings.

Table 2 summarises the results obtained.

Lipids, inflammatory markers, and clinical parameters

As expected, total and LDL cholesterol were reduced from 5.5 (0.9) to 3.8 (0.6) mmol/l and 3.3 (0.8) to 1.8 (0.5) mmol/l, respectively, after 6 weeks of atorvastatin (p = 0.0001) and remained essentially unchanged at week 12. No changes in pulse rate, blood pressure, ESR, CRP, or DAS28 were seen during the study.

After 6 weeks of atorvastatin the AIx improved significantly from 34.1 (11.6) to 30.6 (11)% (p = 0.0002). A further minor improvement in AIx was seen at week 12 (AIx 29.9 (11); p = 0.0002 for comparison with baseline). Expressed as a percentage change from baseline, this is equivalent to a 12% reduction in arterial stiffness after 12 weeks of atorvastatin treatment. There was a significant correlation between the change in AIx and the baseline DAS28, with the greatest reductions in AIx occurring in those subjects with the highest DAS28 (r = -0.5, p = 0.007; fig 1).

There was no correlation between the change in AIx and other baseline variables or changes in lipid levels or DAS28.

Arterial stiffness

At baseline there were significant correlations between AIx and age, pulse rate and height, which are known determinants of arterial stiffness (table 3). No relationship was demonstrated between baseline AIx and blood pressure, ESR, CRP, lipid levels, or DAS28.

DISCUSSION

This is the first study to examine the effect of statin treatment on arterial stiffness in RA. We found that 6 weeks of atorvastatin treatment significantly reduced arterial stiffness in these patients with RA. Arterial stiffness is a marker of vascular dysfunction and is an independent risk factor for cardiovascular disease. Increased arterial stiffness has been demonstrated in association with vascular risk factors such as smoking, hypertension, hypercholesterolaemia, and diabetes. Atorvastatin treatment significantly reduced arterial stiffness in these patients with RA. Arterial stiffness is a marker of vascular dysfunction and is an independent risk factor for cardiovascular disease.

Arterial stiffness therefore appears to be a promising surrogate marker of cardiovascular disease in patients with RA.

The determinants of arterial stiffness are not fully understood, but may include structural and functional components. The endothelium, elastin, and collagen fibres within the intimal medial layers and arterial wall smooth muscle cells all contribute to arterial stiffness. Greater proportions of collagen as occur in more peripheral arteries, or degeneration of elastin fibres as occurs with age, result in increased arterial stiffness. Hypertrophy of smooth muscle cells or increased smooth muscle tone, or both, increases arterial stiffness.

The endothelium, mainly through production of nitric oxide (NO), exerts an important functional influence on arterial stiffness. A number of investigators have demonstrated that inhibition of NO synthesis, by infusion of N(G)-nitro-l-arginine methyl ester (l-NAME) or l-N(G)-monomethyl arginine (l-NMMA), increases arterial stiffness.
Table 2 Results at baseline, week 6, and week 12 of atorvastatin treatment*  

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline</th>
<th>Week 6</th>
<th>Week 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
<td>135 (17)</td>
<td>135 (18)</td>
<td>136 (20)</td>
</tr>
<tr>
<td>Diastolic blood pressure (mm Hg)</td>
<td>83 (7)</td>
<td>84 (8)</td>
<td>84 (7)</td>
</tr>
<tr>
<td>Mean arterial pressure (mm Hg)</td>
<td>102 (10)</td>
<td>103 (10)</td>
<td>102 (11)</td>
</tr>
<tr>
<td>Pulse rate (beats per minute)</td>
<td>69 (10)</td>
<td>71 (9)</td>
<td>69 (12)</td>
</tr>
<tr>
<td>Total cholesterol (mmol/l)</td>
<td>5.5 (0.9)</td>
<td>3.8 (0.6)†</td>
<td>3.9 (0.7)†</td>
</tr>
<tr>
<td>LDL cholesterol (mmol/l)</td>
<td>3.3 (0.8)</td>
<td>1.8 (0.5)†</td>
<td>1.9 (0.6)†</td>
</tr>
<tr>
<td>CRP (mg/l), median (range)</td>
<td>3 (1–41)</td>
<td>3 (1–26)</td>
<td>5 (1–34)</td>
</tr>
<tr>
<td>ESR (mm/1st h), median (range)</td>
<td>18 (1–41)</td>
<td>18.5 (1–77)</td>
<td>21.5 (1–70)</td>
</tr>
<tr>
<td>Augmentation index (%)</td>
<td>34.1 (11.6)</td>
<td>30.6 (11.6)</td>
<td>29.9 (11.6)</td>
</tr>
<tr>
<td>Disease activity score (DAS28)</td>
<td>4.6 (1.3)</td>
<td>4.4 (1.4)</td>
<td>4.4 (1.7)</td>
</tr>
</tbody>
</table>

*Data are mean (SD) unless otherwise stated; †p = 0.0001 for comparison with baseline data; ‡p = 0.0002 for comparison with baseline data.

Table 3 Multiple regression analysis for determinants of baseline AIx  

<table>
<thead>
<tr>
<th>Variable</th>
<th>Regression Coefficient</th>
<th>SE</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>0.38</td>
<td>0.11</td>
<td>0.0002</td>
</tr>
<tr>
<td>Height (m)</td>
<td>−46.1</td>
<td>13.5</td>
<td>0.0002</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>−0.45</td>
<td>0.15</td>
<td>0.0007</td>
</tr>
</tbody>
</table>

r² for the group = 0.59, p<0.0001.
immunomodulatory effects of statins may be an important (NNT = 983).11 These intriguing data suggest that the and statins translates into improved cardiovascular outcomes for patients with RA (and indeed other patients with chronic inflammation). Whether the observed reduction in arterial stiffness with patients even in the absence of increased cholesterol levels, reduces the incidence of major coronary events in diabetic disease: the Scandinavian Simvastatin Survival Study (4S). 1994;148:170–84.

CONCLUSIONS Cardiovascular disease is a major cause of mortality and morbidity in RA. The present study provides important new evidence that atorvastatin improves arterial stiffness in patients with RA and that the vascular benefit of atorvastatin is greater in those patients with more active disease. It has recently been shown that statin treatment significantly reduces the incidence of major coronary events in diabetic subjects even in the absence of increased cholesterol levels, and statin treatment has been recommended in this patient group. Likewise, statin treatment may be advisable in patients with RA (and indeed other patients with chronic systemic inflammation) even in the absence of hyperlipidaemia. Whether the observed reduction in arterial stiffness with statins translates into improved cardiovascular outcomes for patients with RA requires further study.

ACKNOWLEDGEMENT Supported by the National Health and Medical Research Council and Pfizer Australia.

Authors’ affiliations

5 Van Doornum, M Collin, P Wicks, Department of Rheumatology, The Royal Melbourne Hospital, Parkville, Victoria, Australia.

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