

Nutritional Medicine Update with Robert Crayhon, MS CN  
An Interview with John Abramson, MD: The Overselling of Statins

Robert Crayhon: Joining me now is Dr. John Abramson, author of the book *Overdosed America*, someone with a great deal of clinical practice who's also spent many years researching the whole cholesterol story. Dr. Abramson, welcome.

Dr. Abramson: Robert, it's a pleasure to be with you.

RC: Dr. Abramson, this is something that happens across America thousands of times per day. A fifty-ish man or woman gets their cholesterol level checked at their annual exam. Their doctor discusses the results and says that their total and their LDL cholesterol levels are just a bit too high and they should eat a healthy diet and decrease their saturated fats and get their blood test redone in three months. They do that and the levels are still high and they're put on a drug, and they're told they don't have to be so careful about exercise and diet now. What do you think of this approach to preventing heart disease?

Dr. A: Well, that's exactly right, Robert. That's how the scenario goes. I think that there are many things that are wrong with this approach. The most important thing that's wrong with it is that it doesn't address the real causes of heart disease, and if the real goal of our interactions with the medical system are to decrease our risk of heart disease, then this is a very bad way to do it.

Where to begin. First of all, there is not a single randomized control trial that shows that cholesterol-lowering statin drugs are beneficial for women of any age or men over 65 who do not already have heart disease or diabetes. It's never been shown, and the guidelines that claim to be evidence-based simply aren't evidence-based. In fact, the 2001 National Cholesterol Education Program guidelines that made recommendations for women who didn't have heart disease but were at moderately elevated risk, to be put on a statin admitted at the end, it said clinical evidence for these recommendations is generally lacking, and the recommendations made for women are based on extrapolation of the data from men. Similarly for people over age 65, there's no evidence. So, no evidence that it's beneficial for large groups of people.

Now, the key to the scenario that you presented, given that there's clinical evidence lacking for primary prevention for women and people over 65, is the doctor is giving his or her patient the wrong message, because when the doctor says come back in three months and if your cholesterol hasn't budged we'll put you on a statin and you won't have to worry about your diet and exercise, that's exactly the wrong message because diet is far more important than cholesterol level, and exercise is not only more important than cholesterol level, but being unfit is a greater risk for heart disease than the entire Framingham composite risk score. So if somebody's cholesterol level doesn't budge, to put them on a statin and say don't worry about diet and exercise is absurd based on the real scientific evidence. Doctors don't get that. I lecture all over the country and doctors

don't understand that they're making an enormous mistake when they say exactly what you laid out in the scenario, Robert.

RC: So we're talking about the #1 killer of Americans.

Dr. A: Well, let's be careful. We're told that it's the #1 killer, and you should know your numbers, but for women, for example, who are below the age of 75, cancer takes 78% more lives than heart disease. So that #1 killer campaign is a little bit of a fear-mongering effort.

RC: Nonetheless, a major health problem, and what I was going to say is, it's being mismanaged.

Dr. A: Right, it's being mismanaged. Let me tell you to go back to the scenario. The Lyon Diet Heart Study is probably one of the most important studies that's been done to prevent recurrent heart disease. What the study did is it took patients in Lyon, France who had a heart attack and it randomized them into two groups. This is the way the statin studies are done. But instead of putting one group on a statin and the other on a placebo, what the Lyon Diet Heart Study did is it assigned one group to receive counseling about eating a Mediterranean-style diet and the other group simply received counseling on eating a prudent post-heart attack diet. You come back about three or four years later and you see that the group that was randomized, this was a randomized trial, the group that was randomly assigned to be counseled to eat a Mediterranean-style diet had 2 ½ to 3 times less risk of recurrent heart disease and death than the group that was randomized to eat the conventional diet. Well you say, that's very good and obviously the diet had an effect on their cholesterol, but the key point here is that the diet had *no* effect on their cholesterol. The group that was assigned to eat the Mediterranean-style diet had exactly the same cholesterol level as the group that was eating the standard post-heart attack diet. So the bottom line here is that eating a Mediterranean-style diet is 2 ½ to 3 times more effective than a statin in preventing recurrent cardiac events and death in people who already have heart disease and it is not mediated by cholesterol levels whatsoever.

