

Deprescribing in Complex Patients: From Knowledge to Practice

- **Dr Solveig Nilson, MD CCFP, Assistant Clinical Professor**
- **Louise Papillon-Ferland, B.Pharm., M. Sc., Pharmacist, Associate Clinical Professor**

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PRESENTER DISCLOSURE

Presenter: SOLVEIG NILSON

Relationships with financial sponsors:



Any direct financial relationships, including receipt of honoraria:

n/a



Membership on advisory boards or speakers' bureaus:

Member of Canadian Medication Appropriateness and Deprescribing (CADeN)
Health Care Provider Committee



Patents for drugs or devices:

n/a



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PRESENTER DISCLOSURE

Presenter: LOUISE PAPILLON-FERLAND

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Any direct financial relationships, including receipt of honoraria:

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Membership on advisory boards or speakers' bureaus: N/A



Patents for drugs or devices: N/A



Other: Employee of CIUSSS Centre-Sud de l'Île de Montréal (Institut universitaire de gériatrie de Montréal) and Faculté de pharmacie (Université de Montréal)

DISCLOSURE OF FINANC



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None.

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Learning Objectives

1

Engage
patients, caregivers,
and colleagues in
collaborative
deprescribing
practices.

2

Effectively use evidence -
**based deprescribing
practice tools** during
brief interactions with
patients and caregivers.

3

Create
deprescribing plans
considering patient
and medication
specific factors.

Mrs. J, 72 yrs old, booked in for a meeting



Social history:

- Immigrated from Jamaica 24 years ago
- Speaks Patois and English
- 2 daughters and 1 son - two of them live abroad, one is close and involved
- Lives alone in an apartment
- Independent for ADLs and IADLs
- No regular physical activity

Pmhx:

- Diabetes
- Hypertension
- Overactive bladder (OAB)
- Hypothyroidism
- Schizoaffective disorder
- Chronic Pain
- Anxiety
- Mild CKD - GFR 44
- ? Insomnia
- ? Gastroesophageal reflux disease (GERD)

Mrs. J Medication List



Hydrochlorothiazide po 25 mg daily am

Amlodipine 5 mg po daily

Metformin 500 mg po tid

Gliclazide MR 60 mg po daily

Rosuvastatin 10 mg po daily

Lorazepam 1 mg po daily hs

Levothyroxine 75 mcg po daily

Acetaminophen 325 mg 2 tabs po tid prn

Celecoxib 100 mg po daily cc

Calcium carbonate 500 mg po daily

Vitamin D 400 units po bid

Omeprazole 20 mg po daily am

Solifenacin 5 mg po daily

Divalproex 500 mg po BID

Risperidone 2 mg daily

Sertraline 75 mg po daily

Clinical Frailty Scale



1

VERY FIT

People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.



2

FIT

People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.



3

MANAGING WELL

People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.



4

LIVING WITH VERY MILD FRAILITY

Previously “vulnerable,” this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up” and/or being tired during the day.



5

LIVING WITH MILD FRAILITY

People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.



6

LIVING WITH MODERATE FRAILITY

People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7

LIVING WITH SEVERE FRAILITY

Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).



8

LIVING WITH VERY SEVERE FRAILITY

Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.



9

TERMINALLY ILL

Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty**. (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.



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www.geriatricmedicineresearch.ca

Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

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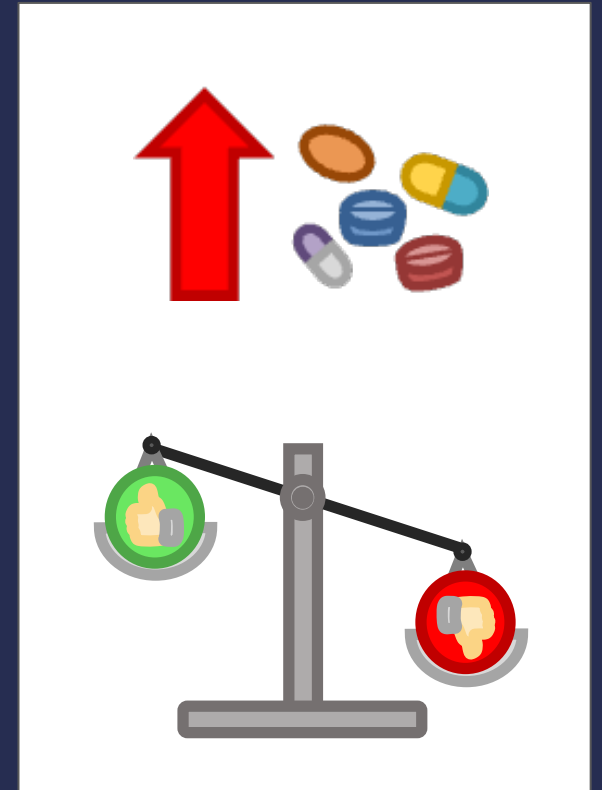
Polypharmacy

Quantitative definition:

- ≥ 5 different medications
- Hyperpolypharmacy starting at ≥ 10 medications

Qualitative definition:

- Taking a combination of medications where the risks surpass the benefits for a specific individual



Prevalence of Polypharmac

The number of medications prescribed to people in Canada increases with age:



18 to 39 years old
take 3+ medications¹



40 to 59 years old
take 3+ medications¹



65 years and older
take 5+ medications²

1. Statistics Canada, Government of Canada; 2021.

2. Drug Use Among Seniors in Canada. Canadian Institute for Health Information; 2022

Prevalence of Polypharmac

Potentially inappropriate medications are commonly taken:



of people in Canada over the age of 65 take 1+ potentially inappropriate medications⁷



The use of potentially inappropriate medications is generally higher in women^{7,8}

7. *Potentially Inappropriate Medication Prescribed to Seniors. Canadian Institute for Health Information; 2025.*


8. *Bureau d'Information Et D'études En Santé Des Populations. Institut National De Santé Publique Du Québec; 2024.*

Consequences of Polypharmacy

Consequences of polypharmacy are multiple and include:

- Drug-drug interactions & drug-disease interactions
- Side effects:
 - Falls and fractures
 - Cognitive deficits
 - Hospitalizations
- Error in medication intake / poor adherence
- Increased costs and use of health care services

Deprescribing



Deprescribing is the planned and supervised process of dose reduction or stopping of medications that might be unnecessary or causing harm.

Farrell, B. *et al.* (2016) 'Methodology for developing deprescribing guidelines: Using evidence and grade to guide recommendations for deprescribing', *PLOS ONE*, 11(8). doi:10.1371/journal.pone.0161248.

Deprescribing is a systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits and it takes into consideration the patient's goals of care, level of functioning, life expectancy, values and preferences. (Scott, et al 2015).

What does the evidence say about

(Systematic review and meta-analysis 2024 - 259 studies)

Mortality (Primary outcome):

- No significant impact in randomised (OR 0.96, 95% CI 0.84–1.09) and non-randomised (OR 0.70, CI 95% 0.36–1.38) studies
- However, ↓ mortality in specific subgroups :
 - The “young old”: (65–79 y.o.) (OR 0.71, 95% CI 0.51–0.99) and
 - Patient-specific interventions : (OR 0.79, CI 95% 0.63–0.99)

Secondary outcomes:

- ↓ in medication burden (# of medications) and potentially inappropriate medications
- No significant change in adverse drug withdrawal events, falls, fractures, adverse drug events, ER visits, hospitalisations, cognition, quality of life

Who should you prioritise?

