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Case study of an abrupt statin intolerance - crucial role of family physicians

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Background & Aim: One of the most prevalent health problems a family physician has to manage is dyslipidemia. It's essential that a correct statin management is implemented to promote right metabolic control and prevent adverse effects (AE).
Method: RCS is a 68 year old active men with history of obesity, hypertension, dyslipidemia and chronic obstructive pulmonary disease, controlled with olmesartan medoxomil 20mg, atorvastatin 20mg, fenofibrate 267mg and aclidinium bromide 322ug. In a routine appointment the patient was asymptomatic, but outside the LDL target. The statin therapy was changed to pravastatin 40mg + fenofibrate 160mg. After a few weeks, in spite of a good LDL target, the patient manifested myalgia in both legs and elevation of AST (66 U/L), CK (2068) and creatinin (1,95 mg/dL). At the time, no therapeutic change was made. After 4 weeks, symptomatic and analytic deterioration was observed and the statin suspended. After 4 months the patient still referred myalgia and still had CK (569U/L), LDL (248,8mg/dL), total cholesterol (TC) (361 mg/dL) and triglycerides (TG) (381mg/dL) elevated. Further investigation showed hypothyroidism (TSH 150 ug/dL and Ft4 0.1ug/dL) in analytic review.
Results: After 1 month of therapeutic with only levotiroxin 300mg the patient became asymptomatic with normal lipid profile, AST, CK and creatinin, without requiring statins. In further appointments the levotiroxin was adjusted to 200mg and the patient remained asymptomatic with no analytic changes.
Conclusions: Statin management should obey to tight monitoring, not only to achieve target values but to prevent possible AE. Secondary causes of dyslipidemia should be investigated before statin introduction and if any AE occurs during therapy. Due to the good accessibility, family physicians have a vital role in statin management and it's crucial to develop skills, knowledge and to be updated in this area.