Gerryatric Musings February 2013

Statins in the elderly: you can forget about primary prevention. Most have what we are trying to prevent. There is some evidence to suggest that higher cholesterol level is protective in the oldest of the old. It is unclear if high cholesterol levels increase vascular risk in those more than 80 years old. A study published in 2011 suggested an inverse relationship between cholesterol levels and all cause mortality. In addition, the time to theoretical benefit is 3-6 years. What is the life expectancy of our residents? The average length of stay in our residential care facilities is around two years and may be lower in some.

Lowering cholesterol may have unintended adverse effects such as myalgia, myopathy, liver function test abnormalities and memory loss. The significant risk factors are hepatic or renal impairment, reduced albumin, infection and polypharmacy. Remind you of anyone?

What about use of statins for secondary prevention. There is benefit in patients with known coronary artery disease. There is reduction in all cause mortality but the research trials lacked women and those with dementia, which are the majority of our clients. The study participants tend to be healthier. In the frail elderly there is an increased risk and a reduced benefit for statin use.

There does appear to be an immediate benefit in acute MI and stroke but this benefit does not extend beyond 6 months. If you are going to use a statin, use the lowest effective dose and chose the cheapest. There is no significant advantage of one statin over another. Atorvastatin and simvastatin serum levels increase as you age. This does not occur with pravastatin, rosuvastatin or fluvastatin. Watch for signs that might suggest an adverse reaction such as weakness, fatigue and myopathy.

Next month: treatment of hypertension.