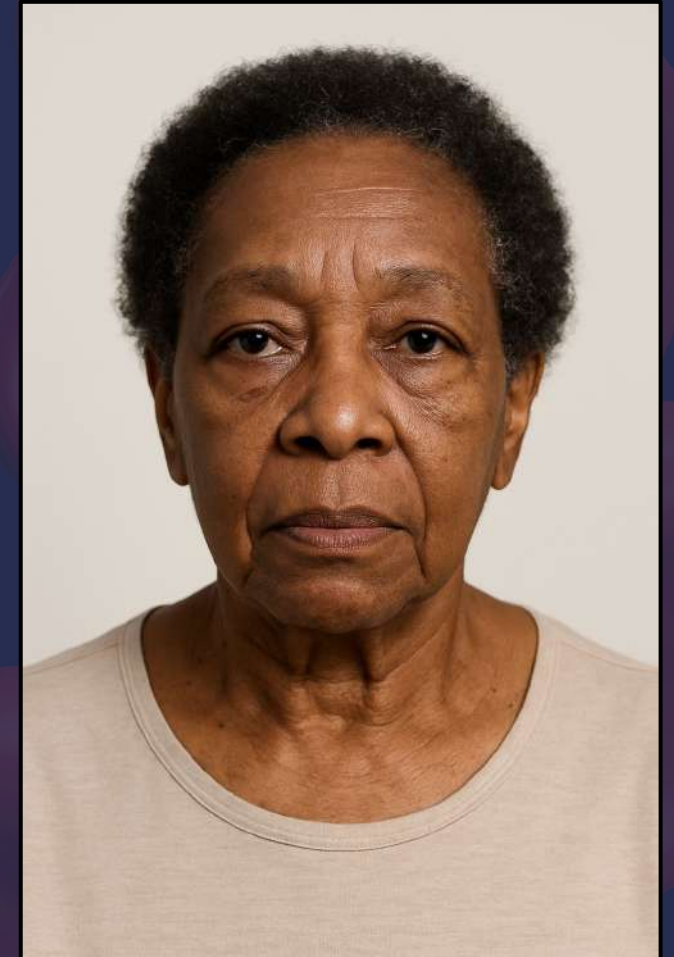
High-risk patients:

- Side effects present
- Polypharmacy
- Presence of potentially inappropriate medications
- Multiple comorbidities, neurocognitive disorder
- Recent and/or multiple hospitalizations
- Adherence challenges
- Isolated and/or frail patients

Who should you prioritise?

High-risk patients:

- Side effects present
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Deprescribing 6 steps

ENGAGE the patient and family caregivers in this process.



IDENTIFY medications to be targeted for cessation



MONITOR withdrawal events and offer support to the patient



REVIEW all current medications



PLAN tapering and withdrawal steps



CLEARLY DOCUMENT the plan and results in the electronic medical record.



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Coe A et al. BMJ Open. 2021;11(9):e052547.

Scott et al. JAMA Intern Med 2015;175:827-834.

Pravodelov V. Med Clin North Am. 2020;104(5):751-765.

Mrs. J's Case



“I struggle with constipation... and I’m constantly drinking water as my mouth feels dry”

On examination:

- Weight 75 kg, Height 165 cm
- BP: 130/80 mmHg
- HR 80 bpm

Recent labs:

- CBC - Hb 125 g/L
- Na 138 mmol/L, K 4.1 mmol/L, Ca 2.3 mmol/L
- ALT 25 IU/L,
- Valproate level 450 umol/L (350-700 umol/L N)
- HbA1C 6.8%
- Creatinine 115, uACR <2 (eGFR 44, stage IIb 2021 CKD-EPI)
- TSH 6.5 mIU/L, FT4 10 pmol/L

Mrs. J's Case



Is this an appropriate moment for reassessment of Mrs. J's medications?

When should deprescribing

Evolving situation

- Hospitalised / discharged
- Transition of care

Stable situation but...

- Request from patient or family member
- High-risk drug combinations
- Prescribing cascades
- Non-adherence
- Refills

Changes in health status

- Change in goals of care
- Change in ADL/IADL
- Emergence of new symptoms
- Progression of chronic disease
- Deterioration of renal function

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- **Refills**

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- **Emergence of new symptoms**
- Progression of chronic disease
- Deterioration of renal function

How can we approach depr

Practical tips...

- Introduce medication reassessment / optimization as first goal
 - Then if some may be ↓, simplified or stopped over time... why not!
- Involve caregiver when appropriate
- Use brochures and book follow-up for discussion/questions
- Team/Interdisciplinary work
 - Pharmacist, Nurse, Specialist...
- Be realistic & safe... start with one medication!



Engaging Patients in Depre

May start before they enter your office !

Is it time to review your medications?

Canadian Medication Appropriateness and Deprescribing Network

Medication use is a fine balance

Medications can help us in many different ways. But medications can also cause us harm. That's why it's important to weigh the potential benefits and harms of taking a medication over time.

What is medication overload?
Medication overload means taking more medications than we need. It also means taking too many medications that, together, cause more harm than good.

What are too many medications?
There is no strict number. When we take even one medication that can cause more harm than good at a particular time in our life, one can be too many.

Medication overload causes harm
Medication overload can cause drug interactions and harmful side effects. Harms from medication overload can be very serious. Some examples include:

- falls & fractures
- hospitalizations
- premature loss of independence
- confusion & memory problems
- ear aches
- death

Who is at highest risk?
People who take multiple medications, older adults, and women are at greatest risk of medication harm. The more medications we take, the greater our risk of experiencing harm.

1 in 10 hospital admissions in older adults are the result of a medication side effect*.

What can you do? Deprescribing may be an option.
Deprescribing means working with your doctor or another health care professional to stop or reduce the dose of a medication that you feel may cause you harm or is not helping you.

Version 2.0 - 2022/09/14

Flip the page for tips on preparing for a medication review.

Preparing for a medication review with your doctor, pharmacist or nurse

Canadian Medication Appropriateness and Deprescribing Network

- Book an appointment** with your doctor, pharmacist or nurse *specifically* to review your medications.
- Questions to ask yourself before your appointment:**
 - How are my medications affecting me? Am I having any problems with them?
 - If my doctor recommended that I stop taking one or more of my medications, would I be willing?
- Prepare your list of questions in advance!**
Here are **5 questions to ask your doctor, pharmacist or nurse** when starting a new medication or reviewing one you are already taking:
 - Why am I taking this medication?
 - What are the potential benefits and harms of this medication?
 - Can it affect my memory or cause me to fall?
 - Can I stop or reduce the dose of this medication (i.e. deprescribing)?
 - Who do I follow up with and when?
- Bring an up-to-date medication list to your appointment.** Ask your pharmacist for a list of all your medications, or make your own ([visit DeprescribingNetwork.ca for a sample record](https://www.deprescribingnetwork.ca)). Include over-the-counter medicines and supplements.

Remember to write down any other questions you would like to ask about your medications, too.

Learn more about deprescribing and medication safety at [DeprescribingNetwork.ca](https://www.deprescribingnetwork.ca)

References
1. Parameswaran Nair, N., Chalmers, L., Connolly, M., et al. (2016). Prediction of Hospitalization due to Adverse Drug Reactions in Elderly Community Dwelling Patients (The PANDI-ED Score). *PLoS One*, 11(10): e0195757. <https://doi.org/10.1371/journal.pone.0195757>

5 Questions to Ask About My Multiple Medications

to help make decisions together with my doctor, nurse practitioner, or pharmacist

Taking multiple medications usually means taking 5 or more medications

- What is the purpose of each of my medications?
- Could I be experiencing any side effects or drug interactions?
- Could lifestyle changes also improve my well-being?
- Are all my medications needed?
- What other information should I know about my medications?

