

Discontinuing statins or not in the elderly? Study protocol for a randomized controlled trial

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Abstract

Background The risk/benefit ratio of using statins for cardiovascular (CV) primary prevention in elderly people has not been established. The main objectives of the present study are to assess the cost-effectiveness of statin cessation and to examine the non-inferiority of statin cessation in terms of mortality in patients aged 75 and over treated with statins for primary prevention.

Methods The Statins In The Elderly (SITE) Study is an ongoing 3-year follow-up, open-label comparative multi-centre randomised clinical trial that is being conducted in two parallel groups in outpatient primary care offices. Participants meeting the following criteria are being included: people aged 75 years and older being treated with statins as primary prevention for CV events who provide informed consent. After randomisation, patients in the statin-cessation strategy are instructed to withdraw their treatment. In the comparison strategy, patients continue their statin treatment at the usual dosage. The cost-effectiveness of the statin-cessation strategy compared to continuing statins will be estimated through the incremental cost per quality-adjusted life years (QALY) gained at 36 months based on the perspective of the French healthcare system. Overall mortality will be the primary clinical endpoint. We assumed that the mortality rate at 3 years will be 15%. The sample size was computed to achieve 90% power in showing the non-inferiority of statin cessation, assuming a non-inferiority margin of 5% of the between-group difference in overall mortality. In total, the SITE study will include 2,430 individuals.

Discussion There is some debate regarding the value of statins in people over 75 years old, especially for primary prevention, due to a lack of evidence of their efficacy in this population, potential compliance-related events, drug-drug interactions and side effects that could impair quality of life. Data from clinical trials guide the initiation of medication therapy for primary or secondary prevention of CV disease but do not define the timing, safety, or risks of discontinuing the agents. The SITE study is one of the first to examine whether treatment cessation is a cost-effective strategy that has no adverse effects on the prognosis of people over 75 years old formerly treated with statins. Trial registration This research has been registered at [clinicaltrials.gov](https://clinicaltrials.gov/ct2/show/NCT02547883) under number NCT02547883, 11 September 2015, <https://clinicaltrials.gov/ct2/show/NCT02547883>

Background

Cardiovascular (CV) events, including ischemic heart disease and cerebrovascular diseases, are the leading cause of death worldwide and are a major cause of morbidity in industrialised and developing countries [1]. CV events are multifactorial, and CV prevention is defined as a coordinated set of actions, at the population or individual level, intended to eliminate or minimise the impact of CV diseases and related disabilities.

According to the “2016 European Guidelines on Cardiovascular Disease Prevention in Clinical Practice”, total CV risk estimation based on a risk estimation system such as the

Systematic Coronary Risk Evaluation (SCORE), which estimates the 10-year risk of fatal CVD, is recommended for adults >40 years old [2]. People are categorised as being at high risk (familial hypercholesterolaemia, blood pressure >180/110, diabetes mellitus without organ damage, or moderate chronic kidney disease [CKD; GFR 30–59 mL/min/1.73 m²], calculated SCORE between 5% and 10%) or very high risk (documented CV disease, diabetes mellitus with target organ damage, severe CKD [GFR <30 mL/min/1.73 m²], calculated SCORE ≥10%) for CV events.

The 2019 American College of Cardiology (ACA) and American Heart Association (AHA) Guidelines on the Primary Prevention of Cardiovascular Disease also recommend that adults aged 40–75 years old being evaluated for CV disease prevention undergo 10-year atherosclerotic CV disease risk estimation [3].

Among the possible interventions to reduce CV risk, statins are recommended for secondary prevention in all patients with CV disease and for primary prevention in patients with an elevated low-density lipoprotein cholesterol level (≥190 mg/dL) or with diabetes mellitus, and those determined to be at sufficient CV risk (high risk and very high risk) after a clinician–patient risk discussion.

