

WHEN SHOULD YOU CONSIDER STOPPING “STATINS” IN OLDER ADULTS?

Center for Women’s Health Research 18th Annual Women’s Health Symposium

February 29, 2020

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DISCLOSURES

- No conflicts of interest to disclose

DEFINITIONS

- “Statin” medications – members of the HMG-CoA reductase inhibitor class of cholesterol-lowering medication, including atorvastatin, pravastatin, simvastatin, and others
- Deprescribing - stopping “statin” medications that a patient has been taking
 - Often proposed in setting of life-limiting illness when the initial expected benefit is diminished by a change in quality of life/quantity of life
 - Different from stopping the medication due to side effects

van der Ploeg, Floriani, et al., “Recommendations for (Discontinuation of) Statin Treatment in Older adults: Review of Guidelines”, J Amer Geriatric Soc, 2019.

RATIONALE

- More recently, guidelines on lipid management suggest clinicians “consider” deprescribing medications in setting of life-limiting illness (aka “deprescribing”)
- Clinicians are lacking specific guidance on:
 - Identification of patients who warrant deprescribing of statins
 - How to discuss the pros and cons of deprescribing statins with patients

van der Ploeg, Floriani, et al., “Recommendations for (Discontinuation of) Statin Treatment in Older adults: Review of Guidelines”, J Amer Geriatric Soc, 2019.

OBJECTIVES

- To identify which patients are appropriate for a discussion of deprescribing of statin therapies.
- To develop a shared decision making communication strategy for discussing statin deprescribing with appropriate patients.

CASE EXAMPLE

- Mr. M is a 78 year-old male with no prior history of obstructive cardiovascular disease, but with cardiovascular risk factors of hypertension and hyperlipidemia.
- In terms of life-limiting comorbidities, he has Parkinson's disease but still lives alone in his home with assistance from his children who help him with shopping and filling his weekly pillbox
- Patient is gradually having some trouble swallowing medications with Parkinson's and family is asking if it is possible to simplify his medication regimen .
- Medications are each prescribed as once-daily and include a moderate-intensity statin taken once daily, three anti-hypertensive medications, an antidepressant, two medications for treatment of Parkinson's disease, and a multivitamin.

EVIDENCE FOR BENEFITS OF STATIN DEPRESCRIBING

- RCT-level evidence:
 - N=368 adults with life expectancy <1 year
 - Randomized to deprescribe statin or continue statin
 - Similar 60-day mortality for those with statin deprescribed vs. statin continued (23.8% vs. 20.3%, p=0.36)
 - Significantly better scores on the McGill quality of life (QOL) scale for those with statin deprescribed vs. statin continued (QOL = 7.11 vs. 6.85, p=0.04)
 - Mean cost savings of \$716 per patient in the statin deprescribed vs. statin continued group

Kutner JS, Blatchford PJ, et al. Safety and benefit of discontinuing statin therapy in the setting of advanced, life-limiting illness. a randomized clinical trial. JAMA Intern Med, 2015.

EPIDEMIOLOGY OF STATIN DEPRESCRIBING – PATIENT PERSPECTIVE

- Survey of patients participating in the RCT of statin deprescribing (n=297)
- Participant demographics: Mean age 72 years, Primary diagnosis: 58% cancer, 8% cardiovascular disease
- Concerns regarding deprescribing statins:
 - Previously told to take statins “for the rest of your life” (18%)
 - Stopping statin now means it was “wasted effort” to have taken it previously (18%)
 - Perceived clinician abandonment (5%)
- Perceived benefits of stopping statins
 - Spending less money on medications (63%)
 - Better quality of life (25%)

Tija, Kutner, et al. Perceptions of statin discontinuation among patients with life-limiting illness. *J Pall Med*, 2017.