For more information about the 5 Questions:

Click or Scan

Logos: IAMP, Institute for Safe Medication Practices Canada, deprescribing.org, CDA/AMC, Canada's Drug Agency, L'Agence des médicaments du Canada




ENGAGE patients and

Some useful questions adapted from the “Patients' attitudes towards deprescribing” questionnaire:

- Do you feel that you are taking a large number of medications ?
- Are you comfortable with the number of medications you are taking ?
- Do you believe that all your medications are necessary ?
- Do you feel that one or more medications may give you side effects or make you uncomfortable ?
- Would you agree to reduce the number of medications that you are taking with appropriate follow-up from your healthcare team ?

ENGAGE patients and care

Some useful questions adapted from the “Patients' attitudes towards deprescribing” questionnaire:

- Do you feel that you are taking a large number of medicines?
 - Are you taking more medicines than you need?
 - Do you have any side effects from your medicines?
 - Do you have any problems with your medicines?
 - Would you agree to reduce the number of medicines that you are taking with appropriate follow-up of your healthcare team?
-  **71%** of Canadian seniors are willing to stop a medication if their doctor says it is possible.
- (Sirois et al., 2016)

Deprescribing 6 steps

ENGAGE the patient and family caregivers in this process.



IDENTIFY medications to be targeted for cessation



MONITOR withdrawal events and offer support to the patient



REVIEW all current medications



PLAN tapering and withdrawal steps



CLEARLY DOCUMENT the plan and results in the electronic medical record.

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Mrs. J Medication List



Hydrochlorothiazide po 25 mg daily am

Celecoxib 100 mg po daily cc

Amlodipine 5 mg po daily

Calcium carbonate 500 mg po daily

Metformin 500 mg po tid

Vitamin D 400 units po bid

Gliclazide MR 60 mg po daily

Omeprazole 20 mg po daily am

Rosuvastatin 10 mg po daily

Solifenacin 5 mg po daily

Lorazepam 1 mg po daily hs

Divalproex 500 mg po BID

Levothyroxine 75 mcg po daily

Risperidone 2 mg daily

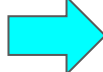

Acetaminophen 325 mg 2 tabs po tid prn

Sertraline 75 mg po daily

Match Medications and Indications

Hypertension Hydrochlorothiazide po 25 mg daily am Amlodipine 5 mg po daily	Chronic pain Celecoxib 100 mg po daily cc Acetaminophen 325 mg 2 tabs po tid prn
DM type II Metformin 500 mg po tid Gliclazide MR 60 mg po daily	Primary prevention - cardiovascular (Diabetes type II) Rosuvastatin 10 mg po daily
Anxiety Sertraline 75 mg po daily	OAB Solifenacin 5 mg po daily
Schizoaffective disorder Divalproex 500 mg po BID Risperidone 2 mg daily Sertraline 75 mg po daily	? GERD vs Gastroprotection Omeprazole 20 mg po daily am
?Insomnia Lorazepam 1 mg po daily hs	Primary prevention - bone health Calcium carbonate 500 mg Vitamin D 400 units po bid
Hypothyroidism Levothyroxine 75 mcg po daily	

Identify orphan medications

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IDENTIFY medications to be targeted for cessation

MONITOR withdrawal events and offer support to the patient

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5

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IDENTIFY medications to be targ

Consider ...

- No benefit:
 - Indication is unclear or absent
 - Ineffective (no observed improvements or evidence lacks clear benefit)
- Potentially inappropriate medications / harms outweigh benefits
 - Especially if there are signs of toxicity
 - Prescribing cascades
- Symptoms are stable or non-existent
- Preventative drugs
 - Potential benefits are unlikely because of limited life expectancy
- Individualize treatment goals and objectives
- Medication burden & cost



Which medications would you target
deprescribing?

Examples of potentially inappropriate medications

- Antihistamines (1st generation)
- Benzodiazepines / zopiclone / barbiturates
- Amitriptyline, doxepin, paroxetine
- Antipsychotics
- Sulfonylureas: glyburide, gliclazide
- Aspirine (primary prevention)
- Warfarin, rivaroxaban
- Digoxin > 0.125mg/day
- Clonidine, alpha-blockers, amiodarone
- Nitrofurantoin
- Muscle relaxants
- NSAIDs
- Estrogens
- Metoclopramide
- Proton pump inhibitors
- GI antispasmodics (ex dicyclomine)
- Mineral oil (oral)
- Anticholinergics

Mrs. J Medication List : Potentially In



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Amlodipine 5 mg po daily	Calcium carbonate 500 mg po daily
Metformin 500 mg po tid	Vitamin D 400 units po bid
Gliclazide MR 60 mg po daily	Omeprazole 20 mg po daily am
Rosuvastatin 10 mg po daily	Solifenacin 5 mg po daily
Lorazepam 1 mg po daily hs	Divalproex 500 mg po BID
Levothyroxine 75 mcg po daily	Risperidone 2 mg daily
Acetaminophen 325 mg 2 tabs po tid prn	Sertraline 75 mg po daily

Anticholinergic Burden Calculator

Recall of Mrs J: “struggles with constipation... constantly drinking water... mouth feels dry”

Anticholinergic burden calculator:
acbcalc.com/

A score ≥ 3 is associated with increased risk of cognitive issues and death

Total ACB Score: **9 High Risk**

Your patient has scored ≥ 3 and is therefore at a higher risk of confusion, falls and death.

Please review their medications and, if possible, discuss this with the patient and/or relatives/carers. Please consider if any of these medications could be switched to a lower-risk alternative.

For help choosing medicines to reduce anticholinergic burden, [click here](#)

- Drugs with possible anticholinergic burden score 1.
- Drugs with definite anticholinergic burden score 2 or 3.
- If you cannot find your medication listed in the calculator, you can assume it scores 0.

Score:	3
Medicine:	Solifenacin
Brands:	Vesicare™
<input type="text" value="Risperidone"/>	
Score:	1
Medicine:	Risperidone
Brands:	Risperdal™
<input type="text" value="Sertraline"/>	
Score:	1
Medicine:	Sertraline
Brands:	Zoloft
<input type="text" value="Lorazepam"/>	
Score:	1
Medicine:	Lorazepam
Brands:	Ativan
<input type="text" value="Metformin"/>	
Score:	1
Medicine:	Metformin
Brands:	
<input type="text" value="Celecoxib"/>	
Score:	1
Medicine:	Celecoxib
Brands:	
<input type="text" value="Omeprazole"/>	
Score:	1
Medicine:	Omeprazole

Mrs. J's Case: Identifying Prescribing

ThinkCascades: Tool for Identifying Clinically Important Prescribing Cascades Affecting Older People

Drug A	Side effect	Drug B
Cardiovascular System (n=2)		
Calcium Channel Blocker →	Peripheral edema →	Diuretic
Diuretic →	Urinary incontinence →	Overactive bladder medication
Central Nervous System (n=4)		
Antipsychotic →	Extrapyramidal symptoms →	Antiparkinsonian agent
Benzodiazepine →	Cognitive impairment →	Cholinesterase Inhibitor or memantine
Benzodiazepine →	Paradoxical agitation or agitation secondary to withdrawal →	Antipsychotic
Selective Serotonin Reuptake Inhibitor (SSRI) / Serotonin-norepinephrine Reuptake Inhibitor (SNRI) →	Insomnia →	Sleep agent (e.g., Benzodiazepines, Benzodiazepine Receptor Agonists, Sedating antidepressant, Melatonin)
Musculoskeletal System (n=1)		
NSAID →	Hypertension →	Antihypertensive
Urogenital System (n=2)		
Urinary Anticholinergics →	Cognitive impairment →	Cholinesterase inhibitor or memantine
Alpha-1 Receptor Blocker →	Orthostatic hypotension, dizziness →	Vestibular sedative (e.g., betahistine, Antihistamines, Benzodiazepines)

McCarthy LM, Savage R, Dalton K, et al. *Drugs Aging*. 2022;39(10):829-840. doi:10.1007/s40266-022-00964-9

Would you increase her levothyroxine ?