RC: And yet statins are being pushed constantly.

Dr. A: They're being pushed constantly. I presented at a conference about three weeks ago, Robert, down in Florida. It was an excellent conference and I presented for an hour about how I saw the scientific evidence. And then two local docs who were cholesterol and heart disease experts rebutted me, rebutted the position that I was presenting on the statins. It took a little while to understand what they were saying but the doctor who was the local cholesterol expert was making the argument, he looked at my data and he said okay, it doesn't appear that there is evidence from clinical trials that statins are effective for women or people over 65 who don't yet have heart disease. But when we do more sophisticated studies like intravascular ultrasounds or 250-slice CAT scans of the heart, we see that almost everybody has evidence of atherosclerosis, even at a very young age, and therefore nobody's really primary-prevention and therefore everybody should be on statins. I finally understand what I think is the pro-statin argument. But there's an

enormous logical flaw in that. There's a logical dishonesty in it, because the clinical trials that have been done have defined primary prevention patients as those who do not have a clinical history of cardiovascular disease. And what we find when we define the group of patients like that is that statins have not been shown to have a benefit for women or people over 65. So the scientists who are claiming to rely upon evidence-based medicine, somehow turn away from evidence-based medicine and go to conjecture and what they believe ought to be true rather than sticking to the results of the studies. And the vast majority of these studies have been designed by the drug companies themselves. It's not like there's some public interest group that's anti-drug that has manipulated the studies against the drug companies' interest. It's exactly the opposite.

RC: You know, all this reminds me of a Peanuts cartoon I saw years ago where Lucy's looking down at the ground and she said, "Look at this butterfly, Linus. It's so beautiful. How did it get here all the way from Brazil?" And Linus looks down and he says, "That's not a butterfly, that's a potato chip." And she looks down and goes, "Wow! How do you think this potato chip got here all the way from Brazil?" And there's this sort of slight-of-hand where the very central argument collapses but yet we're still sold the same product.

Let's go back to the diet discussion you had because in a book, one of my favorite books about the history of both, the health food movement and the awareness of nutrition is called *The Food Factor*, and during World War II in England, they didn't have margarine, they didn't have white sugar, white flour. They couldn't afford them. They had whole grains and they had butter, and the heart disease rates plummeted in England. You'd think they would have learned from that but they didn't, and after the war slowly all these refined foods came back. We have all this data that there's a much less expensive way to treat heart disease than statins which are expensive: The Lyon Heart Study, and then we have the World Health Organization coming out with a study showing that half the people with heart attacks have a normal cholesterol level. So there's all this false, not just in the statin story but even in the cholesterol level story, and yet we've got a natural solution but nobody wants it. Why? Does it come down to money?

Dr. A: The bottom line is yes it does. And it's not a matter of cost. It's not that the statins are too expensive a way to do it. It's that the statins aren't an *effective* way to do it. That's the problem. If it were just money I would say spend your money however you want to spend your money. We're a fairly wealthy country, we can do it. That's not the problem. The problem is that people think they're spending their money and doctors think that they're practicing good medicine, and we're not getting the outcomes we want. This is how bad it is, Robert. There was an article in the *New England Journal of Medicine* a couple of months ago extolling our victory over heart disease, showing that the death rate from coronary heart disease has gone down by 50% in the United States since 1980, and much of that has to do with reducing risk factors like lowering cholesterol. That's in the *New England Journal of Medicine*, and that's what's going to be taken as the gospel. And this was from 1980 to 2000. The truth is that in 2000, Americans were twice as likely as Europeans to be taking a statin at a given level of risk

