

# Older Patients Do Try Lifestyle Modification

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SAN FRANCISCO — A surprisingly high 85% of older adults with hypertension, hyperglycemia, or hyperlipidemia reported engaging in lifestyle modifications, such as diet change or exercise, in a longitudinal study of 666 people, Eleanor M. Simonsick, Ph.D., said at the annual meeting of the Gerontological Society of America.

Patients who reported voluntary lifestyle

modification generally weighed less, had less obesity, and exercised more than patients who denied lifestyle modification. The two groups did not differ, however, in measures of disease such as blood pressure, hemoglobin A<sub>1c</sub> values, and cholesterol levels, with the possible exception of triglyceride levels, reported Dr. Simonsick, an epidemiologist at the National Institute on Aging, Baltimore, and her associates.

Data from previous intervention studies suggest that people with these chronic dis-

eases improve disease parameters through lifestyle modifications, “but these interventions are often very comprehensive and quite rigorous,” she said. Little is known about what people do on their own or how effective the changes may be.

“In terms of their specific conditions, it would appear that additional guidance is required” for voluntary lifestyle modification to improve health, she added.

On the plus side, the results refute the common notion that patients aren’t inter-

ested in lifestyle modification, a misconception that dissuades many physicians from bringing up the subject, some surveys suggest. “I think that we should have more confidence in the patient population, that they may actually be receptive to lifestyle modification,” Dr. Simonsick said. Sociodemographic factors did not affect participation rates in lifestyle modification.

The study analyzed data from the Baltimore Longitudinal Study of Aging (BLSA), which performs 3-day examinations and surveys of participants every 1-4 years, depending on their age. Participants make the trip to Baltimore for these visits, so the study is skewed toward healthier, more highly educated adults, she acknowledged. The study’s results are not representative of the general population, and probably represent the most positive outcomes one might expect to see in terms of effects from lifestyle modification, she said.

Patients in this analysis of visits during 2004 to 2007 had a mean age of 68 years. Half were women, 29% were black, and a majority had more than a college education.

Overall, 47% of participants reported being diagnosed with hypertension, 19% said they had been told they had either diabetes or high glucose levels, 56% said they had been diagnosed with hyperglycemia, and 23% had none of the above.

Among those with hypertension, 83% reported voluntary lifestyle modification, “which is a much higher number than we had expected,” Dr. Simonsick said. Of those who made lifestyle modifications, 90% were taking antihypertensive medication, compared with 91% who did not change their lifestyle.

The obesity rate in hypertensive patients was 31% with lifestyle modification and 65% without, a significant difference. There were no major differences between these groups in systolic or diastolic blood pressures—126/67 mm Hg in the lifestyle modification group, compared with 127/69 mm Hg in the others.

Among participants with hyperglycemia, 85% reported lifestyle modification, and these patients were significantly more likely to be on medication (48% vs. 22% of non-lifestyle modifiers). Fasting glucose levels were slightly higher in the lifestyle modification group than in other patients, but hemoglobin A<sub>1c</sub> values were 6% in both groups.

The higher medication use and higher fasting glucose levels in the lifestyle modification group may be caused by a higher rate of diabetes rather than just hyperglycemia, compared with the non-lifestyle modification group, but the data couldn’t show that explicitly, Dr. Simonsick said.

Among those with hyperlipidemia, 85% reported lifestyle modification, and 62% of these people were taking medication, compared with 54% of non-lifestyle modifiers (a nonsignificant difference).

Obesity rates were 26% in the lifestyle modifiers and 50% in non-lifestyle. Triglyceride levels also were significantly different between groups—though “not remarkably so,” she said—measuring 116 mg/dL in patients who pursued lifestyle modification, compared with 133 mg/dL in those who didn’t.

## BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

### TRICOR® 48 mg and 145 mg (fenofibrate tablets)

Rx only

#### CONTRAINDICATIONS

TRICOR is contraindicated in patients who exhibit hypersensitivity to fenofibrate.

