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Anyone for a statin?

Our surgeries nowadays require us to deal with more well people supposedly at risk of becoming ill, than ill people seeking to get better. While some GPs seem to find this straightforward and rewarding, I find it difficult and frustrating. Here's an example:

A 70-year-old woman with controlled hypertension has come in to discuss her lipid results, which we have checked, several times, as all good doctors must. Her latest figures are total cholesterol 7.0 mmol/l, triglycerides 1.9 mmol/l and total cholesterol:HDL 3.4. Previous levels for TC have been 6.8, 7.2 and 5.7 mmol/l. She is a non-smoker, with no family history of coronary heart disease and is not diabetic. Pre-treatment blood pressure was around 184/90 mmHg.

I turn to the back of the *BNF* and show her the New Zealand tables, explaining that she has a risk of around 20% of suffering a heart attack or stroke in the next 10 years. I also point out that she has a fair chance of dying of something else in the same period. I tell her that if we put her on a statin her risk of a heart attack or stroke will be reduced by about one-third, but her overall risk of dying will be reduced by considerably less than this. I emphasise that we are talking 'statistically' and that we can't predict her individual fate. If she starts a statin, she will need to have regular blood tests, and will have a very small risk of suffering muscle pains or more serious muscle damage.

She seems to understand the concepts, says she wants 'to live forever', and asks whether if she takes the pills she can carry on eating whatever she likes. Her cholesterol fell while she was on the Atkins diet, but she didn't like it much. I tell her that I've just been reading a novel that explores what it would be like to be immortal[1] — not much fun — but we agree that this is probably not relevant. I also tell her that I had my cholesterol checked a few years ago, that it was above recommended levels, and that I had vowed never to have it checked again. In the end, she decides that she will try reducing her fat intake a little — but she enjoys clotted cream — and have her lipids checked again in a year or two.

Does this sound like a competent consultation to you, or a half-baked mishmash of received wisdom, confused messages and personal prejudice?

By coincidence, 2 days later the latest Factfile from the BHF lands on my desk.[2] Entitled, *Communicating Risk to Patients* it summarises as follows:

> *'Patients want and need to know the benefits and risks of investigations and treatments; the way in which health professionals communicate risk affects patients' perception of that risk; patients should be provided with a balanced and dispassionate assessment of the pros and cons of the various options based on well founded data; use of simple visual aids and everyday analogies can help to increase understanding and to ensure that consent is properly informed.'*[2]

I decide to put a bit more effort in. Now I have read the claim in the pages of the *BMJ* (*passim*) that '3 out of 4 GPs say that *Clinical Evidence* has actively changed their practice'. I've never minded being in the minority so I'm not going to get paranoid. Instead, I decide to access the latest edition on my desktop,[3] only to find that I haven't loaded the CD–ROM yet, having never got round to accessing the previous edition. I install it, and look up 'cholesterol lowering'. The most pertinent information I can find comes down to this: in adults aged over 70 years treated with statins for an average of 5.5 years, all cause mortality was 12.9%, and in the placebo group 14.7%. This gives an ARR of 1.8% and a NNT to save one life of 53. Generally women seem to do as well as men, though the evidence isn't very clear.

So, next time I might rephrase my advice by telling this patient that, if I give her and 52 other people with a similar risk profile a statin for 5 years, one death is likely to be prevented; or that in those 5 years, in those same 53 people, one or two cardiovascular events might be prevented; or that the chances of her avoiding such an event by taking a statin are about 25–1 against. I will not, despite the British Heart Foundation's enthusiasm for such aids, show her a chart with rows of smileys and gloomies to illustrate her chances of life, death and disease. I will be tempted to tell her that, in my opinion, the whole guessing game is beset with so many uncertainties that we might just as well consult a chicken's entrails; and that if it weren't for the enormous lobbying power of the drug industry we wouldn't even be having the discussion. But in the end, she will probably say, 'Well, what do you think doctor — you're the expert'.

I wonder what you think — you're all experts too. I live on an island, so e-mails are always welcome.

REFERENCES

1. De Beauvoir S. *All men are mortal.* London: Virago Press, 2000.
2. British Heart Foundation. *Communicating risk to patients. Factfile.* London: British Heart Foundation, 2005.
3. *Clinical Evidence* 12. (CD-ROM). London: BMJ Publishing Group, 2004.