Statins are inhibitors of hydroxymethylglutaryl-CoA reductase and thus reduce the synthesis of cholesterol, especially low-density lipoprotein (LDL)-cholesterol, an independent risk factor for CV events. Numerous large-scale randomised studies over the last 20 years have demonstrated the effectiveness of statins for reducing CV risk in primary and secondary prevention [4]. However information regarding patients over 75 years old is lacking, as no randomised trials have been conducted in this population.

The European Guidelines and the 2019 ACC/AHA Guideline acknowledge that special considerations are required when prescribing lipid-lowering agents in older people because exposure to higher doses (or higher potency) may not increase life expectancy but may increase the risk of adverse effects. Assessment of risk status and a clinician–patient risk discussion are needed to decide whether to initiate or continue statin treatment.

Statins represent one of the largest pharmaceutical industry markets in France; in 2014, around 5 million people were treated with statins, representing a total cost of 550 million

euros. People 75 years and older represent 9.3% of the total population in 2019 [5]. Around 25% of these people are treated with statins, including around 40% in the context of primary prevention.

Given the absence of formal evidence of efficacy and the high level of side effects, the risk/benefit ratio of primary prevention with statins in elderly patients has not been established. With no controlled studies to validate the benefits of statins in this population, there is some controversy in the literature about their use in this age group [6–16].

One previous trial implied that stopping statin medication therapy is safe and may be associated with a number of benefits, including improved quality of life (QOL) among patients with advanced life-limiting illness [17].

We postulate that statin cessation in patients older than 75 years, when prescribed for primary prevention of CV events, will not increase total mortality, and it may improve QOL through the absence of adverse effects, as well as lowering costs for the French National Health Insurance System.

The two main objectives of this study are therefore to assess the cost-effectiveness, in real-life use, of statin cessation in patients over 75 years old being treated for primary prevention of CV events and to examine the non-inferiority of statin cessation in terms of all-cause mortality in patients older than 75 years.

Method And Design

Trial design and settings

The Statins In The Elderly (SITE) Study is a 3-year follow-up, open-label comparative multi-centre randomised clinical trial being conducted in two parallel groups in outpatient primary care offices. Our objective is to conduct a randomised controlled trial that is representative of usual care conditions. Our study is being conducted in general practices in France, and the eligibility criteria are limited, apart from regulatory requirements, to age and treatment with statins for the purpose of primary prevention.

All general practitioners working in primary care centres in France can enrol patients in the study. They need only to use informatics devices to complete the electronic case report forms (e-CRF) during patient follow-up.

Eligibility criteria

The study population consists of patients aged 75 and over who have no history of CV disease and who are being treated with a statin and regularly visiting their GP in France.

Participants meeting the following criteria are eligible for inclusion: people aged 75 years and older who have been treated with statins for at least 1 year for primary prevention of CV events, and who give informed consent.

Participants meeting any of the following criteria are excluded: progressive morbid pathology with a life expectancy of 3 months or less, diagnosed with dementia, suffering from known homozygous or double heterozygous familial hypercholesterolemia, or unable to provide informed consent.

Intervention

In the statin-cessation strategy, the statins are stopped and patients are asked to end their treatment on the day of randomisation. In the comparison strategy, patients continue their statin treatment at the usual dosage.

Randomisation

Randomisation is being carried out centrally using the electronic case report form (eCRF) on the day of the inclusion visit after signing the consent form. Participants are considered enrolled in the trial when randomised.

The randomisation is unbalanced, with a 5:4 ratio in favour of the statin-continuation group. A document describing the randomisation procedure is being kept confidential

within the Clinical Epidemiology Unit.

Outcome measures

Economic endpoints

The cost-effectiveness of the statin cessation strategy compared to continuing statins will be estimated based on the incremental cost per quality-adjusted life year (QALY) gained at 36 months based on criteria of the French healthcare system. QALYs will be measured using the Euro-QOL five-dimension, three-level (EQ-5D-3L) questionnaire at inclusion and at each follow-up visit. This questionnaire has been validated in the French population.

