

# The GeriJournal

Happy Holidays

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## **Xarelto® + ASA for CV**

Bayer, the manufacturer of the anticoagulant, Xarelto®, had an idea. ASA can prevent platelets from clumping in coronary arteries, reducing MI risk in those with coronary artery disease (CAD). Perhaps Xarelto® could enhance that protection, though the dose would have to be low to mitigate bleeding risk. Pairing it with ASA might help with the peripheral vasculature as well. Atherosclerotic narrowing of those vessels (peripheral arterial disease – PAD) can cause tingling and pain in the legs, skin ulceration, gangrene, TIAs, stroke, etc.

COMPASS, published in *NEJM* and *Lancet* evaluated over 25,000 patients, broken up into CAD and PAD groupings. CAD patients included those with a history of past MI, angina, bypass, stent or proven coronary blockage. The PAD group had one or more of the following: amputation, claudication (leg pain with exercise), peripheral bypass surgery, carotid stenosis or an ankle/brachial index (BP at ankle compared to arm) of less than 0.9. Subjects were divided

into three blinded, placebo-controlled groups: Xarelto® 2.5mg BID + ASA 100mg daily, Xarelto® 5mg BID or ASA 100mg daily. The data was compiled and analyzed at McMaster University.

The results were so impressive that the study was halted after just 21 months. There was a 28% reduction in cardiac death, MI and stroke in the PAD group using Xarelto® + ASA vs ASA alone. Limb events sustained an even greater reduction of 46%. The CAD arm of the study had similar results. On the negative side, major bleeding was increased by over 60%, although this was confined largely to the GI tract, not the brain or other critical organs. The 75 and over cohort did not do quite as well as the slightly younger subjects. Their CV event reduction was only 13%, and because their numbers were smaller, this was not clinically significant.

The main impetus for writing this article is the inclusion of Xarelto® 2.5mg in the ODB Formulary. It is a limited use drug (LU 539) covered for patients with proven CAD and PAD and a GFR of at least 15ml/minute. They must also not present a high bleeding risk.

## **Freestyle Foibles**

We've been using Freestyle Libre® for a couple of months now. It's a wonderful system, but there are a few pointers I'd

like to pass along to be sure we minimize problems and get the most out of this exciting device.

Placement – Make sure it's on the back of the arm, not the side. It is less likely to be dislodged that way.

Adherence – The surface must be completely dry before application. Once applied, press firmly around the entire circular adhesive strip. Tegaderm® can be used to further secure the sensor, but is generally not required.

Scanning – Scans should be ordered at least AM and HS, but preferably AM, pre-lunch and HS (and perhaps pre-dinner for PCC/Med-eCare).

Prescriber Visits – Hand the reader to the physician/NP and double-tap the home button. The *Patient History* option provides full 24-hour glucose graphs (the reader logs and retains all values in the 8-hour period before each scan), including overnight and post-prandial levels. Printing the sensor glucose values from the *Administration Record* (not the vitals) is another option, though it is **much less** comprehensive.

Best Candidates – Get a complete, 24-hour profile for new residents on insulin. Stabilize residents with poor control. It may be possible to reintroduce less frequent finger-sticks subsequently.

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