Deprescribing Tips

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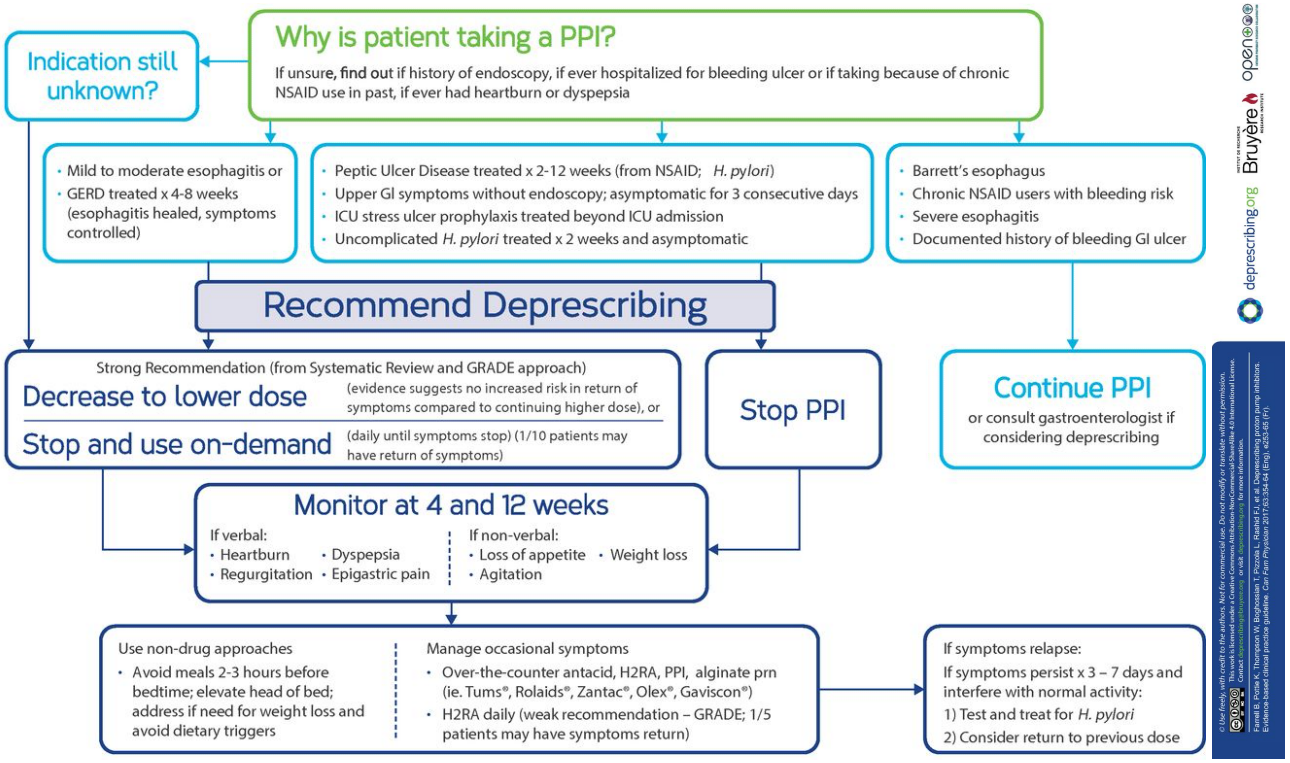
Approach to Deprescribing

Deprescribing is the process of stopping medications that are no longer indicated, appropriate or aligned with a patients' goals of care.[i]

