National Day for Truth and Reconciliation

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Statins and Muscle Pain

Muscle pain is a well-documented potential adverse effect of statin drugs. The big concern is rhabdomyolisis, the release of an enzyme, creatine phosphokinase (CPK), from damaged muscle cells. Excess CPK can overload the kidneys, causing damage.

Most community based patients are aware of this side effect. This awareness can induce complaints of muscle pain when there is no damage. Placebos trigger anticipatory effects like this, but when an actual drug causes them, we call it a nocebo effect.

When a resident experiences muscle pain after starting a statin or after a dose increase, a blood CPK level is warranted. A number of trials show that patients experiencing muscle pain with statins have the same complaints when starting or switching to placebo, In fact, one study in *Atherosclerosis* showed 35% of subjects had pain with placebo, but none with simvastatin! If the CPK is normal and the resident complains of muscle pain, consider a temporary stop to treatment, then reintroducing the statin. A dose reduction or switch can also be considered.

ACE or ARB for HTN

We love our ACEs (perindopril, ramipril, etc.), and ARBs (losartan, valsartan, telmisartan, etc.). They are wonderful drugs for treating hypertension (HTN), heart failure and provide good renal protection in kidney disease.

Angiotensin converting enzyme inhibitors (ACE) have been around longer than angiotensin receptor blockers (ARB). Captopril was the first ACE released in Canada back in 1980. The ARBs came about 15 years later, with losartan being the first member of that group. Even though ARBs have been with us for over 25 years, they still trail ACE inhibitors in popularity for the treatment of HTN, their initial and primary indication.

A large observational study in *Hypertension* sought to explore this apparent underuse of ARBs. It evaluated 3 million patients from Germany, South Korea and the U.S. started on an ACE or ARB between 1996 and 2018. The drugs were used to treat HTN exclusively, and the patients had no history of heart disease or stroke.
With regards to the primary outcomes: acute MI, heart failure, stroke and an overall composite of CV events, there were no significant differences between the two classes. ACE inhibitors, however, did not fare as well in terms of side effects. Not surprisingly, angioedema was seen more than 3 times as often (hazard ratio 3.31) and cough (HR 1.32) were problems in the ACE group. Less expected were occurrences of GI bleeding (HR 1.18) and abnormal weight loss (HR 1.18) among ACE users.

This data should be considered when comparing initiation of treatment with these drugs for HTN, but not other CV or renal indications. Specific drugs within each class used in 2021 differ proportionally from those used through the period examined in the study, and that could have an impact. Lisinopril was the most popular ACE used in the study, and perindopril is the leading ACE now. Since side effect profiles are similar within each class, the authors feel results are still representative.

Creatinines for Tamiflu

I've had a few requests to send out creatinine information to prepare for Tamiflu® dosing. Hopefully flu season will be cancelled again this year, but virus behaviour has proven difficult to predict. Our system is updated regularly with levels from our consultants, plus we can access eHealth for missing values. We will still send out creatinine charts next month to fill any possible gaps.

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