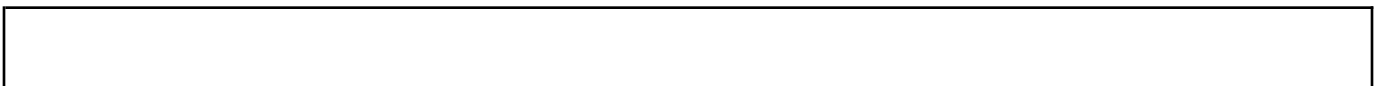


# **Geriatric LTC Pearls from A to Z**

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## Allergy Medications

- Add to anticholinergic burden (see below)
- Remember to discontinue when allergy season is over
- Don't confuse a runny nose (*related to age-related stenosis of medial tear duct*) plus red, dry eyes with allergies

## Asthma Medications

- Asthma is **not** COPD and therefore is **not** treated the same
- Glaxo will no longer be making Flovent, so it is not available. If a patient needs an inhaled steroid for asthma, generic fluticasone will work just as well
- Singulair works well for exercise or cold-induced asthma, but isn't approved for COPD and has many significant G.I. and behavioral side effects

## Anticholinergic Medications

- Anticholinergic effects are additive as multiple AC agents are used together
- Anticholinergic Side Effects
  - o Hyperthermia
  - o Vasodilation
  - o Dilated Pupils (blurry vision)
  - o Dry skin
  - o Hallucinations
  - o Agitation
  - o Tachycardia
  - o Anxiety
  - o Ileus
  - o Urinary Retention
- Magellan Anticholinergic Risk Scale (Attachment 1)

## Appetite Stimulants

- Megace does not lead to increased lean body mass. Any weight gain is due to an increase in fatty weight and increases morbidity and mortality in this population (Attachments 2, 3 and 4)
- Remeron leads to weight gain in just 1 of 8 persons treated for depression – no better than placebo when not treating depression (Attachments 5 and 6)

## **A**spirin for prevention in patients with heart disease

- **United States Preventive Services Task Force Recommendation regarding Aspirin for Primary Prevention in those >60:**

### **The USPSTF recommends against low-dose aspirin use for primary prevention of CVD in adults 60 years or older.**

- *“What can we conclude about the use of aspirin for prophylaxis 150 years after its chemical synthesis? For secondary prevention, in which risk is determined largely by the extent of atherosclerotic disease, the benefits of aspirin outweigh the risks of bleeding. In contrast, for primary prevention, in which risk is determined largely by age and the presence or absence of diabetes, the benefit–risk ratio for prophylactic aspirin in current practice is exceptionally small.”* [Paul M Ridker, MD, MPH; Should Aspirin Be Used for Primary Prevention in the Post-Statin Era? NEJM; 379:16 10/18/18]
- *“Higher all-cause mortality was observed among apparently healthy older adults who received daily aspirin than among those who received placebo”* [J.J. McNeil, et al; Effect of Aspirin on All-Cause Mortality in the Healthy Elderly. NEJM; 379:16 10/18/18]
- *“Aspirin use prevented serious vascular events in persons who had diabetes and no evident cardiovascular disease at trial entry, but it also caused major bleeding events. The absolute benefits were largely counterbalanced by the bleeding hazard.”* [The ASCEND Study Collaborative Group; Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus. NEJM; 379:16; 10/18/18]
- *“Aspirin use in healthy elderly persons did not prolong disability-free survival over a period of 5 years but led to a higher rate of major hemorrhage than placebo.”* [J.J. McNeil, et al; Effect of Aspirin on Disability-free Survival in the Healthy Elderly. NEJM; 379:16 10/18/18]

- “*The use of low-dose aspirin as a primary prevention strategy in older adults resulted in a significantly higher risk of major hemorrhage and did not result in a significantly lower risk of cardiovascular disease than placebo.*” [J.J. McNeil, et al; Effect of Aspirin on Cardiovascular Events and Bleeding in the Healthy Elderly. NEJM; 379:16 10/18/18]