

The Only Truth is Post-Truth: Reluctance to Use Statins

La única verdad es la post-verdad: reticencia al uso de estatinas

MARIANO A. GIORGI¹, MTSAC,

In this issue, the Argentine Journal of Cardiology highlights an important health concern explored by Lucía Helguera et al.: (1) patients' reluctance to take statins.

The authors, from the Argentine Society of Cardiology, conducted the study through a digital and anonymous survey of healthcare professionals (predominantly cardiology specialists) in our country. The survey results indicate that 40.9% of respondents reported receiving an express refusal from their patients to take statins. Among the main reasons given by patients for their refusal, two stand out: "adverse events" indicated by 53.4% of respondents and "the influence of negative information from digital media" by 50.5%.

The issue of "adverse events" is noteworthy, not only because of its frequency, but also because of the sociological complexity of this phenomenon. An adverse event includes not only tangible signs and/or symptoms, but also patients' perceptions and beliefs, as evidenced by the ASCOT-LLA substudy, which identified the placebo effect as a determinant of the reporting of adverse muscle events only when patients (and their physicians) were aware that a statin was being used and not during the double-blind period of the study. (2) Healthcare professionals have an important role to play here, as we cannot declare a patient intolerant to statins without a rational evaluation process, as the SAC proposed in its position statement on the Appropriate Use of Statins. (3) This assignment of attributability can, for example, be facilitated by the system proposed by Rosenson et al. (4), which requires an alliance with the patient due to the time and patience it demands. However, this approach enables the identification of "false intolerants," who may have the opportunity to continue treatment. Not all pains are caused by statins.

The second reason given for refusing to take statins is perhaps the most alarming, as it confronts us with

the immense complexity of the simultaneous interaction between the scientific system, patients, the mass media, industry, and the healthcare system. When faced with an issue relevant to their areas of interest, all of them will probably express an opinion, but they can only do so based on their worldview. They only see what they can see, but they do not see what they cannot. Post-truth and "tailored lies" (5) lurk just one click away as useful resources for simulating solutions to issues of ignorance. As German sociologist Niklas Luhmann points out — and special thanks to sociologist Luis Costa for contributing to this section — the absence of an explanatory center of the world is the underlying condition for this to be feasible. This is a consequence of the proliferation of viewpoints resulting from these systems.

The media should prioritize reporting news, industry should focus on achieving higher sales, and those who spread false information should concentrate on gaining more followers on social media. As doctors, we communicate within these same tensions and viewpoints. Thus, each system communicates and the other understands in its own code, only what is relevant to it. Given the current state of modern society, no one should expect anything other than the meaning of the term "adverse event" to differ among those involved. In an era when everyone wants to share their "point of view," the "adverse event" becomes just another topic of conversation.

That is why, from the perspective of healthcare professionals, it is important to know (and be able to communicate effectively) the best estimate of the prevalence of statin intolerance, 9.1% according to the meta-analysis by Bytyçi et al., (7) and to counterbalance what is reported in the media. In particular, it is important to bear in mind that the influence of "statin-negative" publications has been associated with discontinuation of therapy and a 26% increase in the risk of cardiovascular death and an 18% increase

REV ARGENT CARDIOL 2025;93:321-322. <https://doi.org/10.7775/rac.v93.i5.20939>

SEE RELATED ARTICLE: Rev Argent Cardiol 2025;93:362-365. <https://doi.org/10.7775/rac.v93.i5.20933>



<https://creativecommons.org/licenses/by-nc-sa/4.0/>

©Revista Argentina de Cardiología

¹ Cardiology Section. CEMIC. Associate Professor of Pharmacology. Medicine Degree. CEMIC University Institute. Director, Center for Technology Assessment and Health Decision Analysis. CEMIC University Institute

in the risk of myocardial infarction, as demonstrated in a cohort study of nearly 675 000 people conducted in Denmark in 2015. (8) These results warn us about the dangers of the diverse interpretations of medical news, even among healthcare professionals. (9)

This study becomes even more relevant when viewed in the context of providing local evidence on a social phenomenon that, as noted, transcends the scientific system. As with the results of clinical trials, which vary greatly depending on the country or region where they are conducted, the same is true for statin reluctance. A study by Xie et al., (10), conducted at Mass General Brigham in the United States, reveals that the primary reasons for refusal are a preference for lifestyle changes (51.9%) and fear of adverse events (10.9%).

We live with multiple “truths,” and the information provided by the authors gives us more elements to contribute to our evidence-based perspective.

Conflicts of interest

(See author's conflicts of interest forms on the website).

REFERENCES

1. Helguera L, Carrero C, Giunta G, Lerech E, Costabel JP, Stutzbach P. Reluctance to Use Statins in Secondary Prevention: Worrying Results in the Age of Digital Misinformation SAC 2025 Statin Experience – Argentine Society of Cardiology. *Rev Argent Cardiol* 2025;93: 362-5 <https://doi.org/10.7775/rac.v93.i5.20933>
2. Gupta A, Thompson D, Whitehouse A, Collier T, Dahlöf B, Poulter N, et al; ASCOT Investigators. Adverse events associated with unblinded, but not with blinded, statin therapy in the Anglo-Scandinavian Cardiac Outcomes Trial-Lipid-Lowering Arm (ASCOT-LLA): a randomised double-blind placebo-controlled trial and its non-randomised non-blind extension phase. *Lancet* 2017;389:2473-81. [https://doi.org/10.1016/S0140-6736\(17\)31075-9](https://doi.org/10.1016/S0140-6736(17)31075-9)
3. Sociedad Argentina de Cardiología. Área de Consensos y Normas. Uso apropiado de estatinas en Argentina: documento de posición. *Rev Argent Cardiol*. 2018; 86(Sup.1): 1-13
4. Rosenson RS, Miller K, Bayliss M, Sanchez RJ, Baccara-Dinet MT, Chibedi-De-Roche D, et al. The Statin-Associated Muscle Symptom Clinical Index (SAMS-CI): Revision for Clinical Use, Content Validation, and Inter-rater Reliability. *Cardiovasc Drugs Ther* 2017;31:179-86. <https://doi.org/10.1007/s10557-017-6723-4>
5. Amat M D. Coronavirus y posverdad: Mentiras a medida. *Universidad Nacional de José C. Paz. Bordes* 2021;6:9-17.
6. Luhmann, Niklas (1996). Introducción a la teoría de sistemas. Lecciones publicadas por Javier Torres Nafarrate. Barcelona / México: Anthropos – Universidad Iberoamericana – ITESO. Lección 13:pp233-249.
7. Bytyçi I, Penson PE, Mikhailidis DP, Wong ND, Hernandez AV, Sahebkar A, et al. Prevalence of statin intolerance: a meta-analysis. *Eur Heart J* 2022;43:3213-23. <https://doi.org/10.1093/eurheartj/ehac015>
8. Nielsen SF, Nordestgaard BG. Negative statin-related news stories decrease statin persistence and increase myocardial infarction and cardiovascular mortality: a nationwide prospective cohort study. *Eur Heart J* 2016;37:908-16. <https://doi.org/10.1093/eurheartj/ehv641>
9. Buhse S, Rahn AC, Bock M, Mühlhauser I. Causal interpretation of correlational studies - Analysis of medical news on the website of the official journal for German physicians. *PLoS One* 2018;13:e0196833. <https://doi.org/10.1371/journal.pone.0196833>
10. Xie M, Martin SS, Turchin A. Reasons for non-acceptance of statin therapy by patients at high cardiovascular risk. *Sci Rep* 2025;15:17014. <https://doi.org/10.1038/s41598-025-01930-2>