Long-Term Use of Lipid-Lowering Drugs Slows Progression of Carotid Atherosclerosis
The Tromsø Study 1994 to 2008

Marit Herder, Kjell Arne Arntzen, Stein Harald Johnsen, Anne Elise Eggen, Ellisiv B. Mathiesen

Objective—Data on the effect of lipid-lowering drugs (LLD) on carotid atherosclerosis outside clinical trials are limited. The aim of this study was to determine the effect of LLD on change in carotid intima media thickness and total plaque area in a general population.

Approach and Results—Subjects were 1532 women and 1442 men who participated in a longitudinal population-based study with ultrasound examination of intima media thickness and total plaque area in the right carotid artery at baseline and after 13 years follow-up. Long-term use of LLD was defined as use for >5 years, any-time use of LLD was defined as use at baseline or at 6 years or at 13 years of follow-up. In multivariable models adjusted for age, sex, systolic blood pressure, total cholesterol, high-density lipoprotein cholesterol, prevalent cardiovascular disease, and daily smoking, long-term use of LLD had a protective effect on progression of both intima media thickness (β=-0.0387 mm; P=0.002) and total plaque area (β=-0.400 mm²; P=0.006). There was a weaker protective effect of any-time use of LLD on progression of intima media thickness (β=-0.024 mm; P=0.046) and total plaque area (β=-0.318 mm²; P=0.06).

Conclusions—LLD protected against progression of carotid atherosclerosis. The protective effect was strongest in long-term users. (Arterioscler Thromb Vasc Biol. 2013;33:858-862.)

Key Words: atherosclerosis ■ carotid artery ■ intima media thickness ■ lipid-lowering treatment ■ plaque ■ population-based study

Although randomized clinical trial is gold standard for proving the effect of a given intervention, the generalizability may be limited. There is little knowledge on whether the effect of LLD on atherosclerosis progression seen in randomized clinical trials also applies to other practice settings. The purpose of the present study was to assess the impact of LLD on progression on carotid atherosclerosis in a general population.

The Tromsø study is a single-center, longitudinal population study with repeated surveys of the inhabitants of the municipality of Tromsø, Norway. We have repeatedly, over a period of 13 years, obtained information on the use of LLD and cardiovascular risk factors, and measured IMT and total plaque area (TPA) in the right carotid artery. This enables assessment of the effect of use of LLD and change in carotid atherosclerosis in unselected subjects belonging to a general population.

Materials and Methods
Materials and Methods are available in the online-only Supplement.

Results
Mean observation time was 13.2 years. Of the 2974 participants, 190 women and 253 men had used LLD >5
years (Table 1). At baseline, in 1994 to 1995, the proportion of current LLD users among the study participants was low (1.6% (n=51). In the 6th survey (2007–2008), the percentage of current users had risen to 27% (n=799). At baseline, 89% of those who reported brand names (n=46) used statins, whereas only 4 persons of those who reported brand names (n=713) used ezetimib. Use of LLD was associated with male sex, higher age, systolic blood pressure, total cholesterol, BMI indicates body mass index; BP, blood pressure; CVD, cardiovascular disease; GSM, grey scale median; HDL, high-density lipoprotein; IMT, intima media thickness; LLD, low-density lipoprotein; LLD, lipid-lowering drugs; and TPA, total plaque area.

All values are means (SD) or numbers (%), unless indicated.

*Median (interquartile range).

Long-term use of LLD was defined as use for >5 years; any-time use of LLD was defined as use of LLD in any 1 of the 3 surveys, excluding long-term users.

The multivariable-adjusted mean change (95% confidence interval [CI]) in IMT was 0.174 (95% CI, 0.167–0.182) in never-users, 0.162 (95% CI, 0.145–0.179) in any-time users, and 0.139 mm (95% CI, 0.125–0.156) in long-term users (P for trend, 0.002). The corresponding numbers for mean multivariable-adjusted change in TPA (square-root-transformed) was 1.450 (95% CI, 1.342–1.558) in never-users, 1.391 (95% CI, 1.276–1.505) in any-time users, and 1.098 (95% CI, 0.854–1.342) in long-term users (P for trend, 0.009).

