Lipitor and Crestor Are Better Than Pravachol for HIV Treatment-Related Cholesterol Problems

January 6, 2011

Lipitor (atorvastatin) and Crestor (rosuvastatin)—two drugs in the statin family—were about twice as likely as the statin Pravachol (pravastatin) to help HIV-positive people get their cholesterol and triglyceride levels within the desired range. These data were published online December 28 in Clinical Infectious Diseases.

A number of commonly used HIV treatments can cause a person's cholesterol and triglycerides levels to shift outside of their normal ranges. Total cholesterol and low-density lipoprotein (LDL)—also known as "bad" cholesterol—can increase, as does another lipid, or fat, called triglycerides. Conversely, high-density lipoprotein (HLD)—or "good" cholesterol—can drop.

HIV itself can also play a role in shifting a person's lipids in unhealthy directions.

Statins, a class of drugs that block the liver from making lipids, are one of the most effective treatments in lowering both total cholesterol and LDL. They have also been proven to help prevent the development or worsening of cardiovascular disease. Because of the ways the liver processes these drugs, however, they can interact with the same HIV drugs that negatively affect lipids, and good comparative studies have not been conducted to determine which of the safer statins is best.

To answer this question, Sudershan Singh, MD, from the University of Washington, and his colleagues looked at the effect of three statins with the least potential for drug interactions—Lipitor, Crestor and Pravachol—in 700 people living with HIV. Singh's team was most interested in which statin was most likely to help people achieve the gold standard of efficacy: blood lipids within the desired range, as specified by the National Cholesterol Education Project (NCEP).

Overall, 303 people were taking Lipitor, 280 were taking Pravachol and 95 were taking Crestor. The three groups were all similar in most respects, though the people in the Lipitor group tended to be older than those in the other two groups.

Singh and his colleagues found a marked difference in the efficacy of the three statins. Study volunteers taking Lipitor or Crestor were more than twice as likely to reach NCEP recommended

LDL levels after 12 months of treatment, compared with those taking Pravachol. Moreover, those taking Crestor were also about twice as likely to boost HDL levels as those on Pravachol. Those taking Lipitor were also more likely than those taking Pravachol to reach NCEP recommended HDL levels after 12 months, but the difference was not statistically significant—meaning that it was small enough to have occurred by chance.

In terms of triglycerides, those taking Crestor were more likely to see drops than people taking either Lipitor or Pravachol.

As for safety, the number of people experiencing side effects was low in all groups, and statistically similar. Less than 8 percent of people taking any of the three drugs experienced side effects, with those on Crestor being least likely to have an adverse reaction.

“Current recommendations include treatment of HIV-associated [cholesterol and triglyceride problems] with statins and emphasize the use of [Pravachol] or [Lipitor]. Our findings are consistent with the recent British guidelines that include a recommendation to use [Crestor],” the authors conclude.

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