Deprescribing

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Contents

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What do you think of when you hear the term deprescribing?

ⓘ Start presenting to display the poll results on this slide.

What is deprescribing

"Deprescribing is the planned and supervised process of dose reduction or stopping of medication that might be causing harm, or no longer be of benefit. Deprescribing is part of good prescribing – backing off when doses are too high, or stopping medications that are no longer needed."

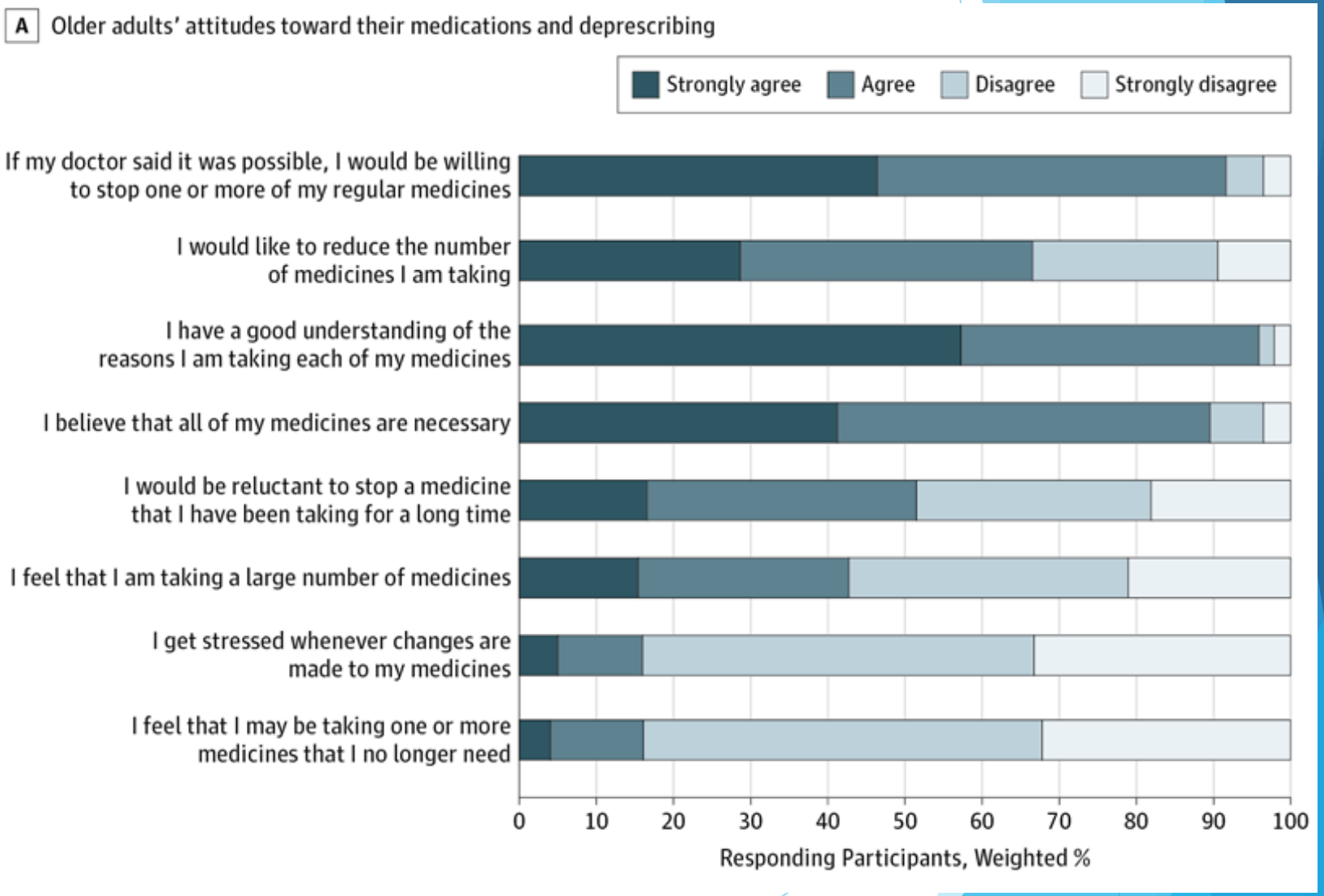
Deprescribing should be **patient-centred** and **individualised** to circumstances, goals and needs

What is Deprescribing? - Deprescribing.org [Internet]. Deprescribing.org. Available from: https://deprescribing.org/what-is-deprescribing/

Why deprescribe?

