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Background: Fibric acid derivatives and HMG-CoA reductase inhibitors are effective in combination for treating patients with familial dysbetalipoproteinemia and severe combined dyslipidaemia, but combination therapy affects compliance and increases the risk of side effects.

Aim: To evaluate the efficacy and safety of monotherapy with atorvastatin, an HMG-CoA reductase inhibitor with superior efficacy in lowering low density lipoprotein cholesterol and triglyceride concentrations, in patients with dysbetalipoproteinemia and severe combined dyslipidaemia.

Methods: Atorvastatin was tested as single drug treatment in 36 patients with familial dysbetalipoproteinemia and 23 patients with severe combined dyslipidaemia.

Results: After 40 weeks of 40 mg atorvastatin treatment decreases in total cholesterol, triglycerides, and apolipoprotein B of 40%, 43%, and 41%, respectively, were observed in the combined dyslipidaemia group, and of 46%, 40%, and 43% in the dysbetalipoproteinemic patients. Target concentrations of total cholesterol (< 5 mmol/l) were reached by 63% of the patients, and target concentrations of triglycerides (< 3.0 mmol/l) by 66%. Treatment with atorvastatin was well tolerated and no serious side effects were reported.

Conclusions: Atorvastatin is very effective as monotherapy in the treatment of familial dysbetalipoproteinemia and severe combined dyslipidaemia.

Abbreviations: apo E, apolipoprotein E; C, cholesterol; FD, familial dysbetalipoproteinemia; HDL, high density lipoprotein; IDL, intermediate density lipoprotein (VLDL remnants); LDL, low density lipoprotein; TG, triglyceride; VLDL, very low density lipoprotein.
METHODS

Patients

We recruited consecutive patients with a tentative diagnosis of dysbetalipoproteinaemia at the lipid research clinic of the University of Amsterdam (Academic Medical Centre and Slotervaart Training Hospital) by retrieving patient records from our clinical database. Eligible patients were men and women between 18 and 80 years of age with a diagnosis of probable dysbetalipoproteinaemia. This diagnosis was made when a patient presented with severe combined dyslipidaemia (both total cholesterol and triglyceride concentrations significantly above the 95th centile for age and sex), occasionally typical xanthomas, and in many cases atherosclerotic vascular disease. All eligible patients were informed about atorvastatin and asked to participate in the study. Patients with poorly controlled diabetes mellitus, hypothyroidism, and hepatic or xanthomas, and in many cases atherosclerotic vascular disease. All eligible patients were informed about atorvastatin and asked to participate in the study. Patients with poorly controlled diabetes mellitus, hypothyroidism, and hepatic or renal dysfunction were excluded. Pregnant or breast feeding women were also excluded.

Before entry to the study and at its completion, all patients underwent a complete physical examination and were counselled on the use of a lipid lowering diet, according to the Dutch national guidelines. Written informed consent was obtained from all patients.

Study design

At the start of the study all lipid lowering drugs were discontinued for eight weeks. After this, baseline lipids, apolipoproteins, and apo E genotyping were undertaken in all patients, together with routine biochemistry. Upon confirmation of homozygosity for apo E2 (argin 158→cys) (E2/E2) or the presence of the apo E2 variant (lys 146→gln), apolipoprotein ultracentrifugation was performed. Subsequently, atorvastatin was prescribed, and patients were examined at regular 12 week intervals, concluding at week 40.

At all visits, the patients were questioned about adherence to the diet and possible side effects of the drug treatment. They then had a physical examination. At each visit, blood samples were taken after an overnight fast for the determination of plasma lipids, apolipoproteins, and safety indices. These measurements were done at the central laboratory of both hospitals in Amsterdam. Extra blood samples were drawn from apo E2/E2 subjects or heterozygous carriers of the apo E2 variant (lys 146→cys) using a mutagenic amplification primer assay followed by digestion with restriction enzyme PvuI as described previously. Identification of the apo E2 variant (lys 146→gln) was by polymerase chain reaction using a mutagenic amplification primer assay followed by digestion with restriction enzyme PvuI as described previously.

Statistical analysis

The analyses, which were done using SAS 6.1.2, addressed the change in lipid and apolipoprotein variables and lipoprotein metabolism.
subfractions before and after atorvastatin treatment. Before analysis, triglyceride, VLDL-C, VLDL-TG, and IDL-TG values were logarithmically transformed. Untransformed concentrations are reported in the tables. Significance was assessed at the 5% level of probability.

RESULTS

Patient characteristics
Fifty nine patients (43 men and 16 women) were included in the study. Clinical and biochemical baseline characteristics are summarised in table 1. The mean age of the patients was 51.5 years (range 28–79 years) and mean (SD) body mass index was 27.2 (4.6) kg/m². Most patients included in the study were of north European descent (97%).

