



## Statins and myopathy

The day following a relevant television documentary (*Lipex*, Close-Up, TV1, 1 November 2005, compiled by Ian Sinclair), I was consulted by a patient with symptoms of angina. He was interested in protective measures to reduce risk but explanations of how treatment with a low-medium dose of a statin might reduce this by about 1 in 10 over 5 years set against a risk of myopathy of 1 in 10,000 were to no avail as his wife now considered the medication “far too dangerous”.

I am sure this situation was echoed in consulting rooms around New Zealand, despite the programme including factual information on risks and benefits. Urban myths about statins (fuelled by talkback radio) are prominent and will no doubt be further stimulated, but there are issues requiring reflection.

The major preventive benefit (in those at sufficiently high risk) and extremely low adverse event rate of statin therapy were restated in the recent review of placebo-controlled trials.<sup>1</sup> We do have to be mindful that these trials generally used fixed low-medium doses of statins while higher doses and combination therapies increasingly being urged<sup>2</sup> could have different benefit/risk equations. The recently published *Z phase of the A-Z Trial*<sup>3</sup> documented nine cases of myopathy (CK >10 times the upper normal limit) among 2263 patient taking simvastatin 80 mg daily for 6 to 24 months (a rate of about 1 in 250).

Atorvastatin, the only other statin available in New Zealand (by Special Authority), even when used in highest recommended doses (80 mg/day) seems to be associated with low rates of myopathy.<sup>4</sup> Additional concomitantly-used drugs (including erythromycin, calcium antagonists, cyclosporine, some antifungals and fibrates), diet (notably grapefruit juice), and other patient-related factors may interfere with metabolic breakdown (or otherwise interact with statins) and increase the risk of myopathy. Not all these factors can be reliably avoided in routine clinical practice and are more likely encountered there than in tightly controlled trials.

Perceptions of risk and benefit of medical interventions among health professionals, patients, and the public often show significant variance from what has been reliably documented.<sup>5</sup> Coverage in the media highlighting particular problems, even when figures given are reasonably factual, is one contributor to these potential distortions. We should strive to put across a correctly balanced view of benefits of risks of proposed therapies and interventions.

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**Disclosures:** I have attended meetings sponsored by Pharmaceutical Companies who market statins in New Zealand (Merck, Sharp and Dohme (NZ) Ltd, Pfizer (NZ) Ltd). I am a member of the Cardiovascular Subcommittee of the Pharmacology and Therapeutics Advisory Committee to PHARMAC.

**References:**

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