- **Benefits to patients**
- Reducing medication burden and complexity
- Reducing the risk of falls*
- Improving and/or preserving cognitive function
- Reduce the risk of hospitalization and death*
- Reducing the risk of medication-related harm
- Cost savings for residents

Patient attitudes to deprescribing



2. Reeve E, Wolff J, Skehan M, Bayliss E, Hilmer S, Boyd C. Assessment of Attitudes Toward Deprescribing in Older Medicare Beneficiaries in the United States. JAMA Internal Medicine. 2018;178(12):1673.

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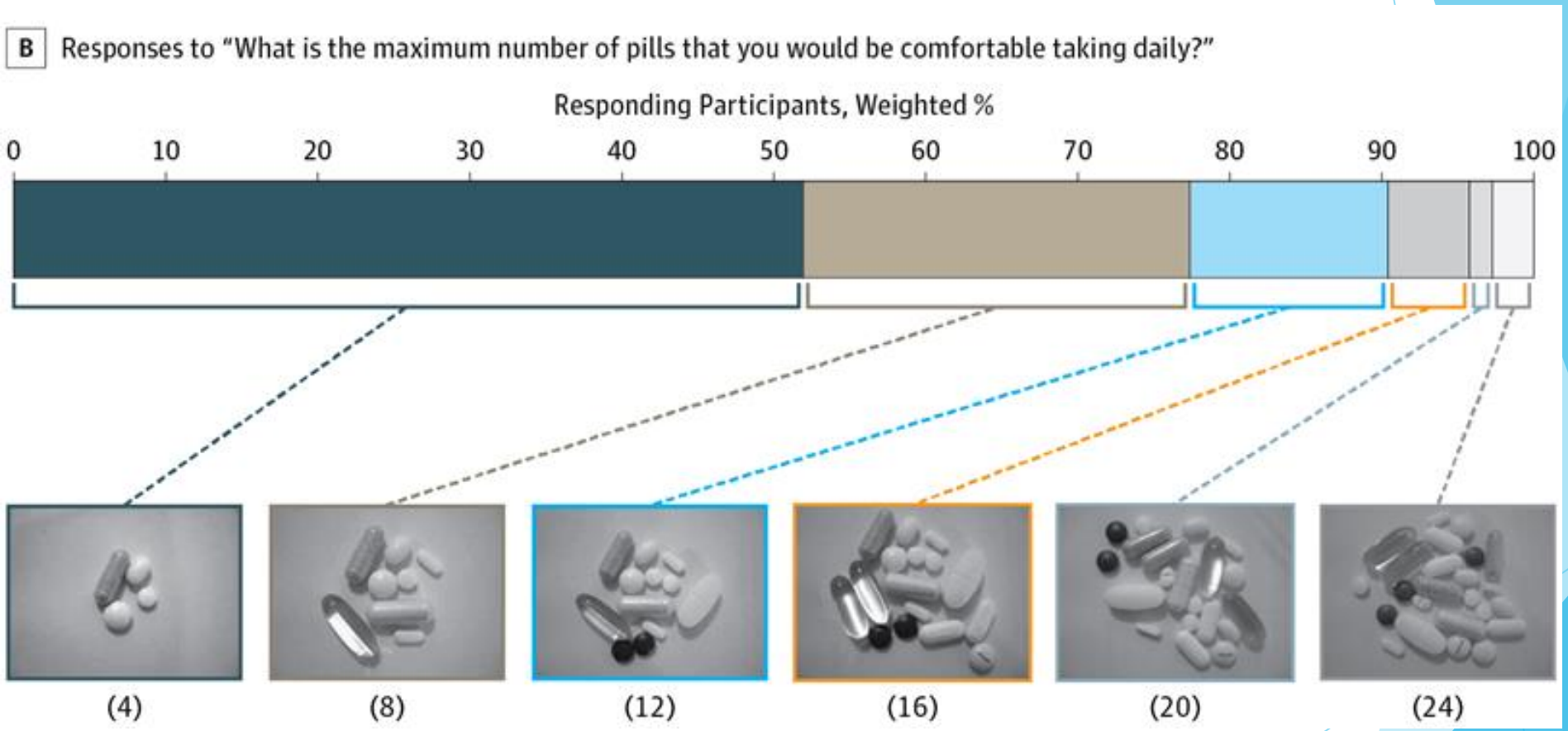

