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BP 101

BP treatment made easy - That's the theme of the latest guidelines from *Hypertension Canada*. [Published in the CMAJ](#) this month, the target BP is 130/80, regardless of diagnosis. Those values are the tipping point for risk reduction. One caveat is that extremely frail residents or those with a history of falls should be treated less aggressively.

Lifestyle changes are key. Na reduction is always prominent. Using a K⁺ salt substitute reduces mortality and is possible in LTC. Adding fruits and vegetables ups K⁺ with additional benefits. Watching for hyperkalemia is a must for residents with renal disease or those taking K⁺-sparing drugs (e.g., ACE inhibitors, ARBs, and some diuretics). Weight loss (GLP-1s?), increased exercise, reduced alcohol intake, and smoking cessation round out the lifestyle section.

Who do we treat? Anyone with a BP > 140/90. Where BP is > 130/80 with elevated cardiac risk from diabetes, heart failure, renal impairment, CAD, peripheral vascular

disease, or age above 75 years, treatment is also recommended.

Drug treatment should start with low-dose combinations of an ACEI (prils) or ARB (sartans) and a thiazide diuretic. If further reductions are needed, a calcium channel blocker (e.g., amlodipine) is added. Other drugs, like β -blockers, are less effective but make sense in the presence of angina, heart failure, or post-MI. Lower doses of multiple agents provide a better BP response with fewer adverse effects than higher doses of individual BP medications. The next step is to increase the dose of the three classes above. If that doesn't get the job done, add spironolactone (as per PATHWAY-2). It was more effective than an added α or β blocker and was well-tolerated. Hyperkalemia was not an issue in the study, however, K⁺ should be checked 2-4 weeks post-initiation and after any spironolactone dose increase.

Antipsychotic Sedation

Many of our antipsychotic medications can cause sedation. A German meta-analysis (*The Lancet Psychiatry*) sought to determine the relative sedative potential of different agents and when to expect this adverse effect to wear off.

Although young schizophrenia patients were the subject of this review, the results are relevant to our senior population.

Where sedation was present, it occurred early, with 83% of the events seen within the first two weeks of treatment. Roughly 50% of cases resolved after one week, but 24% of sedated patients continued to be drowsy after four weeks.

The worst offender of the oral drug arm was quetiapine, causing sedation more than four times as often as placebo. Invega® (paliperidone) was the least sedating, though it still impacted patients 80% more often than placebo. We must watch closely when residents start these drugs, as reactions are variable and unpredictable.

Vit K for Leg Cramps

Nocturnal cramps are painful. They usually affect the calf, arch of the foot, or thigh and seem interminable. They can be caused by drugs (diuretics, statins, etc.), health conditions (diabetes, CHF, renal failure, etc.), and muscle over or underuse, but often the cause is difficult to determine.

Electrolyte abnormalities should be corrected and treatable causes eliminated. Calf stretches can help. Drug therapy has limited effectiveness, but Vitamin K offers promise. Seniors taking 180 mcg of Vitamin K₂ daily for 8 weeks showed reduced cramp frequency (*JAMA Internal Medicine*) from 3.63 to just 0.96 cramps per week. Something to consider!

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