Statin discontinuation in older adults: changing the conversation, not the default

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Few questions in preventive cardiology are more common, or more difficult to address, than deciding when preventive therapy should be stopped. For adults who reach their late seventies after years of successful statin treatment, the clinical question is rarely whether therapy should have been started. The question instead is whether continuing statin treatment still makes sense. Despite millions of older adults taking statins for primary prevention of cardiovascular disease, randomised data to guide treatment decision making have been remarkably scarce.[1] The findings of the SAGA/SITE trial, reported by Fabrice Bonnet and colleagues in *The Lancet Healthy Longevity*, fill that gap. SAGA/SITE provides timely randomised evidence for a treatment decision that has often relied on observational data, expert consensus, and individualised clinical judgement.[1,2] In SAGA/SITE, 1180 adults aged 75 years and older without established atherosclerotic cardiovascular disease were randomly assigned to continue or discontinue statin therapy for primary prevention. Over a 3-year follow-up period, discontinuation met the prespecified criterion for non-inferiority for all-cause mortality, with no apparent differences in cardiovascular events, quality of life, cognitive function, or adverse events between the two arms. These findings support individualised decision making but do not justify routine discontinuation in otherwise healthy older adults. The findings do not support routine deprescribing and do not establish that discontinuation is preferable over continuing therapy. Rather than favouring one strategy over the other, the trial expands the evidence base available to support patient choice. However, these findings should be interpreted in the context of the trial's modest sample size, lower than anticipated event rates, and limited power for subgroup analyses.[2]

The most clinically informative finding might not be the non-inferiority result itself, but the absence of measurable patient-centred benefits after discontinuation of statin treatment. Quality of life, cognitive function, functional status, symptom burden, and adverse events were remarkably similar between groups. For patients who had tolerated statin therapy for at least one year, stopping the treatment did not translate into improved functioning or wellbeing; this finding deserves attention. Many conversations about deprescribing begin with the expectation that reducing medication burden will improve day-to-day life. SAGA/SITE challenges that assumption, at least for older adults who have already tolerated statin therapy for at least a year.[2]

This finding should not be surprising. Patients who have intolerable statin-related adverse effects often do not continue treatment for many years and, hence, will be ineligible for studies such as SAGA/SITE. The participants studied here were long-term statin users for whom treatment was already shown to be acceptable. In that context, the absence of measurable improvement after discontinuation becomes easier to understand and reminds us that deprescribing is not inherently beneficial simply because it reduces the number of medications.

For clinicians, these findings reinforce the importance of individualised decision making rather than a single preferred approach. For older adults who are tolerating statin therapy and wish to continue treatment, evidence from

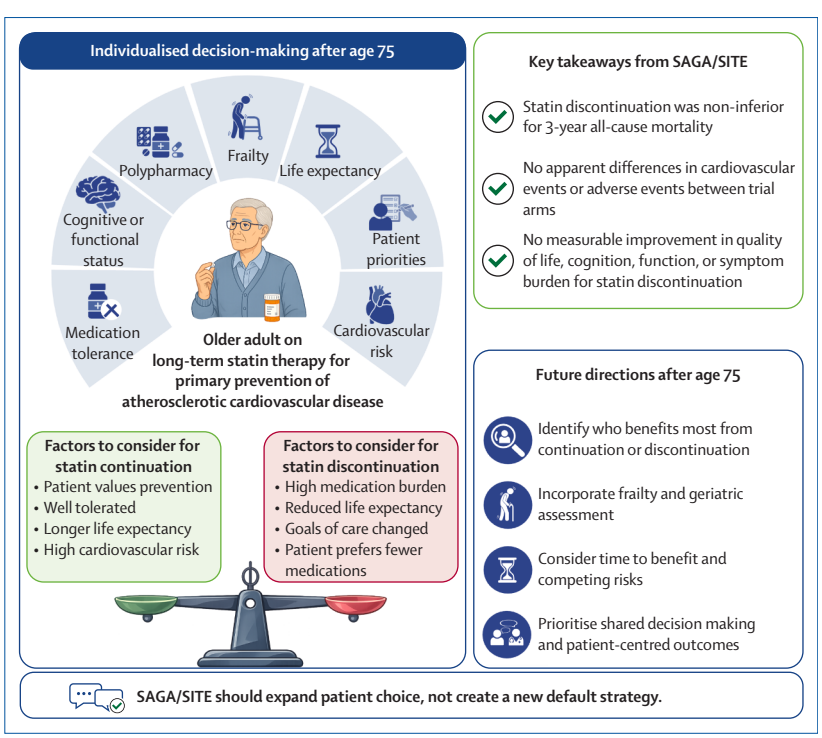


Figure: **SAGA/SITE: expanding patient choice, not creating a new default strategy**
SAGA/SITE supports individualised, shared decision making about statin discontinuation after the age of 75 years, considering frailty, polypharmacy, life expectancy, cardiovascular risk, medication tolerance, and patient priorities.

SAGA/SITE provides little reason to recommend routine discontinuation. Conversely, for patients who prioritise reducing medication burden, have limited life expectancy, have substantial polypharmacy, or whose goals of care have changed, discontinuation might be a reasonable option. Rather than supporting a default strategy, the trial broadens the evidence available for treatment decisions that reflect each patient's individual clinical circumstances and preferences.[2,3]

Deprescribing should not be confused with therapeutic nihilism. The goal is not simply to reduce the number of medications, but to ensure that treatment remains aligned with an individual's expected benefit, overall health status, and personal goals. Age alone should not be used to decide whether preventive therapies should be continued or discontinued. Older adults remain underrepresented in cardiovascular clinical trials and continue to be at risk of undertreatment with evidence-based cardiovascular therapies.[1,3] Interpreting SAGA/SITE as support for routine statin discontinuation would, therefore, extend the findings beyond what the trial can justify.[2]

Important questions remain. The next generation of studies should move beyond asking whether statins can be discontinued safely in older adults and begin identifying who benefits from continuation and who does not. Frailty, competing risks, time to benefit, duration of previous statin exposure, and baseline cardiovascular risk are all likely to matter.[4,5] The results of SAGA/SITE should be considered alongside ongoing trials, including Statins in Reducing Events in the Elderly (STAREE)[6] and Pragmatic Evaluation of Events and Benefits of Lipid Lowering in Older Adults (PREVENTABLE),[7] which will further inform the role of statin therapy in older adults. Findings from these studies will contribute to shifting the field from age-based decision making towards individualised care.

Rather than changing the standard of care, SAGA/SITE expands the available evidence to inform conversations about treatment between clinicians and older adults. The greatest contribution of the trial findings might not be identifying a preferred strategy but enabling treatment decisions that better reflect each patient's goals, preferences, and clinical circumstances. The trial should change the conversation about treatment, not create a new default (figure).

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