1	**Consider the person**	- What are their goals and expectations? - What is most important to the person? - What is their degree of frailty? (e.g. clinical frailty scale) - Can you assess their reasonable life-expectancy? (e.g. ePrognosis)
2	**Consider the medications**	- What are they taking? For how long and how much? - Why are they taking them? - Any adverse effects or possible interactions? (drug-drug or drug-disease)
3	**Identify potential drugs to be ceased/modified**	- Risk/benefit analysis for individual drugs with particular attention to high risk drugs (e.g. Beer's criteria) and those originally prescribed for disease prevention which may no longer be relevant or needed - Medications that duplicate indications and/or classes of agents (e.g. mirtazapine with trazodone at night) - Medications to treat a sign or symptom that may be an adverse drug event from another medication (e.g. amlodipine -> edema -> lasix) - Medications used at a dose that is likely to cause toxicity in the elderly (e.g. rivaroxaban) should have doses reduced - Medications that are associated with multiple drug-drug or drug-disease interactions (e.g. diltiazem) may be substituted - Medications that are taken more than once daily (e.g. three times daily metformin) could be converted to once daily - Multiple medications that are available in combination forms may reduce medication burden (e.g. atacand plus - candesartan/hydrochlorothiazide) - Medications where adherence is an issue (e.g. inhalers, night-time statins)
4	**Prioritize medications to be deprescribed**	- Drugs with least utility or highest risk - Drugs adversely impacting on wellbeing - Patient preference - Drugs with complicated administration regimens
5	**Plan and initiate withdrawal trial**	- Seek consent from patient/carer explaining rationale and steps to take if symptoms recur - Prepare withdrawal plan with appropriate tapering of one medication at a time - Inform other health professionals involved of rationale and tapering plan
6	**Monitor and support**	- Set up a follow-up plan to monitor for any withdrawal/adverse effects or return of symptoms - Review plan with person and ask for feedback - Document result of withdrawal process and move on to next medication if appropriate

Proton pump inhibitor (PPI)

PPIs have a high prevalence of use and overuse. In older adults, their use increased from 26.7% in 2011 to 29.1% in 2016.[iii] Side effects include nausea, headaches, diarrhea, rash, increased risk c. difficile infection, fractures, community-acquired pneumonia, acute interstitial nephritis, vitamin B12 deficiency, hypomagnesemia.



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Cholinesterase inhibitors

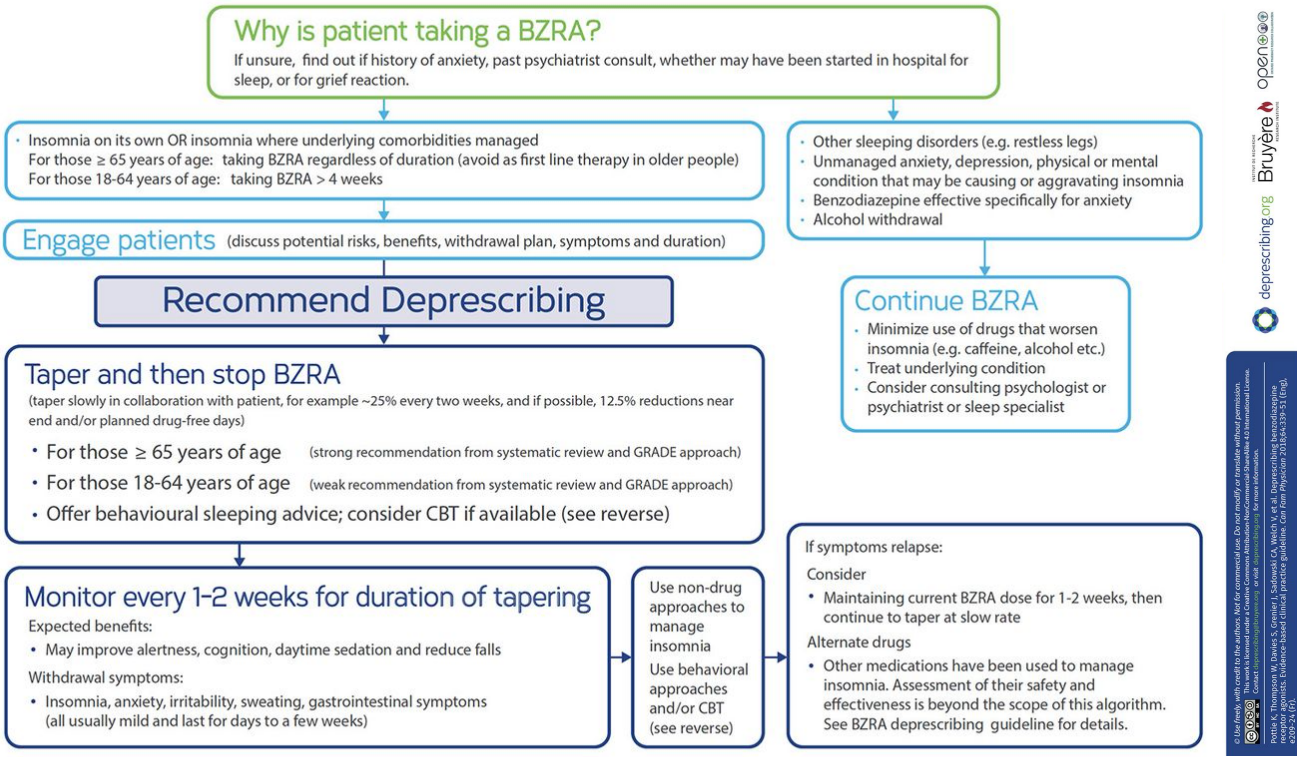
For individuals taking a cholinesterase inhibitor for Alzheimer's disease, Parkinson's disease dementia, Lewy body dementia, or vascular dementia for >12 months, discontinuation should be considered if:

(a) there has been a clinically meaningful worsening of dementia
(b) no clinically meaningful benefit was observed at any time during treatment
(c) the individual has severe or end-stage dementia
(d) development of intolerable side-effects
(e) medication adherence is poor and precludes safe ongoing use of the medication or inability to assess the effectiveness of the medication

Deprescribing should occur gradually (reduction of dose by 50% every 4 weeks) and treatment reinitiated if clinically meaningful worsening of cognition, functioning, neuropsychiatric symptoms, or global assessment that appears to be related to cessation of therapy.[v]

Benzodiazepines

Benzodiazepines use in older adults is associated with increased risk of cognitive impairment, falls and fractures. However, the therapeutic effect of benzodiazepines might be lost within 4 weeks due to receptor changes.



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Tools

Deprescribing.org
Choosing Wisely Canada
Beers criteria
STOPP-START criteria
ePrognosis calculators
Anticholinergic risk scale (ARS)

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[i] Frank, Christopher, and Erica Weir. "Deprescribing for older patients." *CMAJ* 186.18 (2014): 1369-1376. DOI: 10.1503/cmaj.131873

[ii] Primary Health Tasmania. A Guide to Deprescribing. Tasmania, Australia: 2019. https://www.primaryhealthtas.com.au/wp-content/uploads/2018/09/General-information-fact-sheet.pdf

[iii] Canadian Institute for Health Information. Drug Use Among Seniors in Canada, 2016. Ottawa, ON: CIHI; 2018. https://www.cihi.ca/sites/default/files/document/drug-use-among-seniors-2016-en-web.pdf

[iv] Farrell, Barbara, et al. "Deprescribing proton pump inhibitors: evidence-based clinical practice guideline." Canadian Family Physician 63.5 (2017): 354-364. https://www.cfp.ca/content/63/5/354

[v] Ismail, Zahinoor, et al. "Recommendations of the 5th Canadian Consensus Conference on the diagnosis and treatment of dementia." *Alzheimer's & Dementia* 16.8 (2020): 1182-1195. DOI: 10.1002/alz.12105

[vi] Pottie, Kevin, et al. "Deprescribing benzodiazepine receptor agonists: evidence-based clinical practice guideline." *Canadian Family Physician* 64.5 (2018): 339-351. https://www.cfp.ca/content/64/5/339