



EDITOR'S CORNER

DEMENTIA (FEBRUARY 2008)

Q: Usually these modules are evidence based, but there is no reference for the recommendation for statin use. Is there evidence? If so, how aggressively should we treat with statins?

A: There is conflicting evidence on the use of statins in treating established Alzheimer's disease. A number of studies have suggested that statin therapy may be of benefit,^{1,2} but results have not been consistent.



A low dose of simvastatin (20 mg/day) has been linked with a positive effect on brain proteins and cognition in patients with Alzheimers.^{3,4} Similar benefit on cognition and memory was found in a small RCT in which patients were randomized to either atorvastatin 80 mg/day or placebo

for 1 year while continuing with cholinesterase inhibitors. Performance on the AD Assessment Scale-Cognitive Subscale was significantly better for the atorvastatin-treated group at both 6 and 12 months⁵ [LOE I-2, with wide confidence interval].

Although encouraging, these prospective studies have been small, and other studies have shown no benefit.^{6,7} Most recently, despite the overall lack of significance of positive benefit from treatment with atorvastatin in the LEADe study,⁸ further evaluation of data from that study found that individuals with ApoE genotype did have a significant benefit from treatment compared with placebo. Clearly, more research is needed.^{6,8,9} - AF/DH/JW

1. Cramer C, Haan MN, Galea S, Langa KM, Kalbfleisch JD. Use of statins and incidence of dementia and cognitive impairment without dementia in a cohort study. *Neurology* 2008 Jul 29;71(5):344-50. PMID: 18663180.
2. Rosenberg PB, Mielke MM, Tschanz J, Cook L, Corcoran C, Hayden KM, Norton M, Rabins PV, Green RC, Welsh-Bohmer KA, Breitner JC, Munger R, Lyketsos CG. Effects of cardiovascular medications on rate of functional decline in Alzheimer disease. *Am J Geriatr Psychiatry* 2008 Nov;16(11):883-92. PMID: 18978249.
3. Hoglund K, Thelen KM, Syversen S, Sjogren M, von Bergmann K, Wallin A, et al. The effect of simvastatin treatment on the amyloid precursor protein and brain cholesterol metabolism in patients

with Alzheimer's disease. *Dement Geriatr Cogn Disord* 2005; 19:256-265.

4. Sjogren M, Gustafsson K, Syversen S, Olsson A, Edman A, Davidsson P, et al. Treatment with simvastatin in patients with Alzheimer's disease lowers both alpha- and beta-cleaved amyloid precursor protein. *Dement Geriatr Cogn Disord* 2003;16:25-30.
5. Sparks DL, Sabbagh M, Connor D, Soares H, Lopez J, Stankovic G, Johnson-Traver S, Ziolkowski C, Browne P. Statin therapy in Alzheimer's disease. *Acta Neurol Scand Suppl.* 2006;185:78-86. PMID: 16866915.
6. Rockwood K. Epidemiological and clinical trials evidence about a preventive role for statins in Alzheimer's disease. *Acta Neurol Scand* 2006; Suppl 185:71-77.
7. Heart Protection Study Collaborative Group. MRC/BHF Heart Protection Study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo-controlled trial. *Lancet* 2002;360:7-22.
8. Feldman H, Jones RW, Kivipelto M, et al. The LEADe study: A randomized, controlled trial investigating the effect of Atorvastatin on cognitive and global function in patients with mild-to-moderate Alzheimer's disease receiving background therapy of Donepezil. *Neurology* 2008;71:154.
9. Sparks L. Statins and cognitive function. *J Neurol Neurosurg Psychiatry* 2009;80;1-2.

AGE-RELATED MACULAR DEGENERATION (NOVEMBER 2008)

Q: Info point 1 in the module states, "AMD is the most common cause of new vision impairment in individuals over 65 years of age and a leading cause of blindness in older North Americans."

Is there an error? Surely, cataracts must be the most common cause of vision impairment, with AMD the most common UNTREATABLE cause of new vision impairment.

A: This is an important point, as most of us see more patients with cataracts than with AMD. Indeed, cataracts are the most common eye disease associated with vision loss, and are about two-to-three times as common as AMD (17-25% to 7-9% for those aged 60-69).^{1,2}

However, the source for Info point 1 is a Canadian evidence-based review,¹ and it says exactly what is in the module! How can this be?

In looking more deeply at this review and its sources, it becomes apparent that this statement is

accurate when the WHO or the National Eye Institute (NEI) definitions of "visual impairment" are used. The WHO says "Visual impairment includes low vision as well as blindness."³ Low vision is defined as visual acuity of less than 6/18 (20/60), and blindness is a visual acuity less than 3/60 (20/400). [Legally blind in North America is less than 6/60 (20/200)]. NEI says "Low vision is defined as a visual impairment that is not corrected by standard eyeglasses, contact lenses, medication, or surgery and that interferes with the ability to perform everyday activities."⁴

Given modern eye care in Canada, these definitions would exclude most cataracts. If a cataract is causing loss of sight that interferes with a person's normal activities, cataract surgery is usually undertaken - a cataract must no longer be "ripe" before it can be removed.

These numbers also reflect the other reality. Although some patients with AMD can be treated

successfully, most AMD patients do not benefit from the safe and effective treatments available for cataracts. This is consistent with the fact that "The most prevalent condition seen in low vision clinics is age-related macular degeneration."² - LT/AH/JW

1. Jutai J, Hooper P, Strong G, Cooper L, Hutnik C, Sheidow T et al. Terminology, Demography, and Epidemiology of Low Vision. Vision Rehabilitation Evidence-Based Review (VREBR). 2005. 1-61. www.cnib.ca Accessed May 2009. [Note: This reference should *replace* reference 1 in the module, as Jutai et al. Arch Phys Med Rehabil 2007 is incorrect.]
2. Buhmann et al. Foundations for a Canadian Vision Health Strategy: Towards Preventing Avoidable Blindness and Promoting Vision Health. 2007. National Coalition for Vision Health www.visionhealth.ca/projects/documents/Foundations-For-A-Canadian-Vision-Health-Strategy.pdf Accessed May 2009.
3. WHO. Magnitude and causes of visual impairment. Fact sheet 282. November 2004.
4. Low Vision: Goals, Objectives, and Prevalence Data www.nei.nih.gov/nehp/programs/lowvision/goals.asp#sup2

MEMBERS' CORNER *Do you have something to share? Email us at fmpe@mcmaster.ca*



Erella Rousseau, Facilitator in Mississauga Writes:

"We are now officially starting our **13th year** as a **PBSG group** - with one retired now, and picking up a few new ones along the way! We meet to discuss all new modules in the hospital, and do a Jonathan's when we can get expert help - basically a chance for us to toss around more questions about the module and have ongoing discussion in the presence of a knowledgeable colleague - I believe this is an important factor which has contributed to keeping the group active for so long. Erella"

FOUNDATION NEWS AND NOTICES

Important Reminder: For our **PBSG September Groups** and **PBIL members**, renewal invoices will be sent out in August direct to members. Contact information update requests will be sent via email mid June. If you have not sent in an email address, please contact us at fmpe@mcmaster.ca and we can update your record.

FACILITATOR TRAINING WORKSHOPS *contact Heather Haywood 800.661.3249 haywood@mcmaster.ca*

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