Deprescribing Guidelines – Quick reference

MidCentral District Health Board – Te Pae Hauora o Ruahine o Tararua

THINKHauora – Connecting Communities for Wellbeing

Target Patient Groups				
>75 yrs with frailty	5+ regular medicines (polypharmacy)	End-stage chronic conditions	Significant comorbidities (high Charlston Comorbidity Index)	Palliative stage or final year of life

Review Current Medications	
Medications Reconciliation	Match current medication regimen with clinical indication and appropriateness for stage of life and goals of care

Targeting Potential Inappropriate Medications (PIMS)

Cholesterol-lowering agents

STOP statins if

Primary prevention
(i.e. no IHD, stroke or TIA, or PVD)
- >75 yrs with frailty, or
- life expectancy <5 yrs.

Secondary prevention
- life expectancy <5yrs, or
- goals of care = comfort-based or symptomatic care only, or
- >75yrs with frailty syndrome
- >75yrs plus >5yrs exposure to statin with stable vascular disease
- **Adverse effect** (myopathy, falls)

STOP bezafibrate and/or ezetimibe:
- unless for prevention of pancreatitis induced hypertriglyceridaemia

No weaning required

Antiplatelets

STOP antiplatelets if

Primary prevention
(i.e. no IHD, stroke or TIA, or PVD)
- >75 yrs with frailty

Secondary prevention
- life expectancy <5yrs, or
- goals of care = comfort-based or symptomatic care only,

Adverse effects
- gastro-intestinal (GI) bleeding, or presence of anaemia exceed potential clinical benefit.

Dual antiplatelet agents
- generally cease one of the agents within 3-12 months of acute event
- If high risk of bleeding (e.g. elderly, other GI bleed inducing agents), earlier cessation may be appropriate.

No weaning required

Proton Pump Inhibitors

STOP PPI if
- Gastro-oesophageal reflux disorders (**GORD**) that has been treated for 4-8 weeks and patients have no current symptoms.
- **Peptic ulcer** disease with known underlying case removed/treated (NSAIDs, H. *pylori).*
- Prescription for **gastro-protection** due to other medications that have or can be discontinued (NSAIDs, dabigatran, oral bisphosphonates).
- Mild-to-moderate oesophagitis or reflux that can be managed with antacids / alginates.

Weaning may be required

Bisphosphonates

STOP Oral Bisphosphonate if
- Low risk of falls and/or immobility.
- No previous vertebral fractures and ≥5 yrs of treatment.
- Oral bisphosphates should not be used in patients with oesophageal disorders (achalasia, oesophageal stricture, Barrett's oesophagus, oesophageal varices).
- Avoided after certain types of bariatric surgery.
- Hypocalcaemia
- Renal impairment with CrCl < 35ml/min

No weaning required

Glycaemic Control

Recommendations
- Glycaemic targets should reflect the stage of life, including remaining life expectancy, cognitive function, functional status, falls risk and vulnerability.

Patient status	Reasonable HbA1c goal
Healthy	<58mmol/mol (7.5%)
Complex / intermediate	<64mmol/mol (8.0%)
Very complex / poor health	<69mmol/mol (8.5%)

- Hypoglycaemics should be tailored to decrease the risk of hypoglycaemia.
- Prescribing should prevent/minimise the incidence of symptomatic hyperglycaemia.
- Review sulphonylureas

No weaning required

Need assistance? Consider referral to **Primary Care Support Pharmacist** Team. Email pharmacist@thinkhauora.nz