of heart disease. Twice as likely to be taking a statin and three times as likely to be getting a surgical or invasive procedure to open up a blocked artery. So we're getting twice as many statins, three times as many procedures to open up blocked arteries. Instead of ranking the best for coronary heart disease death rates among industrialized countries, we ranked 17<sup>th</sup> among industrialized countries. You might say we were just learning to use statins and we were just starting to use these invasive procedures to open up arteries, so the fact that we were doing more of it means we may have ranked 17<sup>th</sup> but we must have been getting better, except that we were getting worse than nine out of ten industrialized countries. So we're taking twice as many statins, three times as many procedures to open up blocked arteries, and we ranked 17<sup>th</sup> and we're losing ground to nine out of ten industrialized countries. It's nuts. And you say well how can that be? And then you look at this beautiful work that the Center for Disease Control has done, where they create maps of the United States, state by state, and the states that have a higher percentage of people with risk factors for heart disease are darker and you can see in maps from 1991, 1995, and 1999 that the United States just gets darker and darker and darker and we're just moving in the wrong direction. Why? It's Sutton's law. It's because cholesterol is where the money is. The money is not in helping American people to understand that an epidemiologically informed approach to reducing the risk of heart disease has to do with exercising and eating a healthy diet, not smoking, and controlling stress. That that's how to reduce the risk of heart disease. The problem is in our market-based society, where knowledge is largely generated and distributed because of its profit-generating potential, what happens is doctors discipline doctors and intelligent public citizens are confused by what appears to be scientific evidence showing that statins are the best approach to reducing the burden of heart disease. It's almost impossible to get the truth out.

RC: One of the anomalies of all this is that you see a 350 lb. person walking down the street happy because, okay they haven't lost weight but they're on a statin so all is well.

Dr. A: Absolutely right, and we've heard about Avandia recently in the news. Avandia is a very expensive diabetes drug. It can cost up towards \$200 a month to take this drug. The reason, the real primary reason why we treat diabetes, Type II diabetes, is not so much that a high blood sugar causes its own problems, but that there are cardiovascular side effects that are devastating. So three-quarters of people with Type II diabetes eventually die of cardiovascular disease. The reason why we treat people with diabetes is largely to prevent cardiovascular disease. Now comes a drug that costs upwards of \$200 a month, and when you look at its manufacturer's own study that was published in the *Lancet* last September, you see that the study claimed to have looked at a population of pre-diabetic patients - patients whose fasting blood sugars were between 110-125 - randomized them to get treated with Avandia or a placebo, and the article claimed that the Avandia was a good treatment because 60% fewer people developed diabetes who took Avandia than who took the placebo. But when you look at the article you see that the people who took Avandia gained 4 ½ pounds more than the people who took the placebo, that their risk of diabetes was not decreased by 60%, the diagnosis was simply delayed by a year, and the people who took Avandia developed 37% more serious heart disease than the people who took the placebo. That article was spun - that wasn't quite

statistically significant - but that article was spun to doctors as evidence that they should put their pre-diabetics on Avandia, when in fact there was absolutely no evidence that it was beneficial to their health, and in fact it showed that there was a 37% increase in the risk of heart disease. Now, because the article is sponsored by the manufacturer, they get to spin the way they want to, and they make that look like an advantage when I think reasonable people would look at that data and, especially in conjunction with data that shows that lifestyle interventions are very effective at preventing diabetes, and say wait a minute. We don't want to spend \$7,000 on Avandia per patient over three years and increase the risk of heart disease by 37%. That's not what American medicine ought to be about. Unfortunately, Robert, that's where the profit is and that's what's directing what doctors believe to be true about the best way to treat their patients.

