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Cardiovascular Risk Reduction in the Elderly: Best Lipid Strategies

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Lipid Luminations

Dr. Brown:

You're listening to ReachMD, and this is Lipid Luminations, sponsored by the National Lipid Association. I am your host, Dr. Alan Brown, and with me is nurse practitioner Joyce Ross. Joyce is also the President-elect of the National Lipid Association. She's a Consultive Education Specialist in Cardiovascular Risk Intervention and has a clinical affiliation with the University of Pennsylvania Health Care System.

So, welcome, Joyce. It's always great to have a future President of the NLA to interview.

Ms. Ross:

Thank you, Alan. It's a pleasure to be here.

Dr. Brown:

And who knows, I may ask you some insights on the future of the NLA, but today's topic is really about lipid management in the elderly population. I know we did a similar interview in the past, and now that the document, Part 2 of the NLA lipid recommendations has been published, there is some specific information about the elderly in that document. So, I guess I'll start with asking you what sort of the typical questions that we get from the audience when we give lectures is. How old is too old to consider lipid therapy? And a more basic question, is age the number of years that someone has lived valuable at all in determining whether to choose any type of therapy?

Ms. Ross:

I think you hit just exactly where we are today when we talk about the elderly population. You know, I like to talk about the fact that we're 65 to 100, the only group that fits in such a crazy amount of years, and we're all very diverse. We're not only diverse in the 60s, 70s, but in the 80s and 90s we are as well. I know you have a healthy mother who's 90 years old, and she's exercising, doing the right things. If I was going to think about treating her for lipids, if she needed it, I would never hesitate for that if it was her wish to do that.

I think what's really unfortunate is sometimes we just try to put everybody together, and I think newest research and what we've seen lately is that it's really proven that you can't do that, and you must have to think about comorbidities and you have to think about the quality of life, so I think those are things that are very different these days. And I'm excited about our Part 2 recommendations, because we're the only guidelines out there,..., that really talks about what to do. It kind of gives a pathway for treatment. And we're the only ones that really mention treating all the way up there until the 90s, and I think it's exciting.

Dr. Brown:

So, that's very important. I think our audience may hear some noise in the background, but we're very happy to be coming to you directly from the National Lipid Association meeting in San Diego where we're broadcasting live, so you may hear some background noise. I apologize ahead of time for that.

So, yes, my mother, who's 90, is taking a statin. She is healthy. Though being a Jewish boy, there is a Jewish joke that the young man called his mother and said, “How are you mom?” She said, “I’m horrible. I haven’t eaten in 30 days.” So, he was stunned. He said, “Mom, why haven’t you eaten in 30 days?” And she said, “Because I was waiting for your phone call, and I didn’t want to have food in my mouth in case the phone rang.”

Ms. Ross:

I thought that was Irish guilt.

Dr. Brown:

No, we've got a patent on guilt. But with that said, she is taking a statin, because she is healthy, she's still living on her own, still driving, still going to antique shows and selling antiques. That's her hobby after retiring as a physician. So, really, trying to pick an age for any kind of treatment, whether it be dialysis or dyslipidemia, doesn't tell the whole story, does it?

Ms. Ross:

No, it really doesn't. And I think what's really interesting is that when we look at what type of person it is that we're talking about, and you can't just say that just because they have diabetes, perhaps, and hypertension that they're still not going to have a good quality of life. And so we don't really just look at only the comorbidities. We look at the rest of what's going on for the patient. And I think in the past we didn't really study elderly, of course, you know that, and it's gotten much better, but we have a lot more information on women today too.

We also, we found out recently, that you don't really have to treat with as high a dose of medication, because we see that the elderly population actually has lower cholesterol levels. A lot of reasons for that. One is that the people who had really high cholesterol have already died off, unfortunately, but it's also we know that maybe their nutrition is different, they may not eat as much of the foods that are high in cholesterol, and their triglycerides might be down because of the same type of thing. But I think that the uniqueness of the elderly population is becoming the most important thing. And since I am an elderly person, I think it's very great, because the older I get, the younger it seems to be considered elderly.

Dr. Brown:

Well, let's explore that a little bit. I know there's some data that as you get into your 80s, certainly, you run into a situation where you're on multiple medications, and so using high-dose statins like maybe would be mentioned in the ACC 2013 guidelines is something that you wouldn't do, and in fact, those guidelines do say that you might use a lower dose in a “elderly person.” And a second question that always comes up is: What is the data in somebody over 75 that treating with a statin translates into reduction in events, knowing that age is the single biggest risk factor for having a cardiovascular event?

