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Dyslipidemia in The Elderly: How Old is "Too Old" to Treat?

Narrator:

Welcome to ReachMD. You are listening to **Lipid Luminations**, produced in partnership with the National Lipid Association and supported by an educational grant from AstraZeneca. Your host is Dr. Alan Brown, Director of the Division of Cardiology at Advocate Lutheran General Hospital and Director of Midwest Heart Disease Prevention Center at Midwest Heart Specialists at Advocate Health Care.

Dr. Brown:

I'm your host, Dr. Alan Brown. Thank you for joining us at Lipid Luminations. Today's show is being broadcast live at the National Lipid Association Meeting in Chicago. Today my guest is Joyce Ross, a certified registered nurse practitioner and a clinical lipid specialist. She's a Diplomate of the Accreditation Council for Clinical Lipidology, past President of the Preventative Cardiovascular Nurses Association. She is a Consultive Education Specialist at the University of Pennsylvania Health System, and most importantly, she's President-Elect of the National Lipid Association. An extremely intelligent, eloquent person, so I'm very happy that you took the time out of one of your busier meetings to talk with us today, Joyce.

Ms. Ross:

Thank you so much. It's good to be with you again, Alan.

Dr. Brown:

So, you chose a topic to discuss, which I'm actually excited about because we get questions about it all the time, which is: What do we do with the elderly patient with dyslipidemia? How old is too old to treat, for example? It's a recurrent question. And, of course, as you well know, there's some data on effects of our treatment in the elderly. So, let's start with, first of all, how do you define elderly? I hope it's quite a bit older than me.

Ms. Ross:

Well, that's the most important question to talk about. If you think about how we deal with ages through the generations, this is the longest period of time that we talk about a group and we say elderly. From 65 to 100 is 35 years. We all can't be the same. And I think that as we've left the elderly out of many of the clinical trials and discussion, we've not done well. And the good news is that more and more of us are approaching that -- I'm in that population now -- and so it becomes more important to think about we are living longer, we're living healthier, and so we need to think about who are the elderly people?

The ages of 65 to 75 are usually a lot different for people, because it's as you start to feel perhaps your abilities are a little different than they used to be. Your stamina may not be quite as good, and the scariest part, it sets you up for the biggest problem, and that's cardiovascular disease. And we always have to think about stroke, the ability to know about stroke and know about all the things that we can do to prevent that. And of course, it boils down to cholesterol, and that's one of the things that we just really need to help other

people understand in that elderly population.

Dr. Brown:

That's a great segue. I think that it is true that people are much more worried about being debilitated by a stroke than even dying of a heart attack when they get into their older years, and I think we all use that kind of as motivation for our patients in terms of treatment. So, getting back to the most common question that people ask when they are at a lipid meeting: How old is too old to treat? Can you review with us a little bit of the data in the elderly population?

Ms. Ross:

Yes, I'd love to do that, Alan. I think, first of all, as you're aware of our new Part 2 recommendations from the National Lipid Association, one of the segments is dealing with elderly people, and I think it's the first time we've ever taken that particular group and tried to really make some good recommendations for that. When you're thinking about these folks who are a little older, you have to think about those who are well and those who are not well, those who have cardiovascular disease. Certainly, we know that elderly people are more at risk for cardiovascular disease than younger people are, but not everybody has high cholesterol and not everybody who is an elderly person is in secondary prevention. Therefore, the guidelines that we have just started recommending here are specific about whether you are under 80 years old, and that's what we're really considering. I would call that the elite elderly, the people who are really, really older. Some of them may or may not need statin therapy, and I think that's a well-kept secret.