Thirty four patients were homozygous for the apo E2 genotype and two patients were heterozygous carriers of the apo E2 (lys 146→gln) variant. The remaining 23 patients either had an apo E2/E3 or an apo E2/E4 genotype. Baseline lipoprotein subfractions before and after atorvastatin treatment is shown in figs 1 and 2.

Mean plasma lipid concentrations in both groups were 4.24 (3.39) mmol/l for total cholesterol and 1.08 (0.80) mmol/l for triglycerides. Baseline lipoprotein subfractionation could be done in 28 patients with an apo E2/E2 genotype. Seventeen had established cardiovascular disease—that is, angina pectoris, coronary atherosclerosis at coronary angiography, a positive stress test, previous myocardial infarction, or a revascularisation procedure. Six patients had well controlled diabetes mellitus (one was on insulin and the others on oral antidiabetic treatment). Twenty patients were known to be taking one or more drugs that might affect lipid metabolism, including β blocking agents (n = 18), diuretics (n = 6), and oral contraceptives (n = 7). These drugs were prescribed continuously during the course of the study. None of the postmenopausal women who were participating were taking hormone replacement therapy.

Fifty patients completed the study. Five patients dropped out because of adverse events: three patients had gastric complaints (all E2/E3 or E2/E4), one suffered from psychological problems (E2/E2), and one developed viral hepatitis (E2/E2).

Four patients (all E2/E3 or E2/E4) dropped out because of non-compliance.

Efficacy

Lipids and lipoproteins
At 40 weeks of treatment, the efficacy of atorvastatin 40 mg was examined in both patient groups (figs 1 and 2). A significant decrease in total cholesterol, triglycerides, and apo B (by 40%, 43%, and 41%, respectively) was observed in the combined dyslipidaemia group (fig 1); all reductions were highly significant (p < 0.0002). Reductions were also seen for total cholesterol, triglycerides, and apo B concentrations (by 46%, 40%, and 43%, respectively; p = 0.0001) in patients with dysbetalipoproteinaemia (fig 2). Target concentrations of total cholesterol (< 5 mmol/l) were reached by 63% of patients, and target concentrations of triglycerides (< 3 mmol/l) by 66%.

Lipoprotein subfractions
In patients with homozygosity for apo E2 and heterozygous carriers of the apo E2 (lys 146→gln) variant, the efficacy of atorvastatin on lipoprotein subfractions was examined at baseline and after 40 weeks. A significant decrease was observed in almost all lipoprotein subfractions (table 2). For LDL-C, VLDL-C, and IDL-C these reductions were 38%, 59%, and 51%, respectively (p = 0.0001). The VLDL-C to triglycerides ratio, an important marker of dysbetalipoproteinaemia, decreased from 1.15 at baseline to 0.79 after 40 weeks of atorvastatin treatment.

Figure 2 Lipoprotein and apolipoprotein concentrations before and after atorvastatin treatment in patients with dysbetalipoproteinaemia. Mean values are given; triglyceride values were log transformed before statistical analysis.

Table 2 Lipoprotein subfractions before and after atorvastatin treatment in patients with dysbetalipoproteinaemia

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline (n=28)</th>
<th>Atorvastatin 40 mg (n=28)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>VLDL-C* (mmol/l)</td>
<td>4.24 [3.39]</td>
<td>1.72 [2.11]</td>
<td>0.0001</td>
</tr>
<tr>
<td>IDL-C (mmol/l)</td>
<td>1.80 [0.80]</td>
<td>0.89 [0.38]</td>
<td>0.0001</td>
</tr>
<tr>
<td>HDL-C (mmol/l)</td>
<td>1.87 [0.56]</td>
<td>1.16 [0.47]</td>
<td>0.0001</td>
</tr>
<tr>
<td>VLDL-TG* (mmol/l)</td>
<td>1.08 [0.28]</td>
<td>1.19 [0.32]</td>
<td>0.06</td>
</tr>
<tr>
<td>IDL-TG* (mmol/l)</td>
<td>4.08 [4.00]</td>
<td>2.21 [1.70]</td>
<td>0.0014</td>
</tr>
<tr>
<td>VLDL-C/TG (ratio)</td>
<td>1.15 [0.32]</td>
<td>0.79 [0.32]</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

Table 3 Safety indices before and after atorvastatin treatment in patients with dysbetalipoproteinaemia and combined dyslipidaemia

<table>
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<tr>
<td>CPK (U/l)</td>
<td>50 [97 (3)]</td>
<td>86 [32]</td>
<td></td>
</tr>
<tr>
<td>ALAT (U/l)</td>
<td>54 [23 (16)]</td>
<td>24 [19]</td>
<td></td>
</tr>
<tr>
<td>ASAT (U/l)</td>
<td>54 [19 (11)]</td>
<td>15 [8]</td>
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Values are mean (SD). ALAT, alanine aminotransferase; ASAT, aspartamine aminotransferase; CPK, creatine phosphokinase.