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When to deprescribe?

Changes to goals of care	• Changes to life expectancy • Deprescribing can be approached early in the palliative care journey, not just at end of life
Changes to swallowing	• Forward planning is key to enable tapering if possible
Early conversations regarding some chronic disease	• Diabetes/ hypertension may require less aggressive treatment as someone ages • help manage and set expectations
Patient struggling with complex medication regimen (not taking medications) or experiencing significant burden	• Adverse effects • Complicated routines • Difficult to use devices. • Difficulty with adherence

Deprescribing process

- Comprehensive medication history
- Identify potentially inappropriate medications
- Determine if medications can be ceased and prioritization
- Plan and initiate withdrawal/ monitoring

https://onlinelibrary.wiley.com/doi/epdf/10.5694/mja13.00200

Medication history

Patient experiences with medications/ difficulties with the current regimen

- Review overall susceptibility to drug-induced harms, frailty, cognitive impairment, or other geriatric syndromes such as falls
- Previous history of deprescribing
- Patients attitude to taking medications (do you feel you are taking the right amount of medications?)

Medication administration issues

- Swallowing
- Complicated medication regimens
- Issues with adherence/remembering/
- Is access to medications easy
- Device use

Collaboration

- Consider referral to a pharmacist
  - HMR/ RMMR
    Meds Check

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do you regularly engage with a pharmacist or pharmacies for medication reviews?

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Identify inappropriate medications

- Indication still relevant?
  - Prescribing cascade?
- Benefits of current therapy, in view of goals of care.
  - Are preventative medications still providing benefit?
- Adverse drug reactions
  - Realised or high risk
  - Tools like Beers criteria can help
- Drug -Drug interactions
  - Caution Stopping an interacting drug!
  - Many interaction tools available
- Drug - Disease interactions
  - Renal
  - Hepatic
  - Co-morbidities
- Adherence issues
  - Is the patient using the medication therapeutically?
- Sub therapeutic doses

Identify inappropriate medications

Medications that benefit from tapering

- Pharmacology and pharmacokinetics of the medication
- The risk of recurrence of symptoms – PPIs
- Adverse drug withdrawal effects – Benzodiazepines
- Rebound phenomenon – Beta Blockers +

A general rule of thumb is to reduce the dose by 50 percent every two to four weeks, with monitoring at each dose reduction and at two to four weeks after cessation. Stepping down through available dose formulations is another approach.

Medication Cessation for Adults in the Last Days of Life

Drug Class	Symptoms Associated with Withdrawal	General Recommendations for Medication Management of Withdrawal Symptoms
Alpha-blockers	Rebound hypertension, agitation with sudden cessation	Parenteral opioid or benzodiazepine.
Anticholinergics	Anxiety, headache, dizziness	Parenteral opioid for headache or benzodiazepine for anxiety and dizziness.
	Nausea, vomiting	Parenteral antiemetic.
Anticonvulsants	Emergence or re-emergence of seizures	Continuous parenteral benzodiazepine. Seek relevant specialist advice.
Antidepressants	Dysphoric mood, agitation, headache	Parenteral opioid or benzodiazepine.
Anti-reflux medications	Heartburn, nausea.	Consider parenteral anti-reflux medication, parenteral anti-emetic and opioid.
Antiparkinsonians	Rigidity, resulting in pain	Parenteral opioid.
Antipsychotics	Dyskinesia, nausea, vomiting, agitation	Regular parenteral antipsychotic. Seek specialist advice.
Benzodiazepines	Delirium, agitation, insomnia, seizures	Continuous parenteral benzodiazepine. Seek relevant specialist advice.
Beta-blockers	Rebound tachycardia, palpitations, re-emergence of angina	Parenteral opioid or benzodiazepine. Consider nitrate patch for angina.
Digoxin & other antiarrhythmics	Re-emergence of rapid atrial fibrillation or other arrhythmias, resulting in breathlessness.	Parenteral opioid or benzodiazepine.
Diuretics	Fluid retention associated with breathlessness or peripheral oedema.	Parenteral opioid or benzodiazepine.
Nitrates	Re-emergence of angina	Convert to nitrate patch. Treat symptoms with parenteral opioid.
Steroids	Hypothalamic-pituitary axis suppression in long-term use	May develop acute adrenal crisis and if concerned, seek relevant specialist advice.
	Re-emergence of painful inflammatory condition	Parenteral steroid.