In multivariable-adjusted regression analysis, long-term use of LLD was an independent predictor for both IMT (β=–0.0387 mm; P=0.0002) and TPA (β=–0.400 mm²; P=0.006), showing a protective effect against progression of atherosclerosis (Table 2). Any-time use of LLD also showed a protective, but weaker effect on IMT (β=–0.024 mm; P=0.046) and TPA (β=–0.318 mm²; P=0.06; Table 2), indicating a dose–response relationship. The estimates were not substantially changed when we excluded participants who reported cardiovascular disease at baseline or at follow-up (n=649), neither for long-term use of LLD (β=–0.0616 mm; P=0.0011 for ΔIMT; and β=–0.376 mm²; P=0.02 for ΔTPA) or any-time use of LLD (β=–0.0308 mm; P=0.002 for ΔIMT; and
β = −0.260 mm²; \( P = 0.2 \) for \( \Delta \text{TPA} \). Long-term or any-time use of LLD was not independently associated with change in GSM.

**Discussion**

The main finding of our study was that long-term use of LLD, as well as any-time use of LLD, protected against progression of IMT and TPA during the 13 years observation time. The protective effect of long-term use of LLD on atherosclerosis progression was stronger than for any-time use of LLD, indicating a dose–response relationship. This coincided with a favorable change in lipid levels, most pronounced in long-term LLD users.

The study results imply that the effect of LLD on progression of carotid atherosclerosis seen in randomized clinical trials and patient series also applies to subjects belonging to the general population. A meta-analysis of 11 randomized controlled trials showed regression of IMT in 7 trials and slowing of progression in 4 trials, indicating a benefit of statin in early stages of the atherosclerotic process. Another review showed that the strength of the statin effect on IMT was closely associated with reduction in LDL-cholesterol. This is in accordance with our findings, where the reduction of LDL was greatest in the long-term users.

Progression of carotid IMT and TPA are correlated, but probably represent different atherosclerotic entities. Few clinical studies have studied the effect of statins on progression of carotid plaque burden, and most of these have been with small sample size. One larger study used a plaque score method based on plaque presence and severity, and showed a significant difference in plaque score change between statin use and placebo, and similar results have also been found by the general population. A meta-analysis of 11 randomized controlled trials showed regression of IMT in 7 trials and slowing of progression in 4 trials, indicating a benefit of statin in early stages of the atherosclerotic process. Another review showed that the strength of the statin effect on IMT was closely associated with reduction in LDL-cholesterol. This is in accordance with our findings, where the reduction of LDL was greatest in the long-term users.

Progression of carotid IMT and TPA are correlated, but probably represent different atherosclerotic entities. Few clinical studies have studied the effect of statins on progression of carotid plaque burden, and most of these have been with small sample size. One larger study used a plaque score method based on plaque presence and severity, and showed a significant difference in plaque score change between statin use and placebo, and similar results have also been found.

**Table 2. Multivariable-Adjusted Regression Analysis of the Effect of Use of Lipid-Lowering Drugs (LLD) and Cardiovascular Risk Factors on Progression of Atherosclerosis**

<table>
<thead>
<tr>
<th></th>
<th>( \Delta \text{IMT}, \text{mm} )</th>
<th>( \Delta \text{TPA}, \text{mm}² )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \beta ) (SE)</td>
<td>( P ) Value</td>
</tr>
<tr>
<td>Age, y</td>
<td>0.0005 (0.0004)</td>
<td>0.2</td>
</tr>
<tr>
<td>Male sex</td>
<td>0.019 (0.007)</td>
<td>0.006</td>
</tr>
<tr>
<td>Systolic blood pressure, mmHg</td>
<td>0.0002 (0.0002)</td>
<td>0.4</td>
</tr>
<tr>
<td>HDL-cholesterol, mmol/L</td>
<td>−0.009 (0.009)</td>
<td>0.3</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>0.011 (0.003)</td>
<td>0.0005</td>
</tr>
<tr>
<td>Cardiovascular disease (yes/no)</td>
<td>0.017 (0.013)</td>
<td>0.2</td>
</tr>
<tr>
<td>Daily smoking (yes/no)</td>
<td>0.024 (0.007)</td>
<td>0.001</td>
</tr>
<tr>
<td>Use of LLD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any-time use of LLD</td>
<td>−0.024 (0.012)</td>
<td>0.046</td>
</tr>
<tr>
<td>Long-term use of LLD (yes/no)</td>
<td>−0.0387 (0.01)</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

HDL indicates high-density lipoprotein; IMT, intima media thickness; \( \Delta \text{IMT} \) and \( \Delta \text{TPA} \), change in IMT and TPA from baseline to follow-up; and TPA, total plaque area.

