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Elderly BP and Strategy

Much has been written about BP control. While the elderly are typically underrepresented in clinical trials, a number of recent studies have examined BP treatment and outcomes in seniors. Dr. Chris Brymer of the University of Western Ontario focused on some of these at a lecture I attended earlier this year.

A 2007 study in *J Am Ger Soc (JAGS)* showed that aggressive BP control is undesirable in those over 75 years of age. Systolic BPs from 130-139 and diastolic BPs of 80-89 (standing) are best. While high BP was hazardous (also evidenced by the *HYVET* study in 2008), pressures below those ranges significantly upped five-year mortality.

A 2009 Cochrane review of primary anti-hypertensive research showed that only three drug groups, ACE inhibitors (Coversyl®, Altace®, etc.), newer calcium channel blockers (CCBs – Norvasc®, Plendil®) and thiazide diuretics have been proven to reduce mortality related to hypertension (HTN).

Angiotensin receptor blockers (ARBs – e.g. Avapro®, Atacand®) are related to ACE inhibitors and are often used when ACE inhibitors cause a cough. They reduce BP, but there is no evidence that they reduce HTN mortality (except perhaps Micardis®; *ONTARGET*). Older CCBs (Adalat®, Cardizem®, Isoptin®), may actually increase mortality in HTN (*ACCOMPLISH*).

While Altace® has the best historical evidence for mortality reduction in HTN, Coversyl® (perindopril) has received quite a bit of recent support. Frail elderly are able to walk farther and fall less often (vs. placebo – *CMAJ 2007*) when taking Coversyl®. It also (as well as Altace® and some other ACE inhibitors) reduced dementia onset by 65% in another study (*Arch Int Med 2009; 169: 1195-1202*).

β-blockers (not atenolol) should be used for HTN with CAD or after a recent MI. Metoprolol or bisoprolol are preferred for HTN in the presence of CHF (*Cochrane Rev 2007*). Finally, EC ASA 81mg plus Pariet® and a low dose statin reduces mortality in hypertensives over 75 (*CMAJ 2011; 183:E1189-1202*).

Proper drug selection and moderate BP control are the keys to HTN therapy. Pushing BP too low not only causes

dizziness and falls, but increases mortality as well.

Bad Benzos

Benzodiazepines are getting very little love these days. We know about all the nasty side effects they can cause. Their benefits are marginal as well, with a possible gain of thirty minutes of sleep when used for their hypnotic effect.

Now a study (*BMJ 2012 Feb 27*) suggests that benzodiazepine (BNZ) use increases risk of death by 4-5 times. A group of over 10,000 patients with at least one prescription for a BNZ was compared to 25,000 similar non-BNZ users on a U.S. database. Even those taking fewer than 18 doses of BNZ (or related hypnotic drugs) had a 3.6 fold risk of dying compared to controls. The risk increased to 5.32 fold for those taking more than 132 doses per year. Cancer risk was also increased, some 35% higher in the high use group, even though patients with major cancers were excluded from each study group.

The results were similar across all age groups, although they have been challenged. Some suggest hypnotic users must be fundamentally different from non-users, even though the two groups were matched for similarity. Still, we now have another reason to avoid this undesirable drug class.