If you use the most common risk calculators, no matter which one you like best, you're going to find that age is the pushing factor, and you may be inclined to want to treat with a statin drug in patients because they come out high risk, but it's basically about their age. If you have a patient who is over 80 years old who's primary prevention and you're worried about their risk, you might want to do some interesting things. You could do this from 65 to 100 too, but I think it particularly becomes important when you look at the over 80 population. You want to sit down and have a really good conversation with them. The conversation has to center about what their life is about, what their goals are, their other concomitant disease processes? By age 80 we have a lot of things, and we always have to think about that. What are the drugs that we're going to be giving those people for their other problems, and how do they interface and how would they be affected by a statin drug? So, a good conversation, and also worrying about the other diseases and the cost of medication, and so, we don't want to give medication unless it's necessary. So, if you have just your age as a risk factor and maybe just one thing, maybe you just don't want to treat with a statin; maybe you're going to want to treat with lifestyle, continuation of good lifestyle. People got to be over 80 because they did something right.

Dr. Brown:

Yes, so that's very interesting. You know, I often tell people that 5-year risk over 75 we still show a pretty significant reduction with treatment, at least in the secondary prevention trials.

Ms. Ross:

Mm-hmm.

Dr. Brown:

So, if you have a patient who is living in an extended care facility with terrible rheumatoid arthritis and they're bedridden, you might make a different decision than someone who's living an active life and seems like they're going to be healthy over the next 5 to 7 years. Do you ever consider those types of things?

Ms. Ross:

I think you have to. I think you have to consider what the lifestyle is of the person, and lifestyle is not just about do you go out every day, do you work, what is that about? Lifestyle has to do with what the people around you are doing so much. I am fortunate enough to live

in a 55+ community, and there's literature that talks about people who live in those kind of environments or live in continuing care retirement communities seem to live older and they seem to live more well, and that's associated, of course, with being around other like-minded people, which of course is a lot. The other thing about that is there's the ability to exercise, to do the things that you want to do, to eat properly. I think when you're looking at the age population, you've got to look at those people who have access to good education, to good healthcare providers, and to good information for themselves. So, I think that we always have to think about that with the well elderly and those who unfortunately are in a nursing home or in another kind of setting or in their home and they're really not able to get out and do the things they want to do.

Should we be treating people with statin drugs who have cancer and they're dying? Of course not. I think we have to use our heads, and I think that no one would advocate for that kind of a treatment. But certainly, in a 90-year-old who's very active, who may live to 120 -- you know, you could live to 120 -- we really have to treat and we have to bring that patient... It's a centered program. The patient and the provider have to have a good conversation and talk about all those things that I was mentioning: the polypharmacy, the cost of their medication, the availability of getting medication, their history of maybe taking medication without difficulty.

Dr. Brown:

So, it really is, being a health care professional, you have to sit down. I know some patients of mine, they say they've lived their life well; they don't want to take another pill. If they die tomorrow, they don't care. They're 85 years old. And it's hard to argue with someone. They should still have their right to make those decisions, right? And my mother just had her 90th birthday, thank God. She's healthy, retired physician, does antique shows, sells antiques on the weekend; and she's on a statin, and I'm very happy that she is because I don't see a short-term bad outcome for her.

Ms. Ross:

I think that the fact that she's doing the right things, she's still very active at her age, and I'm so happy for you that you still have your mother alive. I mean, that is wonderful. It sounds like you might have gotten some of those good genes, I hope.

Dr. Brown:

Oh, I hope so. She does reprimand me on a daily basis.

Ms. Ross:

That's good, so that keeps her mind active too. I think that taking a statin in that situation is probably absolutely the right thing to do to prevent what could happen; and of course, it does go up, the risk of a heart attack and stroke go up as you age. My concern for the older folks is that for those who haven't been treated well aggressively in the years where they were building up the cholesterol in their arteries, there are many, many years of high cholesterol that cause the problem, so it's much better when we can see people earlier and treat them and continue that, and I think that's the message we have to talk about. Just because you turn 75 doesn't mean I'm taking your statin away. You've lived well. You've lived a life even if you have had a heart attack at some point and you've been on the statin for years, and here you are reaching an age where somebody says, "Well, you don't need it anymore." That's just not the way.