On levothyroxine 75 mcg po daily

TSH = 6.5 mIU/L

(normal range from your lab : 0.45–4.50 mIU/L)

Which target for her



Guidelines - American Thyroid Association - Key points :

- Normal TSH ranges are higher in older populations
 - 97.5% confidence interval in healthy elderly persons = 7.5 mIU/L
 - Higher TSH targets may be appropriate.
- Reasonable to ↑ TSH target to 4–6 mIU/L in persons > 70–80 years.

Endocrine Society Scientific Statement on Hormones and Aging (2023) :

“Whether the target TSH range for treated thyroid dysfunction should be the same as the range used to define thyroid dysfunction in an older individual requires evaluation”

Perspective from other guid

HAS guideline (Haute autorité de santé)



- Target = TSH within normal limits according to age
- Proposed upper limit :

65-69 years old	6 mUI/L
70-79 years old	7 mUI/L
80-89 years old	8 mUI/L
90-99 years old	9 mUI/L
≥ 100 years old	10 mUI/L



→ Online tool to identify possible tar

Working Towards Safer Deprescribing

Optimize your medication regimen with MedSafer, an App powered by science that helps identify medications that could be adjusted based on your current health priorities. MedSafer generates a customized report from proven, best prescribing practices to help you and your healthcare provider (e.g., doctor, nurse practitioner, pharmacist) create a plan for your better health.

[Start the MedSafer interview](#)



MedSafer.org

High risk medications that you may be able to deprescribe today, with the supervision of a healthcare practitioner. These are medications that can lead to falls, fractures, hospitalizations, and premature loss of independence.

Celecox, celecoxib

Regular use of NSAIDs (ibuprofen, naproxen, aspirin, celecoxib, etc.) can worsen hypertension. Talk to your healthcare provider about this type of medicine. To learn more about this class of medications, see the link below.

With chronic kidney disease there is a risk of worsening kidney function with the regular use of NSAIDs (ibuprofen, naproxen, aspirin, celecoxib, etc.). Talk to your healthcare provider about the risks and benefits of taking them. You can also discuss limiting or avoiding its short term use. To learn more about this class of medications, see the link below.

How to stop this medication

If you decide to deprescribe this medication you should let your pharmacist or physician know. It can be stopped right away and doesn't require any gradual dose reduction.

Deprescribing steps

ENGAGE the patient and family caregivers in this process.



IDENTIFY medications to be targeted for cessation



MONITOR withdrawal events and offer support to the patient



REVIEW all current medications



PLAN tapering and withdrawal steps



CLEARLY DOCUMENT the plan and results in the electronic medical record.

Farrell B et al. Am Fam Physician. 2019;99(1):7-9.

Coe A et al. BMJ Open. 2021;11(9):e052547.

Scott et al. JAMA Intern Med 2015;175:827-834.

Pravodelov V. Med Clin North Am. 2020;104(5):751-765.

At this point,
which medications would you want to discuss
reassessing first?

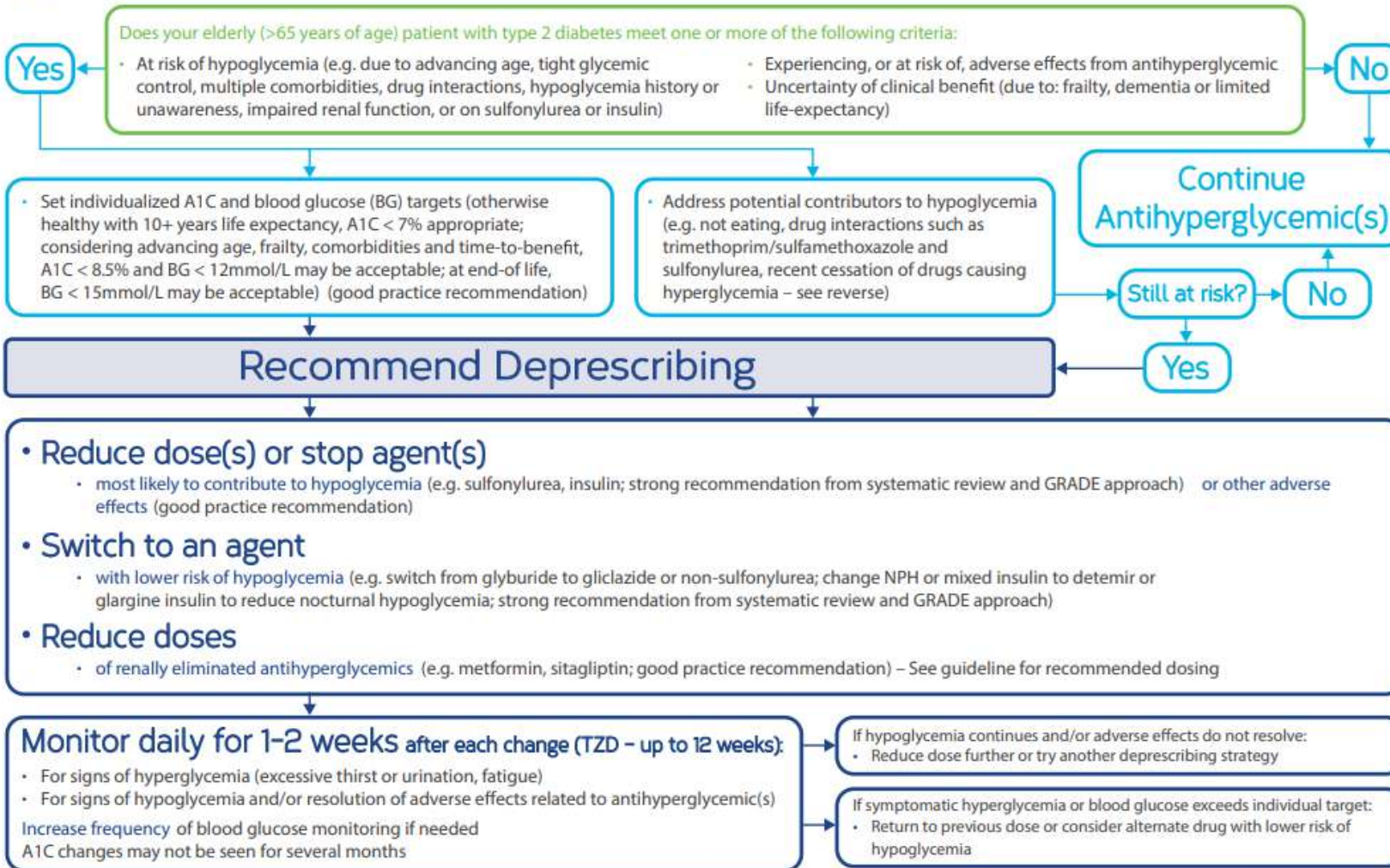
Prioritizing Deprescribing



- Make one modification at a time, whenever possible;
- Progressively discontinue treatments when there is a risk of adverse effects associated with withdrawal.
- Some useful resources for tapering available :
 - <https://deprescribing.org/>
 - <https://www.deprescribingnetwork.ca/>
 - <https://tapermd.com/>
 - <https://kiktools.amsterdamumc.org/falls/decision-tree/>

Prioritize the drug...