Values are regression coefficients (SE) expressed in mm change in IMT and mm² change in TPA for a 1-unit/SD change in continuous variables and for presence vs absence of categorical variables.

Long-term use of LLD was defined as use for >5 yr; any-time use of LLD was defined as use of LLD in any 1 of the 3 surveys, excluding long-term users.

*Each variable is adjusted for all the other variables presented in the table.

†Square-root-transformed values.
for coronary plaque.11 Statins were the dominating LLD in our study, whereas only 4 participants used a combination of statins and ezetimib, which has been found to be associated with regression of TPA,11 but with increase in IMT.19 A recent review of 9 randomized and 8 observational studies with number of participants ranging from 8 to 149 showed that statin treatment tended to halt plaque progression and increase plaque echogenicity.9 We observed no effect of statins on plaque echogenicity (GSM) in our study.

Our study has some important weaknesses. The use of LLD in the population increased considerably over the 13-year study period. It can be questioned whether our estimates of use of LLD over time truly reflect the participants’ use of LLD in the observation period. We calculated duration of use based on information from both questionnaires and lists of current medication at 3 points in time. Although previous studies have shown that repeated self-reported use of drug that are used regularly reflect chronic exposure,20,21 subjects may have failed to report use of LLD because they were not aware of the nature of the drug they were taking, and they could have forgotten to fill-in all brand names in the medication lists. The study results may have been influenced by selection bias caused by nonattendance at follow-up because of death, disease, or disability.13 Progression of atherosclerosis may have been more pronounced and use of LLD more frequent in nonattendees. However, immortal time bias is avoided,22 as the outcome variable is progression of atherosclerosis over a 1.3-year period, and can be measured in both users and nonusers of LLD. Progression of IMT is prone to measurement error, and is suggested as the reason for lack of association between progression of IMT and cardiovascular end points in a recent meta-analysis.23 Use of 3-dimensional ultrasound to measure plaque volume could have increased the ability to demonstrate change in plaque burden.24 The use of different ultrasonography equipment in the 4th and the 6th survey, and nonstandardized uptake angles is likely to have increased the measurement error.25 Any such misclassification would affect the exposed and unexposed groups equally. Furthermore, misclassification both of the exposure to LLD and of progression of atherosclerosis would lead to underestimation of the true effect of use of LLD.

It has been debated whether statins have a role as a primary prevention tool for cardiovascular disease, or whether the effect is limited to secondary prevention in patients who manifest disease.26–29 In our study, use of LLD independently predicted slower progression of carotid atherosclerosis also in participants without prevalent cardiovascular disease. However, the observational study design does not allow inferences about whether the beneficial effect of LLD on atherosclerosis outweighs any possible negative effects of LLD in primary prevention.

The strengths of the study are the large study cohort, the population-based design, and a follow-up of >13 years, enabling us to assess whether the effect of LLD on atherosclerosis also applies to subjects treated outside the more rigorous terms of a randomized controlled trial.

In conclusion, our study shows that LLD slowed the progression of carotid atherosclerosis in the setting of a population-based observational study. The protective effect was strongest for long-term users.

Sources of Funding
The present study was supported by grants from the Northern Norway Regional Health Authority and from the Simon Fougner Hartmann’s Family Foundation.

Disclosures
None.

References

**Significance**

Our population-based longitudinal study has shown that lipid-lowering drugs (LLD) have a protective effect on the progression on carotid atherosclerosis in a general population, including healthy subjects with no clinical disease. There was a stronger protective effect in long-time users (>5 years) than in any-time users (use of LLD at any point of time in the observational period) and never-users, indicating a dose–response relationship. Change toward a more favorable LDL-cholesterol level was most pronounced in long-time users. The estimates did not change significantly when subjects with cardiovascular disease were excluded. Our study could indicate that LLD may be useful in primary prevention of atherosclerosis progression.
Long-Term Use of Lipid-Lowering Drugs Slows Progression of Carotid Atherosclerosis: The Tromsø Study 1994 to 2008
Marit Herder, Kjell Arne Arntzen, Stein Harald Johnsen, Anne Elise Eggen and Ellisiv B. Mathiesen

Arterioscler Thromb Vasc Biol. 2013;33:858-862; originally published online February 7, 2013; doi: 10.1161/ATVBAHA.112.300767
Arteriosclerosis, Thrombosis, and Vascular Biology is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2013 American Heart Association, Inc. All rights reserved.
Print ISSN: 1079-5642. Online ISSN: 1524-4636

