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Don't Push BP Too Low

We all know the hazards associated with high blood pressure…stroke, MI, CHF, renal damage, etc. In our zeal to prevent such problems, we sometimes push BP too low and do more harm than good.

Both the *Canadian Hypertension Education Program* and *American Heart Association* recommend treating to a target systolic BP of less than 150 mm Hg in those over 80 years of age. This target has been relaxed from the stricter level of 140 mm, as there was no evidence of improved outcomes with the lower BP. While diastolic BP is less of a focus, it is important that it stays above 60 mm Hg to ensure proper tissue and organ perfusion. In diabetics the overall target is lower, at 130/80, due to increased renal vulnerability.

A couple of recent studies confirm the perils of overshooting on BP reduction. A cognition analysis of 172 elderly patients with hypertension (*JAMA Intern Med. 2015:175:578-585*) was notable. MMSE dropped by nearly three points when patients with dementia or mild cognitive impairment took antihypertensives and had "low" systolic BP (less than 128 mm). This compared to a smaller reduction of less than one point when the BP was above 128 mm.

In a Michigan analysis of more than 5,000 seniors, aggressive BP lowering (systolic BP < 120 mm) also proved to be counterproductive. There were significantly more falls and cardiac events in the low BP group (average systolic BP 110 mm). Let's try to be more conservative when using these medications. We may see improvements in cognition and falls reduction, which would provide tremendous benefits for both residents and staff.

Statins for CA

The *Women's Health Initiative* from the 1990s continues to give us useful information. This planned 15-year program was stopped in 2002, when researchers realized that combination estrogen/progestin treatment increased cardiovascular morbidity and mortality.

Participants continued to be followed, however, and those taking statins for cholesterol reduction were found to have a far lower cancer mortality rate. The rate of cancer deaths among statin users was 78% of that of the non-statin users. Mortality rates from most cancers (with the exception of lung cancer) were much lower in the statin group. Men also appear to show a similar benefit in overall and prostate cancer specific survival, based on the analysis of Medicare Part D data in the US. Statins appear to have anticancer effects, though prospective studies are required to confirm this.

Formulary Additions

Some useful medications have been added to the ODB Formulary over the past two months. Invokana®, an oral antidiabetic drug highlighted in the June GeriJournal will be covered on July 29th. The same applies to Monurol®, a unique antibiotic for ESBL resistant UTIs, reviewed in the November 2014 GeriJournal.

Late last month, the Anoro Ellipta® inhaler was added. It is an excellent addition to the COPD market. Like Ultibro® (May 2015 GeriJournal), it is a LAMA/LABA combination of two bronchodilators and is steroid free. Anoro® offers the added advantage of being self-contained. There is no capsule to load and puncture, as is the case with Ultibro® (and Spiriva®). It is also dosed once per day and has a large dose counter on the front to help the nurse/resident track the number of doses remaining in the device.

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