EPIDEMIOLOGY OF STATIN DEPRESCRIBING –CLINICIAN PERSPECTIVE

- Retrospective study of statin deprescription among adults ≥ 60 years in a Geriatric subacute evaluation unit in Australia between 2012-2013
- Among patients admitted to the unit (n=672), 46% of them (n=309) were taking statin medications at the time of unit admission
- Among the n=309 patients who were taking a statin at time of admission to the unit, n=54 (17.5%) had their statin discontinued by the time of discharge
- Predictors of statin deprescription included:
 - Age ≥ 80 years (OR: 6.1, 95% CI: 2.1-17.9)
 - Primary prevention indication for statin use (OR: 5.0, 95% CI: 2.0-12.3)
 - Lack of improvement in functional status during hospital admission (“Functional Independence Measure”, OR: 3.8, 95% CI: 1.5-9.5)
 - Discharge to residential living facility/skilled nursing facility (OR: 3.3, 95% CI: 1.2-9.8)

Noaman S, Al-Mukhtar O, et al. Changes in Statin Prescription in Geriatric Subacute Unit. Heart Lung Circ, 2019.

EPIDEMIOLOGY OF STATIN DEPRESCRIBING – CLINICIAN PERSPECTIVE

- Survey of general practitioners in Switzerland
- Used case vignettes of a severely cognitively/physically impaired 82-year old male patient taking 7 medications to ask about willingness to deprescribe
 - Vignettes varied whether patients did/did not have a history of cardiovascular disease (CVD)
 - 7 Medications the patient was taking included a statin (atorvastatin 40 mg daily), angiotensin-converting enzyme inhibitor, calcium-channel blocker, aspirin, acetaminophen, and tramadol for pain
- Survey responses from n=157 general practitioners (56% response rate), 72% of respondents were male, and half of patients had practiced >25 years
- Statin deprescription if no history of CVD: 100% (76% would deprescribe aspirin)
- Statin deprescription if +history of CVD: 76% (32% would deprescribe aspirin)
- Significantly less likely to deprescribe statins if +history of CVD as compared to no history of CVD ($p < 0.001$)
- Open-ended responses for reasons to deprescribe statins included: lack of benefit (36%), no priority, not in >80 years old; not appropriate prevention

Mantelli, Jungo, et al. How general practitioners would deprescribe in frail oldest old with polypharmacy: the LESS study. BMC Fam Pract, 2018.

GUIDELINE RECOMMENDATIONS

- Review of 18 international guidelines for lipid treatment
- Palliative care circumstances: 3 of the 18 guidelines noted clinicians may “consider” deprescribing statins – no clear mandate to deprescribe even in these guidelines
 - Examples of instances where deprescribing may be appropriate: short life expectancy, multimorbidity or increasing comorbidities, frailty, or functional decline
- American College of Cardiology (ACC)/American Heart Association (AHA) 2018 guidelines one of first to offer specific guidance on “deprescribing” or avoiding initiation of statins in certain populations:
 - Explicitly addressed the topic of “deprescribing”
 - Considered increasing frailty and worsening functional status as circumstances for deprescribing

van der Ploeg, Floriani, et al., “Recommendations for (Discontinuation of) Statin Treatment in Older adults: Review of Guidelines”, J Amer Geriatric Soc, 2019.

EVIDENCE SYNTHESIS: WHO TO CONSIDER FOR DEPRESCRIBING IN 2020

- Fairly clear consensus for deprescribing in patients meeting these criteria if patients/caregivers agree:
 - Hospice/Palliative care patients (Kutner RCT data support deprescribing for <12 months prognosis)
 - Dependent for activities of daily living/cognitively impaired and with no prior history of cardiovascular disease
- Gray zone – appears many clinicians/patients would favor deprescribing in these situations but not all:
 - Dependent for activities of daily living/cognitively impaired and + prior history of cardiovascular disease
 - Age >80 years
 - Multimorbidity or increasing comorbidities
 - Increasing frailty/worsening functional impairment