The table to the left lists some common classes of medications, which may be associated with withdrawal effects. **This is not a comprehensive list and only general recommendations have been made for treatments which may provide symptomatic relief from these withdrawal effects**

Remember that anticipatory prescribing is the key

https://www.sahealth.sa.gov.au/wps/wcm/connect/5fc189804a24008cb979f990d529bdaa/Medication+Cessation+for+Adults+in+the+Last+Days+of+Life+Fact+Sheet.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5fc189804a24008cb979f990d529bdaa-nwKrzT.

Determine if medications can be stopped and prioritisation

- Is the patient willing?
- Is the patient medically stable/ able to withstand changes to medications
- Is it safe to do so now or will it be in the future?
- Have there been Previous attempts at deprescribing this agent?
- Consider drug-drug interactions and how this might effects medications.
- Prioritisation
  - One medication at a time – stepwise approach
  - Which medication first? Easy win or most critical?

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What are some barriers that you face when deprescribing?

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Barriers

- Patient still perceives the benefits of medication.
- No actual harm has been realized.
- Length of medication use.
- Specialist/ other prescriber commenced medications.
- Limited time
- Lack of evidence
- Sense of abandonment, giving up hope.

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What do you find as an enabler to deprescribing?

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Enablers

Patient has no perceivable benefits from the medication.

Experiencing adverse drug reactions to the medication.

Cessation could lead to QOL improvements.

Evidence based guidelines

Suggesting “trials” to keep the patient in control.

Easy to measure effects or outcomes

Plan withdrawal/ follow up/ monitoring

Medication plan	Create and communicate a clear withdrawal plan, including follow ups, time frames, tapering schedules and prioritization. • Document changes to all relevant parties including specialists/ pharmacist
Monitor	Monitor patient for ADRs, withdrawal and return of symptoms • Can we do it at home or does it need to be done in the hospital? • Communicate to the patient key things to watch out for • Scheduled follow-ups and review – pharmacist?
Communication	Ensure the patient has a method of contacting you regarding questions or concerns
Manage expected issues	Consider non-pharmacological therapies to manage predicted issues

Deprescribing resources

Tasmanian PHN deprescribing guidelines

- https://www.primaryhealthtas.com.au/resources/deprescribing-resources/

A GUIDE TO deprescribing

phn TASMANIA An Australian Government Initiative | primary health TASMANIA | CPS Experts in Medicines CONSULTANT PHARMACY SERVICES

ANTIHYPERTENSIVE AGENTS

KEY POINTS

- Lowering blood pressure reduces risk of a range of long-term consequences, this benefit is still evident in the elderly.
- Less aggressive control of blood pressure in the elderly gives results equivalent to those achieved with more aggressive control.
- Low blood pressure may be associated with increased morbidity and mortality in the elderly.
- Patients being treated for hypertension are more likely to fall if they have proven postural hypotension.
- Adverse effects of many antihypertensive agents are likely to be more common in the elderly.
- Withdrawal of antihypertensives should be gradual.