TRICOR is contraindicated in patients with hepatic or severe renal dysfunction, including primary biliary cirrhosis, and patients with unexplained persistent liver function abnormality.

TRICOR is contraindicated in patients with preexisting gallbladder disease (see WARNINGS).

#### WARNINGS

**Liver Function:** Fenofibrate at doses equivalent to 96 mg to 145 mg TRICOR per day has been associated with increases in serum transaminases [AST (SGOT) or ALT (SGPT)]. In a pooled analysis of 10 placebo-controlled trials, increases to > 3 times the upper limit of normal occurred in 5.3% of patients taking fenofibrate versus 1.1% of patients treated with placebo.

When transaminase determinations were followed either after discontinuation of treatment or during continued treatment, a return to normal limits was usually observed. The incidence of increases in transaminases related to fenofibrate therapy appear to be dose related. In an 8-week dose-ranging study, the incidence of ALT or AST elevations to at least three times the upper limit of normal was 13% in patients receiving dosages equivalent to 96 mg to 145 mg TRICOR per day and was 0% in those receiving dosages equivalent to 48 mg or less TRICOR per day, or placebo. Hepatocellular, chronic active and cholestatic hepatitis associated with fenofibrate therapy have been reported after exposures of weeks to several years. In extremely rare cases, cirrhosis has been reported in association with chronic active hepatitis.

Regular periodic monitoring of liver function, including serum ALT (SGPT) should be performed for the duration of therapy with TRICOR, and therapy discontinued if enzyme levels persist above three times the normal limit.

**Cholelithiasis:** Fenofibrate, like clofibrate and gemfibrozil, may increase cholesterol excretion into the bile, leading to cholelithiasis. If cholelithiasis is suspected, gallbladder studies are indicated. TRICOR therapy should be discontinued if gallstones are found.

**Concomitant Oral Anticoagulants:** Caution should be exercised when anticoagulants are given in conjunction with TRICOR because of the potentiation of coumarin-type anticoagulants in prolonging the prothrombin time/INR. The dosage of the anticoagulant should be reduced to maintain the prothrombin time/INR at the desired level to prevent bleeding complications. Frequent prothrombin time/INR determinations are advisable until it has been definitely determined that the prothrombin time/INR has stabilized.

**Concomitant HMG-CoA Reductase Inhibitors:** The combined use of TRICOR and HMG-CoA reductase inhibitors should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

Concomitant administration of fenofibrate (equivalent to 145 mg TRICOR) and pravastatin (40 mg) once daily for 10 days increased the mean C<sub>max</sub> and AUC values for pravastatin by 36% (range from 69% decrease to 321% increase) and 28% (range from 54% decrease to 128% increase), respectively, and for 3 $\alpha$ -hydroxy-iso-pravastatin by 55% (range from 32% decrease to 314% increase) and 39% (range from 24% decrease to 261% increase), respectively.

The combined use of fibric acid derivatives and HMG-CoA reductase inhibitors has been associated, in the absence of a marked pharmacokinetic interaction, in numerous case reports, with rhabdomyolysis, markedly elevated creatine kinase (CK) levels and myoglobinuria, leading in a high proportion of cases to acute renal failure.

The use of fibrates alone, including TRICOR, may occasionally be associated with myositis, myopathy, or rhabdomyolysis. Patients receiving TRICOR and complaining of muscle pain, tenderness, or weakness should have prompt medical evaluation for myopathy, including serum creatine kinase level determination. If myopathy/myositis is suspected or diagnosed, TRICOR therapy should be stopped.

**Mortality:** The effect of TRICOR on coronary heart disease morbidity and mortality and non-cardiovascular mortality has not been established. **Other Considerations:** In the Coronary Drug Project, a large study of post myocardial infarction of patients treated for 5 years with clofibrate, there was no difference in mortality seen between the clofibrate group and the placebo group. There was, however, a difference in the rate of cholelithiasis and cholecystitis requiring surgery between the two groups (3.0% vs. 1.8%).

