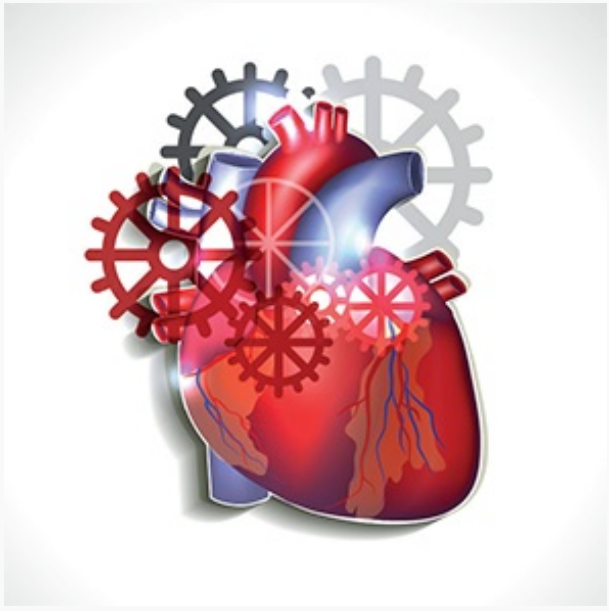
Heart Disease: Major Risk Factor for Many Rheumatology Patients

Vanessa Caceres October 14, 2015

Rheumatic diseases, such as rheumatoid arthritis (RA), systemic lupus erythematosus (SLE) and vasculitis, can affect the body in many ways, but perhaps the most serious is the increased risk of heart disease for many patients.



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As the risk of atherosclerosis in autoimmune disease patients gains increased attention, rheumatologists and cardiologists are collaborating more often to refer patients to each other and, at some institutions, see patients in a combined clinic.

The ultimate goal is to decrease inflammation to control rheumatic disease and lower the risk for heart disease, says cardiologist Donna Denier, MD, Franklin Square, N.Y. “When you see a reduction in inflammation, you see a reduction in cardiac mortality as well,” she says.

The Challenges

Although rheumatologists focus on the joints, it’s only natural to evaluate the patient as a whole person with preexisting conditions or risk factors that could be caused by rheumatic disease, says rheumatologist Orrin Troum, MD, Providence Saint John’s Health Center, Santa Monica, Calif.

Of course, patients with a disease such as RA who are also at increased risk for cardiovascular disease can’t be cured overnight. These patients bring a number of challenges, in addition to the usual challenges of treating inflammatory disease.

“One major challenge includes awareness of the increased risk and initiating the conversation with the patient about the need for risk assessment and management,” says Eric Matteson, MD, rheumatology chair at Mayo Clinic, Rochester, Minn.

Patients with RA or related diseases may not even know they are at greater risk for cardiovascular disease, but the risk is almost equal to the increased risk that diabetic patients have, Dr. Denier says. Additionally, cardiovascular signs may appear at an earlier age in these patients than in a normal patient population.

Another challenge is evaluating a patient’s medications that could further increase the risk for heart disease. For example, rheumatologists often prescribe steroids, which do not interact well with the aspirin or anti-platelet drugs a cardiologist might prescribe, Dr. Denier says.

Additionally, certain drugs used to treat RA, such as prednisone, can increase risks to the heart, says rheumatologist M. Elaine Husni, MD, MPH, director, Arthritis & Musculoskeletal Treatment Center, Cleveland Clinic, Cleveland.

Some RA drugs may cause worsening or death in established heart failure patients, says Sabahat Bokhari, MD, associate professor of medicine-cardiology, and director of nuclear cardiology, Columbia University Medical Center, New York Presbyterian Hospital, New York.

Patients often express hesitancy about using multiple medications at the same time, which makes treatment difficult, says Joan M. Bathon, MD, director, Division of Rheumatology, Columbia University College of Physicians and Surgeons, New York.

“A patient may feel they don’t need cholesterol-lowering medication or may say that the cholesterol meds make their muscles feel worse,” Dr. Troum says.

As patients are commonly told to lose weight, change their diet, and exercise more—be it to help their joints or decrease the risk of heart dangers—there are the usual barriers to accomplishing those, Dr. Bathon says. “They’re no different from other patients [in that way],” she says.