- Most harmful and least beneficial (presence of side effects)
- Easy to discontinue (low risk of withdrawal)
- For which the patient is willing to stop



What should we do about her gliclazide ?

HbA1C 6.8 %

Deprescribing.org
<https://deprescribing.org/wp-content/uploads/2018/08/AHG-deprescribing-algorithms-2018-English.pdf>



Mrs. J Medication List

High impact

- Stop gliclazide

- Stop solifenacin
- Stop celecoxib

- Stop Benzo

Easy to do

- Switch BP med

Difficult to do



- Stop Calcium

- Stop PPI

Low impact

Engaging the patient in depres sedatives



How would you approach Mrs. J about her sedative ?



Choosing the right words!

1. Direct approach

“I see you are taking a lot of pills. I would like to discuss them with you to reassess them and make sure that each one is still helping you.”

2. Indirect approach

“How is your sleep?... There are some new studies on sleeping pills that I want to discuss with you.”

3. Emotional approach

“Regarding your memory problems, falls, etc.... I am concerned that...”

Choosing the right words!

4. Risks and benefits

"If we reduce the dose or stop your medication, you may have more difficulty sleeping for a few nights, but we can work on that to help you sleep without medication. However, you may feel more awake in the morning and be less at risk of falling. "

5. Exploring options

"What matters most to you? Is this something you would be willing to consider?"

6. Using the EMPOWER brochure

"Read this and we'll discuss it at your next visit."

EMPOWER Brochures



You May Be at Risk


You are taking one of the following sedative-hypnotic medications:

<input type="checkbox"/> Alprazolam (Xanax®)	<input type="checkbox"/> Diazepam (Valium®)	<input type="checkbox"/> Temazepam (Restoril®)
<input type="checkbox"/> Bromazepam (Lectopam®)	<input type="checkbox"/> Estazolam	<input type="checkbox"/> Triazolam (Halcion®)
<input type="checkbox"/> Chlorazepate	<input type="checkbox"/> Flurazepam	<input type="checkbox"/> Eszopiclone (Lunesta®)
<input type="checkbox"/> Chlordiazepoxide-amitriptyline	<input type="checkbox"/> Loprazolam	<input type="checkbox"/> Zaleplon (Sonata®)
<input type="checkbox"/> Clidinium-chlordiazepoxide	<input type="checkbox"/> Lorazepam (Ativan®)	<input type="checkbox"/> Zolpidem (Ambien®, Intermesso®, Edluar®, Sublinox®, Zolpimist®)
<input type="checkbox"/> Clobazam	<input type="checkbox"/> Lometazepam	
<input type="checkbox"/> Clonazepam (Rivotril®, Klonopin®)	<input type="checkbox"/> Nitrazepam	<input type="checkbox"/> Zopiclone (Imovane®, Rhovane®)
	<input type="checkbox"/> Oxazepam (Serax®)	
	<input type="checkbox"/> Quazepam	



Other ways to help you sleep

- Try to get up in the morning and go to bed at night at the same time every day.
- Do some deep breathing or relaxation exercises before you go to bed.
- Get exercise during the day, but not during the last three hours before you go to bed.
- Read or watch TV in a chair or on your couch, instead of in your bed.
- Try not to use any substances that may keep you awake. This includes caffeine, alcohol, tobacco or other products that contain nicotine.
- Use a sleep diary to help you understand what is disrupting your sleep. Your doctor or nurse may be able to give you a sleep diary, or you can find one in our brochure, **How to get a good night's sleep without medication:** (<https://www.deprescribingnetwork.ca/sleep>).
- Check out the Sleepwell website (mysleepwell.ca), which offers online cognitive behavioural therapies to improve sleep.



Tapering program

Below is an example of tapering program for sedative-hypnotic medication. Make sure to talk to your doctor, nurse or pharmacist before you try reducing your dose or stopping your medication. Together, you will develop a plan that is right for you.

WEEKS	TAPERING SCHEDULE							✓
	MO	TU	WE	TH	FR	SA	SU	
1 and 2	●	●	●	●	●	●	●	
3 and 4	◐	●	◐	◐	●	◐	◐	
5 and 6	◐	◐	◐	◐	◐	◐	◐	
7 and 8	◐	◐	◐	◐	◐	◐	◐	
9 and 10	◐	◐	◐	◐	◐	◐	◐	
11 and 12	◐	◐	◐	◐	◐	◐	◐	
13 and 14	◐	◐	◐	◐	◐	◐	◐	
15 and 16	✗	◐	✗	✗	◐	✗	◐	
17 and 18	✗	✗	✗	✗	✗	✗	✗	

EXPLANATIONS

● Full dose ◐ Half dose ◑ Quarter of a dose ✗ No dose

You May Be at Risk 11

How to get a good night's sleep without medication



6 STEPS TO ENSURE A GOOD NIGHT'S SLEEP

STEP 1 - Start a sleep diary

Familiarize yourself with your baseline sleep profile to help you determine the best strategy to implement.

STEP 2 - Develop good sleep habits

Developing good sleep habits will improve your sleep.

STEP 3 - Dispel myths

Correct any false beliefs you may have concerning sleep.

STEP 4 - Manage daily stress

Various issues have an impact on sleep as you age: medical and psychological issues, medications, lifestyle changes (retirement for example), biological factors, or pain.

STEP 5 - Benefit from good sleep hygiene

Avoid caffeine, nicotine, alcohol and exercises before going to bed. The bedroom should be sleep-inducing: dark, quiet and at a comfortable temperature.

STEP 6 - Taper off sleeping pills

Follow the tapering-off program provided on page 19 under the supervision of your doctor or your pharmacist, if you are currently taking sleeping pills.

STEP 2 - Develop good sleep habits



1. Take an hour before going to bed to relax.

Sleepiness is a gradual process and a relaxation period before going to bed helps quiet the mind.



2. Establish a going-to-bed routine.

Once your going-to-bed routine is established, it will signal to your brain and your body that bed time is coming soon and will induce sleepiness.



3. The time to go to bed is when you feel sleepy.

Look for sleepiness signs: yawning, heavy eyelids, etc.



4. After 20 minutes of tossing and turning, get out of bed.

If you can't fall asleep, leave the room and do a non-stimulating activity: quiet reading, listening to soft music. Go to bed when you feel sleepy again.



5. Stick to a regular wake-up time.

Getting up every day at the same time notwithstanding the time you went to bed the night before is conducive to getting a good night's sleep.



6. You should not read, use devices, or watch TV in bed.

It is recommended to only use your bed for sleeping.



7. Limit naps during the day.

Time spent sleeping during the day counts in your total sleep time. Napping after dinner could disturb your night's sleep.