RC: Well let's look at where all the profit is. You've spoken about it. It's estimated that we spend \$2 trillion dollars in America to buy the food that we don't need that makes us obese. We spend another \$2 trillion taking care of the health problems caused by that overweight and obesity. And if you think about it, and it's almost too Machiavellian to believe, but the failure of statins actually by creating the need for more invasive procedures to rescue damaged arteries or at least postpone the ultimate death of the patient is also another way to generate profit. So I'm not saying that there's a bunch of people sitting in a room going "Great! We're so glad statins don't work." Clearly it looks mostly like there's drug companies just pushing them on everyone, but the question is: What kind of a world do we live in when there are so many direct-to-consumer advertisements telling patients what to go ask their doctors about? And I just want to add this, when you look at the bottom of these drug ads for cholesterol-lowering medications, the new drugs in particular, have fine print that says things like, "Oh by the way, this drug does not prevent heart disease or heart disease-related deaths." Well then what's the point?

Dr. A: Well actually, that was taken off in 2004 I think. I've been looking at that issue, that disclaimer, with the ASCOT study, looked at 10,000 people with hypertension and three other risk factors for heart disease, put half of them on Lipitor and half of them on a placebo, and there was around a 36% decrease in the risk of heart disease in the people on the Lipitor, and the FDA allowed Lipitor and I believe the other statins to take that disclaimer off. Problem with that study is a) it was stopped prematurely when there was this statistically significant reduction in cardiovascular disease but there was not a statistically significant reduction in overall mortality, which is the key factor, the key outcome. The second problem with that study is that there were 2,000 women in that study - 2,000 women who had hypertension and three other risk factors, half on Lipitor, half on a placebo - and the women who were put on the Lipitor developed 10% more heart attacks than the women who were put on the placebo. The FDA allowed the drug companies to change the label, especially on Lipitor, to say that Lipitor does prevent heart attacks, based on the ASCOT study, when in fact there was no evidence, and if anything, counter-evidence to show a benefit for women who have high blood pressure and at least three other risk factors.

RC: Let's talk about what does prevent heart disease. Exercise, quitting smoking, something along the lines of the Mediterranean diet. Things like that?

Dr. A: Let's talk about exercise first. When doctors are following the guidelines that are endorsed by the National Institutes of Health, they look at people who have two or more risk factors for heart disease and then they score their risk for developing heart disease over the next 10 years, their probability for developing heart disease, according to the Framingham risk score. If your risk of developing heart disease over the next 10 years is between 10-20%, then the guidelines create a threshold for when you should be on a statin; if your LDL level, your bad cholesterol level's above 130 you should certainly be on a statin, if you are in that 10-20% risk group, and there was a revision that suggested you should be offered a statin if your LDL is above 100. Now, exercise, physical fitness, is not even included in that composite risk score that determines what your risk of developing a heart attack is over then next 10 years, and we see from studies that unfitness – being physically unfit – explains twice as much of the risk of dying over the next 10 years as does the Framingham risk score. And the Framingham risk score doesn't even have exercise in it. So doctors are basically being trained not to address the exercise issue when they put people on statins.

RC: What about diet?

Dr. A: Diet is enormously important. We talked about the Lyon Diet Heart Study. That's a randomized controlled study. We've seen other randomized studies. We've seen the Nurses' Health Study that shows that nurses who eat fish once a week have a 31% reduction in their risk of heart disease. That's exactly as effective as a statin, eating fish once a week. Now that's an observational study, but it fits in with the pattern that we're seeing in the randomized controlled trials.

So, diet and exercise are extremely important. Smoking is extremely important. Now, doctors are kind of fed this line that a) they're not good at counseling, and b) nobody listens to them when they do counseling. There was a beautiful study that looked at senior citizens who were admitted to the hospital with a heart attack and simply suggesting that they quit smoking while they were in the hospital significantly decreased their risk of dying. But treating them with a statin doesn't significantly reduce their risk of dying. Simply counseling them when they're in the hospital to quit smoking. So, part of the distortion of our knowledge that happens because our knowledge is fundamentally serving commercial interest, part of it is to push statins and to push profit-seeking ways to improve health, and part of it works on the other side to discredit the effectiveness of the things that people can do to reclaim responsibility for their own health. And what we know, what the real truth is, is that two-thirds of our health is determined by how we live our lives and where we live our lives. In other words, we're responsible for most of our health. Certainly medical science has just wonderful benefits to offer some people who are sick, but playing catch-up is not nearly as effective as being responsible and taking preventive action to live a healthy lifestyle. But that gets dismissed because there's not much money in it.