Because of chemical, pharmacological, and clinical similarities between TRICOR (fenofibrate tablets), Atromid-S (clofibrate), and Lipid (gemfibrozil), the adverse findings in 4 large randomized, placebo-controlled clinical studies with these other fibrate drugs may also apply to TRICOR.

In a study conducted by the World Health Organization (WHO), 5000 subjects without known coronary artery disease were treated with placebo or clofibrate for 5 years and followed for an additional one year. There was a statistically significant, higher age-adjusted all-cause mortality in the clofibrate group compared with the placebo group (5.70% vs. 3.96%, p<0.01). Excess mortality was due to a 33% increase in non-cardiovascular causes, including malignancy, post-cholecystectomy complications, and pancreatitis. This appeared to confirm the higher risk of gallbladder disease seen in clofibrate-treated patients studied in the Coronary Drug Project.

The Helsinki Heart Study was a large (n=4081) study of middle-aged men without a history of coronary artery disease. Subjects received either placebo or gemfibrozil for 5 years, with a 3.5 year open extension afterward. Total mortality was numerically higher in the gemfibrozil randomization group but did not achieve statistical significance (p=0.19, 95% confidence interval for relative risk G:P=91-1.64). Although cancer deaths trended higher in the gemfibrozil group (p=0.11), cancers (excluding basal cell carcinoma) were diagnosed with equal frequency in both study groups. Due to the limited size of the study, the relative risk of death from any cause was not shown to be different than that seen in the 9 year follow-up data from World Health Organization study (RR=1.29). Similarly, the numerical excess of gallbladder surgeries in the gemfibrozil group did not differ statistically from that observed in the WHO study.

A secondary prevention component of the Helsinki Heart Study enrolled middle-aged men excluded from the primary prevention study because of known or suspected coronary heart disease. Subjects received gemfibrozil or placebo for 5 years. Although cardiac deaths trended higher in the gemfibrozil group, this was not statistically significant (hazard ratio 2.2, 95% confidence interval: 0.94-5.05). The rate of gallbladder surgery was not statistically significant between study groups, but did trend higher in the gemfibrozil group, (1.9% vs. 0.3%, p=0.07). There was a statistically significant difference in the number of appendectomies in the gemfibrozil group (6/311 vs. 0/317, p=0.029).

#### PRECAUTIONS

**Initial therapy:** Laboratory studies should be done to ascertain that the lipid levels are consistently abnormal before instituting TRICOR therapy. Every attempt should be made to control serum lipids with appropriate diet, exercise, weight loss in obese patients, and control of any medical problems such as diabetes mellitus and hypothyroidism that are contributing to the lipid abnormalities. Medications known to exacerbate hypertriglyceridemia (beta-blockers, thiazides, estrogens) should be discontinued or changed if possible prior to consideration of triglyceride-lowering drug therapy.

**Continued therapy:** Periodic determination of serum lipids should be obtained during initial therapy in order to establish the lowest effective dose of TRICOR. Therapy should be withdrawn in patients who do not have an adequate response after two months of treatment with the maximum recommended dose of 145 mg per day.

**Pancreatitis:** Pancreatitis has been reported in patients taking fenofibrate, gemfibrozil, and clofibrate. This occurrence may represent a failure of efficacy in patients with severe hypertriglyceridemia, a direct drug effect, or a secondary phenomenon mediated through biliary tract stone or sludge formation with obstruction of the common bile duct.

**Hypersensitivity Reactions:** Acute hypersensitivity reactions including severe skin rashes requiring patient hospitalization and treatment with steroids have occurred very rarely during treatment with fenofibrate, including rare spontaneous reports of Stevens-Johnson syndrome, and toxic epidermal necrolysis. Urticaria was seen in 1.1 vs. 0%, and rash in 1.4 vs. 0.8% of fenofibrate and placebo patients respectively in controlled trials.