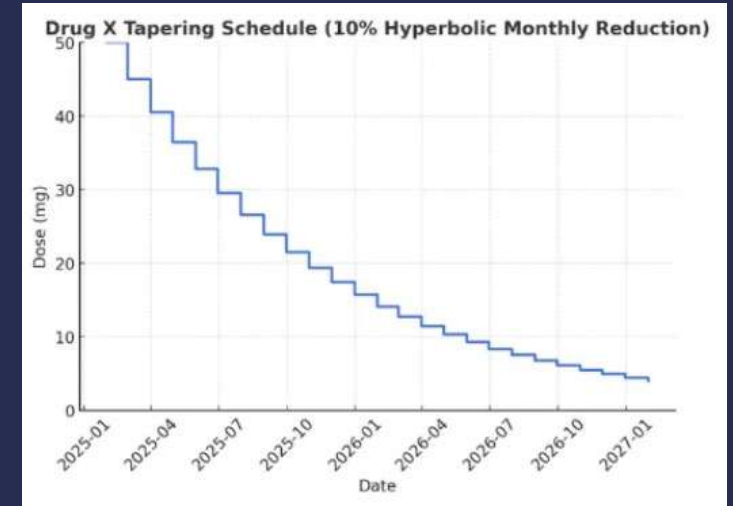


8. Time spent in bed should equal total sleep time, as much as possible.

Your sleep efficiency ratio should be above 85% on most days.

Benzodiazepines tapering : G

- **Individualize** tapering process to minimize withdrawal
- Goal = discontinuing or ↓ to lowest dose
- Initial pace of the BZD taper :
 - ↓ 5 to 10% every 2–4 weeks.
 - Should typically **NOT** exceed 25% every 2 weeks.
- Consider **pausing or slowing** taper if significant symptoms
- Consider **hyperbolic tapering** if withdrawal symptoms
- In older adults, **do NOT** switch to long-acting BZD for tapering



“ It may take months to years to fully taper off BZDs, particularly if on a high dose for an extended period of time. ”

Take your time !

BZD: Longer duration = longer a

DURATION OF USE	RECOMMENDED TAPER RATE	RECOMMENDED TAPER DURATIONS	COMMENTS
< 2 to 4 weeks	N/A	N/A	Tapering may not be required unless there are signs of (or multiple risk factors for) withdrawal syndrome
4 weeks to 6 months	10% to 25% of current BZRA dose every 1 to 2 weeks (consider slower rate at end)	1 to 3 months	Factors to be considered in deciding on rate of tapering include current BZRA dose, half-life of the agent, severity of substance use disorder or other BZRA adverse effects, emergence of withdrawal symptoms, presence of polysubstance use, drug formulation and ease of dividing/compounding, and patient preference
> 6 months	10% of current BZRA dose every 2 to 4 weeks (slower rate at end)	3 to 6 months	

Deprescribing 6 steps

ENGAGE the patient and family caregivers in this process.



IDENTIFY medications to be targeted for cessation



MONITOR withdrawal events and offer support to the patient



REVIEW all current medications



PLAN tapering and withdrawal steps



CLEARLY DOCUMENT the plan and results in the electronic medical record.

Farrell B et al. Am Fam Physician. 2019;99(1):7-9.

Coe A et al. BMJ Open. 2021;11(9):e052547.

Scott et al. JAMA Intern Med 2015;175:827-834.

Pravodelov V. Med Clin North Am. 2020;104(5):751-765.

Deprescribing Coplan!

1. Pain Management & NSAID Use

- STOP celecoxib re: renal risk (eGFR) and HTN.
- Trial topical NSAID (e.g., diclofenac gel).
- Promote non-pharmacological strategies - PT referral done

2. Diabetes / HTN / CKD

- STOP gliclazide: ↑ risk of hypoglycemia & HbA1c well-controlled
- Continue statin as indicated due to high CV risk with diabetes
- Consider switching HCTZ to ACE inhibitor or ARB, especially given DMII & CKD
- Consider addition of SGLT2

3. OAB / Anticholinergic Burden

- STOP solifenacin due to anticholinergic side effects (constipation, dry mouth)
- Solifenacin may be due to polyuria 2ary diuretic (prescribing cascade)
- If still symptomatic, trial mirabegron

Deprescribing Coplan!

4. Benzodiazepine Use (lorazepam)

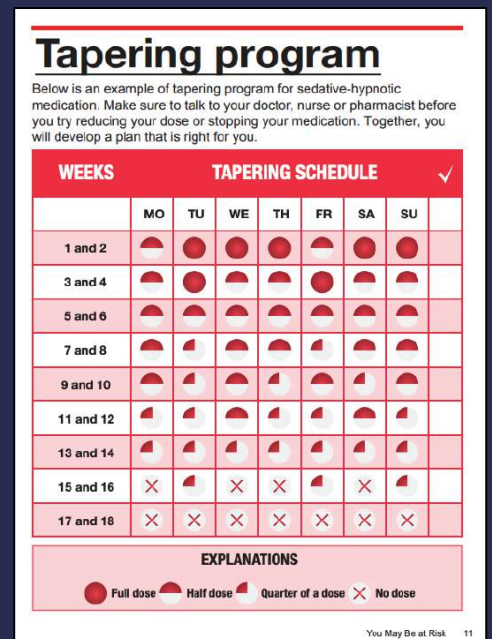
- Consider gradual tapering over several months
- ↑ risk of falls and cognitive impairment
- Encourage non-pharmacological approaches (e.g., CBT, sleep hygiene) → Brochures given

5. Anxiety/Schizoaffective disorder

- Stable mental status - Continue current regimen for now

6. Other

- Keep same dose levothyroxine
- R/A calcium supplement in favor of nutritional intake vs constipation



Deprescribing Coplan!

Monitoring & Follow-Up:

- BP, glycemic control, pain control
- HbA1c, TSH, Creatinine & lytes, eGFR, uACR in 3-6 months
- Mental health status + ADEs from psychotropics
- Consider tapering PPI if no other indication & symptomatic after stopping celecoxib
- Re-discuss benzo use at next appointment

12 years later.....



Mrs J., age 84, presents to your office to follow up post-hospitalization after a fall

- Now known with major neurocognitive disorder
- Her daughter is present with her to help with comprehension
- In the last 12 years, developed HFrEF and her DMII treatment has intensified
- 2 falls in past year
- In hospital was delirious during the nights and initiated on low-dose quetiapine
- Delirium has resolved in home environment
- Her appetite has decreased
 - Weight now 66 kg
 - BP sitting 115/78 mmHg HR 66 bpm



Mrs J., age 84, presents to your office to follow up on hospitalization after a fall

Most recent bloodwork:

- HbA1C 7.2 %
- Hb 110 g/L
- Na 138 mmol/L, K 4.1 mmol/L, Ca 2.3 mmol/L
- ALT 25 IU/L
- Valproate level 450 umol/L (350-700 umol/L)
- Creatinine 170 (eGFR 25)
- TSH 7.5 mIU/L, FT4 10 pmol/L

Family is concerned as she is not as sharp as she was and is now reliant on homecare for cleaning, medication assistance, and bathing



Clinical Frailty Scale



1

VERY FIT

People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.



2

FIT

People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.



3

MANAGING WELL

People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.



4

LIVING WITH VERY MILD FRAILITY

Previously “vulnerable,” this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up” and/or being tired during the day.



5

LIVING WITH MILD FRAILITY

People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.



6

LIVING WITH MODERATE FRAILITY

People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7

LIVING WITH SEVERE FRAILITY

Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).