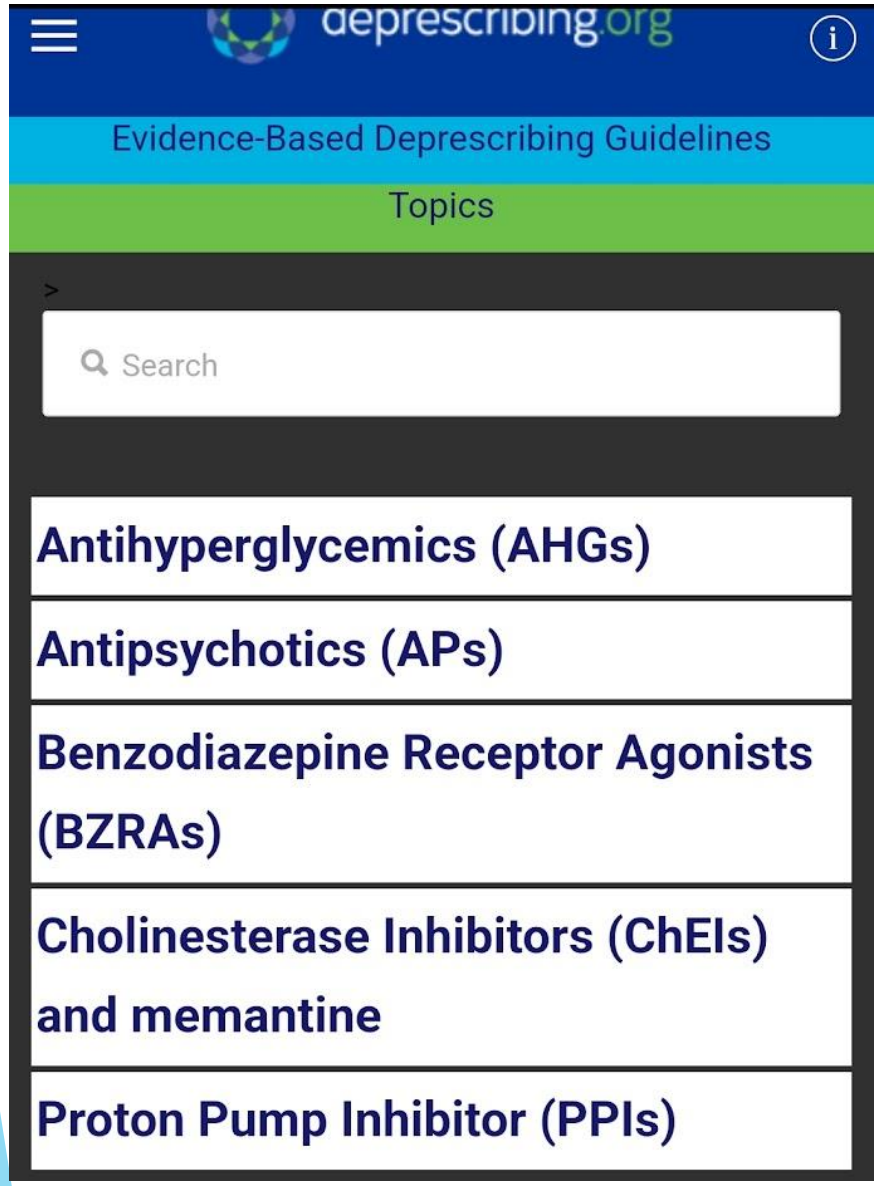
CONTEXT

This guide considers the use of antihypertensive agents in elderly patients.

