The GeriJournal

Volume 18, Number 11
November 2023
A publication of GeriatRx Pharmacy

Beers List

To those unfamiliar with Beers List, it is not a list of beers, but a selection of drugs that may be *potentially* inappropriate to use in the elderly. The list was created by Dr. Mark Beers in 1991 and has been updated several times since. The American Geriatric Society is now the steward of this list and the latest update was released earlier this year. Several drugs have been added or had their recommendations revised.

As a reminder, some long-time members of the list include older antihistamines (e.g., Benadryl® & Atarax® - when used routinely), tricyclic antidepressants (Elavil®, etc.), and urinary incontinence drugs (Ditropan® & Detrol®). These drugs have lots of anticholinergic activity, so they often cause confusion, constipation, falls, and urinary retention. Many more drugs are on the list, but a full review is not possible here.

New additions of interest include Xarelto® (avoid long-term use due to higher risk of bleeding than apixaban); PPIs such as lansoprazole and pantoprazole (high *C. diff* and fracture risk if used for more than 8 weeks – OK in some high acid GI conditions or H2 antagonist failure); sliding scale regular or rapid-acting insulin without basal insulin (avoid due to increased hypoglycemia risk in all care settings); Aspirin (only for high-risk residents, e.g. diabetics and those with a vascular event history).

The 2023 list can be accessed from the web. GeriatRx pharmacists monitor your residents and will recommend alternatives where warranted.

Osteoporosis Canada

Osteoporosis Canada has updated its bone health guideline (October's *CMAJ*) for the first time since 2010. Postmenopausal women continue to be a focus of the guideline, but men aged 50 and above are also highlighted.

Risk factors haven't changed much. Steroids, alcohol, and smoking are problematic. Low body weight, prior fragility fractures, and secondary conditions like renal failure and Paget's disease point to poor bone density. Those with FRAX scores (compilation of risk factors) yielding a 10-year fracture risk greater than 20% OR bone mineral density T-score less than -2.5 standard deviations from peak bone mass OR previous hip, vertebral or two fragility fractures (humerus, pelvis, and distal forearm in addition to vertebrae) benefit most from drug therapy. Balance training (one-leg standing) and lower limb strengthening (hands-free sit-to-stand is my favourite) reduce falls and fractures.

We throw at least 1,000 IU of vitamin D at everyone, but if individuals are well nourished, have a balanced diet, and are not vitamin D deficient, there is no evidence of benefit from additional vitamin D or supplemental calcium.

The primary treatments remain the same. Bisphosphonates (Fosamax® and Actonel®) and Prolia® are our go-to medications. The guideline shows bisphosphonates are to be used first for 3-6 years, but Prolia® is the best choice when there is a contraindication such as dysphasia, or intolerance. It gets complicated after that. We know bisphosphonates stick to bone and retain activity for several years and osteonecrosis of the jaw and femoral fractures increase with extended use. A drug holiday is recommended after 6 years, but that might be dangerous in high-risk patients. A switch to denosumab could make sense at that point. Jaw issues and femoral fracture risk don't seem to accelerate as quickly as with bisphosphonates. Prolia® is linked to more hospitalizations, however. Let's do our best to prevent fractures with a well-tolerated program.

Prepared by Randy Goodman
Board Certified Geriatric Pharmacist