Ms. Ross:

Yes, you're correct. We see the age of the cardiovascular events and other vascular events go up precipitously from the 50s to the 60s and 70s, and what we also see and we don't talk as much about is stroke, and we see that the people who have strokes in our country

are usually the older people. I don't think we're treating numbers anymore. I think we're treating the risk of what could happen to someone. And since we know that the risks are very inherent in the population, I think we need to have a good conversation with our patients. This whole patient-centered approach which the NLA has really embraced really makes me hopeful because it doesn't say, "Go and do this," and you don't tell somebody, "Do this because I said so." It's really sitting down like I would be sitting with you, Alan, if you were my patient and perhaps talk about the fact that I really think we need to consider the possibility of statin therapy for you because of X, Y and Z. It would be really rationale, and I think that the patient has the right and the obligation to sit there and tell you what they think. But before you do that, you've got to ask all those questions. Do you think you'd like to take or would you take a medication? -- a good way to start a conversation. Second, what concerns do you have about the medication? And, of course, you know that it's going to come up, "Oh, my liver is going to fall out, and I'm going to have muscle aches and pain," and so you have to answer that fear because you don't want to get an incorrect response because you didn't investigate. Other things that you talk about is: What is your life like? Do you exercise? Are you dieting? Are you following a good plan for your life? What are your plans for the future? And most people tell you, "Hey, I'm planning to be around a while." So, given that, you have to think, well, that's probably a good reason. By the time you finish the conversation, very frequently the patient has already decided in their head that, "Yeah, I can do it." But the big thing I think you have to think about is cost. You brought up this polypharmacy that we see, and you have to look at the drugs that they're taking and look and see is there something you can do to put those together, maybe have one drug instead of two? This type of thing. But we know that you do have to be careful with that Cytochrome P450 pathway, and we do know that some of the other medications our patients take really are involved with that. So, you do have to have a really good idea about what statins are the most appropriate for that patient.

Dr. Brown:

So, I think this bears a little bit of clarification, because what we're talking about now is primary prevention in the elderly population, which is always under a lot of scrutiny. We do have data over age 65 and, in fact, over 75 for secondary prevention, that there's a significant reduction in cardiovascular events, so do you approach people with established atherosclerosis differently in terms of how forcefully you recommend therapy?

Ms. Ross:

I think you do. I think you do all the same things that I was talking about, but I think that you might want to go back and see what is their plan for their life? I can't emphasize that enough, because people know what they expect to do in their life. They expect to live longer, they expect to live healthy, and they have to know the steps to getting to that. And I think in the NLA we've made a big step with saying that all people over 65 are not created equal, they are very different and very diverse, and that we need to treat them that way. And we do know that when you're into the 90s, sure, if you need to take a statin drug, you should, because it's not about that same thing when you're young or if you have FH or something. It's something about you are at an age where you are much more likely to develop a cardiovascular problem or have a stroke. And so prevention is worth a pound of cure to me.

Dr. Brown:

If you're just tuning in, you're listening to ReachMD. I am Dr. Alan Brown, and I'm with nurse practitioner and President-elect of the National Lipid Association, Joyce Ross. Joyce is a consultive education specialist in cardiovascular risk intervention and clinically affiliated with the University of Pennsylvania Health System.

So, this discussion brings me a little bit back to my mother, who would probably be embarrassed if she knew I was talking about her, but she is a retired physician. She's fairly healthy for 90 years old, and she has no atherosclerotic vascular disease, so I went through this struggle with her. She does have hypertension and elevated cholesterol and wasn't sure that she should go on a statin when she was 80 or 82. And so I think in conjunction with what you were saying, the discussion we had was that we should have a low threshold for stopping the medicine if she had side effects, that we expected her to live at least into her 90s because she was healthy at 80, and that there was a likelihood that a cardiovascular event would be the most likely cause of her demise, and so we'd give it a try. But knowing that she didn't have established disease, our threshold for stopping for side effects—drug interaction, cost, etc.—would be much lower than possibly a patient who already had two heart attacks and a couple of bypass surgeries.

Ms. Ross:

Yes. One of the things that you bring up in discussing your mother in that decision to treat, you know, electron beam CAT scans are wonderful. They are a way of looking -- I call it the crystal ball of life, because you can look into those vessels without any intervention at all. There's nothing, no medication, it's quick, it's easy, and it's not super expensive, unfortunately not generally covered by insurance. But when you're making that hard decision, I would assume that your mother is going to have some calcification in her coronary arteries at 90. But is she a percentage where you would say, “I think we need to treat that”? Sometimes that electron beam CAT scan can be a very vital thing in use for our elderly, and we have recommended that. In our recommendations we state that we think it's a viable thing to consider.