Dr. Brown:

So, that's a very important point and an important differentiation, I think. I'm glad you commented on that. There are 2 different issues. My mother, for example, has been on a statin for many years. It never dawned on me to stop it, and it didn't dawn on her, but there are some doctors who would consider discontinuing it at a certain age. And the reasons to do that would be if it was affecting their lifestyle, right, so if they were having myopathy or they couldn't afford the medication, as you pointed out. And then the other question is: Do you start it at someone that age? And that's a little different question.

Ms. Ross:

It is a different question, and it's a different question as you look at the segments of the elderly population. When I'm thinking about the group 65 to 75, I see that very differently than 75 to the 80 group, as you mentioned, 5-year segments. One of the things we haven't done that I really advocate for is the use of calcium scoring in this population. It's amazing that you can see some people who are elderly who do not have a real burden of calcium in their coronary calcification score. When you see that, you are feeling better about not treating something that doesn't need treating. So, you're treating with all the things you can put together with their lifestyle, with their other comorbidities, what other test you can pull in to give you a good chance to have that conversation. And in that patient who may have a lot of health issues but still remains active, takes 5 or 6 other drugs, they may say, "I want to be aggressively treated." And so, if we have an idea that everybody gets stopped being treated at a certain age, well that defies what this person has lived for. I go back to your mother again. To say to her, "I'm going to take your statin away because you're a certain age," would be really not appropriate, but sitting down with her provider and saying, "Is this appropriate for me to consider to continue?" that's what we want to do.

Dr. Brown:

So, let's talk a little bit about what data we have. I think the biggest worry about treating someone in that age group, obviously, one is the common statement that if you've made it to 85 you're likely to make it to 90 because you've already passed the risk, and we know that the risk correlates directly with age, right?

Ms. Ross:

Right.

Dr. Brown:

And that's where the calcium scoring helps you determine how much you have to worry about this individual, and if they don't have atherosclerosis at 85, you probably could save them a pill, right? I think that was your point. But, what is the data in patients who are over 75 years old in terms of the benefits of treatment, and are they any more prone to developing side effects, whether it be myopathy or drug interactions?

Ms. Ross:

You ask a really good question, Alan. I think they're two-fold here. First of all, when you're looking at a patient, look at their past history and whether they have had difficulty with certain medication, that kind of thing. It's not easy to answer those kinds of questions. With an elderly person, you have to sit down and have that conversation about all the variables we've been talking about, because we don't have those clinical trials that we use so fiercely in the other populations. And, of course, everyone's aware that we didn't study older people for a long time because they didn't live that long and it wasn't necessary, they felt. Today we see elderly populations up to 75, sometimes higher than that, that are in the literature, in the clinical trials. So, moving forward, we have a lot more information. But I think about the PROSPER trial because that's one of the ones that I've always fallen back on that was one of the first to treat and look at the patients that were older and how they did.

So, the question that you ask, are they safe and efficacious, I think, when you look at the safety, they are as safe in the elderly population as they are in the younger population. That's not to say that they don't have a higher risk for having a problem related to the fact that their renal function may not be as good, but those are the type of patients you're going to be talking to more and making sure that they are aware of symptoms to report to you. You may also be able to use less medication because of that same reason. What's important to understand is that in your frail elderly person who you still want to treat, you may want to be a little bit less aggressive than that 50% drop that we've talked about. It may be in your elderly population, who are a little more frail, maybe you'll want to go for a 30%. And there are older people who can't take statins, like every other generation, and you need to understand that we don't want to try giving them statins when they had a history of not being able to tolerate them before. I surely wouldn't do that to an older person. But, what I might want to consider in that situation is those non-statin therapies that we have. We have good things out there. The bile acid sequestrants have been around for a long time, and you also have the use of ezetimibe that can be helpful in this population and get them that 30% that you're going to look for.

