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Do Celebrity Heart Attacks Influence Public Health?

LIPID LUMINATIONS

You are listening to ReachMD, the Channel for Medical Professionals. Hi, this is Dr. Ian Goldberg, president of the National Lipid Association and I would like to welcome you to Lipid Luminations hosted by Dr. Larry Kaskel presented by the National Lipid Association.

Celebrities often influence the way we dress, but when a celebrity dies of a heart attack, do they impact the way we take care of ourselves? When a public figure dies from a sudden heart attack, our media-obsessed society can't get enough of the details. While it is clear that celebrities can influence fashion, do they actually have an impact on how we take care of our health? My guest today is Dr. James Ehrlich. Dr. Ehrlich is a chief medical officer of Atherotech Inc and he is an authority in the integration of imaging, physiologic, and laboratory technologies with conventional office-based assessment. Dr. Ehrlich has delivered over 150 lectures to physician audiences in 3 continents during the past 5 years and is also director and founding member of the Society of Atherosclerosis Imaging.

DR. LARRY KASKEL:

James, welcome back to Lipid Luminations.

DR. JAMES EHRLICH:

Thank you.

DR. LARRY KASKEL:

So, when someone dies that is well known from a heart attack and as you know many people are dying of a heart attack every day, but these are the guys that get the attention. What happens with the Coronary Risk Assessment Center? Do they see more patients for a week or two and then it kind of dies down again?

DR. JAMES EHRLICH:

Exactly, I think you get a temporary blip. I think people basically live in a state of denial and they have to relate strongly to the individual, who has succumbed to a heart attack to send the message that they should be checked. So, in general, these centers are seeing patients, who have colleagues that seem more fit than they are, suddenly drop dead or a marathon runner that they know or a family

member. So, the wake-up call, there is really very little call to action for early detection. Most of us are sitting in front of the television set with a bag of doritos and to get somebody to find out information that might scare them is not easy. So, when we hear about celebrities, generally there is a feeling of vulnerability.

DR. LARRY KASKEL:

If it can happen to them.

DR. JAMES EHRLICH:

If it can happen to them, presumably they have the best doctors in the world. Presumably, they have fitness trainers and are eating right and all those things. There is a marked transmission of this feeling of vulnerability, which affects a lot of people early on and then within a period of few weeks, there is the general dismissal of that information and people go back to their normal thing.

DR. LARRY KASKEL:

We go back to the denial of death.

DR. JAMES EHRLICH:

Right.

DR. LARRY KASKEL:

In my practice, it is usually either the next-door neighbor or a brother or like you said a colleague at work that was fine one day and the story is always the same. They went in, they had a stress test. They were told they were fine, next day they drop dead. So, let's talk about that whole stress test concept. Let's do a thallium stress test, someone passes it. You and I both know you can pass it with flying colors and have, you know, 20 vulnerable plaques that are 30% stenotic.

DR. JAMES EHRLICH:

That's right and that is the usual situation, so the overwhelming majority of the people who are asymptomatic will pass every stress test in the world in the weeks prior to their devastating event and when we look it the other way, which is what about people who have true indications for a thallium stress. A very important study by Dan Berman and his colleagues over Cedars-Sinai looked at that situation and the majority of individuals, who pass their stress test, who would have been told you are fine actually have a CHD equivalent amount of plaque and they have enough coronary atherosclerosis as measured by electron beam tomography that they have the same risk as somebody who has already had a heart attack. So, if you were at high enough risk to get a thallium, you should expect to pass it in most cases. In this study 92% of people actually passed their thallium and yet a full 56% of them had a coronary calcium score of greater than 100, so they were really at high risk and yet would have been told by most physicians, congratulations you passed your stress test.

DR. LARRY KASKEL:

So, I think the thallium should be saved for someone, who is symptomatic to see if they have obstructive disease.

DR. JAMES EHRLICH:

That's right and that's the recommendations of most societies. I think it's a greatly over-utilized test, the concern is also radiation. We are talking to about equivalent to about 800 chest x-rays with a thallium.

DR. LARRY KASKEL:

Hmm.

DR. JAMES EHRLICH:

And about 250 to 350 with a Cardiolite. So, this is not a trivial amount of radiation and it should be reserved for those people who you are now trying to make a decision, is this obstructive

coronary artery disease.

DR. LARRY KASKEL:

And what about how much radiation do we see and just a cardiac calcium scan versus a CTA.

DR. JAMES EHRLICH:

The cardiac calcium scan, if it's done with electron beam tomography, it is 0.7 mSv, which is about 14 chest x-rays. If it's done with a 64-slice scanner, about triple the amount of radiation, still not a huge amount.

DR. LARRY KASKEL:

So, it sounds like it is less than a thallium.

DR. JAMES EHRLICH:

Oh, much, much less and then a CT angiogram is generally in the neighborhood of about 400 to 500 chest x-rays, about 14 mSv, depending on technique. Now, there is a very promising pill that has just been developed by a group of radiation biologists and antioxidant scientist that will be broadly promoted in the next few months that one can take before any imaging procedure and will very satisfactorily abolish or quench the free radicals that are generated by ionizing radiation and so.

DR. LARRY KASKEL:

And that's named, sir?

DR. JAMES EHRLICH:

And that is called Bio-Shield developed by Premier Micronutrient Corporation at Nashville Tennessee. So, it's a very nice pill that will be available fairly soon.