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://atvb.ahajournals.org/content/33/4/858

An erratum has been published regarding this article. Please see the attached page for:
/content/33/5/e116.full.pdf
/content/33/11/e133.full.pdf

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Arteriosclerosis, Thrombosis, and Vascular Biology can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Arteriosclerosis, Thrombosis, and Vascular Biology is online at:
http://atvb.ahajournals.org//subscriptions/
In the article by Herder et al, which appeared in the April 2013 issue of the journal (Arterioscler Thromb Vasc Biol. 2013;33:858–862. DOI: 10.1161/ATVBAHA.112.300767), there was an error in the online-only Materials and Methods supplement. In the 1st paragraph, the sentence that started with “During follow-up…” should have been: During follow-up, 1515 persons died and 468 persons moved out of the municipality. Of the remaining 4744 subjects who were invited to participate in the 6th survey, 2975 subjects attended the follow-up carotid ultrasound examination. One participant was excluded due to lack of valid written consent, leaving 2974 subjects to be included in the present study.

The online-only Supplement has been corrected.
Correction

In the article by Herder et al, which appeared in the April 2013 issue of the journal (*Arterioscler Thromb Vasc Biol*. 2013;33:858–862. DOI: 10.1161/ATVBAHA.112.300767), there was an error in the Results section. On page 859, the 2nd column, the first paragraph should have been:

The multivariable-adjusted mean change (95% confidence interval [CI]) in IMT was 0.174 (95% CI, 0.167–0.182) in never-users, 0.162 (95% CI, 0.145–0.179) in any-time users, and 0.139 mm (95% CI, 0.122–0.156) in long-term users (P for trend, 0.002; Figure, A). The corresponding numbers for mean multivariable-adjusted change in TPA (square-roottransformed) was 1.450 (95% CI, 1.342–1.558) in never-users, 1.391 (95% CI, 1.151–1.630) in any-time users, and 1.098 (95% CI, 0.854–1.342) in long-term users (P for trend, 0.009; Figure, B).

The online version of the article has been corrected and is available at http://atvb.ahajournals.org/content/33/4/858.full.
Materials and methods

Subjects

Eligible for the present study were all who participated in the carotid ultrasound examination in the 4th (1994-1995; baseline) and the 6th (2007-2008; follow-up) survey of the Tromsø study. The follow-up time was 13 years. In the 4th survey, all inhabitants aged 55–74 years and random 5-10% samples of subjects in the age groups 20–54 years and 75–84 years were invited to a carotid ultrasound examination, and 6727 (76% of the eligible population) attended. During follow-up, 1515 persons died and 468 persons moved out of the municipality. Of the remaining 4744 subjects who were invited to participate in the 6th survey, 2975 subjects attended the follow-up carotid ultrasound examination. One participant was excluded due to lack of valid written consent, leaving 2974 subjects to be included in the present study.

The Tromsø Study is approved by the Regional Committee for Medical and Health Research Ethics, the Norwegian Data Protection Authority.

Lipid-lowering drugs

To assess the use of LLD over time, we provided data on use of medication from the 4th, 5th and 6th surveys. Information was based on questionnaire data and self-reported written lists of all current medication, checked by a trained technician. In the 4th survey (baseline), participants below the age of 70 were asked ‘Have you used cholesterol lowering drugs during the last 14 days?’ (yes/no). In the 5th survey in 2001-2002, all participants were asked about current or previous use of LLD (‘Do you use cholesterol lowering drugs?’, answer categories: currently/previously/never). In the 6th survey, all participants were asked about current or previous use of LLD (‘Do you use, or have you used cholesterol lowering drugs?’, answer categories: currently/previously/never) and the age when they first started with LLD.
(‘If you use or have used cholesterol lowering drugs, how old were you the first time?’). In addition, the participants were asked to write a list of the brand names of all current medication they had used the previous week (4th survey) or the preceding four weeks (5th and 6th survey) and/or bring the medication with them to the study center. The questionnaire was checked by a trained technician at the study site, and participants had to confirm if no medication use was reported. Based on data from all three surveys, we calculated the duration of use of LLD. Any-time use of LLD was defined as use of LLD in any one of the three surveys, excluding those with a known duration of more than five years. Long-term use of LLD was defined as use either more than 5 years (current age minus age at start), or reported use in at least two of the three surveys (each conducted more than 5 years apart).