When to Refer to a Cardiologist

Although it may have been common in the past to wait for a heart problem to emerge before referring a patient to a cardiologist, the emphasis now is on quicker preventive care, says cardiologist Guy Mayeda, MD, Good Samaritan Hospital, Los Angeles. He’s seen many patients who have damage to the heart or blood vessels but are not yet symptomatic. “The sooner they get referred to a cardiologist, the better the patient can improve with a collaborative effect,” he says. In that kind of patient, the cardiologist will recommend the rheumatologist prescribe aggressive therapy to get the inflammation under control, he adds. The cardiologist may also see early signs of such problems as a pericardial effusion, in which fluid accumulates around the heart and compresses it, leading to possible death if untreated, Dr. Mayeda says.

Although many clinicians preach the value of preventive care, what actually happens in practice can depend on one’s setting, says Dr. Bathon, who has done research related to heart problems in rheumatic disease. In one scenario, the rheumatologist may take an interest in treating cholesterol or related heart issues. However, with everyone tight on time and with guidelines about cholesterol levels ever in flux, this does not happen that often.

A second option is referring patients to a cardiologist simply because their disease puts them at a higher risk. “That works well in academic centers, but many cardiologists are unaware of the risk,” Dr. Bathon says.

In his area, Dr. Troum has seen the primary care physician (PCP) serve as the quarterback to decide which other specialists a patient may see. Dr. Troum will advise that a patient with RA or a related disease see a cardiologist, but then the PCP ultimately makes the call.

In a third scenario that’s increasing in popularity, the patient can visit collaborative clinics and be seen by specialists from both sides of the fence, Dr. Bathon says.

Collaborative Care at Clinics

Some institutions with joint rheumatology–cardiology clinics include Mayo Clinic, Cleveland Clinic and Johns Hopkins in Baltimore.

“This greatly fosters coordination of care and better management and permits a more systematic evaluation and collection of relevant data in these patients,” says Dr. Matteson. “Something we see a lot is that because of the dominance of the rheumatic disease in terms of symptoms and the effect on day-to-day life, other important health aspects, such as cardiovascular disease assessment, are often neglected.” This motivated specialists to have the combined clinic, he says.

At Cleveland Clinic, the connection is made with the help of electronic medical records, Dr. Husni says. When tracking information about a person diagnosed with lupus or psoriatic arthritis, for example, an electronic best practice alert reminder pops up and prompts the physician to refer to preventive cardiology. By doing this for at least five years, Cleveland Clinic has been able to raise patient awareness about cardiovascular risk factor screening and management, and specialists are looking more closely at novel biomarkers that could reveal who is at greater risk for

heart disease, Dr. Husni says.

Moving Forward

More sophisticated diagnostic tools will help make heart risks associated with rheumatic disease easier to spot, Dr. Bokhari says. “There has been a great deal of advancement in non-invasive imaging for the diagnosis of rheumatoid heart disease. With the help of echocardiography, cardiac MRI, and radionuclide imaging, symptomatic patients can be diagnosed,” he says.

As rheumatologists and cardiologists move toward greater collaboration at the practice level, there are also more efforts to research issues of joint interest.

For example, there’s research underway to investigate whether methotrexate can reduce the rate of second heart attacks compared with placebo, Dr. Bathon says. There is also a clinical trial now to compare etanercept (Enbrel) with tocilizumab (Actemra) to evaluate the risk for heart disease in RA patients, adds Dr. Bathon, who is a former editor of the journal *Arthritis & Rheumatology.*

Researchers are still trying to track why patients with certain rheumatic diseases are at greater risk for heart issues—and why certain patients are at an even higher risk beyond the traditional risk factors, such as smoking or being overweight, Dr. Husni says.

There’s also a large trial underway called PRECISION to assess the cardiovascular effects of daily celecoxib (Celebrex) and ibuprofen compared with naproxen, which are commonly used in RA and osteoarthritis patients for arthritis pain, says Dr. Husni (Cleveland Clinic is a sponsor of the trial). The prospective study involves more than 22,000 patients at increased risk of developing cardiovascular disease. Results should be reported in about a year, she says.

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