RECOMMENDED DEPRESCRIBING STRATEGY

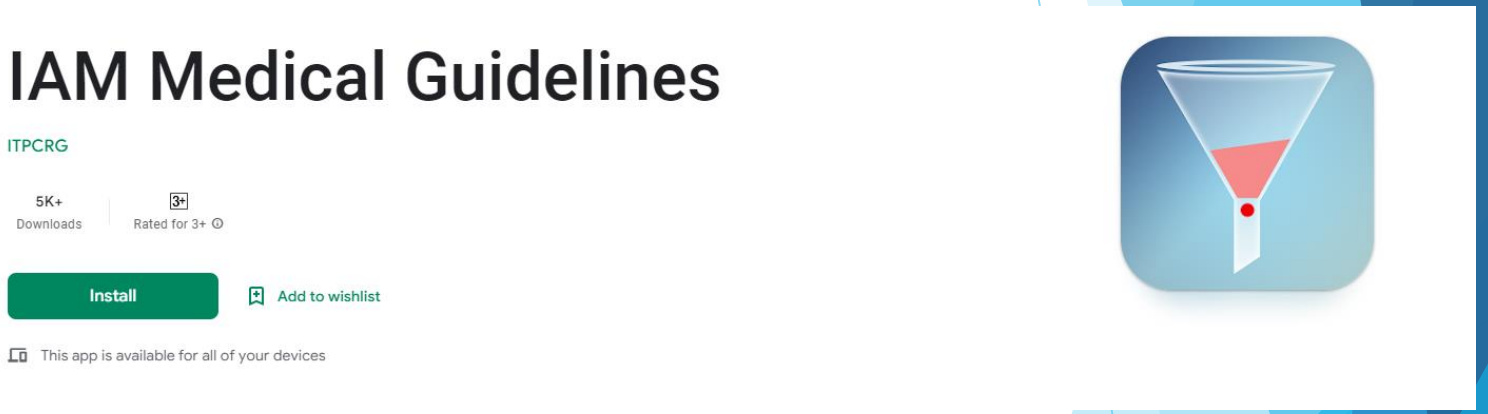
- Many patients are receiving multiple agents that lower blood pressure. Reduction and cessation strategies should focus on one agent at a time.
- Reduction or cessation of antihypertensive agents should be considered:
  - In frail elderly and/or immobile patients
  - In patients with a high falls risk
  - In patients with confirmed postural hypotension (>20mmHg fall in systolic on standing, and/or >10mmHg fall in diastolic on standing)

