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Stick with the Statin

There is no question that polypharmacy is a major problem in our senior population. Adding drugs is easy to do when problems are detected, but there is often a reluctance to discontinue medications which may be ineffective or the cause of unrecognized adverse effects.

One of the target classes for deprescribing is "statins". The logic is that it takes years for these drugs to demonstrate strong benefit, so stopping them in the latter part of a senior's life will do no harm. Several studies, however, have shown quite the opposite.

A paper published this month in *JAMA Network Open* is the latest to support continuation of statins. It compared 4,000 Italian seniors who stopped their statin to a similar group who continued taking their statins. In each group other therapies were maintained, so the change in statin was the only alteration. This very short, six-month study showed significant increases (among the "stop-statin" group) in hospital admissions for heart failure, adverse CV outcomes, emergency admissions for any cause and death from any cause. These increases occurred across the spectrum of CV disease. No benefits were seen from deprescribing. We should think twice before stopping well tolerated statins.

Options for Steroids Injected into the Knee

I can't imagine having an intraarticular (i.a) injection directly into my knee. The thought of this rekindles awful childhood memories (no needles please!). The latest information on an alternative, therefore, is great news for anyone like me.

The news was delivered at the OARSI (Osteoarthritis Research Society International) 2021 World Congress. Kenalog® (triamcinolone) 40mg was injected either i.a. into the knee or as a standard i.m. injection to treat painful osteoarthritis. While the i.a. injection produced a superior pain response at 4 weeks, there was no significant difference at 8, 12 or 24 weeks in the 145 subjects. There were also no differences in stiffness, function or quality of life scores. The i.a. group experienced more side effects, and infection and cartilage breakdown are particularly troubling with this technique. Since i.a. injections require an experienced hand or specialist to administer and i.m. injections do not, the i.m. route is advantageous. Residents with OA of multiple joints might also be better served with a systemic i.m. injection.

EAP Delegation

Until recently, the Exceptional Access Program (EAP), formerly Section 8, required considerable form filling and faxing to attain ODB coverage for critical medications. The faxing process is being discontinued as of December 31st of this year. It is being replaced by secure online submissions though the SADIE portal. Most prescribers are familiar with SADIE, as they use it to manage their billing activities.

In a nutshell, one or more individuals in a care home, pharmacy or prescriber's office can act as an MD or NP's delegate (authority to submit an EAP document) or designate (fill out majority of EAP; must be submitted by prescriber). Delegates and designates initiate the process by creating accounts on *GoSecure*, an Ontario site. The MD or NP provide their acceptance on *GoSecure*, then log into SADIE adding the individual(s) to their approved list. EAP turnaround time will be much quicker with this process. GeriatRx will be happy to act as your delegate/designate for these orders to save you time in the future. For additional information, go to SADIE@Ontario.ca.

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