



Editorial

What are the *Normal* Consequences of Aging?

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Too often the medical community *lends a deaf ear* to patients who have vague complaints of adverse reactions to prescribed medications. In no population is this more common than in the treatment of the elderly. How can we comprehend this skepticism? One bias may be due to the tremendous attention given to the normal aging process and the knowledge that as one gets older we tend to heal slower, ache more and find ourselves associated with a decline in various physiological and cognitive functioning. Because of our defensive nature of doubting that our recommendations of therapy could actually be associated with a decline in various bodily functionings.

As a Clinical Pharmacist and Prescription Safety Advocate I challenge every Researcher, Physician, Pharmacist, Journalist, and Patient to keep an open mind with regards to balancing possible benefits and consequences associated with pharmacologic therapies. The revelation that patients are often harmed from medication treatments should not be a surprise to many. Finger pointing is not necessary. Together we all need to develop effective data collections and monitoring techniques to help detect and analyze and complications from these panaceas.

One such medication that is prescribed at an incredibly high incidence includes the statins. Also known as 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors are commonly prescribed for patients who have hyperlipidemia without any evidence of cardiovascular disease (CVD). Most physicians and patients would gladly trade any minimal adverse effect of their use

because of a perceived tremendous cardiovascular benefit to its long-term use. The literature today demonstrates the disparity between the true incidence of complications and the minimal benefit in primary prevention of heart disease. What are the consequences of using a therapy that may prevent a future disease? No harm no foul?

The idea that a therapy may prevent a dire health condition in the future is complicated by the fact that over twenty years has passed since widespread use of this class of medications came to market without any epidemiologic proof that they are working for primary prevention. Patient complaints often described as muscle pain or weakness, fatigue, impotence, loss of libido and erectile dysfunction (E.D.), and memory loss are seldom characterized as associated drug induced complications. Objective laboratory results that indicate increases in blood sugar or hepatic complications including significant elevations of liver enzyme levels are rarely considered justifications to stop statin therapy. This is remarkable when one considers that these drugs have the potential for rhabdomyolysis and death exists.

To be considered is the limited evidence showing that primary prevention with statins can improve patient quality of life among people at low cardiovascular risk. Without cost effectiveness consensus or consideration of the minimal reporting of adverse effects to the U.S. Food and Drug Administration (FDA), it is very unlikely that physicians and researchers are being provided with full information about the complications related to this class of drugs.

Recognition and awareness of medications ability to compromise a patient's well being along with improved efforts to develop comprehensive and straightforward knowledge about risks and benefits would improve health care and the quality of care for all who utilize pharmacologic therapies.

It is my hope that the Journal of **Drug Intoxication & Detoxification : Novel Approaches**, can examine the many classes of medications that due to the lack of knowledge or recognition of toxicity continues to infect patients with an impaired quality of life.

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