DR. LARRY KASKEL:

Let's pick a celebrity. One celebrity that we are all familiar with, the recent death of Tim Russert. According to Tim's physicians, he was in good care. His lipids, if you looked at his lipids, were pretty good. He was on a statin. His HDL probably could have been higher. We know that he did have atherosclerotic disease. I think he did have a coronary calcium scan at one time, but it seems like we failed him. It seems like we did not do enough.

DR. JAMES EHRLICH:

Well, you know, Tim was taken care of by a very good clinician in Washington DC, who thought highly enough of early detection that he ordered an EBCT heart scan way back in 1998, and it was at that time that we knew that Tim was a CHD equivalent and had more plaque that 94% of man of his age. So, conventional therapy from 1998 to very recently would be to put somebody on a plaque-stabilizing drug and that's what was done and Tim had a good response to that as far as LDL lowering. Now, it's only really been in the last few years that we have appreciated the concept of residual risk and Tim Russert could be considered a poster child for this concept.

DR. LARRY KASKEL:

By just looking at him?

DR. JAMES EHRLICH:

Ya, he had metabolic syndrome and in talking to his doctor, he probably also did have sleep apnea, although was never tested. It was recommended to him. So, Tim had the criteria for metabolic syndrome and we know now that if an Epo-B had been looked at, that would have been still very high, even in the phase of an LDL of 68, which is what his LDL was 6 weeks before he died. He passed the stress test repeatedly including 6 weeks before his death.

DR. LARRY KASKEL:

Sir, as we know that most people will.

DR. JAMES EHRLICH:

Ya and so he is an example of how aggressively subclinical disease can progress and so his

calcium score might have been in the 1000s a couple of years ago.

DR. LARRY KASKEL:

And other things, if you look at him, there are some that questioned that he had just written from a long flight from Italy and that is somehow sitting on a plane and being at a high altitude somehow may have triggered some sort of prothrombotic milieu leading to a clot.

DR. JAMES EHRLICH:

Oh, this is very possible. We should think about coronary heart disease as having 2 basic elements. There is atherosclerosis, which he clearly developed, the development of plaque and then there is thrombosis and there is a triggering event, so atherosclerosis in a sense loads the gun and a rupture of plaque or some triggering episode can pull the trigger and so it very well could be that this kind of stress ultimately ruptured a plaque. I think the lesson really is that we are in a new era now. Tim was treated by conventional therapy that most people would believe was adequate, but he went through probably 8 or 9 years of subclinical coronary atherosclerosis progression and then really in the last year of his life, he was on triple therapy. He was on Niaspan, he was on fibrates, he was on statins. So, it's amazing, we are now in a new era where people coming in now with coronary disease or evidence of risk factors can be treated more aggressively because LDL lowering is just not enough.

DR. LARRY KASKEL:

All right, so I want to know what else we can do for these people. If he is on triple therapy, we have got his lipids under control, he is on an aspirin, let's say he is on his fish oil, is there something else that we should be thinking about that may be not FDA approved that might improve his antioxidant levels so that we are still kind of maximizing what we are doing for him.

DR. JAMES EHRLICH:

Well, I think, in the case of Russert, it is hard to undo 9 years of what turned out to be monotherapy with therapy that was actually more aggressive in his last year. So, unfortunately he slipped through the cracks. Most of us who are aggressive consider adding things like fish oil and getting LDL as low as possible. Looking at residual risk factors and doing advanced lipid testing, may be there is something we are missing LPa.

DR. LARRY KASKEL:

But he would have been covered for that.

DR. JAMES EHRLICH:

Yeah, he would have been covered with everything.

DR. LARRY KASKEL:

And even if he had, you know, small dense LDL particles on his advanced lipid test, he would have been treated for that. So, perhaps if we check the fibrinogen on him, perhaps if we check an insulin level on him, those things may have been high.

DR. JAMES EHRLICH:

They probably would have been, but even then you could argue that they were covered near the end and he was treated as if he had metabolic syndrome. He could have been tested for sleep apnea and treated that way. He could have had an LpPLA2 inflammatory biomarker to see if he had active inflammation. Obviously, he probably did near the end.

DR. LARRY KASKEL:

What would James Ehrlich have done if he came to see you exactly as he was besides saying all right I need to get a sleep apnea test on you, what else could you have done?

DR. JAMES EHRLICH:

Hopefully, I would have instituted the therapy as soon as I appreciated the value of combination lipid therapy. I would have looked at advanced lipids and done inflammatory biomarkers and see if they were elevated. I would have gotten LDL may be down to about 50 and certainly the new guidelines developed by the American Diabetes Association, American College Of Cardiology suggested in patients with severe metabolic syndrome the Epo-B should now be below 80 and that would be my goal is to get Epo-B whatever measures that are necessary, I would have added a fibrate fairly early because of the diet course study, a study that looked at diabetes and looked at combination therapy of statins and fenofibrate. Certainly, I am a big believer in Niaspan, so my goal would have been to get his Epo-B below 80. Also, to make sure that he had an inflammation under control, so I would have ordered an LpPLA2 and advanced lipid test, looked at Epo-B and obviously mention sleep apnea if he had it, he would have had one of the modalities and then we measured to make sure that that's under control.

DR. LARRY KASKEL:

James Ehrlich of Atherotech, thank you again for coming on Lipid Luminations. It was a pleasure talking with you.

DR. JAMES EHRLICH:

Thank you.

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