Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/living-rheum/cardiovascular-disease-comorbidities-in-spa/13337/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Cardiovascular Disease & Comorbidities in SpA

Announcer:
You're listening to ReachMD. This episode of *Living Rheum*, titled "Cardiovascular Disease in SpA" is sponsored by Novartis US Clinical Development and Medical Affairs. The host and speaker have been compensated for their time. This program is intended for health care professionals.

Here's your host, Dr Anisha Dua.

Dr Dua:
Hypertension, dyslipidemia, and obesity can be frequent in patients with spondyloarthritis, or SpA for short, leading clinicians to believe that there may be an increased cardiovascular risk in these patients.[1] These comorbidities have led to poor patient-reported outcomes, worse treatment response, and increased mortality, making it more important than ever for clinicians to better understand cardiovascular risk.[1,2]

This is ReachMD, and I'm Dr Anisha Dua. Joining me to discuss cardiovascular risk in SpA is Dr Elaine Husni. Dr Husni is an Associate Professor, Director of the Arthritis and Musculoskeletal Center at the Cleveland Clinic. Dr Husni, thanks so much for being here today.

Dr Husni:
Thanks, Anisha. Really great to be here. Excited to talk about these topics.

Dr Dua:
So am I. So, let's dive right in, Dr Husni. Can you tell us about some of the cardiovascular issues that are found in SpA patients, and what in particular puts them at increased risk of cardiovascular disease?

Dr Husni:
Yeah, this is such a big topic. I think in general, cardiovascular disease has been shown in multiple research studies to really have an increased incidence in our patient population, so, not only spondyloarthropathies, but also rheumatoid arthritis and lupus.[3,4] And so, there's been a lot more recent studies that have really looked at the complications, in regards to spondyloarthropathy. Those are including atherosclerosis, conduction disturbances, as well as the traditional leading to myocardial infarction.[1,5,6] So, we really need to become almost like mini-cardiologists nowadays in trying to understand what are these traditional risk factors, how do we pick them up in our patients, and how do we best screen for cardiovascular disease so that we can avoid some of these complications.

Dr Dua:
Those are really good points. There's a slew of different types of cardiovascular complications, which I know you touched on, and hopefully through this talk, we'll be able to talk in more detail about ways we can try to identify it, and ways we can try to prevent this in our patients. So, let's start with some of the medicines.

So as we know, some of the medications that we use, like NSAIDs, are important for disease control, especially in the spondyloarthritidies, but we know that these can affect cardiovascular disease risk.[5]

So, how do you go about balancing some of the medications that we need to use to try to control the disease activity with the risks that they might have in terms of affecting cardiovascular health, or causing cardiovascular complications?

Dr Husni:
Sure. I mean, NSAIDs are something we use a lot both personally and with our patients, right? If you have a headache or you have

some sort of muscle ache, you would take an NSAID. But I think the main problem in spondyloarthropathy is that there's a role for more chronic use in these patients. And what can we do to really mitigate some of their risks when you're taking it chronically, 'cause that's when we are most worried about increasing your blood pressure, or changes in your creatinine clearance, and so really need to better understand what the long-term use, what we can be doing.[7,8] I do think that there are certain subgroups of patients that I probably avoid chronic NSAIDs. So that would be patients that might be on a blood thinner or might have a previous history of a stomach ulcer where taking an NSAID chronically may cause more complications. But there are also groups of people where I think it is a little safer—better tolerated, I should say—and that's, sort of, in our younger patient population who's never had any stomach ulcers, not on any concomitant meds that can cause some increased incidence of cardiovascular disease. So, I think this is really a clinical, sort of risk-benefit ratio, that we do with our patients, because certainly in spondyloarthropathy, chronic NSAIDs can be very, very helpful, but we have to weight that against the risks.

Dr Dua:
Are there any other classes that you think we should touch on, or be aware of, when we're thinking about cardiovascular risks in our SpA patients?

