Heart to Heart: Experts Discuss Cardiovascular Risk in Rheumatoid Arthritis

Podcast Transcript

Dr. Fleischmann: Welcome to RheumNow. This podcast is sponsored by AbbVie, US Medical Affairs. I'm Dr. Roy Fleischmann, and I'm a Clinical Professor of Medicine at the University of Texas Southwestern Medical Center in Dallas and Co-Medical Director of the Metroplex Clinical Research Center in Dallas. I'm joined today by Dr. Christina Charles-Schoeman, a fellow rheumatologist. Christina, could you please introduce yourself?

Dr. Charles-Schoeman: Absolutely. Hi, Roy. My name is Christina Charles-Schoeman. I'm a Professor of Medicine and Chief of the Division of Rheumatology at UCLA.

Dr. Fleischmann: Thanks, Christina. Highlighted by recent studies, cardiovascular risk in patients with rheumatoid arthritis is a hot-button issue and top of mind to many rheumatologists. Our goal today is to discuss how we can mitigate cardiovascular risk in our patients with RA while controlling their disease activity. Christina, please reiterate why you feel it's important to us, as rheumatologists, to be thinking about cardiovascular risk in our patients with rheumatoid arthritis?

Dr. Charles-Schoeman: Roy, I think there are a couple of main reasons. The most important is that cardiovascular disease is the most frequent cause of death in patients with RA. The risk is 50% higher in these patients than the general population. They're more likely to develop cardiovascular disease and to experience cardiovascular events, including heart failure, myocardial infarction, and stroke.

The second reason is that we're the people who are seeing these patients. They trust us. Many of my RA patients do not see their primary care provider regularly, but I'm seeing them every few months. So, I think we do share a responsibility to address this very frequent cause of death in patients with RA.

I saw a patient the other day, a 65-year-old woman. She's got longstanding RA, 20 years. She's seropositive, she's hypertensive, her blood pressure is modest control at best, 145 over 82. And, her LDL cholesterol is right around 160 milligrams per deciliter. Father died of an MI at 50, BMI's borderline at 30. She's sedentary because of low back pain and doesn't exercise. And she doesn't see her primary. She has real cardiovascular risk factors that have to be addressed and that can be modified, and I think we don't have to do that all in one visit, but we have to start the conversation and we have to start the process, to improve that patient's outcome.

Dr. Charles-Schoeman: Roy, can you discuss some of the other characteristics that may increase cardiovascular risk in certain patients with RA?

Dr. Fleischmann: Yeah. So I think that you actually touched on most of them. Patient characteristics, including co-morbidities and lifestyle choices such as prior cardiovascular events, older age, smoking, hypertension, and diabetes contribute to cardiovascular disease risk in patients with RA.

There have been multiple studies over the years which have stressed that the risk of cardiovascular disease in patients with RA is markedly increased in patients who have higher disease activity as well as those with seropositivity. This is primarily because inflammation in RA promotes arteriosclerosis and vascular dysfunction that leads to cardiovascular disease.

When I was in training, which was prior to the widespread use of methotrexate, so you could do the math to see how long ago that was, I was taught that patients with RA had an 8 to 50 year decreased survival, primarily due to the systemic complications of active RA, and this was mainly due to cardiovascular disease.

Interestingly, there was a recent report from Scandinavia that, mortality has significantly improved in patients with RA over the past ten years, primarily due to more active and effective treatment of their RA and mitigation of their other risk factors. And the decrease in mortality was primarily due to decrease in their cardiovascular disease. Therefore, throughout treatment I keep all of these factors in mind to continually assess each of my patient's individual cardiovascular risk, and mitigate as best as I can.

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Dr. Fleischmann: So, Christina, how do you typically assess cardiovascular risk in patients with RA?

Dr. Charles-Schoeman: You know, I start very simply, Roy, with getting a non-fasting lipid panel. I'm seeing these patients every few months. I'm getting labs every few months. I get a quant LDL, and the rest of the non-fasting lipid panel. I do this at least once a year and I do it more frequently if there are abnormalities or if I'm changing therapy.

Our center has the AHA/ACC guidelines following the LDL quant in the report, so anything greater than 100 milligrams per deciliter in an LDL gets flagged for evaluation and for discussion. And I show the results to the patient, and that's how I initiate the discussion about cardiovascular risk, about the AHA guidelines for statin therapy.

What I find is I start the discussion at one visit. Many RA patients don't want to go on additional therapy, and this becomes a topic of discussion when we check these lipid panels as we move forward. And that's how you start the process. I also work with some great cardiologists who help me to take that further.

Dr. Fleischmann: So Christina, you're in a center that actually focuses on this. I have heard from many community rheumatologists that this is actually up to the PCP to do. I happen to agree with you, right, that at least I need to start the discussion, I need to identify the patient and yes, then I probably will refer them back to the cardiologist, but I'll still make sure that whatever suggestions that they've made have actually been followed by the patient.

Do you think that that's an appropriate way of doing it? Or do you think the PCP should be doing it? What should a rheumatologist be doing?

Dr Charles-Schoeman: I think it varies greatly. We have some great primary care providers that make my life easy, and they're on it, and they address it, and I don't need to do a thing. Then there are other circumstances where the patient themselves may have a great primary, but they never see the primary. They don't trust the primary. They don't want to go to another doctor's visit and so if a patient is in that category and they're not seeing a primary care doctor, then I think we have to do something.

We can't ignore the fact that they haven't had a lipid panel in three years. And while, certainly, we counsel the patient on the importance of seeing the primary care provider, if it's not happening, then I think it falls to us to at least get the process started with a simple lipid panel and a referral to a nice cardiologist if there are some abnormal findings. So, at the end of the day, we don’t add all that more to our plate, if we’re in a busy practice and we can’t do all of that appropriate screening and follow-up.