Healthcare resources and costs will be extracted from the French Administrative Health Care Database (Système National des Données de Santé, SNDS) by a merging procedure, operated by the French National Health Insurance Fund and using data from the SITE trial. The SNDS gathers all reimbursement data for 98.8% of the French population [18]. The time horizon of the study (36 months) implies a discounting of costs and outcomes. In accordance with the methodological economic guidelines of the French National Health Authority (Haute Autorité de santé, HAS), we will apply a 4% discount rate.

Following cost-effectiveness analysis (CEA), budget impact analysis (BIA) will provide useful information about the sustainability of the statin-cessation strategy if it were applied to the entire French healthcare system. It will consider outpatient costs, hospital costs, medical and non-medical costs induced or avoided by stopping statins, and all budgetary implications related to changes in health management and/or health status improvement. The difference between induced and avoided costs will provide the net benefit to the healthcare system of widespread adoption of the statin-cessation strategy for primary prevention among elderly individuals in France.

Main clinical endpoint

Overall mortality will be the primary clinical endpoint. As the investigators are general practitioners (GPs), they are informed of the death of their patients and will therefore

constitute the source of mortality data in this trial.

Secondary endpoints

- QOL score measured by the Quality of Life Scale SF12, which has been validated in geriatric populations
- Incidence of CV events
- Incidence of non-CV events (diabetes and cognitive disorders)

Timeline and recruitment

This study employs the research network of French universities' primary care departments (PCDs). Each PCD appoints a coordinating physician by geographic area to mobilise investigating physicians (486 expected in the study).

The recruitment of GPs all across France maximises representativeness and limits the impact of potential local practices. The representativeness of the investigators is being documented by collecting data about their sociodemographic profiles, activity, and training.

Patients are being recruited through consultations over a period of 36 months. Eligible patients not included in the study are being reported, along with the reason for non-inclusion.

Conduct of research

Table 1 outlines the different phases of the study and data collection.

Table 1: Design of the SITE study

	<i>Study period</i>					
TIMEPOINT	Pre- inclusion T -1	Inclusion T 0	M3 +/- 1 month	M12 +/- 3 months	M24 +/- 3 months	Close- out M36 +/- 3 months
ENROLMENT						
Information/eligibility screen	ü					
Standardised questionnaire ¹	ü		ü	ü	ü	ü
MMSE ²	ü					ü
Consent signature		ü				
INTERVENTION						
ASSESSMENT						
SF12 and EQ-5D-3L Questionnaires ³		ü	ü	ü	ü	ü
Clinical examination ⁴	ü	ü	ü	ü	ü	ü
Biological tests ⁵	ü(*)		ü	ü	ü	ü
ECG ⁶		ü		ü	ü	ü
Clinical event data collection ⁷		ü	ü	ü	ü	ü
Compliance ⁸		ü	ü	ü	ü	ü
CVRF collection ⁹		ü	ü	ü	ü	ü
SE/SAE ¹⁰ collection		ü	ü	ü	ü	ü

1. Standardised questionnaire with six questions to search for coronary disease history, stroke, or unnoticed peripheral artery disease.
2. Mini-Mental State Examination (French version, GRECO).

3. Quality of Life Questionnaire SF12 (self-administered) and EQ-5D 3L (self-administered).
 4. Clinical examination: examination as recommended by good clinical practices in the field of cardiovascular medicine (blood pressure, CV data, and lung auscultation).
 5. Laboratory tests: lipid (EAL), blood glucose, HbA1c (if diabetic), electrolytes, creatinine, creatinine clearance, and serum albumin.
- (*) In the absence of a balance sheet dated within 12 months before pre-inclusion, laboratory tests are prescribed at pre-inclusion and should be performed until the day of the inclusion visit.
6. ECG: electrocardiogram based on recommendations (once every 3 years if permanent arterial hypertension (HTA) and once a year if overt diabetes).
 7. Reports of significant clinical events occurring between visits
 8. Compliance assessed by Morisky questionnaire (eight items) at baseline (all patients) and during follow-up (only in the group of patients in whom statin therapy is continued).
 9. Total CV risk factors: weight, waist circumference, smoking, hypertension, diabetes, previous family history of CV disease among first-degree relatives, HDL and LDL cholesterol.
 10. SE/SAE: Side effects and serious adverse events, respectively.