Dr Husni:
Yeah, so there's been a lot now looking at COX-2 selective inhibitors versus traditional, nonsteroidal anti-inflammatory medications that we see, And we do have to keep in mind that the COX-2 selective inhibitors were really developed to improve on the gastrointestinal side effects. And unfortunately the cardiovascular effects are what's sort of been under scrutiny with some of these selective COX inhibitors, and there are several large trials looking at the differentiation between these.[9] And I think the message is that we really need to try to go at the lowest dose in the shortest amount of time period as we can with these, and maybe give people breaks every once in a while. But I do think that in certain patient populations, a COX-2 selective can be very helpful in those that have more GI side effects and then having more regular monitoring in those that are on chronic NSAIDs.

So, checking their blood pressure, checking their renal function, and their LFTs, so that we know that we can safely continue these NSAIDs.

Dr Dua:
Yeah. No, that, that makes sense. You just touched on my next question. What are some of the screening tools that you can recommend for looking for these cardiovascular complications, or these comorbidities, in our patients? I know you mentioned checking some of their blood tests—are there any other things that you specifically counsel patients on, or check in terms of bloodwork, or imaging studies, or anything else that, that helps you in your screening for cardiovascular complications?

Dr Husni:
So, I think it's important to, you know, just do the basics first, which are what I consider the, the traditional risk factors, so that's checking your cholesterol, checking your blood pressure, and looking at your renal and liver function tests. Also, of course, doing an exam as well, and I think those are the important things that we can pick up on, that's easy for us to do in our clinics, as well as looking at the medications that they're on, and then some obvious risk factors, such as, stop smoking, and counseling them on that because we know that that's been shown to really make diseases harder to treat. So, I think raising awareness of this connection that you're talking about, between cardiovascular complications, comorbidities, and patients with spondyloarthropathy, would be a first important step.

Dr Dua:
Absolutely, I totally agree. I'm trying to figure out, you know, working with our other providers, whether our patient is really focusing their care with us as rheumatologists, whether they have a primary care doctor that they consistently see and relate to, and that they trust. So basically figuring out who their team is to try to make sure we're approaching the patient from all the different angles that need to be covered, and not missing any gaps. Thank you for that. We spoke about the cardiovascular risk, and screening tools for our SpA patients. But let's take a look at prevention strategies.

So, Dr Husni, what are some ways that we can reduce this cardiovascular risk in our patients?

Dr Husni:
Yeah, so I think, you know, as we are thinking about cardiovascular risks, there are also things that patients can do. And so I've been, you know, a huge proponent of looking at different wellness strategies that can also help in that prevention world.

So, if their BMI is not in the normal range, then I do think that elevated BMI is a risk factor for being more insulin sensitivity, risk factors for having high blood pressure. So I think getting to a more normal weight would be one example of things to strive for, talking about nutrition and diet. And then, of course, there's also things that can increase your risk, such as a sedentary lifestyle, so talking about movement and exercise. And then there's also things, like, that can be really helpful, if you're a smoker you should stop smoking. So I

think there's a lot of education that needs to be done. I don't think you can do that all in one visit, and I'm not saying that we should all become, sort of, mini-wellness instructors, but I think it's important to educate the patient and then to provide them avenues, depending on what they need, in terms of some of these wellness strategies for prevention, and maybe refer and work in a team.

Dr Dua:
Yeah. No, absolutely, working with our cardiologists, working with our primary care providers and like you said, all of those things are super important, and seem like a lot to try to tackle in one visit, it's definitely something that the benefit we have is that we have longitudinal relationships with these patients, right? And so, we can kind of bring up different issues as they arise, or as long as we're hitting all the different areas. But you mentioned a lot of interesting things, and I'm hoping that we can elaborate on some of those soon. Before we close, do you have any final thoughts on cardiovascular disease and SpA that you'd like to share with our audience?

