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cc. The Right Honourable Jeremy Hunt, MP
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Concerns about the latest NICE draft guidance on statins

Introduction:

We are concerned about your draft guidance on CV risk for discussion and debate. We would ask for a delay until our concerns are addressed. Whilst we agree with much of the guidance, our concerns focus on six key areas: **medicalization of healthy individuals, true levels of adverse events, hidden data, industry bias, loss of professional confidence, and conflicts of interest**

The draft guidance recommends offering statin treatment for the primary prevention of CVD to people who have a 10% or greater 10-year risk of developing CVD.

1. Medicalisation of five million healthy individuals.

Firstly, we believe that the benefits in a low risk population do not justify putting approximately five million more people on drugs that will then have to be taken lifelong.

The important questions for clinicians and for patients include: (1) does treatment of elevated cholesterol levels with statins in otherwise healthy persons decrease mortality or prevent other serious outcomes? (2) What are the adverse effects associated with statin treatment in healthy persons? (3) Do the potential benefits outweigh the potential risks? Recent papers have **suggested that statin therapy should not be recommended for men with elevated cholesterol who are otherwise healthy.**²

Furthermore, Atorvastatin 20mg is also recommended as the first-line treatment. This appears counter intuitive, as Atorvastatin has never been demonstrated to reduce mortality for primary prevention any clinical study. (3b)

2. Conflicting levels of adverse events

In emphasising the cost per Quality Adjusted Life Year (QALY), NICE is clearly making a major assumption that the key issue is mortality reduction, and that statins lead to very few adverse effects. We would question this very strongly.

The levels of adverse events reported in the statin trials contain worrying anomalies. For example, in the West of Scotland Coronary Prevention Study (WOSCOPS, the first primary prevention study done), the cumulative incidence of myalgia was 0.06% in the statin arm, and 0.06% in the placebo arm³.

However, the METEOR study found an incidence of myalgia of 12.7% in the Rosuvastatin arm, and 12.1% in the placebo arm⁴. Whilst it can be understood that a different formulation of statin could cause a different rate of myalgia, it is difficult to see how the placebo could, in one study, cause a rate of myalgia of 0.06%, and 12.1% in another. This is a two hundred fold difference in a trial lasting less than half as long.

Furthermore, the rate of adverse effects in the statin and placebo arms of all the trials has been almost identical. Exact comparison between trials is not possible, due to lack of complete data, and various measures of adverse effects are used, in different ways. However, here is a short selection of major statins studies.

AFCAPS/TEXCAPS: Total adverse effects losartan 13.6%: Placebo 13.8%

4S: Total adverse effect simvastatin 6%: Placebo 6%

CARDS: Total adverse effects atorvastatin 25%: Placebo 24%

HPS: Discontinuation rates simvastatin 4.5%: Placebo 5.1%

METEOR: Total adverse effects rosuvastatin 83.3%: Placebo 80.4%

LIPID: Total adverse effects 3.2% Pravastatin: Placebo 2.7%

JUPITER: Discontinuation rate of drug 25% Rosuvastatin 25% placebo. Serious Adverse events 15.% Rosuvastatin 15.5% placebo

WOSCOPS: Total adverse effects. Pravastatin 7.8%: Placebo 7.0%

Curiously, the adverse effect rate of the statin, it is always very similar to that of placebo. However, placebo adverse effect rates range from 2.7% to 80.4%, a thirty fold difference.

3. Hidden data

Without access to the raw data, it is difficult to understand how statin related adverse events, and placebo related adverse events can mirror each other so precisely, whilst the absolute rates can vary thirtyfold (almost three thousand per cent). These data most certainly require analysis by a third party with appropriate expertise.

A further serious concern is that the data driving NICE guidance on statins comes almost entirely from pharmaceutical company funded studies. Furthermore, these data are not available for review by independent researchers, only those who work for the Oxford Cholesterol Treatment Trialists Collaboration (CTT).

The CTT has commercial agreements with pharmaceutical companies which apparently means that they cannot release data to any other researchers who request to see it. Which, in turn, means that the latest reviews of the data by NICE and also by the Cochrane group are totally reliant on the CTT 2012¹ meta-analysis analysis of this concealed data?

4. Industry bias

The overdependence on industry data raises concerns about possible biases. Extensive evidence shows that industry funded trials systematically produce more favourable outcomes than non- industry sponsored ones.^{5,6}

Notably, only one major non-industry funded study on statins has been done. ALLHAT-LLP. The main findings were summarised: *'Although pravastatin has been shown in multiple large clinical trials to reduce CHD morbidity and mortality, **NO** benefit was demonstrated in ALLHAT-LLT, the largest clinical event trial of pravastatin published to date.'* (6b)

True levels of adverse events

We are also concerned that the rate of adverse effects in post-marketing studies is, in most cases, far higher than that found in the pre-marketing studies. In part this is due to the fact that the clinical trial populations studied in premarketing trials are highly selected. Furthermore, industry sponsored trials include pre-randomisation run-in periods where those who fail to tolerate statins are excluded. RCT patients may therefore not represent the population that will actually take the drugs in the real world. RCTs may thus grossly underestimate adverse effects such as myopathy or cognitive impairment,⁷ and fail to detect drug interactions e.g. amlodipine and statins.