Sample size

According to data from the French National Institute for Statistics and Economic Studies (National de la Statistique et des Études Économiques, INSEE), we assume that mortality at 3 years in both groups will be 15%.

The SITE's sample size was computed to achieve 90% power in showing the non-inferiority of statin cessation in comparison to statin continuation, assuming a 2.5% unilateral risk and a non-inferiority margin of 5% of the between-group difference in overall mortality at 3 years after randomisation (nQuery Advisor software, v. 7.0).

We do not have to deal with multiple tests, as cost-effectiveness analyses do not require statistical testing [19].

We also assume that 20% of the individuals randomised to the statin-continuation group may spontaneously stop their treatment during follow-up. Therefore, to ensure 90% statistical power in under-treatment analysis, it was decided to include 20% more individuals in the statin-continuation group. In total, 2,430 individuals will be enrolled in the SITE study, including 1,080 in the statin-cessation group and 1,350 in the statin-continuation group.

Data management

Electronic case report forms (eCRFs) are the primary data-collection instrument for the study. Medical information for individual participants obtained as a result of this study are considered confidential, and disclosure to third parties is prohibited. eCRFs are being labelled with a unique trial number.

Consent forms sent to sponsors may contain patient identifiers for the purpose of monitoring, as described in the trial risk assessment. Such information will be kept in secure, locked storage.

Statistical methodology

In the non-inferiority analysis, the bilateral 95% confidence interval (CI) for the between-group difference in the 3-year mortality rate will be estimated. Considering <5% change as clinically non-significant, we will consider non-inferiority demonstrated only if the 95% CI upper bound of the 3-year mortality difference between the two groups is below 5%. This analysis will primarily be performed according to an under-treatment principle. Formally, patients who do not receive the trial treatment as planned in the protocol will be excluded from the analysis. An intention-to-treat analysis will also be performed with the aim of maintaining the initial effect of randomisation. The missing = failure strategy (failure being defined as death) will be used in the non-inferiority analysis.

Secondary clinical analyses will be conducted according to the intention-to-treat principle: all randomised patients will be analysed in the group in which they were initially randomised, and all of their data will be used regardless of eventual treatment changes during the study. As economic analysis is not based on statistical tests, no adjustment of the α -level is needed to deal with multiple comparisons. In all analyses, $p < 0.05$ will be taken to indicate statistical significance.

The economic analysis will also be conducted according to the intention-to-treat principle. First, the point estimate of the incremental cost/utility ratio and its bootstrap 95% confidence interval will be calculated. We will then estimate the incremental net monetary benefit (INMB) adjusted for potential confounding factors (adherence to statins at baseline, treatment length, and particular statin dosage) using multiple linear regression models. Acceptability curves will then be plotted. The value of information will also be examined according to the principles proposed by Claxton [19].

Safety and adverse event reporting

The adverse events expected during this research are mainly those related to the age of the study population, such as CV events, diabetes and/or its complications, cognitive disorders and dementia, falls, cancers, deaths, and adverse effects of concomitant therapies. Given that one group of patients will continue to use statins, adverse reactions listed in the summaries of product characteristics are also expected.

The unit charged with security and vigilance must be notified immediately of any serious adverse events (SAEs), regardless of whether expected or unexpected, via the eCRF.

To ensure the safety of patients throughout the trial, a one-time evaluation will be conducted on data available to the security and vigilance unit of the promoter. Thus, data on SAEs of CV morbidity and all-cause mortality in both groups of patients will be evaluated by the security and vigilance unit of the sponsor during each annual safety report.