**Cardiovascular risk factors at baseline**

Non-fasting lipid levels were measured at baseline and follow-up. In the 4th survey, lipid levels were measured twice with an interval of 4–12 weeks and the averages of these values were used in the analyses. Analyses of non-fasting serum total cholesterol, HDL-cholesterol and triglycerides were done by enzymatic colorimetric methods. As serum low density lipoprotein (LDL) concentration was not measured in the 4th survey, we calculated LDL levels according to Friedewald’s formula: LDL-cholesterol = Total cholesterol – HDL-cholesterol – (0.45 x triglycerides) in subjects with triglyceride levels below 4.52 mmol/L. LDL was analyzed by homogeneous enzymatic colorimetric method in the 6th survey. All analyses were performed at the Department of Laboratory Medicine, University Hospital of North Norway. Height and weight were measured in participants wearing light clothing and no footwear. Blood pressure was recorded three times at one-minute intervals after two minutes of seated resting with the use of an automatic device (Dinamap Vital Signs Monitor 1846, Criticon) and by specially trained technicians. The mean of the last two recordings was used for analyses.
Information on angina pectoris, myocardial infarction, stroke, daily smoking, diabetes, use of antihypertensives and antidiabetics was obtained from questionnaires at baseline and follow-up. Cardiovascular disease was defined as prevalent angina pectoris and/or previous myocardial infarction and/or stroke.

*Carotid ultrasound measurements*

High-resolution B-mode ultrasonography at baseline was performed with Acuson Xp10 128, ART-upgraded duplex scanners equipped with 7.5 MHz linear array transducers, while GE Vivid 7 duplex scanners with linear 12 MHz transducers were used at follow-up. The ultrasonographers were blinded to laboratory and clinical data. Subjects were examined in the supine position with the head slightly tilted to the left side. The sonographers were instructed to view the arteries from all possible angles, in order to find the optimal view for visualization of plaque and IMT in each subject. No fixed angle of insonation was used. ECG-triggered uptakes of the 10 mm distal segment of the far (CCA-FW-IMT) and near wall (CCA-NW-IMT) of the common carotid artery and of the proximal 10 mm segment of the far wall of the carotid bifurcation (BULB-FW-IMT) were obtained. Plaques were included in the IMT measurements if present in the predefined location of interest. Mean IMT from the 3 pre-selected images was calculated for each location. The average of the mean IMT from the three locations was used in the analyses. A plaque was defined as a localized protrusion into the vessel lumen of more than 50% thickening compared to the adjacent IMT. Six locations were scanned for the presence of plaques, the far and near walls of the right common carotid artery (CCA), bifurcation (bulb) and internal carotid artery (ICA). The outline of each plaque was marked manually on still images, with calculation of plaque area. In subjects with more than one plaque, TPA was calculated as the sum of all plaque areas. Plaque echogenicity was assessed as the standardized median of the gray scale distribution of each plaque (GSM). In subjects with more than one plaque, the GSM of the total plaque area was estimated as a
weighted mean of the GSM value of each single plaque. There was acceptable inter- and intra-observer and inter-equipment reproducibility of IMT and plaque measurements.1-4

**Statistical analysis**

Differences between groups were analyzed using \( t \)-test or Wilcoxon rank sum tests (continuous variables) and \( \chi^2 \) (dichotomous variables). Within-group changes between baseline and follow-up were tested by paired (repeated) \( t \)-test for continuous variables and McNemar’s test for categorical variables. Values are presented as means (SD), median (interquartile range) or numbers (%). TPA was square-root-transformed to approximate normal distribution. Change in IMT (\( \Delta \text{IMT} \)) and squared TPA (\( \Delta \text{TPA} \)) was calculated subtracting the values obtained in the 4th survey from the values from the 6th survey. We used ANCOVA (proc glm procedure in SAS) to calculate the adjusted mean change in IMT and TPA in categories of LLD use, adjusted for age, sex and cardiovascular risk factors. Linear regression models were used to calculate \( p \) for trend across categories (never-, anytime-, and long-term use of LLD). Linear regression models were fitted with \( \Delta \text{IMT} \) and \( \Delta \text{TPA} \) as dependent variables, and age, sex, systolic blood pressure, total cholesterol and HDL-cholesterol, cardiovascular disease, daily smoking and use of LLD as independent variables. Categories of LLD-use were entered as dummy-variables, with never-use of LLD as the reference. Two-sided \( p \)-values < 0.05 were considered statistically significant. Stata SE 12 (StataCorp LP, College Station, TX, USA) and the SAS software, version 9.2, were used for all analyses.
References