8

LIVING WITH VERY SEVERE FRAILITY

Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.



9

TERMINALLY ILL

Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty**. (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.



DALHOUSIE UNIVERSITY

www.geriatricmedicineresearch.ca

Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

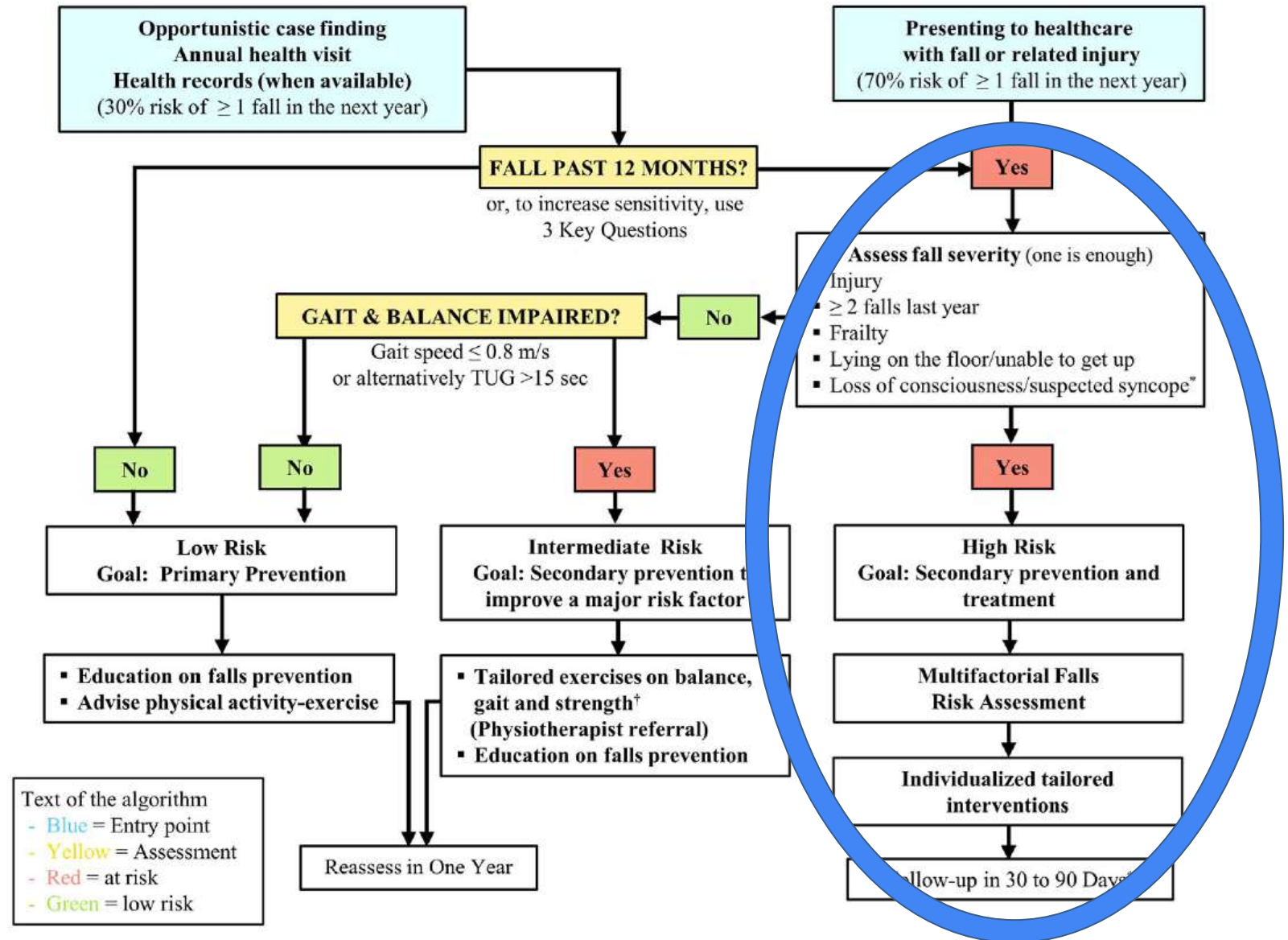
Update: Mrs. J's Current Medication

Furosemide 40 mg po daily	Levothyroxine 75 mcg po daily
Candesartan 16 mg po daily	Vitamin D 10,000 units po q 1 week
Carvedilol 25 mg po bid	Pantoprazole 40 mg po daily am
Spirolactone 25 mg po daily	Risperidone 2 mg po daily + Quetiapine 25 mg po hs prn
Semaglutide 1 mg subcutaneous q 1 week	Divalproex 500 mg po bid
Metformin 500 mg po daily	Duloxetine 60 mg po daily
Empagliflozin 10 mg po daily	Pregabalin 75 mg po bid
Insulin Lantus 25 U subcutaneous daily hs	Hydromorphone 1 mg po q4h prn
Rosuvastatin 10 mg po daily	Acetaminophen 325 mg 2 tabs po tid prn

Fall risk assessment

World guidelines for falls prevention

World guidelines for falls prevention and management for older adults



Fall risk assessment



- **2 falls in past year - “lost her balance”**
- **Orthostatic hypotension screening +**
 - Lying to standing : SBP 132 → 103 mmHg with dizziness
- **Cardiovascular and neurological assessment**
 - Peripheral neuropathy 2nd DMII
- **Using 4-wheel walker**
- **Gait / physical assessment :**
 - ↓ walking speed
 - Shuffling gait
 - Stiffness / Cogwheeling
- **Has medical alert system for fall detection**

**Which
medications
should we
reassess ?**

Which medications should w

STOPPFall

Benzodiazepines

**Benzo "related
drugs"**

Antipsychotics

Opioids

Antidepressant

Anticholinergics

Antiepileptics

Diuretics

**Alpha-blockers
(antihypertensives)**

**Alpha-blockers
(BPH)**

**Centrally-acting
antihypertensives**

Antihistamines

Vasodilators

**Overactive
bladder agents**

STOPP Criteria

Benzodiazepines

**Benzo "related
drugs"**

Antipsychotics

Opioids

Antidepressant

Anticholinergics

Antiepileptics

Diuretics

**Alpha-blockers
(antihypertensives)**

**Alpha-blockers
(BPH)**

**Centrally-acting
antihypertensives**

Antihistamines

Vasodilators

**Overactive
bladder agents**

Mrs J : Which meds to prioritize for dep with respect to fall risk ?

Assess relation with current symptoms :

- **Orthostatic hypotension**
 - Hypovolemic status - R/A furosemide dosing
 - Carvedilol (Beta + alpha blocker)
 - SGLT-2 inhibitor (empagliflozin)
 - Antipsychotic side effect
- **Extrapyramidal / Parkinsonian side effects :**
 - Quetiapine, Risperidone
- **Hypoglycemia?:**
 - R/A insulin dose
- **Gait / balance impairment (+/- drowsiness)**
 - Pregabalin
 - Hydromorphone
 - AP, (AD, divalproex)

Which HbA1C target now fo

Status	Functionally independent	Functionally dependent	Frail and/or with dementia	End of life
Clinical Frailty Scale	1-3	4-5	6-8	9
A1C target Low risk hypoglycemia (no insulin or sulfonylurea)	≤7.0%	<8.0%	<8.5%	A1C measurement not recommended. Avoid symptomatic hyperglycemia or any hypoglycemia
A1C target Higher risk hypoglycemia (on insulin or sulfonylurea)		7.1-8.0%	7.1-8.5%	

Example of deprescribing process

Short-term

Progressively with next follow-ups

Depending of symptoms/evolution :

- ↓ and stop quetiapine
- ↓ furosemide
- ↓ semaglutide
- Stop hydromorphone

- ↓ insulin (to avoid hypoglycemias)
- ↓ risperidone dose (EPS)
- ↓ pregabalin (? neuropathic component)
- ↓ HF medications +/- empagliflozin (If symptomatic orthostatic hypotension/ low BP persists)
- R/A pantoprazole

Tapering program

Here is an example of a tapering schedule for someone taking pregabalin. Speak to your doctor, nurse and pharmacist to develop a tapering plan that's right for you.

