The Prudent Prescriber

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Pharm Reps ≠ Rational Prescribing
(PR) (RP)

Deprescribing: Is it Time to Get Started?

The Problem: Polypharmacy in the Elderly

- In developed countries, approximately 30% of patients aged 65 or older are prescribed five or more drugs. JAMA. 2008; 300(24):2867–2878.
- One in five drugs commonly used in older people may be inappropriate, increasing to one in three among those living in nursing homes. Intern Med J. 2007;37(6):402–405.
- The number of drugs that a patient is taking is the single most important predictor of harm. J Gen Intern Med. 2014;29(10):1379–1386.

The Concept of Deprescribing

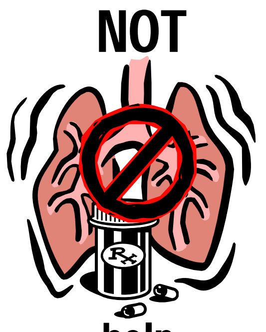
Simply put, deprescribing is the process of trial withdrawal of inappropriate medications. Evidence suggests that ceasing use of medications is as least as complicated as initiating treatment. Deprescribing is not about denying medications to eligible patients. It's a positive, patient oriented intervention with uncertainties. It requires share decision-making.

CHF?

Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

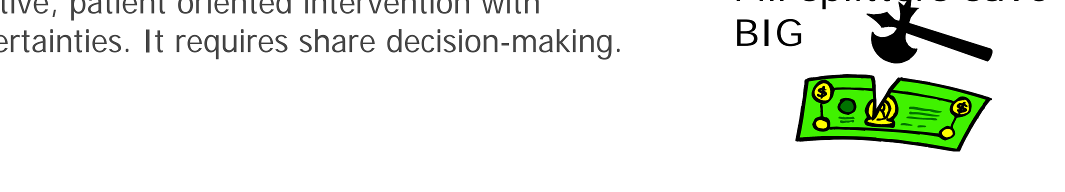
Avoid these expensive "me-too" drugs:
Intermezzo
Vimovo
Livalo
Pristiq
Viibyrd
Edarbi
Daliresp

Antibiotics do **NOT** help acute bronchitis



ß-blockers in post-MI save lives

Pill splitters save BIG



Treat patients > 60 years to 150/90

Lunesta→eszopiclone
Namenda→memantine
Axert→almotriptan
Prandimet→repaglinide/metformin
Jaylyn→dutasteride/tamsulosin
Ortho Tri-Cyclen Lo→Tri-Lo-Marzia, Tri-Lo-Spirntec, & others

The Barriers to Deprescribing

1. As a physician, I frequently lamented that I didn't have time to deal with the 9 medications that my 84-year-old patient was taking, particularly after I had attended to her 3.3 medical problems and discussed 1.7 of her relatives.
2. I have played lip service, but rarely acted on the credo that you could stop almost all chronic medications on almost all patients, without a problem.
3. I have always been reticent to stop medications that another clinician has initiated.
4. I have few skills-- "how to do it"-- in the art and science of tapering and discontinuing medications.
5. Finally, successful deprescribing involves shared decision making, often not only with the patient, but also often with the elderly patient's family.

Benefits of Deprescribing?

A systematic review of 31 medication withdrawal trials of patients 65 years of age and older demonstrated that use of hypertension and psychotropic drugs could be discontinued without harm in 20% - 100% of patients. Withdrawal of psychotropic drugs was associated with reduction in falls and improvement in cognitive and psychomotor function. Age Ageing 2014;43(1):20-25. Many of the individual studies are quite small and underpowered, so the overall effects are not great. Deprescribing may improve overall medication adherence through a variety of mechanisms, including reducing the number of medications taken (and costs), simplifying the medication regimen, increasing self-efficacy and reducing adverse drug reactions.

Evidence suggests that withdrawal of specific classes of medications leads to a resolution of adverse drug reactions noted to be caused by those groups of drugs. For example, stopping benzodiazepines decreases falls and increases cognitive function; ceasing nonsteroidal anti-inflammatories improves blood pressure and decreasing antipsychotics in Alzheimer's patients decreases mortality.

Potential Harms of Deprescribing?

#1 Withdrawal of a medication may result in a physiological response. This can generally be prevented (or minimized) by tapering the dose before totally withdrawing the medication. Withdrawal reactions can lead to increased health services, but their impact on health services is small.

#2 A lack of symptoms of a condition may indicate that the medication is working or that the underlying condition has resolved. A trial of medication withdrawal to determine which of these two scenarios is occurring is sometimes appropriate. Review of medication trials showed varying rates of condition relapse for different medications and between studies.

#3 Stopping a medication may result in changing pharmacokinetics of other medications taken by that patient. For example, discontinuing use of a cytochrome P450 enzyme inhibitor may lead to an increased clearance of medications that are metabolized by that enzyme, resulting in decreased serum levels.

A Deprescribing Protocol

Scott et al (JAMA Internal Medicine May 2015) describe a deprescribing five-step protocol.

1. Ascertain all drugs the patient is currently taking and the reasons for each one.
2. Consider the overall risks of drug-induced harm in this patient.
3. Assess each drug for its eligibility to be discontinued: Valid indication? Part of a prescribing cascade? Actual or potential harm clearly outweighs any potential benefit? Symptoms have completely resolved? Drugs are imposing an unacceptable treatment burden?
4. Prioritize the drugs for discontinuation. Think about the pragmatic aspects of deprescribing. Start with the drug with the greatest harm and least benefit? Or the drug easiest to discontinue? Or the drug that the patient is most willing to discontinue first?
5. Implement the discontinuation regimen. Get patient buy in. Instruct the patient and his/her family about what to look for. Eliminate one drug at a time.

A Helpful Tool

You have decided to make a commitment to deprescribing. The New Zealand medical community has come to your rescue. Remember these are the only other docs in the developed world that have to deal with direct to consumer advertising. In April 2010, the Best Practices Advocacy Centre of New Zealand published an "in the trenches" guide to deprescribing. Their website, http://www.bpac.org.nz/BPJ/2010/April/stopguide.aspx offers a plethora of practical tips about how to discontinue antihypertensives, corticosteroids, statins, benzodiazepines, antidepressants, acid suppression agents, NSAIDs, bisphosphonates and anti-parkinsons drugs.

How do you start?

Where are the low hanging fruit? Is it approaching the frail, declining patients who are in palliative care or hospice? Do you try to shoehorn deprescribing into a regular office visit or perhaps more prudently, schedule a separate deprescribing visit? Do you approach it from the respective of eliminating drugs whose onset of effectiveness is longer than the predicted lifespan of your patient? Think statins, bisphosphonates and tight control of diabetes? Can you commit to one office visit a day dedicated to deprescribing? How about purging all glyburide from your elderly?

Finally, the ultimate technique in deprescribing is taking great care in writing each new prescription.

You may access previous issues at http://www.rmhp.org/providers/prudent-prescriber.

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