CVD RISK IN HIV PATIENTS

This study reviewed a multicentre clinical prospective cohort of 19,829 HIV-infected adults who received care in inpatient and outpatient settings since 1995. The objective was to determine the extent to which existing and de novo cardiovascular disease (CVD) risk estimation tools predict myocardial infarction (MI) and were reliable. This included rigorous MI adjudication.

The bottom line is that the pooled cohort equations were more moderately calibrated in the Centers for AIDS Research Network of Integrated Clinical Systems, but predicted consistently lower MI rates than actually occurred, underestimating the true risk.

Combination antiretroviral therapy (ART) has positively affected the lives of HIV-infected individuals and continues to narrow the gap in life expectancy between people with HIV and the general population. Unfortunately, treatment can lead to dyslipidaemia and lipodystrophy, increasing the risk of CVD in these individuals.¹

Large cohort studies have identified an increased risk of MI, apparently in association with long-term ART, and higher rates of MI in people infected with HIV versus uninfected individuals.² ³

In addition to this, CVD risk factors such as hypertension, diabetes and smoking are also increased among HIV–infected individuals.³ Lipid–lowering agents, such as statins, also have immunomodulatory effects that can be beneficial for individuals with HIV.¹ This is an area of current active research. Careful management of lipids, hypertension and diabetes, and active support for smoking cessation are extremely important in this group of patients.

CVD AND LIVING WITH CANCER

This paper focuses on the increased risk of cardiovascular diseases, such as myocardial infarction, stroke and heart failure, in patients treated with some cancer therapies. The authors conclude that appropriate risk management and early detection of heart problems can prevent long-term illness and reduce multi-morbidity in people living with and beyond cancer.

TAKE-HOME MESSAGE
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Cancer survival rates have doubled in the UK in the last 40 years,¹ with more than 2.5 million people living with or beyond a diagnosis.² Between 2010 and 2011, more than half of all cancer patients in England and Wales survived for 10 years or more, rising to 78% of women with breast cancer, 84% of men with prostate cancer and 98% of those with testicular cancer.¹
However, cancer treatments can have cardiovascular consequences either directly, affecting heart physiology, or indirectly through increasing cardiovascular risk factors. The toxic effects of cytotoxic drugs or radiotherapy can include acute coronary syndrome, hypertension, arrhythmias, symptomatic left ventricular dysfunction and subsequent heart failure. Indirect effects are caused by drugs that block or influence the metabolic pathways and can speed up atheroma formation, or lead to thromboembolisms. After cancer treatment, people living with and beyond cancer should receive a follow-up appointment with their GP to help them with rehabilitation, support and self-management.

This review is important because it provides an opportunity to identify potential side-effects, address existing symptoms and promote health and lifestyle advice. It is important that hospitals provide good and helpful treatment summaries and highlight potential cardiovascular issues, especially with regard to long-term follow-up. Referral to secondary care cardiology services should occur for people with cancer who have abnormal cardiac function or cardiovascular symptoms during surveillance. Primary and secondary care recognising the growing cardiac burden for people during and after cancer treatment is a shared responsibility. Older people may already have comorbidities before their cancer treatment starts, so it is important that they are well informed, that prevention and risk reduction strategies are in place, and that if cardiac problems occur, they are diagnosed early.


COLORECTAL CANCER AND FATTY LIVER DISEASE
Ahn JS, Min YW, Hong SN, et al. Non-alcoholic fatty liver diseases and risk of colorectal neoplasia. Aliment Pharmacol Ther 2017;45:345–53.

A total of 26,540 asymptomatic adults underwent colonoscopy and abdominal ultrasonography as part of a health check programme. The study revealed that patients with non-alcoholic fatty liver disease (NAFLD) had a higher prevalence of any colorectal neoplasia (38.0% versus 28.9%) and advanced colorectal neoplasia (2.8% versus 1.9%) than those without. The risk of any, or advanced, colorectal neoplasia was higher for those with severe liver disease than those with mild liver disease.

TAKE-HOME MESSAGE

Colorectal cancer is a significant health issue, being the third most commonly diagnosed cancer, and the fourth leading cause of cancer death worldwide.1 Fat in the liver, related to weight gain, is a rapidly increasing cause of chronic liver disease.2 NAFLD affects liver structure and function, and leads to cirrhosis, organ failure and cancer.3 It is also associated with an increased risk of type 2 diabetes, chronic kidney disease and cardiovascular disease (CVD).4 CVD is the leading cause of death in patients with NAFLD, with cancer being the second highest cause and liver disease the third.5

In the clinic, we need to be aware of the increased risk of colorectal neoplasia in these patients, and ensure that the patients are enrolled with the NHS occult blood screening programme. We need to be alert to new abdominal symptoms, unexpected weight loss and rectal bleeding. The use of weight loss and exercise regimes can lead to the regression of NAFLD, as well as improve dyslipidaemia and reduce the risk of atherosclerosis, which is driven by insulin resistance. The improvement in the concomitant metabolic abnormalities may also reduce the risk of carcinogenesis.