TAPERING PROGRAM EXAMPLE* (PREGABALIN)

WEEK	TIME	MO	TUE	WE
1	Morning	●	●	●
	Night	●	●	●
2	Morning	●	●	●
	Night	●	●	●
3	Morning	●	●	●
	Night	●	●	●
4	Morning	●	●	●
	Night	●	●	●
5	Morning	●	●	●
	Night	●	●	●
6	Morning	●	●	●
	Night	●	●	●

What the symbols mean:

● Full dose ● Three quarters of a dose ● Half a dose

* Do not cut your capsules. Not all dosing fractions may be available.



You May Be at Risk

You are taking one of the following medications for pain:

- Gabapentin (Neurontin®)
- Pregabalin (Lyrica®)



A GUIDE TO **deprescribing** **phn** TASMANIA **primary health TASMANIA** **CPs** Experts in Medicine

GABAPENTINOIDS

KEY POINTS

Cabapentinoids are effective for some patients with neuropathic pain, but typically only 1 in 8 patients obtain a benefit.

Amitriptyline, nortriptyline or duloxetine, or non-pharmacological strategies are often as, or more, effective than gabapentinoids.

The high renal clearance of gabapentinoids means that patients with renal impairment are at particularly high risk of accumulation and adverse effects.

Cabapentinoids are not shown to be more effective than placebo for sciatica or non-specific low back pain.

Avoid co-prescribing gabapentinoids with other CNS depressants (opioids, benzodiazepines, antidepressants).

BENEFIT VERSUS HARM

Favours Continuing Medication		Favours Deprescribing Medication	
Main Benefits Reduction in pain	Increased Benefit • use for post herpetic neuralgia or diabetic neuropathy	Decreased Benefits • Use in sciatica or non specific low back pain • Use for non-neuropathic pain • Use of low doses	
Main Harms CNS Adverse Effects and gait problems	Reduced Harm • Use of lower doses	Increased Harms • Concurrent opioid or benzodiazepine • High risk of misuse	

RECOMMENDED DEPREScribing STRATEGY

- Regardless of indication, trial dose reduction or deprescribing every 3-6 months to assess ongoing benefits and to reduce the risk of adverse effects.
- In patients without clear signs of neuropathic pain, gabapentinoids should be tapered and ceased where possible.

BACKGROUND

Use of gabapentinoids (gabapentin and pregabalin) has increased markedly since subsidisation of pregabalin on the Pharmaceutical Benefits Scheme (PBS) was introduced in 2013. In the 2020-2021 financial year, pregabalin was the 15th most prescribed medication in Australia with a total volume of over 4 million prescriptions and a total government cost

RECOMMENDED DEPREScribing STRATEGY

- Regardless of indication, trial dose reduction or deprescribing every 3-6 months to assess ongoing benefits and to reduce the risk of adverse effects.
- In patients without clear signs of neuropathic pain, gabapentinoids should be tapered and ceased where possible.

<https://www.deprescribingnetwork.ca/patient-handouts>

<https://www.primaryhealthtas.com.au/wp-content/uploads/2023/03/A-guide-to-deprescribing-gabapentinoids.pdf>

Useful resources

phn
TASMANIA

An Australian Government Initiative



**primary
health**
TASMANIA

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

Deprescribing fact sheet

A guide to deprescribing allopurinol

A guide to deprescribing anticholinergics

A guide to deprescribing anticoagulants

A guide to deprescribing antiepileptic drugs (AEDs)

A guide to deprescribing antihyperglycaemics

A guide to deprescribing antihypertensives

A guide to deprescribing antiplatelets

A guide to deprescribing antipsychotics

A guide to deprescribing benzodiazepines

A guide to deprescribing bisphosphonates

A guide to deprescribing cholinesterase inhibitors

A guide to deprescribing gabapentinoids

A guide to deprescribing glaucoma eye drops

A guide to deprescribing inhaled corticosteroids

A guide to deprescribing long-acting nitrates

A guide to deprescribing non-steroidal anti-inflammatory drugs (NSAIDs)

A guide to deprescribing opioids

A guide to deprescribing proton pump inhibitors (PPIs)

A guide to deprescribing statins

A guide to deprescribing vitamin D and calcium

Consumer resource: Managing Your Medications brochure

Consumer resource: Managing Your Medications card

Deprescribing Tools to Help You

Canadian Medication Appropriateness and Deprescribing Network

- Evidence-based tools to help ensure medications are used safely
- Patient resources in 9 different languages
- <https://www.deprescribingnetwork.ca/>

Deprescribing.org

- Deprescribing research and guidelines support healthcare providers and patients in reducing or stopping medications that may be harmful or no longer needed.
- <https://deprescribing.org/>

GERI-RxFILES 4th Edition

Assessing Medications with Older Adults

Alternatives to explore, when less may be more

2024

www.RxFiles.ca



Geri-RxFiles

- Incorporates the Beers & STOPP Criteria
- Frail older adults

Medication Related Deprescribing

Patient engagement is key!

- **Start with the easy wins.**
 - One medication at a time
 - Use non-pharmacological interventions
- **Start where the patient wants**
 - Use deprescribing guidelines and algorithms
 - Taper drugs that may cause withdrawal or rebound
 - Reasonable approach: decrease the dose by 25% at weekly intervals (or longer) with close monitoring
 - **Adjust taper rate to what works for the patient**
- **Educate patients and caregivers**
 - Reassure regarding symptoms and how to manage
 - Advise of symptoms that should be reported to prescriber or seek emergency treatment
- **Follow up for success** - *patients need to feel supported.*
 - A decrease in dose may still be considered a win!
- **Document the outcome** – med stopped? dose reduced? Update medication list.

« DEPRESCRIBING IS AN ES
GOODPRESCRIBING »

- Barbara Farrell

Make Deprescribing Happen: An Online Course for Clinicians

Making It Happen: Deprescribing Education Program

is a free, evidence-informed, interactive online course developed to increase clinicians' awareness, knowledge and skills around deprescribing.

**Asynchronous
(2-3 hours total)**

Who is this program for?

Primary care clinicians and trainees, including family physicians, clinical nurses, nurse practitioners, and pharmacists

How will I learn?

- Application of learnings in a patient case
- Interactive activities and quizzes
- Insights from deprescribing champions
- Through key tools, resources, and key concepts summaries

What will I learn?

- How to identify opportunities for deprescribing
- How to engage patients in the process
- How to use evidence-informed tools for deprescribing
- How to collaboratively develop, implement and monitor a deprescribing plan

**Learn more and register to the
FREE program here:**
daloptx.deprescribingnetwork.ca



THANK YOU!



PLEASE FILL OUT YOUR SESSION

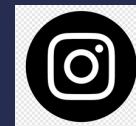
EVALUATION NOW



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