**Hematologic Changes:** Mild to moderate hemoglobin, hematocrit, and white blood cell decreases have been observed in patients following initiation of fenofibrate therapy. However, these levels stabilize during long-term administration. Extremely rare spontaneous reports of thrombocytopenia and agranulocytosis have been received during post-marketing surveillance outside of the U.S. Periodic blood counts are recommended during the first 12 months of TRICOR administration.

**Skeletal muscle:** The use of fibrates alone, including TRICOR, may occasionally be associated with myopathy. Treatment with drugs of the fibrate class has been associated on rare occasions with rhabdomyolysis, usually in patients with impaired renal function. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevations of creatine phosphokinase levels.

Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. CPK levels should be assessed in patients reporting these symptoms, and fenofibrate therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed.

#### Drug Interactions

**Oral Anticoagulants:** CAUTION SHOULD BE EXERCISED WHEN COUMARIN ANTICOAGULANTS ARE GIVEN IN CONJUNCTION WITH TRICOR. THE DOSAGE OF THE ANTICOAGULANTS SHOULD BE REDUCED TO MAINTAIN THE PROTHROMBIN TIME/INR AT THE DESIRED LEVEL TO PREVENT BLEEDING COMPLICATIONS. FREQUENT PROTHROMBIN TIME/INR DETERMINATIONS ARE ADVISABLE UNTIL IT HAS BEEN DEFINITELY DETERMINED THAT THE PROTHROMBIN TIME/INR HAS STABILIZED.

**HMG-CoA reductase inhibitors:** The combined use of TRICOR and HMG-CoA reductase inhibitors should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination (see WARNINGS).

**Resins:** Since bile acid sequestrants may bind other drugs given concurrently, patients should take TRICOR at least 1 hour before or 4-6 hours after a bile acid binding resin to avoid impeding its absorption.

**Cyclosporine:** Because cyclosporine can produce nephrotoxicity with decreases in creatinine clearance and rises in serum creatinine, and because renal excretion is the primary elimination route of fibrate drugs including TRICOR (fenofibrate tablets), there is a risk that an interaction will lead to deterioration. The benefits and risks of using TRICOR with immunosuppressants and other potentially nephrotoxic agents should be carefully considered, and the lowest effective dose employed.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility:

Two dietary carcinogenicity studies have been conducted in rats with fenofibrate. In the first 24-month study, rats were dosed with fenofibrate at 10, 45, and 200 mg/kg/day, approximately 0.3, 1, and 6 times the maximum recommended human dose (MRHD) of 145 mg/day, based on mg/meter<sup>2</sup> of surface area. At a dose of 200 mg/kg/day (at 6 times the MRHD), the incidence of liver carcinomas was significantly increased in both sexes. A statistically significant increase in pancreatic carcinomas was observed in males at 1 and 6 times the MRHD; an increase in pancreatic adenomas and benign testicular interstitial cell tumors was observed at 6 times the MRHD in males. In a second 24-month study in a different strain of rats, doses of 10 and 60 mg/kg/day (0.3 and 2 times the MRHD based on mg/meter<sup>2</sup> surface area) produced significant increases in the incidence of pancreatic acinar adenomas in both sexes and increases in testicular interstitial cell tumors in males at 2 times the MRHD (200 mg/kg/day).

A 117-week carcinogenicity study was conducted in rats comparing three drugs: fenofibrate 10 and 60 mg/kg/day (0.3 and 2 times the MRHD), clofibrate (400 mg/kg/day; 2 times the human dose), and gemfibrozil (250 mg/kg/day; 2 times the human dose) (multiples based on mg/meter<sup>2</sup> surface area). Fenofibrate increased pancreatic acinar adenomas in both sexes. Clofibrate increased hepatocellular carcinoma and pancreatic acinar adenomas in males and hepatic neoplastic nodules in females. Gemfibrozil increased hepatic neoplastic nodules in males and females, while all three drugs increased testicular interstitial cell tumors in males.

