

Is the person ≥ 65 years of age taking and tolerating a statin for primary or secondary prevention?

Given evidence of benefit for statins in those 65-75 years, the decision to discontinue statins is most relevant in those >75 years; however, some persons 65-75 years may have factors warranting discussion of discontinuation

Does the person have a factor that may prompt a conversation about discontinuation?

- Presence of frailty
- Change in health status
- Patient or clinician concern about pill burden
- Functional limitations
- Cognitive impairment
- Very complex health/increasing care needs (e.g., living in long-term care)
- Advanced illness

No

Continue Statin

Yes

Suggest discontinuing

Conditional recommendation that applies to **primary and secondary prevention**

Yes

Is the person at end-of-life?

No

Suggest continuing

Conditional recommendation that applies to **primary and secondary prevention**

Have a conversation

- At end-of-life, probably no difference in chance of death at 60 days or cardiovascular events over 1 year
- Different approaches may be better for some patients depending on their circumstances
- Talk to patients/carers about their values and preferences to find the right choice for them as individuals

Monitoring

No role for lab monitoring following discontinuation

Have a conversation

- For older patients **not** at end-of-life, there might be an increased chance of cardiovascular events after stopping but we are very uncertain
- Different approaches may be better for some patients depending on their circumstances
- Talk to patients/carers about their values and preferences to find the right choice for them as individuals

Re-evaluation

- Periodically reassess decisions (e.g., annually)
- If discontinuing, reassess statin use if cardiovascular (CV) risk changes

Document

Document discussions and communicate with relevant care team members

Tapering and reducing doses

- We did not find any evidence on dose reduction or if tapering is needed
- If a person is tolerating their current statin dose, dose reduction is likely unnecessary
- In older adults with severe frailty, reducing the dose could be considered if a person is experiencing muscle pain or weakness
- High dose statins include atorvastatin 40-80 mg or rosuvastatin 20-40 mg

Statin Intolerance

Recommendations from other [guidelines](#) include:

- Prescribing an alternative statin, reducing the dose, intermittent dosing, or therapy with another lipid-lowering medication

Engaging patients and carers: conversation points

People change over time and reassessing long-term medications is good practice

Rationale for considering option of discontinuation: making sure medications are still the best fit for individual patients (necessary, effective, safe, consistent with goals)

“What matters most” (values, preferences, healthcare goals):

- Most patients value lowering the chance of future CV events but others might place less value on the chance of benefit from statins; patients may have different levels of risk aversion
- Some patients may be bothered by taking many medications and prioritize lowering pill burden, or there may be other things they prioritize about their current health

Evidence

- In people at end-of-life, there is probably no difference in chance of death for 60 days after a statin is stopped or the chance of CV events over 1 year
- In older adults not yet at end-of-life, there might be an increased chance of CV events after stopping but we are very uncertain about this
- We do not know whether patients will feel better after stopping a statin but they will take one less medication
- Chance of benefit from starting/continuing statins depends on individual cardiovascular risk (e.g., can be estimated in primary prevention using 10-year CV risk calculator for persons 65-75 years)
 - Canadian risk calculators available from [PEER](#) and [CCS](#)

Incorporating frailty and life expectancy into decisions

- People with a [Clinical Frailty Scale](#) of 4 or more are living with frailty were excluded from randomized controlled trials of statin initiation
- Many older adults with frailty are at high risk of CV disease but are also at risk of adverse drug events and polypharmacy
- Frailty alone should not be a reason to stop a statin but may prompt a conversation
- Given the uncertainty in evidence, decisions around statins in persons living with frailty should be guided by “what matters most” (see Conversation Points above)
- Estimating life expectancy is challenging. There is no one best index or measure. Several [calculators](#) exist including a Canadian one ([Project Big Life](#)). These calculators may be helpful to guide decision making in conjunction with clinical expertise
- **“End-of-life”** in the one randomized controlled trial informing our recommendations was based on the [surprise question](#) (“would a clinician be surprised if this patient died in the next year?”)