



**BRIEF QUESTIONS
AND ANSWERS
ON CURRENT
CLINICAL
CONTROVERSIES**

Q: Should hypercholesterolemia be treated in patients older than 65?

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A: FOR THE PATIENT over 65 with known atherosclerosis, the answer is an emphatic Yes! For older patients without known atherosclerosis, the answer is less clear, and depends on whether or not they have multiple risk factors for cardiovascular events.

■ WHY THE CONTROVERSY?

Although patients older than 65 are at increased risk for cardiovascular disease, there has been a long controversy over whether they should be treated for hypercholesterolemia. Some studies^{1,2} have found little or no correlation between cholesterol and coronary heart disease morbidity and mortality, and recommend that physicians be "cautious about initiating cholesterol-lowering treatment in men and women above 65 to 70 years of age."²

Resolving this controversy was difficult, because few studies of cholesterol-lowering therapy have included older patients. However, more recent studies are making the question easier to answer.

■ TREATMENT CLEARLY PREVENTS A SECOND CARDIOVASCULAR EVENT

Several recent studies provide the best data yet that treating hypercholesterolemia in older patients who have atherosclerotic disease can prevent recurrent cardiovascular events such as stroke or myocardial infarction.

Lowering cholesterol, particularly with HMG CoA reductase inhibitors (statins), has been shown to improve endothelial function,³ promote regression of atherosclerosis,⁴ and improve clinical outcomes such as cardiovascular and total mortality.⁵⁻⁷

Recent secondary prevention studies have enrolled patients aged 65 to 75 at entry, permitting subgroup analysis of whether these beneficial effects of statins extend to the elderly. In the 4S,⁵ the CARE,⁶ and the LIPID⁷ trials, older patients obtained a benefit comparable to or greater than that of their younger counterparts. For instance, in the CARE study,⁶ to prevent one fatal coronary event or nonfatal myocardial infarction, 67 patients under age 65 needed to be treated for 5 years with pravastatin, compared with only 15 patients between ages 65 and 75. For all patients, the benefit from statin therapy is seen early, within 1 to 2 years of starting therapy.

■ CAN TREATMENT PREVENT THE FIRST EVENT?

Persons older than 65 without known atherosclerotic disease but with multiple risk factors may benefit from lipid-lowering therapy, although the current data are less clear.

Unfortunately, despite the large attributable risk of cardiovascular disease, clinical trials traditionally enrolled few patients older than 65. One recent primary prevention study, AFCAPS/TexCAPS,⁸ recruited a significant number of older patients. In this study, patients up to age 73 years were treated with lovastatin or placebo. A comparable reduction in cardiovascular events was seen in treated patients both over and under the median age, with 87 patients needed to be treated for 5 years to prevent a cardiovascular event.

■ RECOMMENDATIONS

Patients over age 65 with known atherosclerosis should be treated for hypercholesterolemia. Also, the encouraging data from the AFCAPS study support treating hypercholesterolemia in patients aged 65 to 74 without known athero-

**The higher
the risk,
the greater
the benefit
of treatment**

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sclerosis but with multiple risk factors.

There is, however, little support in the literature for lipid-lowering in patients 75 and older for either primary or secondary prevention. In fact, assessing cardiovascular risk in this age group can be difficult and confounded by multiple comorbidities.⁹ For highly functioning patients over age 75 with an active life expectancy of at least 2 and preferably greater than 5 years, lowering lipids per the National Cholesterol Education Program (NCEP) guidelines¹⁰ should be considered. The cost-effectiveness of therapy in this age group has not been established. Hopefully, future clinical trials will address which elderly patients will benefit most from therapy and what their target cholesterol levels should be.

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