In a 21-month study in mice, fenofibrate 10, 45, and 200 mg/kg/day (approximately 0.2, 0.7, and 3 times the MRHD on the basis of mg/meter<sup>2</sup> surface area) significantly increased the liver carcinomas in both sexes at 3 times the MRHD. In a second 18-month study at the same doses, fenofibrate significantly increased the liver carcinomas in male mice and liver adenomas in female mice at 3 times the MRHD. Electron microscopy studies have demonstrated peroxisomal proliferation following fenofibrate administration to the rat. An adequate study to test for peroxisome proliferation in humans has not been done, but changes in peroxisome morphology and numbers have been observed in humans after treatment with other members of the fibrate class when liver biopsies were compared before and after treatment in the same individual.

Fenofibrate has been demonstrated to be devoid of mutagenic potential in the following tests: Ames, mouse lymphoma, chromosomal aberration and unscheduled DNA synthesis.

**Pregnancy Category C:** Safety in pregnant women has not been established. Fenofibrate has been shown to be embryocidal and teratogenic in rats when given in doses 7 to 10 times the maximum recommended human dose (MRHD) and embryocidal in rabbits when given at 9 times the MRHD (on the basis of mg/meter<sup>2</sup> surface area). There are no adequate and well-controlled studies in pregnant women. Fenofibrate should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Administration of approximately 9 times the MRHD of 145mg/day of fenofibrate to female rats before and throughout gestation caused 100% of dams to delay delivery and resulted in a 60% increase in post-implantation loss, a decrease in litter size, a decrease in birth weight, a 40% survival of pups at birth, a 4% survival of pups as neonates, and a 0% survival of pups to weaning, and an increase in spina bifida.

Administration of approximately 10 times the MRHD to female rats on days 6-15 of gestation caused an increase in gross, visceral and skeletal findings in fetuses (domed head/hunched shoulders/rounded body/abnormal chest, kyphosis, stunted fetuses, elongated sternal ribs, malformed sternbrae, extra foramen in palatine, missshapen vertebrae, supernumerary ribs).

Administration of approximately 7 times the MRHD to female rats from day 15 of gestation through weaning caused a delay in delivery, a 40% decrease in live births, a 75% decrease in neonatal survival, and decreases in pup weight, at birth as well as on days 4 and 21 post-partum.

Administration of fenofibrate at 9 to 18 times the MRHD to female rabbits caused abortions in 10% to 25% of dams and death in 7% of fetuses at 18 times the MRHD.

**Nursing mothers:** Fenofibrate should not be used in nursing mothers. Because of the potential for tumorigenicity seen in animal studies, a decision should be made whether to discontinue nursing or to discontinue the drug.

**Pediatric Use:** Safety and efficacy in pediatric patients have not been established.

**Geriatric Use:** Fenofibric acid is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection.

#### ADVERSE REACTIONS

**CLINICAL:** Adverse events reported by 2% or more of patients treated with fenofibrate during the double-blind, placebo-controlled trials, regardless of causality, are listed in the table below. Adverse events led to discontinuation of treatment in 5.0% of patients treated with fenofibrate and in 3.0% treated with placebo. Increases in liver function tests were the most frequent events, causing discontinuation of fenofibrate treatment in 1.6% of patients in double-blind trials.