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HOW TO ADDRESS DEPRESCRIBING: SHARED DECISION MAKING

- Shared Decision-Making: A meeting between two experts
 - Clinician – expert in benefits/risks of deprescribing clinically
 - Patient – expert in their perspectives of the relative weight of these benefits and risks
- Including patients in decision-making improves the following among patients with chronic, life-limiting disease:
 - Patient Satisfaction
 - Adherence to the treatment plan
- Barry M, Edgman-Levitan S. Shared decision making – the pinnacle of patient-centred care. *N Engl J Med*, 2012.
- Joosten E, DeFuentes-Merillas L, et al. Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status. *Psychother Psychosom* 2008

SHARED DECISION MAKING APPROACH

Agency for Health Research Quality (AHRQ) SHARE approach

1. Seek your patient's participation
2. Help your patient explore and compare treatment options
3. Assess your patient's values and preferences
4. Reach a decision with your patient.
5. Evaluate your patient's decision.

APPLYING THE AHRQ SHARE APPROACH

I. Seek your patient's participation

- Summarize the health problem
- Ask your patient to participate (and family/caregivers if appropriate)
- Example language:
 - “There are pros and cons to continuing your statin medication – I want to go over the options so we can find what is best for you.”
 - “I’m happy to share my views and help you reach a good decision. Before I do, would you like more details about your options?”

APPLYING THE AHRQ SHARE APPROACH

2. Help your patient explore and compare treatment options

- “What have you heard about stopping statins or other prescription medications?”
- “Let me tell you what the research says about the benefits and risks of stopping this medication.”
- “Could you tell me how you understand the treatment choices I’ve presented to you?”

APPLYING THE AHRQ SHARE APPROACH

3. Assess your patient's values and preferences

- “As you think about your options, what's important to you?”
- “When you think about the possible risks and benefits of stopping this medication, what matters most to you?”

APPLYING THE AHRQ SHARE APPROACH

4. Reach a decision with your patient

- Help your patient move to a decision
- “It is fine to take more time to think about the treatment choices. Would you like some more time, or are you ready to decide?”
- “Are there other people that you want to talk to in order to help you make this decision?”
- “What additional questions do you have for me to help you make your decision?”

APPLYING THE AHRQ SHARE APPROACH

5. Evaluate your patient's decision.

- Make plans to reassess this decision in the future
- “Let’s plan on reviewing this decision next [appropriate timeframe].”

CASE EXAMPLE

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- Patient is gradually having some trouble swallowing medications with Parkinson's and family is asking if it is possible to simplify his medication regimen .
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PRACTICE TIME!

TABLE DISCUSSIONS

Consider the patient from the case

Talk about how you would discuss stopping a statin with this patient

Consider if the Agency for Health Research Quality (AHRQ) SHARE approach may be helpful

1. Seek your patient's participation
2. Help your patient explore and compare treatment options
3. Assess your patient's values and preferences
4. Reach a decision with your patient.
5. Evaluate your patient's decision.

ACKNOWLEDGEMENTS

Dr. Huebschmann's research mentors and clinical collaborators relevant to developing this talk:

- CWHR senior faculty: Judith G. Regensteiner PhD, Jane Reusch MD, Wendy Kohrt PhD, and Anne Libby PhD
- Drs. Regensteiner, Reusch, and other members of the ACTIVE research laboratory



CASE EXAMPLE #2

- Ms. M is a 82 year-old female with no prior known history of cardiovascular disease, but with cardiovascular risk factors of hypertension and hyperlipidemia.
- In terms of life-limiting comorbidities, she has moderately severe dementia but still lives in her home with assistance from her daughter who lives with her providing weekly medication set-up and preparing meals for her.
- Patient was hospitalized last week for a new diagnosis of atrial fibrillation and while inpatient had her statin medication stopped to minimize polypharmacy (decreased medication list from 12 down to 8 by stopping this and three vitamins that patient was taking).
- Patient and daughter present to clinic to discuss whether to remain off of “statin” and vitamins or to restart