C-reactive protein and statins: by Jupiter!

Sir,
I was alerted when I read that atherosclerosis may play only a minor role in CKD [1]. As one who used to perform autopsies with Dr James Davson, I can assure Dr Wheeler that there is plenty of atherosclerosis in CRF [2]. If it is unique in some way, that, for example, could be due to the content of indoxyl sulphate.

I believe those experts [3] who have listed C-reactive protein (CRP) as a risk factor, as well as a marker, for coronary artery disease. The Copenhagen authors who wrote the paper on CRP levels and polymorphisms were undoubtedly studying the pentameric C-reactive protein. In the meantime, monomeric CRP (mCRP) has been shown to play an active role in inflammation-associated cardiovascular disease [4]. The mCRP arises from macrophages and incites endothelial cells and neutrophils.

If more justification is required for the administration of statins in CRF, it will surely follow from the evidence that statins reduce renal fibrosis and progression [5,6].

Conflict of interest statement. None declared.

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Reply

Sir,
I respect Dr Wardle’s comment that he has observed extensive atherosclerosis in patients with ‘CRF’ from personal experience of post-mortem studies.

I did not wish to imply that CKD patients do not develop atherosclerosis, but rather that other pathologies (such as cardiomyopathy) may make a more important contribution to the development of premature cardiovascular events. This view is supported by the recent 4D and AURORA trials in which statins did not positively impact on cardiovascular outcomes in CKD stage 5 patients receiving dialysis (as I explain in my review). I apologize if Dr Wardle found my article confusing in this respect.

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