So, again, I'll go back to what I said, it's all about the conversation with that elderly person to really understand who is it sitting in front of me, what are their goals in life, what are their potentials for remaining healthy? And sometimes it's not just the patients, it's the family.

So, I think that as we see people in different populations from the earliest in our years, when we see the pediatric population, there are similarities to the elderly population, because the families tend to get involved. And if you've got a son or daughter who says, "I don't want my mother or father taking the statins because they're going to kill them," you have another patient to talk to.

Dr. Brown:

Right, so important. If you're just joining us, you're listening to Lipid Luminations on ReachMD. I'm your host, Dr. Alan Brown, and I'm having the pleasure of speaking with Joyce Ross, a certified registered nurse practitioner, clinical lipid specialist and President-Elect of the National Lipid Association.

So, Joyce, you kind of feel like if you're reaching that age group where you would be considered "elderly" and you feel well, it's almost a sin to cause somebody to feel badly. So, do you think the threshold for stopping medication particularly in a primary prevention group if they're having side effects would be lower than maybe in a younger individual where you might push them a little more to stick with the therapy?

Ms. Ross:

Well, that's a really hard question to answer. Again, I'm going to say the same thing I said before, what does the patient want to do? What are their wishes? What is their tolerance to having a little bit of discomfort, perhaps? Is there discomfort really related to their medication? As you age, of course, the chances of arthritides and other things becomes much more prominent. I don't want to frighten people away from taking medication that's going to be beneficial for them, but I certainly don't want to push medication on people who I think it may not help as much. Just as I mentioned before, we sometimes, instead of going for that 50% drop, could be satisfied perhaps with going to a 30% drop in that population.

Dr. Brown:

And as you also mentioned, some risk stratification, whether it be with the calcium score or some other assessment, and whether they have atherosclerosis, carotid IMT or even just a vascular screen to see if they have atherosclerosis. You're going to be more pushy with that individual, right?

Ms. Ross:

Yes, I think so. I think so. And I love the fact that by the time people get a little bit older, they're getting used to now having conversations with their providers, and I think that's very helpful when you get to these situations where they're not worried about having a conversation with a physician or the nurse practitioner and they're not worried about having to do what they want to do. I think we're finally getting this elderly population to the point where we all know we can talk. And since I am a member of the elderly population, I think I can speak a little differently, because I don't see myself as any different than I used to be, and I don't want anyone to look at me as a patient or a person and treat me any differently because I'm still the same person I used to be.

Dr. Brown:

Well, that's a very important final point that I am very excited that you brought it up. I remember one of the state legislatures was struggling with the cost of dialysis in their state, and they were going to determine whether or not there was an age cutoff for who should get dialysis and who shouldn't; and whatever age they picked, many of the legislators were reaching that age, so that ended up being dropped. And age is not a great way to identify the health of people anymore or what therapy ought to be appropriate. Is that true? And I think you've gone through a lot of good suggestions in terms of looking at the patient where they might be in that age group, but there are other determinants that determine how aggressive you're going to be with them than just the number. So, in the last couple of minutes, I'd love to hear your thoughts on that.

Ms. Ross:

You hit it right on the head, Alan. I think what we need to do is we always have to make sure of who we are treating, and I think that that relationship and that discussion is really going to be important. And age is different for you, different for me. It's different for what our parents were at those ages. So yes, I do, I think it's a new time for people who are older. I think 35 years of anybody's life in one category is really a strange thing to do. And I love the idea of thinking of people over really 80 as really older people today, so maybe we need to change that.

Dr. Brown:

Well, I'm so disappointed we ran out of time, but I really enjoyed your comments and your insights on managing the elderly with risk factors and the use of medications. Thank you very much for joining us.

Ms. Ross:

Thank you so much, Alan; it was a pleasure.

Dr. Brown:

And you've been listening to Lipid Luminations on ReachMD. Thank you for joining us at the National Lipid Association meeting in Chicago, Illinois.

Narrator:

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