# Mucky Meds: A (practical) approach the nightmare med list

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# Faculty/Presenter Disclosure

- Faculty: Michelle Gibson
- Relationships with financial sponsors:
  - None

- Faculty: Erin Beattie
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  - None

# Disclosure of Financial Support

- This program has NOT received financial support.
- This program has NOT received in-kind support.

- Potential for conflict(s) of interest:
  - None

# Mitigating Potential Bias

- Not applicable

# Objectives

- Participants will learn and apply an approach to a challenging medication list.
- Participants will develop practical strategies for deprescribing.
- Participants will discuss approaches to particularly challenging classes of medications, including benzodiazepines and opioids.

# Overview

- A case
- An approach
- A harder case to practice
- We crowd-source ideas

# Case of Gordon B.

- 75-year-old widower in your practice.
- Falling and confused – getting worse
- PMHx:
  - Bipolar disorder * 50 years
  - Spinal stenosis & DDD
  - DM 2
  - Gout
  - Atrial fibrillation and venous stasis

- Amitriptyline 100mg daily
- Lithium 300mg bid
- Metformin 1000mg bid
- Glyburide 10mg bid (on hold)
- Warfarin (on hold)
- ECASA 81mg daily (new)
- Ramipril 10mg daily
- Digoxin 0.125mg daily
- Lorazepam 1mg qhs
- Colace 100mg bid
- Senokot ii po qhs prn
- Furosemide 40mg prn
- Indomethacin 50mg tid prn
- Naproxen 250mg tid prn
- Prochlorperazine 10mg prn
- Tylenol #3 i-ii q4h prn
- Oxycocet i-ii q4h prn

# Medication Review in minutes

- What drugs are they on?
- Why are they on them?
  - Match the drug with the indication
- Is the drug/dose appropriate right now?
- What drugs aren't they on?
  - Why not?

# Oops- forgot?

- Over the counter:
  - Acetaminophen products (many)
  - Gravol
  - A wild array of bowel meds
- Pharmacy list:
  - Zopiclone
  - Eye drops
  - Antimicrobial cream

# Then …

- Make a list of what they are actually taking
- Try “lumping” vs. “splitting”
- Organize around a problem list
- Note the indication(s) for each med

# Example- "Cardiovascular"

- Diabetes Mellitus 2
- CKD – CrCl 25 mls/min
- A fib
- Venous insufficiency edema/ ulcers

- ~~Glyburide - on hold~~
- ~~Metformin 1000 mg bid~~
  - Stop due to renal fn.
  - Consider gliclazide?
- Ramipril 10mg daily
- Digoxin 0.125mg daily
  - Level?
- Warfarin – on hold
  - Why?
- ECASA 81 mg daily
- Furosemide 40 mg prn
  - Why?

# Example - Pain

- DDD
- Spinal stenosis
- Gout
  - How often?

- ~~Indomethacin 50mg tid prn~~
- ~~Naproxen 250mg tid prn~~
  - Recheck renal function
- Tylenol #3 i-ii q4h prn OR
- Oxycocet i-ii q4h prn ?
  - Add neuropathic agent?
- Colace 100mg bid
- Senokot ii po qhs ~~prn~~ regularly

# Example – Psychiatric meds

- Bipolar disorder

- Amitriptyline 100mg daily
  - +Anticholinergic
  - Check with psych
- Lithium 300mg bid
  - Level?
- Lorazepam 1 mg po qhs
  - Why?
  - How long?

# Example - Other

- Why is he on…
- Prochlorperazine prn?

# Implied step

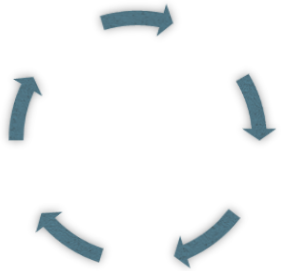
- Is the indication still appropriate at this point for this patient?
- Is the dose appropriate for this patient at this time?
- Goals of care come in to play here.

# What about what's missing?

- Problem list can be helpful here, too.
- E.g.
  - CAD?  - Why no GTN spray?
- Goals of care again

# Pick your priorities

- Get these implemented
- Where possible, make one change a time
- Lather, rinse, repeat!
- This will often be an iterative process



# WARNING!

- What follows is not comprehensive.  It represents advice based on clinical experience, knowledge of drugs, and occasionally evidence.
- For any individual patient, the following advice might not apply.

# Anticholinergic Drugs

- Expected: TCAs, opioids, benzos, many other psych meds, bladder meds, antihistamines
- Unexpected: Digoxin, furosemide, ranitidine, nifedipine, warfarin, atenolol, paroxetine
- Anticholinergic Cognitive Burden Scale

# Drugs to reconsider

- TCAs, especially amitriptylline, imipramine
  - Can use nortriptylline, desipramine judiciously
- NSAIDs
  - Of the "potentially inappropriate" medications in 2015 updated Beers Criteria, these are the #1 most commonly prescribed
  - Indomethacin = the WORST! (most adverse effects)

# Drugs to reconsider

- Reflux medications
  - Often get by without either an H2 blocker or a PPI
  - PPI Deprescribing Algorithm
- Digoxin
  - **If** they need it, keep therapeutic level <1.0
  - In general, don't go above 0.125mg daily/q2day
- Furosemide
  - Reserve for CHF, lower dose if possible … unless low eGFR/high ACR – then need higher doses.

# Drugs to reconsider

- Propranolol for essential tremor
  - More CNS effects than other β-blockers
  - Nadolol might be a better peripherally acting agent
- Anticholinergic bladder agents
  - Often don't work – try lower doses, or d/c
  - They all cross the BBB despite marketing claims!

# Drugs to reconsider

- Benzodiazepines
  - Try to avoid (no kidding); if can't avoid, try oxazepam, clonazepam, LOW doses
  - Weaning is almost always required – even if ordered 'prn' – many patients take them very regularly.
  - Consider trazodone, melatonin for sleep

Benzo Deprescribing Algorithm

# Drugs to reconsider

- Dopamine agonists (ropinerole, etc.)
  - Very sedating in frail older demented patients
  - Levodopa/Carbidopa usually better tolerated
- Antipsychotic agents
  - Whole other talk!  Explore other options, have clear indications, review regularly, non pharmacological interventions first
  - Antipsychotic Desprescribing Algorithm

# Additional resources

- STOPP and START criteria – Arch Int Med (Euro Geri Med 1 (2010) 45-51.
- AGS Beers Pocket Card
- Medstopper.com
- deprescribing.org
  - All the algorithms
  - Also - Helpful links

# Questions?

- Contact us:

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