

Letters to the Editor

Statins in older adults

Editor, – The recent article (Aust Prescr 2013;36:79-82) suggests statins could be less effective in older patients, may have more adverse effects and should be used in lower doses.

While this may be true in seriously ill patients or those with dementia, we feel that there is insufficient evidence to follow this advice in otherwise fit elderly people. The fact that the relationship of cholesterol to cardiac events in the elderly is less consistent does not negate trials showing a decrease in events no matter what the starting cholesterol is, or the greater decrease in events in higher compared to lower dose statins. With an increased incidence of events in the elderly, the absolute drop with statins may well be greater.

The evidence on loss of memory with statins is minimal in otherwise fit elderly patients. There are anecdotal reports of this only. Myopathy requires drug cessation but this is in the minority of patients. Risks with liver enzyme elevation appear slight at the most.


We feel that following the advice in the article could increase cardiac and other atherosclerotic events in otherwise well elderly people.

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Sarah Hilmer and Danijela Gnjidic, the authors of the article, comment:

 We thank Mark Sheppard and Alistair Begg for pointing out the limitations of making clinical judgements based only on chronological age. In older people, in the presence of increasing inter-individual variability, biological age, which is analogous to the degree of frailty, is a much better predictor of outcomes than chronological age. Amongst older people, frailty affects the use, pharmacokinetics, pharmacodynamics, safety and efficacy of medicines.^{1,2}

Clinical trials in older people do not show benefits of statins for primary prevention of cardiovascular disease.³ The participants in these trials are generally fit. The frail are predominantly excluded based on comorbidity, co-medication or impaired

physical or cognitive function. In frail older people, we know more about adverse events (from observational studies) than we do about efficacy, which requires randomised controlled trials.⁴

We wish to clarify what is known about adverse effects of statins in fit older people. The majority of the evidence that statins cause cognitive impairment is from case reports and case series, in which the impairment was generally reversible within days to weeks of stopping the statin. Therefore, if statin-associated cognitive decline is suspected, it is reasonable for clinicians to consider a trial of statin withdrawal. Amongst clinical trial participants who were generally fit, myalgias were reported in 5–10%, myositis in 0.1–0.2%, and rhabdomyolysis was rare. A clinician treating one hundred fit older patients, 40% of whom are taking statins, is expected to see 2–4 patients with myalgias. The elevated hepatic transaminases observed with statins are of uncertain clinical significance.

The prescription of statins for primary prevention should be individualised on the basis of clinical judgement.⁵ Our article aims to raise awareness of the benefits and risks of statins to help clinicians apply the existing evidence to their patients.

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Prescribing for persistent non-cancer pain

Editor, – I read the article on principles of prescribing for persistent non-cancer pain, anticipating I might get some insight into the management of non-cancer pain in the elderly (Aust Prescr 2013;36:113-5). Unfortunately I was disappointed. I have worked in a residential aged-care facility as a GP for the past nine years and the incidence of non-cancer chronic



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pain is high – possibly around 60% of our residents aged over 75 years are affected.

The practice I work in prescribes paracetamol up to the maximum advised dose (4000 mg/day) as baseline therapy. Some of our residents require additional pain management. We prescribe quite a lot of opioids, mostly commencing with buprenorphine patches. In a percentage of residents this is insufficient and we mostly use sustained-release oxycontin or even fentanyl patches.

The facility provides physiotherapy, hydrotherapy and occupational therapy but psychotherapy is not readily accessed.


We prefer not to use regular high dose codeine-containing analgesics as we believe there is a problem with metabolites accumulating. Also constipation seems to be a big problem with codeine.

My impression is that dependence and addiction is not a problem in the very elderly, possibly due to some age-related change to the nervous system.

I would be pleased to have some feedback.

John Vanlint
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Milton Cohen, the author of the article, comments:

 Thank you for your letter. I appreciate your disappointment as, due to space constraints, the article was limited to principles of prescribing rather than being a more comprehensive treatise on pharmacotherapy for patients with persistent non-cancer pain.

Your use of opioids for patients in residential aged care when paracetamol and physical measures have been insufficient reflects good quality use of those medicines, especially as you avoid the short-acting prodrugs such as codeine (which about 10% of Caucasians will not convert to morphine). I would however sound a word of caution about transdermal fentanyl, as the lowest dose patch (12 microgram per hour) is approximately equivalent to oral oxycodone 20 mg per day which would be a high dose in that age group.

Addiction is not an issue in the elderly, in contrast to altered cognitive function and constipation which are the main limiting factors. Dependence,

as defined by a withdrawal syndrome if the dose is reduced too quickly, can be minimised by keeping doses low and reducing slowly.

For more information on practical pharmacotherapy for managing pain, may I refer you to the following articles:

Cohen ML, Wodak AD. Opioid prescribing in general practice: a proposed approach. *Med Today* 2012;13:24-32.

Katz B. Pain in older people: often unrecognised and undertreated. *Med Today* 2012;13:35-38.

Prescribing for refugees


Editor, – Thank you for your editorial on prescribing for refugees (*Aust Prescr* 2013;36:146-7).

Another area of prescription writing can be for immunisations for those in the ‘visiting family and friends’ category. Many of our refugees who have now been here for years are returning home with their Australian-born children. Keeping these kids on schedule for their government-funded vaccines is important as they may return to their parents’ country of origin at a young age.

Adequate preparation with travel immunisations such as hepatitis A and typhoid, and in some cases malaria chemoprophylaxis, is important. The parents themselves may or may not be immune to hepatitis A and many of those returning home as adults are at risk for typhoid. Keeping up to date with new information relating to travel health is fast becoming an area of specialty.

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Mitchell Smith, one of the authors of the editorial, comments:

 Thank you for raising the additional issue of travel health in people with a refugee background. Although by definition refugees are often prevented from returning home even to visit, some are able to do so many years later. Certainly standard immunisations are important, although not a prescribing issue as such. There is good evidence that people returning to a resource-poor country to visit friends and relatives are at increased risk of infectious diseases in particular. Appropriate travel advice and broader community education is therefore important.