Dr Husni:
Yeah, I think the world of spondyloarthropathy is just growing. For instance, we now have a group of non-radiographic axial spondyloarthropathies, and we even have indications for certain treatments for this group, yet the data may be a little more sparse in this group.[5] So I think that's exciting to look forward to help really personalize some of the treatments that we're seeing. We also know that there could be some subclinical inflammation that can be going on. Meaning, many times you and I treat our patients for spondyloarthropathy and whether or not there could be some underlying, low grade inflammation that can actually be contributing to some of these comorbidities. We just need to be more aware of, and especially in this world where many of our patients—I'm sure you're having this, Anisha—where they're asking us, "Hey, I'm feeling great. Can I get off my disease modifying agent?" And so, I think all of these are gonna play a role in, yes, your, you know, activity of your spondyloarthropathy is doing better, but are we able to take you off the medicine and still maintain a good healthy lifestyle and limit your comorbidities.

Dr Dua:
Yeah. I think that's such an important point, with trying to make sure we are balancing how to use the least amount of medicine possible, but also actually make sure that we're not just going by, you know, self-reported, "I feel better," 'cause there are so many more complications with these systemic diseases, that can cause a lot of, like we talked about, other effects outside of their joints. So, trying to balance that is always challenging, but something that hopefully as we keep practicing, become better at. That's a really great way to round out the discussion on this topic. I wanna thank my guest for helping us better understand the risk of cardiovascular disease in spondyloarthritis. Dr Husni, it was really great speaking with you today.

Dr Husni:
Yeah, thanks so much for really pinpointing some of these important questions that we see clinically and having a forum to discuss it.

Announcer:
This industry podcast was sponsored by Novartis US Clinical Development and Medical Affairs. If you missed any part of this discussion or to find others in this series, visit reachmd.com/living-rheum.

This is ReachMD.

Be part of the knowledge.

References:

1. Zhao SS, Robertson S, Reich T, Harrison NL, Moots RJ, Goodson NJ. Prevalence and impact of comorbidities in axial spondyloarthritis: systematic review and meta-analysis. *Rheumatol (United Kingdom)*. 2020;59:iv47-iv57. doi:10.1093/rheumatology/keaa246
2. Papagoras C, Markatseli TE, Saougou I, et al. Cardiovascular risk profile in patients with spondyloarthritis. *Jt Bone Spine*. 2014;81(1):57-63. doi:10.1016/j.jbspin.2013.03.019
3. Chodara AM, Wattiaux A, Bartels CM. Managing cardiovascular disease risk in rheumatoid arthritis: clinical updates and three strategic approaches. *Curr Rheumatol Rep*. 2017;19(4):1-17. doi:10.1007/s11926-017-0643-y
4. Zeller C, Appenzeller S. Cardiovascular disease in systemic lupus erythematosus: the role of traditional and lupus related risk factors. *Curr Cardiol Rev*. 2008;4(2):116-122. doi:10.2174/157340308784245775
5. Toussirot E. The risk of cardiovascular diseases in axial spondyloarthritis. Current insights. *Front Med*. 2021;8:1-8. doi:10.3389/fmed.2021.782150
6. Ferraz-Amaro I, Rueda-Gotor J, Genre F, et al. Potential relation of cardiovascular risk factors to disease activity in patients with axial spondyloarthritis. *Ther Adv Musculoskelet Dis*. 2021;13:1-10. doi:10.1177/1759720X211033755
7. Lee A, Cooper MG, Craig JC, Knight JF, Keneally JP. The Effects of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

on Postoperative Renal Function: A Meta-Analysis. *Anaesth Intensive Care*. 1999;27(6):574-580. doi:10.1177/0310057X9902700603
8. Varga Z, Sabzwari SRA, Vargova V. Cardiovascular risk of nonsteroidal anti-inflammatory drugs: an under-recognized public health issue. *Cureus*. 2017;9(4):1-12. doi:10.7759/cureus.1144
9. Borer JS, Simon LS. Cardiovascular and gastrointestinal effects of COX-2 inhibitors and NSAIDs: achieving a balance. *Arthritis Res Ther*. 2005;7(suppl 4):14-22. doi:10.1186/ar1794