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Effects of Bisoprolol on Lipoprotein Cholesterol Subfractions and Apolipoproteins in Patients with Hypertension

H. Drexel, H. R. Schmid, F. Follath, F. W. Amann

Non-selective beta-blockers tend to increase triglycerides and low-density lipoprotein (LDL) cholesterol while decreasing the atheroprotective high-density lipoprotein (HDL) cholesterol, particularly the HDL2 cholesterol subfraction. The aim of this study was to investigate whether the highly beta1-selective beta-blocker bisoprolol shares with non-selective beta-blockers these effects on blood lipids in patients treated for mild or moderate essential hypertension. In particular, HDL cholesterol and its subfractions HDL2 cholesterol and HDL3 cholesterol as well as apolipoproteins A1 and B were investigated. In a multicentre outpatient trial, 86 hypertensive patients received bisoprolol for eight weeks. Diastolic blood pressure was reduced from a baseline of 102 ± 7 mmHg (mean ± SD) to 87 ± 8 mmHg after 8 weeks of therapy with bisoprolol. Systolic blood pressure decreased from 159 ± 17 mmHg to 139 ± 14 mmHg. Blood pressure was normalized in 69 % of patients with 5 mg bisoprolol once daily and, after increasing the dosage to 10 mg bisoprolol once daily in non-responders, in 80 % of patients. Treatment with bisoprolol decreased triglycerides by 4.8 % and LDL cholesterol by 1.7 %, whereas HDL cholesterol increased by 5.2 %, which was attributable to an increase by 9.2 % of HDL2 cholesterol and by 3.0 % of HDL3 cholesterol, respectively. None of these single changes were significant at the p < 0.05 level. Surprisingly, however, all lipid effects were in the favourable direction and opposite to the changes usually observed with non-selective beta-blockers. In a mathematical model derived from angiographic studies, the improvement of lipid risk factors brought about by bisoprolol equalled that of a decrease in age by 3.5 years. We thus conclude that effective antihypertensive doses of bisoprolol do not exert the typical dyslipidaemic effects of beta-blockers but rather tend to induce small but favourable changes in plasma triglycerides, LDL and HDL cholesterol, and especially in the atheroprotective HDL2 cholesterol subfraction. J Clin Basic Cardiol 2001; 4: 57–60.

Key words: bisoprolol, beta-blocker, blood lipids, LDL cholesterol, HDL cholesterol, HDL subfractions, apolipoproteins
Methods

Patients
The study was conducted by general practitioners in Switzerland as a multi-centre outpatient study. After informed written consent had been obtained, patients with mild to moderate essential hypertension were enrolled into the study if they fulfilled two criteria: (a) a morning sedentary diastolic blood pressure at > 2 blood pressure readings of > 90 mmHg, and (b) no severe organ damage due to longstanding hypertension. Criteria for excluding patients were: contraindications for beta-blockers, renal or hepatic dysfunction, history of stroke or myocardial infarction within the preceding 6 months, pregnancy and lactation. Concomitant use of other drugs that could affect the serum lipids was avoided during the study, in particular no diuretics or drugs affecting lipid metabolism were used. Also, no other antihypertensive drugs were allowed during the trial. If a patient had already taken antihypertensives before the study, the drugs were discontinued 4 weeks prior to the onset of the protocol.

Prior to the onset of treatment, a lipid profile was obtained, which included measurements of the plasma concentrations of triglycerides, cholesterol, HDL cholesterol, LDL and HDL₃ cholesterol subfractions, LDL cholesterol, and apo A1 and apo B. Serum creatinine and serum potassium were also measured before and after treatment, and sedentary blood pressure and heart rate were recorded.

Biochemical methods
Lipid and lipoprotein measurements were performed as previously described [11]. In short, after an overnight fast and complete abstinence from ethanol for 12 hours, venous blood was drawn without the use of a tourniquet in a sitting position. Plasma was frozen immediately after centrifugation and stored at −20 °C. The frozen samples were collected from all participating physicians by a courier within 5 days and transported in a container at −20 °C to the analyzing center. Only non-haemolytic plasma samples were further processed; patients whose plasma samples were haemolytic were excluded from the analysis.