Important findings from some other non-industry sponsored studies

A double blind randomised controlled trial that compared 1016 low risk patients receiving simvastatin 20 mg or pravastatin 40 mg with placebo showed that both drugs had a significant adverse effect on energy/fatigue exercise score with 40% of women reporting reduced energy or fatigue with exertion.⁹ Reducing exercise capacity in a healthy group when physical inactivity is a major contributor to the development of cardiovascular disease is extremely counterproductive.

A large observational study involving 153,840 postmenopausal women aged between 50 and 80 years enrolled in the Women's Health Initiative study found that statins were associated with a 48% increased risk of developing diabetes.⁸

Potential psychiatric symptoms including depression, memory loss, confusion, and aggressive reactions have also been associated with statin use.¹⁰

Erectile dysfunction, to take another significant adverse effect, is not mentioned in the statin trials. Yet, when it was specifically looked for, around 20% of men appeared to be affected.¹¹

5. Loss of professional confidence

We are also concerned that GPs feel that this guidance is a 'step too far. It is instructive to note that a survey of 511 GPs carried out by Pulse magazine revealed that *'...almost six out of ten (57%) oppose the plan to lower the current 10-year risk threshold for primary prevention, while only 25% support it. Furthermore, 55% would not personally take a statin or recommend a family member does so based on a 10% 10-year risk score.'* (11b)

More recently the General Practitioners Committee (GPC), which negotiates on behalf of GPs in the UK passed the following resolution: *'In light of the Cochrane review of the*

effectiveness of antiviral influenza treatments, the GPC will request that NICE refrain from recommending a reduction to the current treatment threshold for primary prevention of cardiovascular disease with statin therapy unless this is supported by evidence derived from complete public disclosure of all clinical trials' data' (11c)

Asking GPs to meet targets that they feel uncomfortable with risks a damaging split within the profession, and a loss of confidence among the public, who are likely to recognise increasingly that GPs are being asked to prescribe statins despite feeling it is inappropriate.

6. Conflicts of Interest (real and perceived)

We are also seriously concerned that 8 members of NICE's panel of 12 experts for its latest guidance have direct financial ties to the pharmaceutical companies that manufacture statins.¹² Furthermore, some members of the guideline panel are also involved in next generation, more expensive, cholesterol lowering drugs, which are not yet on the market.¹² If cholesterol lowering becomes established in low risk people, the indications for these new cholesterol lowering drugs such as the ApoB Antisense drugs and PCSK9 inhibitors will probably expand as well. We feel that parties with industry conflicts should not be participants in generating recommendations regarding drug use that will influence medical care across the population.

We fear that the CTSU could be perceived as having a major conflict of interest in the area of cardiovascular disease prevention/lipid modification, which has an impact on the Unit's perceived objectivity. We strongly urge that other researchers, for example, the Cochrane Stroke Group and Cochrane Heart Group, should be able to scrutinize and assess all the data that the CTT has utilised over the years to produce their extremely influential studies.

CTT is a part of the Clinical Trials Service Unit (CTSU) in Oxford, which has carried out many very large studies on statins, and other lipid modification agents with pharmaceutical company support, and has received hundreds of millions in funding over the years. To consider just one such study (REVEAL). REVEAL is being funded by Merck Sharp & Dohme, which developed anacetrapib. A grant of £96 million towards the cost of this multi-million dollar study has been provided to the University of Oxford.(13)

We are concerned that financial conflicts of interest and major commercial bias may have corrupted the database on statins, resulting in an underestimate of the incidence of statin side-effects. Unless all of the data are made available it is impossible to establish a cost per QALY, as there may be DALYs [disability adjusted life years] not accurately accounted for.

We call for all of the data from the clinical trials to be made available to credible researchers, for example, the Cochrane Stroke and Heart Groups. We believe that there is a need for a more robust post-marketing analysis of suspected adverse effects from statins prescribed in a community setting.

To conclude we urge you to withdraw the current guidance on statins for people at low risk of cardiovascular disease until all the data are made available. The potential consequences of not doing so are worrying: harm to many patients over many years, and the loss of public and professional faith in NICE as an independent assessor. Public interests need always to be put before other interests, particularly Pharma.

Yours Sincerely

Sir Richard Thompson, President of the Royal College of Physicians

Professor Clare Gerada, Past Chair of the Royal College of General Practitioners and Chair of NHS Clinical Transformation Board

Professor David Haslam, General Practitioner and Chair of the National Obesity Forum

Dr J S Bamrah, Consultant Psychiatrist and Medical Director of Manchester Mental Health and Social Care Trust

Dr Malcolm Kendrick, General Practitioner and Member of the British Medical Association's General Practitioners sub- Committee

Dr Aseem Malhotra, London Cardiologist.

Dr Simon Poole, General Practitioner

David Newman, Assistant Professor of Emergency Medicine and Director of Clinical Research, Mount Sinai School of Medicine, New York

Professor Simon Capewell, Professor of Clinical Epidemiology, University of Liverpool

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