BODY SYSTEM Adverse Event	Fenofibrate* (N=439)	Placebo (N=365)
<b>BODY AS A WHOLE</b>		
Abdominal Pain	4.6%	4.4%
Back Pain	3.4%	2.5%
Headache	3.2%	2.7%
Asthenia	2.1%	3.0%
Flu Syndrome	2.1%	2.7%
<b>DIGESTIVE</b>		
Liver Function Tests Abnormal	7.5%**	1.4%
Diarrrhea	2.3%	4.1%
Nausea	2.3%	1.9%
Constipation	2.1%	1.4%
<b>METABOLIC AND NUTRITIONAL DISORDERS</b>		
SGPT Increased	3.0%	1.6%
Creatine Phosphokinase Increased	3.0%	1.4%
SGOT Increased	3.4%**	0.5%
<b>RESPIRATORY</b>		
Respiratory Disorder	6.2%	5.5%
Rhinitis	2.3%	1.1%

\* Dosage equivalent to 145 mg TRICOR

\*\* Significantly different from Placebo

Additional adverse events reported by three or more patients in placebo-controlled trials or reported in other controlled or open trials, regardless of causality are listed below.

**BODY AS A WHOLE:** Chest pain, pain (unspecified), infection, malaise, allergic reaction, cyst, hernia, fever, photosensitivity reaction, and accidental injury.

**CARDIOVASCULAR SYSTEM:** Angina pectoris, hypertension, vasodilation, coronary artery disorder, electrocardiogram abnormal, ventricular extrasystoles, myocardial infarct, peripheral vascular disorder, migraine, varicose vein, cardiovascular disorder, hypotension, palpitation, vascular disorder, arrhythmia, phlebitis, tachycardia, extrasystoles, and atrial fibrillation.

**DIGESTIVE SYSTEM:** Dyspepsia, flatulence, nausea, increased appetite, gastroenteritis, cholelithiasis, rectal disorder, esophagitis, gastritis, colitis, tooth disorder, vomiting, anorexia, gastrointestinal disorder, duodenal ulcer, nausea and vomiting, peptic ulcer, rectal hemorrhage, liver fatty deposit, cholecystitis, eructation, gamma glutamyl transpeptidase, and diarrhea.

**ENDOCRINE SYSTEM:** Diabetes mellitus.

**HEMIC AND LYMPHATIC SYSTEM:** Anemia, leukopenia, ecchymosis, eosinophilia, lymphadenopathy, and thrombocytopenia.

**METABOLIC AND NUTRITIONAL DISORDERS:** Creatinine increased, weight gain, hypoglycemia, gout, weight loss, edema, hyperuricemia, and peripheral edema.

**MUSCULOSKELETAL SYSTEM:** Myositis, myalgia, arthralgia, arthritis, tenosynovitis, joint disorder, arthrosis, leg cramps, bursitis, and myasthenia.

**NERVOUS SYSTEM:** Dizziness, insomnia, depression, vertigo, libido decreased, anxiety, paresthesia, dry mouth, hypertonia, nervousness, neuralgia, and somnolence.

**RESPIRATORY SYSTEM:** Pharyngitis, bronchitis, cough increased, dyspnea, asthma, allergic pulmonary alveolitis, pneumonia, laryngitis, and sinusitis.

**SKIN AND APPENDAGES:** Rash, pruritus, eczema, herpes zoster, urticaria, acne, sweating, fungal dermatitis, skin disorder, alopecia, contact dermatitis, herpes simplex, maculopapular rash, nail disorder, and skin ulcer.

**SPECIAL SENSES:** Conjunctivitis, eye disorder, amblyopia, ear pain, otitis media, abnormal vision, cataract specified, and refraction disorder.

**UROGENITAL SYSTEM:** Urinary frequency, prostatic disorder, dysuria, abnormal kidney function, urolithiasis, gynecomastia, unintended pregnancy, vaginal moniliasis, and cystitis.

#### OVERDOSAGE

There is no specific treatment for overdose with TRICOR. General supportive care of the patient is indicated, including monitoring of vital signs and observation of clinical status, should an overdose occur. If indicated, elimination of unabsorbed drug should be achieved by emesis or gastric lavage; usual precautions should be observed to maintain the airway. Because fenofibrate is highly bound to plasma proteins, hemodialysis should not be considered.

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