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Statin au Matin

From time to time we are asked the best time to administer statins. According to conventional wisdom, the best time has always been evening or bedtime. Since the liver produces a considerable amount of cholesterol overnight, late day administration seems quite sensible.

This sensible recommendation, however, is not always the most appropriate. Many residents receive no other medications at dinner or bedtime, and it is inconvenient and time consuming to add medication at these times. In fact, most of the newer statins are broken down slowly by the liver and retain their effectiveness regardless of administration time.

Lipitor® and its active metabolites have the longest period of action in the body, and can be given at any time. Crestor® and Pravachol® have half-lives of close to one day, and can likely be given in the morning without significant loss of cholesterol control. Zocor®, Mevacor® and Lescol® have short half-lives and must be given late in the day to be effective. If you would like us to review the administration times of statins in your facility, please speak to your consultant pharmacist, or give me a call in the pharmacy.

Restless Legs

Do your legs seem to have a mind of their own, particularly at night? Do they dance, tingle, ache or otherwise feel kind of strange? You may be experiencing Restless Legs Syndrome (RLS).

RLS is a poorly understood infirmity which is often not recognized or misdiagnosed. Its prevalence increases with age, and it may affect as many as 25% of nursing home residents. It is more common in women and those with renal failure, anemia, and diabetes. RLS can cause wandering or sleep disturbance, which in turn may lead to prescribing of inappropriate medications.

An evaluation of RLS can be difficult in demented residents. If your resident has the urge to move their legs, especially when at rest, and movement results in relief, RLS is possible. If drugs used to treat Parkinsons Disease (Requip®, Mirapex®, Sinemet®) resolve the problem, RLS is likely. These drugs are the mainstays of RLS treatment. Neurontin® (gabapentin) may also be useful.

Predisposing conditions such as those listed above, family history and anemia are all supportive of a diagnosis. RLS-like abnormalities such as: peripheral neuropathy (in diabetics), varicose veins, cramps, and intermittent claudication, should be ruled out before making a definitive RLS diagnosis.

Iron should be given if ferritin levels are low, and mild narcotics may be used for leg pain. Please consider RLS as a diagnosis before treating residents with leg symptoms. You may lose an Astaire or Rogers, but you will be thanked in the end.

Prostate Cancer

Prostate cancer is a far too common affliction in elderly males. Chronic treatment with antiandrogens such as Androcur®, Euflex®, Lupron® or Zoladex® is often required.

Blocking testosterone in males can cause osteoporosis, just as loss of estrogen at menopause can begin the osteoporotic process in females. Addition of bisphosphonates (Actonel®, Fosamax®) should be considered for all men taking these drugs. In addition to their positive effect on bone, they can limit metastases and progression of the cancer.

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