

Letter to the Editor

From CARDS to AURORA: One Disease, Two Responses

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Key words:
Rosuvastatin,
kidney,
cardiovascular

Manuscript received:
September 11, 2009;
Accepted:
February 4, 2010.

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The effects of atorvastatin on diabetic kidney disease patients have recently been reported. Thus, in the CARDS trial patients with diabetes and no prior cardiovascular disease (CVD) were randomized to atorvastatin, 10 mg/d, or placebo. In the subgroup of patients with an estimated glomerular filtration rate of 30 to 60 mL/min/1.73 m² (34% of the overall study population) there was a 42% reduction in major cardiovascular events with atorvastatin, similarly to the 37% reduction observed in the overall study.¹

In contrast, although it has been shown that rosuvastatin at 10 mg/day is effective in lowering LDL-cholesterol and high-sensitivity C-reactive protein in hemodialysis patients,² the AURORA trial reported that, in this population, treatment with rosuvastatin had no significant effect on the composite primary endpoint of death from cardiovascular causes, nonfatal myocardial infarction, or nonfatal stroke.³

Taking into account that rosuvastatin produces greater reductions of LDL-cholesterol when compared with other statins,⁴ how is it possible to explain these unexpected results?

CVD is a continuum, from risk factors to organ damage and finally overt clinical CVD and end-stage renal failure. Available

data show that when statins are prescribed during the first, or even middle stages of the continuum, there is an important improvement in cardiovascular prognosis. However, when administered at advanced stages the benefits of statins or other therapies are small or even null.⁵ All these data emphasize the importance of early treatment for the prevention of CVD, including renal failure.

References

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