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Anaphylaxis P&P Revision

GeriatRx Policy and Procedure 4.18 has been renamed. The former name, *Adrenaline Kit*, was not descriptive enough, and did not apply to homes using auto-injector adrenaline products like EpiPen® and Allerject®.

We have also made a few modifications to the policy based on input from one of our LTC docs. This MD does double duty in the ER Department at the hospital directly across from the LTC. He understands the complexities of sending and receiving acutely ill residents.

As per the October GeriJournal, he emphasized that adrenaline (epinephrine) must be given for all anaphylactic reactions. Antihistamines are only to be given as secondary treatment for itchy, uncomfortable skin reactions. Diphenhydramine (Benadryl®) is no longer the preferred antihistamine to treat these reactions, as it can be quite sedating. If a resident's responsiveness is blunted, administering Benadryl® could be harmful. Second-generation antihistamines, like loratadine (Claritin®) or cetirizine (Reactine®) are preferred as they are less sedating. The P&P is now named *Anaphylaxis Response and Treatment*.

Drop LDL to Limit Stroke

An article published in *Circulation* last month caught my eye. It followed more than 5,000 participants using a new cholesterol-lowering injectable drug, evolocumab (Repatha®), for 5 years after the original study ended. The investigators wanted to know if a very low LDL cholesterol of 1 mmol/L improved outcomes relative to the current target of 1.8 mmol/L in those with a prior history of ischemic stroke.

This was an opportunity to highlight the wonders of Repatha®, and the results were impressive. There was a 31% reduction in MACE (major adverse cardiovascular events), a 27% reduction in all strokes, and a 25% reduction in ischemic strokes. Past statin studies had shown increases in bleeds and hemorrhagic stroke with extreme LDL lowering, but that was not the case with these prior stroke sufferers.

Pushing LDL down to 1 mmol/L may be desirable in patients with a history of ischemic stroke. Evaluating Repatha® vs. conventional statin plus ezetimibe therapy will be interesting, as will patient factors in this multi-year investigation.

Low D and Pneumonia

Much has been written about vitamin D, and how people lacking it will surely suffer from every scourge imaginable. Sadly, ingesting vitamin D rarely seems to improve outcomes. That being said, the latest study showing an association between vitamin D deficiency (serum $25OHD_3$ less than 25 nmol/L) and increased pneumonia mortality is worth looking at.

This Danish study was relatively small, following 514 individuals hospitalized for pneumonia for up to 180 days after admission. The patients' median age was 74, and 44% were women. Vitamin D-deficient patients died three times as often at 90 days and 180 days post-hospital admission compared to vitamin D-sufficient ($25OHD_3$ greater than 50 nmol/L) patients. The study authors adjusted for confounding factors between the two groups, like smoking status, COPD comorbidity, age, and BMI. The severity of the initial pneumonia symptoms was also taken into account. The difference in death rates was stastically significant, but the size of the deficient group (29) was very small. Though proof of benefit from supplemental D is lacking, denying it seems counterintuitive.

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