The sponsor's security and vigilance unit must communicate adverse events and developments in the research in a timely manner in accordance with current regulations:

- to the French National Agency for the Safety of Medicines and Health Products, L'Agence Nationale de Sécurité du Médicament et des Produits de Santé (ANSM).
- to the research ethics committee. The committee will ensure, if necessary, that the research participants were informed about the side effects and confirm their consent.

On the date of first inclusion, the security and vigilance unit prepares a safety report including:

- a list of serious side effects of the research,
- a concise and critical analysis of the safety of participants in the research.

This report is sent to the ANSM and the French Central Ethics Committee (Comité de Protection des Personnes, CPP) within 60 days of the date of first inclusion.

Trial registration

This research has been registered with clinicaltrials.gov under the number NCT02547883.

Amendment

To extend inclusions, the protocol was amended in March 2019 to also include patients from hospital departments.

Discussion

The proportion of the population represented by people aged 75 and older is increasing at a rapid rate in industrialised countries. According to the French National Institute of Demographic Studies (Institut National d'Études Démographiques, INED), life expectancy at age 75 in France is 11.5 years for men and 14.4 years for women. Statins are among the most widely prescribed pharmacological treatments in this population.

Data from clinical trials guide the initiation of medication therapy for primary or secondary prevention of CV disease but do not clearly define the timing, safety, or risks of discontinuing treatment with these agents. As a result, the number of medications often accumulates, particularly in elderly people, with increased risk of drug-drug interactions and side effects.

There is debate regarding the value of statins in people aged 75 and over, especially for primary prevention, particularly due to the lack of evidence of their efficacy in this population, potential compliance-related events, drug-drug interactions, and side effects that could impair the QOL of patients in this age group who are treated with statins [20–28]. In addition, the health economics literature does not ensure cost-effectiveness of statin therapy for primary prevention in this population [29–30].

To date, the SITE study is one of the largest studies conducted in France in the primary care setting among GPs, who are usually poorly trained with regard to randomised clinical trials. Therefore, to perform such a study, we have implemented a specific online questionnaire, which is as short as possible and includes only the key variables to limit the problem of missing data, and have provided specific online courses to train the GP investigators in good clinical practices in the field of clinical research.

Our study will have some limitations. First, we acknowledge that this is a pragmatic trial without blinding. The study participants and their physicians will know whether statin therapy has been continued or discontinued. The choice was to evaluate a strategy of discontinuing statins rather than to evaluate statin prescriptions alone. In theory, the absence of blinding could lead to a measurement bias due to greater surveillance of CV events in the discontinuation group. This will be closely monitored through the data from the SNDS. In addition, this is why the total mortality rate was chosen as our primary endpoint. Second, patients with previous dementia cannot be included in the trial, and our results will not be generalizable to this population. Third, although our sample is quite large, we cannot exclude a tendency from the investigators to recruit people with very few CV risk factors rather than patients with advanced disease and poor outcomes. Particularly, the inclusion of patients with diabetes mellitus will be monitored. Finally,

patients treated with statins are being included in the SITE trial regardless of the specific agent. Therefore, we will not be able to examine specific treatments or dosages.

However, we believe that the SITE study will be one of the first to show that a strategy of treatment cessation is cost-effective and does not adversely affect the prognosis of people over 75 treated with statins.

Trial Status

Patient recruitment started on the 15th June, 2016. The recruitment completion date is expected on the 31st December, 2019.

The protocol version number is 8.0, 5th June, 2019

Declarations

Ethics approval and consent to participate

The study protocol was approved by the local ethic committee (Comité de protection des personnes Sud-Ouest et Outre-mer III) the 29th of April 2015, number 2015-A00600-49, and all patients included in the SITE study sign an informed consent.

Consent for publication

Not Applicable

Availability of data and material

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Author contributions

FB and JPJ are co-principal investigators of the study. AB and NH designed the study. All authors provided intellectual content for the development of the manuscript. All authors have read and approved the final manuscript.

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