BENEFIT VERSUS HARM



Deprescribing resources

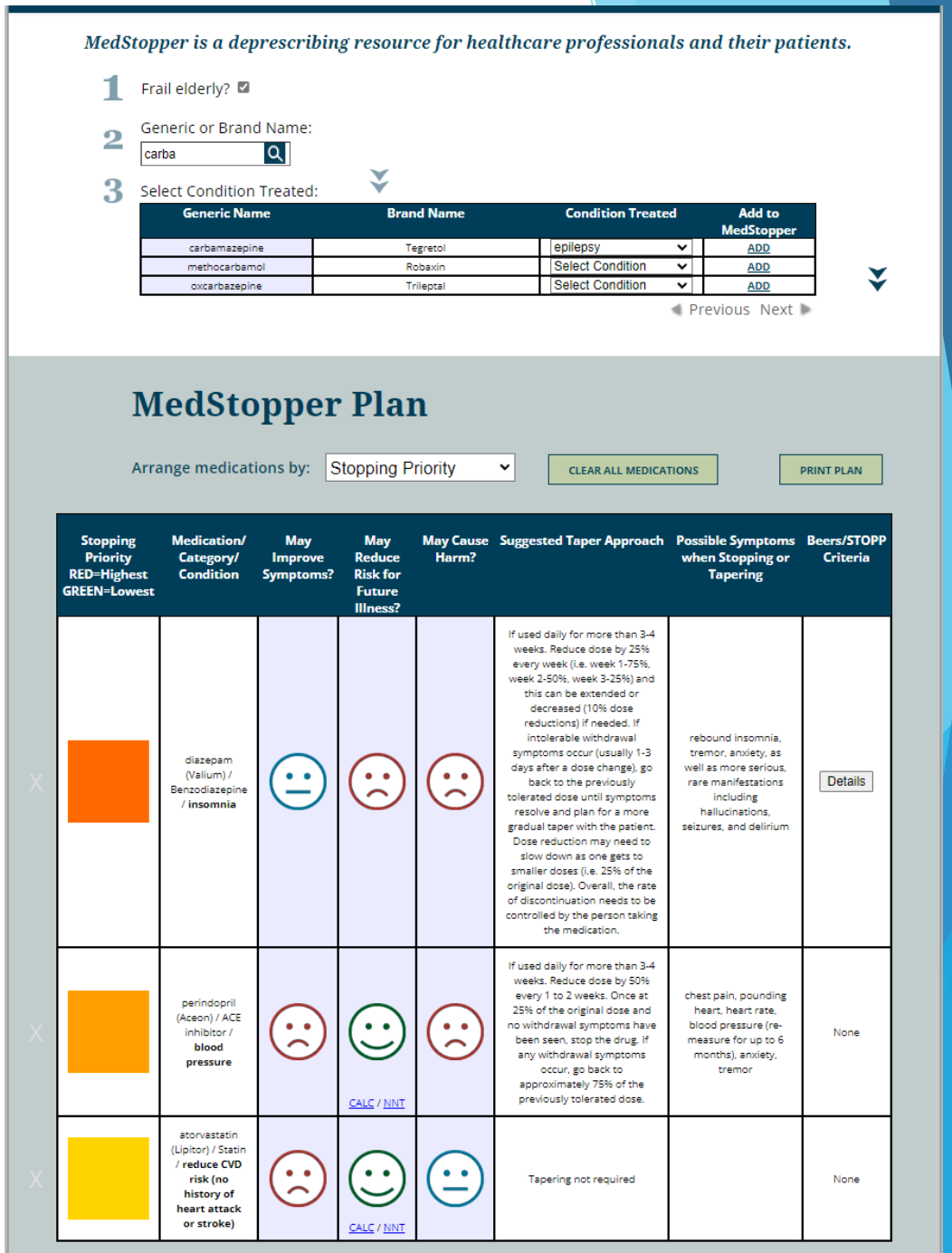
IAM Medical Guidelines App



Deprescribing resources

Medstopper

http://medstopper.com/



MedStopper is a deprescribing resource for healthcare professionals and their patients.

1 Frail elderly? ☑

2 Generic or Brand Name:

carba

3 Select Condition Treated:

Generic Name	Brand Name	Condition Treated	Add to MedStopper
carbamazepine	Tegretol	epilepsy	ADD
methocarbamol	Robaxin	Select Condition	ADD
oxcarbazepine	Trileptal	Select Condition	ADD

◀ Previous Next ▶

MedStopper Plan

Arrange medications by: Stopping Priority

CLEAR ALL MEDICATIONS PRINT PLAN

Stopping Priority RED=Highest GREEN=Lowest	Medication/ Category/ Condition	May Improve Symptoms?	May Reduce Risk for Future Illness?	May Cause Harm?	Suggested Taper Approach	Possible Symptoms when Stopping or Tapering	Beers/STOPP Criteria
X	diazepam (Valium) / Benzodiazepine / **insomnia**	😐	☹	☹	If used daily for more than 3-4 weeks. Reduce dose by 25% every week (i.e. week 1-75%, week 2-50%, week 3-25%) and this can be extended or decreased (10% dose reductions) if needed. If intolerable withdrawal symptoms occur (usually 1-3 days after a dose change), go back to the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient. Dose reduction may need to slow down as one gets to smaller doses (i.e. 25% of the original dose). Overall, the rate of discontinuation needs to be controlled by the person taking the medication.	rebound insomnia, tremor, anxiety, as well as more serious, rare manifestations including hallucinations, seizures, and delirium	Details
X	perindopril (Aceon) / ACE inhibitor / **blood pressure**	☹	🙂 CALC / NNT	☹	If used daily for more than 3-4 weeks. Reduce dose by 50% every 1 to 2 weeks. Once at 25% of the original dose and no withdrawal symptoms have been seen, stop the drug. If any withdrawal symptoms occur, go back to approximately 75% of the previously tolerated dose.	chest pain, pounding heart, heart rate, blood pressure (re-measure for up to 6 months), anxiety, tremor	None
X	atorvastatin (Lipitor) / Statin / **reduce CVD risk (no history of heart attack or stroke)**	☹	🙂 CALC / NNT	😐	Tapering not required		None

Deprescribing resources

- Beers Criteria
- Stopp/ Start
- Anticholinergic burden index

Questions?

Thank you for your time!