Table 3 Safety indices before and after atorvastatin treatment in patients with dysbetalipoproteinaemia and combined dyslipidaemia

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Values are mean (SD). ALAT, alanine aminotransferase; ASAT, aspartamine aminotransferase; CPK, creatine phosphokinase.
dyslipidaemia. Drugs with proven efficacy in FD patients, however, lipid lowering drugs are required to control pre-existing metabolic disorders. In the majority of FD and lifestyle adjustments, followed by the correction of the reduced by 46%.

Clinically significant increases in creatinine phosphokinase activity (that is, to more than three times the upper limit of normal (193 U/l)). Only γ-glutamyl transferase (γ-GT) showed mild increases in four patients after the first eight weeks of treatment. These disappeared during the study. In one subject the γ-GT value exceeded three times the upper limit of normal (58 U/l) and remained high, most probably because of a high alcohol intake. Mean baseline and 40 week concentrations of alanine aminotransferase, asparagine aminotransferase, and creatine phosphokinase are given in table 3. None of the differences reached significance.

**DISCUSSION**

We have studied the efficacy and safety of atorvastatin in patients with severe combined dyslipidaemia and dysbetalipoproteinaemia. Our findings show that this drug is a very effective cholesterol and triglyceride lowering agent in the treatment of both groups of patients. Target concentrations of total cholesterol (< 5 mmol/l) were reached in 63% of patients, and of triglycerides (< 3 mmol/l) in 66% of patients.

FD comprises a separate nosological entity in the spectrum of severe combined dyslipidaemia, with an extremely atherogenic lipoprotein profile and therefore a high risk of premature atherosclerosis. It should be managed aggressively with lipid lowering treatment and is usually responsive to such interventions. First line treatment should be diet and lifestyle adjustments, followed by the correction of pre-existing metabolic disorders. In the majority of FD patients, however, lipid lowering drugs are required to control dyslipidaemia. Drugs with proven efficacy in FD include nicotinic acid, clofibrate, fenofibrate, gemfibrozil, lovastatin, and simvastatin. Un fortunately, many patients remain hyperlipidaemic on diet and single drug treatment and often require combination treatment with a fibrac acid derivate and a statin. However, it is well established that combination treatment affects compliance and increases the risk of side effects such as liver dysfunction or myopathy.

Atorvastatin is an established and effective HMG-CoA reductase inhibitor. Clinical studies with this agent have shown that LDL cholesterol concentrations may be decreased by up to 61% at doses of 80 mg, and triglycerides may be reduced by 46%. Furthermore, it has been found recently that atorvastatin reduces both VLDL and LDL apo B production and in addition increases the clearance of triglyceride-rich lipoproteins.

McKenny and colleagues recently reported that atorvastatin is very effective as monotherapy in lowering both cholesterol and triglycerides in patients with combined dyslipidemia. In this study, we addressed the question of whether atorvastatin might also be a good candidate as monotherapy in 23 patients with severe combined dyslipidaemia and 36 patients with molecularly diagnosed dysbetalipoproteinaemia. In keeping with the results of McKenny and colleagues, atorvastatin showed good efficacy and safety in our patient cohort. In the group with severe combined dyslipidaemia, total cholesterol, triglycerides, and apo B decreased by 40%, 43%, and 41%, respectively, while in the patients with dysbetalipoproteinaemia the decreases were 46%, 40% and 43%. Furthermore, VLDL-C and VLDL-TG fell by 59% and 46%, respectively, and IDL-C and IDL-TG by 51% and 46% compared with baseline. The VLDL-C/TG ratio fell from 1.15 to 0.79.

Data on the efficacy of lipid lowering drugs in the treatment of FD are only available for small numbers of patients. The confidence intervals in those studies were large, making it difficult to draw firm conclusions about differences in various therapeutic regimens (table 4). Treatment of FD patients with fibrates generally results in a decrease in total cholesterol of up to 48%, and an increase in HDL of up to 33%. Triglyceride concentrations were decreased by up to 68%. IDL, as a marker of FLD, decreased by 34% when treatment with gemfibrozil was initiated. In the treatment of FD with statins, total cholesterol was decreased by up to 46% and HDL was raised by up to 25%. Triglycerides were decreased by up to 42%. IDL showed a reduction of 50% after treatment with simvastatin 20 mg.

We investigated the efficacy of atorvastatin in 36 FD patients, a substantially larger population than previously reported. Moreover these patients were followed for a longer period of time than in most other studies. However, a definite disadvantage of our study is the lack of a control or placebo group. The use of placebo groups in treatment studies of genetic dyslipidaemia is no longer considered ethical, and the relatively small number of FD patients precluded the use of a formal double blind control comparison. We have, however, compared baseline and 40 week lipid and lipoprotein concentrations and have shown highly significant and impressive reductions on 40 mg atorvastatin monotherapy. Side effects were mild and generally transient, as reported for other studies with this drug.

**Conclusions**

Atorvastatin proved to be both effective and safe when given as monotherapy in the treatment of severe combined dyslipidaemia and familial dysbetalipoproteinaemia.
References