Cholesterol and triglycerides were measured enzymatically using the cholesterol CHOD-PAP method and the triglyceride GPO-PAP method, respectively. HDL cholesterol, LDL cholesterol, and HDL₃ cholesterol were determined using a stepwise precipitation procedure with dextrane sulphate [19, 20]. The results obtained by this stepwise HDL cholesterol precipitation procedure are easily comparable to those obtained by HDL cholesterol subfraction analysis using rate zonal ultracentrifugation [10]. Plasma concentrations of apo A1 and B were determined by turbidimetric immunoprecipitation assays (Uni Kit T, Roche) on a Cobas Mira. These methods have been shown to give excellent agreement with nephelometric assays [21]. LDL cholesterol was calculated [22].

Treatment
Bisoprolol was administered once daily as a 5 mg tablet in the morning at an initial dose of 5 mg/day. If blood pressure was not lowered to values ≤ 155/90 mmHg within two weeks, the dosage of bisoprolol was increased to 10 mg/once daily in the morning. Treatment was continued for a total of eight weeks. During the study the patients were regularly interviewed for the presence of subjective symptoms or adverse reactions.

At the end of the study blood pressure and heart rate were recorded and measurements of lipid parameters, serum creatinine and serum potassium were repeated.

Lipid formula
The amount of atherosclerosis in the coronary tree can be quantitated as the extent of coronary atherosclerosis (ie the number of lesions with ≥ 50 % narrowing). The quantitative interrelation of risk factor levels (eg age, lipids, etc.) with the extent of disease can be determined as recently reported [12]. Then the effects of the various lipids and of age on the disease extent are compared. The amount of a given lipid, that increases disease extent by the same amount as an age increase of one year, can be standardized as an age-equivalent of 1 year. The age equivalents of 1 year are: an increase by 0.092 mmol/l of LDL cholesterol, by 0.101 mmol/l of triglycerides, as well as a decrease by 0.020 mmol/l of HDL₂ cholesterol and by 0.046 mmol/l of HDL₃ cholesterol, respectively. In the present study the changes of the various lipids observed after 8 weeks of bisoprolol treatment were entered into the formula to obtain the total age equivalent of the lipid effects brought about by bisoprolol.

Statistical analysis
Values before and after 8 weeks of therapy were compared using a t-test for paired data with a level of significance set at p < 0.05.

Results
A total of 86 patients (46 men, 40 women) were included into the analysis. Clinical characteristics of patients are summarized in Table 1. Effects of treatment on serum potassium, creatinine, and blood pressure are given in Table 2.

Lipid effects
Levels of blood lipids obtained before and at the end of the study are summarized in Table 3 and Figure 1. There was no
Figure 1. Plasma levels of triglycerides and HDL cholesterol before and after 8 weeks of treatment with bisoprolol (means, bars indicate SEM)

Haemodynamic effects
At baseline, average (± SD) blood pressure was 159/105 (± 19/± 7) mmHg and heart rate was 76 (± 9) min⁻¹. After two weeks of treatment, diastolic blood pressure was at or below 90 mmHg in 59 patients (69 %). In the 27 patients whose diastolic blood pressure was still above 90 mmHg, bisoprolol was increased to 10 mg once daily. After another 6 weeks of treatment, 10 of the 27 patients had diastolic blood pressure readings of 90 mmHg or less. Considering also these 10 patients with adequate blood pressure control under 10 mg bisoprolol per day, diastolic blood pressure was normalized in 69 (80 %) of the patients. Average systolic blood pressure was 139 ± 14 mmHg and diastolic blood pressure was 87 ± 8 mmHg at the end of the study. Heart rate was reduced from 76 ± 9 to 67 ± 9 min⁻¹. Thus average reduction of systolic blood pressure was 20 mmHg, average reduction of diastolic blood pressure was 18 mmHg, and heart rate was reduced at average by 9 min⁻¹.

All but 2 patients completed the study (drop out rate 2.3 %). Minor side effects like fatigue were reported by a total of 12 patients (14 %), no serious adverse events were observed during the study.

There were no significant changes of serum creatinine or serum potassium levels after 8 weeks of bisoprolol treatment.