Dr. Brown:

Yes, certainly, in all patients. At our institution it's now $49.

Ms. Ross:

Oh, that's wonderful.

Dr. Brown:

Since we launched that, we had 400 people sign up for it just since the beginning of the year, so I think EBCT makes a lot of sense to the patients too, whereas maybe advanced lipid profiles, hs-CRPs, Lp-PLA2 blood levels, all of them give you a little insight on whether or not you should be more worried about the patient, but a calcium score is understandable.

Ms. Ross:

It's there.

Dr. Brown:

You've got it.

Ms. Ross:

It's in your face. You know, I think what's interesting too when you have the score, even if you’re doing it for a younger person for another reason—maybe they’re not really willing to take care of themselves and their an FH-er—you might want to convince them that they indeed have a lot of plaque in their coronary arteries and need to do something. But in the elderly population, they have stayed healthy for a long time, and I've been shocked over the years to see some pretty darn low calcium scores in people who are older. Over the years they have done the right thing. But if you have had high cholesterol over the years and haven't taken care of it, by the time you get to be 65 and older, you're going to have more coronary calcification, but it's something viable to treat. It's something you can put your finger on and say, “I’m going to treat this because I know I’ve got vulnerable plaques in there. Let’s make them stable.”

Dr. Brown:

So, I think that's very helpful, again, because primary prevention is such a difficult decision in an older patient, and when you really go back and look at the ACC recommendations, there is no calculator for a 10-year risk in somebody who's 90 years old.

Ms. Ross:

That's right.

Dr. Brown:

Or even 80 years old, so you have a struggle with determining choose a dose and treat risk. Now, we know that there's soon to be published some additional recommendations that are probably going to give people some thresholds for treatment, but in your practice, if you see a person for primary prevention and you determined their lipids are too high, what kind of numbers would make you think about treating someone for primary prevention as an octogenarian?

Ms. Ross:

Well, it would have a lot to do with whether they have other concomitant disease processes. Certainly, if they're diabetic or even if they have insulin resistance, I would still be very more apt to treat them. I also think that if they have hypertension, because we know the classic way to get to the stroke along with a little cholesterol, it's really important, but I think when you take a look at those two things that are prevalent in our population. And unfortunately, the elderly are doing just like everybody else. They're getting bigger. And we have a lot of people who are overweight in our country, but we see a lot of very overweight elderly population, and I think that's a huge risk factor. So, when someone has a lot of risk factors that way, I'm much more inclined to say, “Let’s do what we can here.” But I think the bottom line, Alan, is that you have to ask the patient, “What is it you want to do with your life? What is it you're willing to be able to do?” And I think that most of the time if they are coming to see you for primary prevention, they really want to do something, but I don't think it can be an on-the-spot decision sometimes. Sometimes they're going to give 3 to 6 months. We recommend in our guidelines to try changing your lifestyle and see if it does anything for you, and then maybe consider something later on.

Dr. Brown:

Yes, and I think in the NLA recommendations we do fall back a little bit closer to ATP III, which did look at conglomeration of risk factors, not just a 10-year risk calculator. For somebody who had two or more risks, with age being one of them, you'd have a number below which you wanted to treat. So, I think most of us in the absence of clearcut randomized controlled trials that were a requirement for the ACC document, we fall back on observational data.

Ms. Ross:

Yes, we have to do that.

Dr. Brown:

And epidemiologic data that led to looking at those other risk factors.

Ms. Ross:

Yes, I think a lot has happened since the 2013 ACC/AHA document was put out there. That was good work put out there, and it was wonderful for the time, and now I think we have new evidence, new ideas, new thoughts to consider, and that's what's wonderful in the field of dyslipidemia. We have grown so much from way back in '83 when you had the finding out of the receptor for the LDL. I mean, if you think about it, in medicine things go slow most of the time. This is really giant leaps. So, I think that we move forward; we move forward together with all of our organizations to try to crystalize the right plan for the right people at the right time.

Dr. Brown:

I think that's a wonderful synopsis. And the reason we're all still interested in lipidology is it's never boring, right?

Ms. Ross:

That's right.

Dr. Brown:

So, Joyce, thank you so much for being here today. Unfortunately, we've run out of time, but, as always, I really enjoyed talking with you.

I'm Dr. Alan Brown. You've been listening to Lipid Luminations sponsored by the National Lipid Association on ReachMD. Please visit ReachMD.com/lipids where you can listen to this podcast as well as others in the series. And please make sure to leave comments and share the podcast with your colleagues. We welcome your feedback, and I am your host, Dr. Alan Brown. Once again, thank you for listening.