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Bleeding with Afib Tx

Atrial fibrillation can cause blood to stagnate and clot in the heart. Clots pumped toward the brain can block cerebral vessels, causing strokes. Anticoagulants are prescribed to prevent these clots. Heart rate-reducing drugs, like diltiazem and β-blockers, are often added to reduce AFib symptoms, including palpitations, dizziness & shortness of breath.

Unfortunately, diltiazem can interfere with anticoagulant elimination (via CYP 3A4 in the liver & the P-gp pump in the GI tract/kidneys). If the anticoagulant accumulates in the body, it may cause a bleed.

The *Annals of Internal Medicine* sought to quantify the relevance of this diltiazem-anticoagulant interaction. Two groups of 23,000 Afib patients were compared. One group used the β-blocker, metoprolol, for rate control. The other group took diltiazem. The diltiazem group had 5.4 more bleeds per 1,000 patients/year. There were 9.2 more bleeds in the high-dose (>120 mg/day) diltiazem group vs. metoprolol. The numbers aren't huge, but we need to exercise caution when combining diltiazem with an anticoagulant.

Statins Don't Get Old

There was a time when statins were a top deprescribing target in the elderly. What benefit could they offer in the final years of life? A closer look at the data has changed that thinking. A large retrospective Israeli study (*J Am Geriatrics Soc*) is providing further support that we should stick with statins in our seniors.

The study compared nearly 16,000 seniors over 80 years of age. Participants were split into two groups: statin users and non-users. All users began taking statins before they turned eighty. Outcomes were assessed after four years of treatment to determine whether there were differences in mortality, coronary events, or dementia. Two prominent statin side effects, muscle pain and diabetes, were also part of the comparison.

The most compliant users (those who took at least 80% of their statin doses – this is not LTC!) had a huge 42% mortality reduction. Coronary events were reduced by 20% across the statin group, though no dementia benefit was seen. Myopathy and diabetic events were similar between the groups.

This was a retrospective study (a prospective study would be unethical), but the evidence points to a strong statin benefit, with little concern for these two prominent adverse effects.

Deprescribing Psychotropics

The American Society Clinical Psychotropic Task Force (don't worry, there were two Canadians on the panel) published recent psychotropic deprescribing guidelines. Some of their recommendations have direct application to LTC.

We should consider stopping these drugs when: a) therapeutic response is inadequate (less than 25% symptom reduction), b) improvement in at least one core target symptom is not achieved after an adequate trial, or c) the psychotropic drug adds to fall risk in a resident who has fallen or is at an increased risk of falling.

Pharmacology played a role in several of the consensus statements. Patients taking multiple psychotropics should only have one med changed at a time so the response can be properly evaluated. If a drug has been effective, deprescribing should only be considered after a lengthy period (several months or more). Anticholinergic drugs (e.g., olanzapine or quetiapine) must be tapered slowly, with the gradual introduction of replacement drugs. This will prevent relapse and anticholinergic rebound (nausea, vomiting, diarrhea, insomnia, etc.). Long-acting drugs (aripiprazole, fluoxetine, vortioxetine, and extended-release injections), however, leave the body slowly and can be stopped with little concern for withdrawal reactions.

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