RC: What percentage of statin use in this country do you think is actually warranted?

Dr. A: The best study we have is on Canada. We can assume that in Canada the use is, if anything, more conservative than the United States, and we see data from I think 1996 in Canada that shows that 74% of statin use is for primary prevention, meaning for people who do not have heart disease or diabetes. Amongst that 74%, how many are women and how many are men over 65? It's going to be a goodly percentage, so I think what we're going to see is that somewhere around 30 or 40% of statin use simply is not justified by the scientific evidence. But that said, Robert, even if we look at very high risk men who don't have cardiovascular disease already, the men in the WOSCOP Study that was published in the *New England Journal of Medicine* in 1995, where if you treat those very high risk men with a statin, you reduce the risk of developing heart disease by 31% and the risk of dying by 22%. But in real terms, that translates in, if you treat 50 high risk men for 5 years, one of them will benefit because they were taking a statin drug. So it's not a slam dunk, even for the highest risk men who don't have a history of cardiovascular disease or diabetes, it's not a slam dunk that taking a statin is going to benefit you. In fact, there's 49 out of 50 chances that it won't benefit you. When we tell those numbers to patients, many patients suddenly are willing to listen to the idea of diet and exercise and quitting smoking because they realize that statins aren't the cure-all that they're made out to be.

RC: So what is the solution for either the practitioner, a nutritionist, or a colleague of a practitioner who's prescribing statins right and left to patients they may have in common? Or the patients getting the statins? Show them a copy of your book or summon some of the Lyon Diet Study data? How do we begin to wake up the statin dispensers?

Dr. A: Please show them a copy of my book or show them the article that I wrote that was published in the *Lancet* in January 2007, showing that there's no evidence for women or people over 65 for primary prevention. But I think there's a deeper problem here, Robert, and you've been bringing it up. I think there's what we call an epistemological problem. There's a problem with the way that our knowledge is produced and disseminated, so that we think that medical knowledge is produced and disseminated in order to improve our health and it's really been privatized as the truth and it's produced and disseminated in order to maximize corporations' return on investment. And I think the first step in becoming medically literate, medically competent, and medically empowered is to understand that most of the knowledge that is put forth in the medical journals, in the guidelines, in doctors' continuing education classes, when the drug reps come and bring lunch, when patients hear drug ads on TV, when they hear public service advertisements from organizations – supposedly non-profit organizations that they have grown to trust over the years which really are taking money from the drug companies – when the doctors' professional societies which now have grown dependent on drug company money. When we hear medical information from all of these sources that we are taught to trust and really have no alternative but to trust, we have to understand that most of the information that's coming our way is coming our way because it's commercially beneficial to the producing organizations, the producing corporations, for that information to come our way. What we need to do is become

intelligently self-empowered. Step one is to understand that most of preventive medicine has to do with living your life in a healthy way. Absolutely get your blood pressure checked. And I'm not against the recommendations which say get your cholesterol checked every five years. There's no organization that says get your cholesterol checked more than every five years and yet it's become a standard part of each year going by that we get our cholesterol checked. I'm not against intelligently using medical screening, and we do need to treat blood pressure by non-pharmacological means hopefully, but sometimes with drugs. We need to use medical science but we also need to understand ultimately that most of what goes on with our health, most of how we're going to age and die, has to do with how we live our lives now. And it's that message of empowerment that I think is so important for the public and for doctors to understand.

RC: The book is *Overdosed America*, and Dr. John Abramson, thanks so much for being with us.

Dr. A: Robert, it's a pleasure talking with you.