Dr. Fleischmann: So, I agree with you, and I think that you hit on a very important point, and that is the patient's reluctance to actually follow through. But I don't have access to the things that I could show the patient and say, here's the problem. It's like an X-ray of the hand, Here's the problem. But what I do is I start out by saying every article on rheumatoid arthritis starts off with rheumatoid arthritis it's a systemic inflammatory disease. And we talk about the systemic manifestations, primarily the cardiovascular risk. So, I think that we're both on the same page. Rheumatologists should identify and suggest the patient be followed really carefully, and if they aren't, probably take control.

Dr. Charles-Schoeman: Yeah, Roy. I think you bring up a great point If we don't start the conversation in the setting of their RA and their inflammation related to the RA, I don't think we get there very effectively.

Dr. Fleischmann: Yeah. So that brings up the question of what's the relationship, between disease activity and RA and cardiovascular risk. As we stated before, reducing RA disease activity, especially achieving true remission, is measured either by the ACR/EULAR definitions of remission, including either Boolean remission or CDAI remission, have been shown to reduce the risk of cardiovascular disease significantly, and this has been noted in multiple studies, including a post hoc analysis from a large prospective safety study of RA patients.

And these reports, patients with RA in remission have been observed to have a comparable risk of cardiovascular disease versus patients without RA. It's also been reported that remission in RA correlates with improved cardiovascular function with improvement in markers of cardiovascular disease risk in patients in remission versus those with continued disease activity. And as I noted previously, better disease control in recent decades has led to improved cardiovascular disease outcomes, especially mortality.

So Christina, although as rheumatologists, disease control is always top of mind, it's not the whole picture for mitigating cardiovascular risk for our patients. What steps can rheumatologists take to help patients with RA mitigate their overall cardiovascular risk?

Dr. Charles-Schoeman: Yeah, it's a great question. I think there are really simple things that we can do as we see these patients time and time again over many years and beyond the RA disease activity just picking away at the risk factors, if they're smoking, you ask them how many cigarettes they're smoking now, and you continue to have at it each time that they come to the visit.

I had a patient years ago who was long term smoker, known him for about 15 years, and he showed up one visit and I asked him how many cigarettes he was smoking, and he said, “I quit.”

I couldn't believe it. I said, “Why did you quit?”

He said, “Because I couldn't drive down here one more time, and have you ask me how many cigarettes I was smoking,” and boy, you know, persistence pays off.

But I think that these constant ongoing conversations without feeling you have to manage every single cardiovascular risk factor and provide all the patient’s education in one visit where you just don’t have the time to get through your day. It’s not realistic. But again, some reminders about known cardiovascular risk factors.

I think the other thing I find very important and effective is having a good cardiologist as part of the team, a cardiologist who patients like, who understands the risk associated with RA, and who can perform that cardiovascular risk assessment for you and give further information so you're not the sole provider with the responsibility that we're not really trained for as rheumatologists.

I think that’s really effective and helps you get through the visit and address a really important cause of morbidity and mortality in our patients.

Dr. Fleischmann: Yeah, so you make some really interesting points. And thinking back, patients don't like the part of the discussion where I talk about diet, or I talk about exercise, or I talk about smoking cessation. They don't like that. It's a very difficult conversation and there are different ways of handling it. But I do think that you're right, that you have to constantly talk about it. I usually turn around and say, “It's my job as a physician to inform you. What the risks are. It's your job to either follow it or not follow it.” But, my responsibility is to keep telling you about this.

Charles-Schoeman: I agree. I agree, 100%. I think the one way that I have found some impact on diet has been when we've gone over the cholesterol, and 99% of patients do not want to start a therapy to lower their cholesterol. But, they will ask me, what can I do to lower that? And then we get at targeted things in their diet that may increase their cholesterol, and that sometimes gets me there in terms of moving towards a healthier diet and feeling like they're doing something to get them out of taking another therapy. Sometimes that gets me forward.

Dr. Fleischmann: I think that that's a reasonable point, but then it depends upon where you are regionally. So, in Southern California.

Dr. Charles-Schoeman: Here we go, that’s right.

Dr. Fleischmann: People don't want to take another medication.

Dr. Charles-Schoeman: Roy, I'm from the Midwest. I know. Beef and potatoes. I grew up in Ohio. I got you. I got you.

Dr. Fleischmann: But here in Texas, patients don't like to give up the diet. So, I actually do turn around and say you have two choices. All right. One choice is change your diet. The other is, is you can take a medication. And I actually find that more patients will take the medication than change their diet.

Dr. Charles-Schoeman: Oh, I got you. I got you. I agree. Everybody, everybody's different. And I think that persistence, gentle persistence, you know, bringing it up, not every visit, every other visit, just putting it on the chart to revisit it at some point. And I think we will make slow progress if we do that, without adding a big burden to our clinic visit.

Dr. Fleischmann: Right. So, I think the point that we're making is you have to give the patient options.

Dr. Charles-Schoeman: Absolutely. If they drive their treatment plan, it's going to be more effective.

Dr. Fleischmann: Christina, you brought up multiple excellent points that really highlights the importance of working to mitigate cardiovascular risk in our patients with RA. Thank you so much for taking the time to join me today.

Dr. Charles-Schoeman: Roy, it's always a pleasure. Thanks so much for inviting me.

Dr. Fleischmann: And, if you'd like to learn more about cardiovascular risk, there's a downloadable summary of some of the topics we've discussed today on the RheumNow *Therapeutic Updates* page. Thank you for listening today.