

GET UP: A Small Bit of Movement Makes a Big Impact - Frankly Speaking EP 59

Transcript Details

This is a transcript of an episode from the podcast series "Frankly Speaking" accessible at Pri-Med.com. Additional media formats for this podcast are available by visiting <http://www.pri-med.com/online-education/Podcast/exercise-frankly-speaking-ep-59>

Dr. Frank Domino:

Your next patient, Benjamin M, presents to your office for a followup of his hypertension, hyperlipidemia. He takes his medications and is happy to announce that his numbers look great, yet he does not exercise and eats poorly. You know this approach only makes his numbers look better and not necessarily his risk of heart disease or dying in general. How do you counsel someone who is taking their medications but not doing the things you need them to do to live longer?

Hi, this is Frank Domino, professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. And joining me today is a socio professor, Dr. Alan Ehrlich. Dr. Ehrlich is also in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and senior editor at DynaMed. Welcome to the show, Alan.

Dr. Alan Ehrlich:

Thanks, Frank. Listen, Frank, what are you worried about? This guy, he says his cholesterol is good and his blood pressure is good. Isn't managing risk factors what we care about most?

Dr. Domino:

Well, it is important, when we think about risk factor modification, that we use medications to

help. But this gentleman has received the message that all he has to do is take his pills and that's going to improve his risk of having adverse outcomes. We know, in patients with heart disease, taking a cholesterol-lowering medicine or taking a blood pressure medicine will lower their risk of adverse outcomes. But for in a patient like this, who hasn't had those outcomes yet, when it's used for primary prevention, medications have a very small, if any, impact at all on the outcomes we care about. So, I think we need to get the message across, that he's gonna have to change his behaviour, or taking these medications are probably not gonna help him.

Dr. Ehrlich:

Well, if he's like any of my patients, he's going to say, "I don't have time to exercise." How much exercise does he need to do to improve his health?

Dr. Domino:

Well, it's really interesting. I used to say you need... There was a number of different organizations that made a variety of recommendations. But this group in Sweden did a really wonderful study, where they used their registry databases. They enrolled over 800 patients and they gave them activity trackers. And they tried to determine, over the course of 15 years, what level of activity lowered the risk of adverse cardiovascular outcomes. And believe it or not, very little did. It was as little as 20 to 30 minutes of light intensity exercise led to the same degree of lower cardiovascular risk as moderate to severe intensity exercise at a more frequent basis. The message that they concluded with is that it takes very, very little exercise and activity to give you that benefit that we look for so much with a variety of medications.

Dr. Ehrlich:

So, how would you explain it to this patient, because he clearly seems somewhat resistant to the notion of doing anything other than taking a pill?

Dr. Domino:

Well, the first thing I'd probably do is make sure he understands that taking the pill does not provide a benefit. And I just wanna stop and clarify for all of us that the drugs we use for primary

prevention have limited to no efficacy. Let's take aspirin, for example. Well, aspirin post cardiac event, post MI, lowers the risk of death and recurrent cardiovascular outcomes. But in patients who don't have a cardiac event, they provide almost no benefit, and the benefit they provide is dramatically offset by the risk of gastrointestinal bleeding that occurs with them. Let's look at statins, there is no data that use taking a statin for primary prevention improves cardiovascular mortality rates. It improves some cardiovascular end points but only as a composite, not individual endpoints like MI or death.

Here are two groups of medicines we use constantly that patients believe are lowering their risks that probably have no real benefit. On the other hand, 30 minutes of late exercise, that's something like a walk, twice a week, can improve this outcome. So how do we discuss it with them? The first thing I'd ask them is, if he says he's too busy, ask him if he's interested in trying to improve his risks by doing some exercise. And if he is, and his excuse is he's too busy, help him explore what his options might be. It could be that he just takes a walk over a break period at work. It could be he buys a standing desk and uses it for at least half the day. It could be so many things, but I think, as we've gotten more sedentary in more and more of our jobs, our working in front of a computer screen, we have less and less we can do to get any sort of activity at work that's recognized and felt important. On the other hand, we've prioritized work, and there's very little benefit to your heart disease or mortality risk from working.

Dr. Ehrlich:

Well, I know a lot of companies do have gyms or things where they encourage their employees. When you're talking to patients like this, do you ever calculate their risk using Framingham calculators or pooled cohort equation calculators? Is that something you find helpful, Frank?

Dr. Domino:

I do. I actually find using the American Heart Association, American College of Cardiology risk calculator to be very, very helpful, because sometimes I'll put my patients' risk in both before and after being on medicine, and make them aware that the benefit they're getting is extremely small. And then I talk about something like this, where we have really good data that shows just a

little bit of a change in their behavior can have a bigger impact. What do you use, Alan?

Dr. Ehrlich:

Well, I use the same one, the American College of Cardiology, which is based on the pooled cohort equations. And I do find them helpful. I think that a lot of patients, just as this gentleman, focus on numbers. So, just as he's focused on his cholesterol and his blood pressure numbers, when you can then show him some percentage and say, "This is your risk," and you can educate him about how exercise can decrease that risk, I think that can be very powerful.

Dr. Domino:

What I do when I do use the calculator, in particular, is I play with the HDL. I make them aware that if we bump up their HDL, even 10%, their risk goes down dramatically. And it's something they don't always appreciate. And I make that very clear to them, that the only way we can improve that number that improves outcomes is through exercise. So, I do use that as a tool. I do think though, in general, we're fighting a mass media. There are advertisements constantly about loving your number for A1Cs and other type ads that make people believe that it is about those numbers. And the reality of the matter is it's about changing behavior and living a little bit better.

Dr. Ehrlich:

Sounds good, Frank.

Dr. Domino:

Alan, thanks for discussing this with me. Practice pointer, as little as 30 minutes of late intensity exercise twice a week improves all-cause mortality and cardiovascular outcomes. Join us next time when we discuss the new American Academy of Neurology guidelines on screening for mild cognitive impairment.