Discussion
The data of the present study demonstrate that bisoprolol, administered at a daily dose of 5 to 10 mg, sufficiently controlled hypertension in about 80 % of patients. At this dosage, bisoprolol had no adverse effects on total plasma cholesterol or triglycerides, LDL cholesterol, HDL cholesterol, LDL₂ cholesterol, HDL₃ cholesterol, or apo A1 or apo B. That plasma levels of apo A1 and B remained constant, indicates that there was no change in the number of particles in the VLDL+HDL+LDL range or in the HDL range. Bisoprolol proved even superior to traditional beta₁-selective blockers in that it had not only no adverse influence on lipid metabolism, but rather induced a favourable trend in triglycerides, LDL cholesterol, HDL cholesterol, and in its two subfractions, HDL₂ and HDL₃ cholesterol. Quantitative data derived from our angiographic lipid formula indicate that the grand total of lipid effects brought about by bisoprolol decreased the risk for coronary atherosclerosis by the same amount as a decrease in age by 3.5 years. It should, however, be kept in mind that this “gain” of 3.5 years refers to an amount of angiographic extent of coronary atherosclerosis and does not mean automatically that clinical morbidity or mortality are postponed by 3.5 years.

These data agree well with and extend the findings of previous studies that found that bisoprolol did not adversely influence total cholesterol, HDL cholesterol, or LDL cholesterol [16–18]. Frithz and Weiner reported that bisoprolol had no undesirable effects on total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides in 42 patients studied over 10 months [16]. Fogari et al. reported from a study with a follow-up of three years that bisoprolol did not adversely affect HDL cholesterol or triglycerides, while propranolol and atenolol both deteriorated these lipid parameters [17].

The mechanisms by which beta-blockers usually lower HDL cholesterol levels and increase plasma triglycerides is not firmly established. One explanation is that beta-blockade leaves naturally occurring alpha-adrenergic stimulation un-opposed. Predominant alpha stimulation decreases the activity of lipoprotein lipase, the key enzyme of triglyceride hydrolysis, whereas the enzyme would be activated by stimulation of beta₂ receptors [23, 24]. Low lipoprotein lipase activity in turn leads to an accumulation of plasma triglycerides and a concomitant decrease of HDL cholesterol, specifically HDL₂ cholesterol as was observed for beta-blockers [15]. In one trial, propranolol reduced HDL₂ cholesterol by 38 % and also reduced apo A1 [25]. Thus, the lipid changes typically seen with non-selective beta-blockers can be readily explained by the catecholamine-induced alpha-receptor mediated inhibition of lipoprotein lipase activity [23].

While the adverse changes of lipid metabolism are very pronounced with non-selective beta-blockers, they have also been observed to a lesser extent with beta₁-selective agents atenolol and metoprolol. Among these compounds, the beta₂-stimulating (that does not block beta₂-receptors) celiprolol (that has a mild beta₂-stimulating action) would not negatively interfere with lipoprotein lipase activity and thus can be expected not to deteriorate triglycerides or HDL. Our data clearly support this concept. A large body of literature also underlines this view. In a comparative study with propranolol and atenolol over 18 months, bisoprolol affected the triglycerides less than propranolol or atenolol and had no significant effect on HDL cholesterol levels. Total cholesterol and LDL cholesterol were not affected significantly either [17, 18]. Taken together, thus, the lipid-neutral effects of bisoprolol apparently are a consequence of the high beta₁-selectivity of the compound.
Our study also demonstrated a potent antihypertensive effect and high safety of bisoprolol in patients with mild to moderate hypertension. About 69% of the patients were sufficiently treated by 5 mg of bisoprolol daily. Increasing the dosage to 10 mg bisoprolol daily resulted in an overall response rate of about 80%. No serious adverse events were reported. Minor side-effects were reported by 14% of the patients, but drop-out rates were only around 2%.

In conclusion, thus, bisoprolol is an effective antihypertensive drug that is well tolerated by most patients. There is a slight beneficial influence of bisoprolol on the lipid fractions measured. Hence bisoprolol appears rather to decrease than increase the lipid-mediated risk for developing or accelerating coronary atherosclerosis.

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References


Appendix

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