

# QUICK REFERENCE GUIDE

## A PERSONALISED APPROACH

1	<b>CONSIDER THE PATIENT</b>	<ul style="list-style-type: none"> <li>Assess the person's life expectancy and degree of frailty.</li> <li>What are the person's goals and expectations?</li> </ul>
2	<b>CONSIDER THE MEDICATIONS</b>	<ul style="list-style-type: none"> <li>What medication is the person taking (including prescription, over-the-counter, vitamins and herbal preparations)?</li> <li>Why are they taking them (including dose, frequency and duration)?</li> <li>Are there any adverse effects or possible interactions (drug-drug or drug-disease)?</li> </ul>
3	<b>IDENTIFY POTENTIAL DRUGS TO BE CEASED/ MODIFIED</b>	<ul style="list-style-type: none"> <li>Consider the risks and benefits for individual drugs with particular attention to high risk drugs and those originally prescribed for disease prevention which may no longer be relevant/ needed.</li> <li>Prioritise drugs to establish which could be appropriately deprescribed.</li> </ul>
4	<b>PLAN AND INITIATE WITHDRAWAL TRIAL</b>	<ul style="list-style-type: none"> <li>Discuss with and seek consent from patient/carer explaining rationale and steps to take if symptoms recur.</li> <li>Develop a withdrawal plan with appropriate tapering of one medication at a time.</li> <li>Inform other health professionals involved of rationale and tapering plan.</li> </ul>
5	<b>MONITOR AND SUPPORT</b>	<ul style="list-style-type: none"> <li>Monitor progress with person with consideration of adverse effects or return of symptoms.</li> <li>Review plan with patient and ask for feedback.</li> <li>Document result of withdrawal process and move on to next medication if appropriate.</li> </ul>

	KEY POINTS	FACTORS TO CONSIDER	STRATEGY
<b>ANTIHYPERTENSIVES</b>	<ul style="list-style-type: none"> <li>Lowering blood pressure reduces risk of range of long-term consequences.</li> <li>Low blood pressure may be associated with increased morbidity and mortality in the elderly.</li> <li>Patients being treated for hypertension are more likely to fall if they have proven postural hypotension.</li> <li>Adverse effects of antihypertensives are more common in the elderly.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Lifestyle modification is beneficial and supports reduction of antihypertensives.</li> <li>✓ In patients over 85, benefits of treatment are unclear. Assess with consideration of prognosis, comorbidities and quality of life.</li> <li>✓ Patients who are frail and at high risk of falls are more likely to fall as a results of antihypertensives.</li> <li>✗ Some agents with an antihypertensive effect may have been prescribed specifically for other comorbidities.</li> </ul>	<ul style="list-style-type: none"> <li>Reduction or cessation should be considered in patients: <ul style="list-style-type: none"> <li>➤ who are frail elderly or immobile</li> <li>➤ who are at high risk of falls</li> <li>➤ who have postural hypotension.</li> </ul> </li> <li>Focus on one antihypertensive agent at a time.</li> <li>Taper at approximately 25% per month over 3 – 4 months.</li> </ul>
<b>ANTIPLATELET AGENTS</b>	<ul style="list-style-type: none"> <li>Aspirin is effective in preventing recurrence of cardiovascular events.</li> <li>The absolute benefit of prophylaxis in primary prevention is about one order of magnitude lower than for secondary prevention.</li> <li>Risk of gastrointestinal bleeding increases with age.</li> <li>The risk of major bleeding with dual antiplatelet agents is more than twice that of either agent alone.</li> <li>Recurrent minor bleeding can have a significant impact on quality of life.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Low cardiovascular event risk.</li> <li>✓ Presence of suspected adverse effect.</li> <li>✗ Five or more years life expectancy in patients who are well and functionally independent.</li> </ul>	<ul style="list-style-type: none"> <li>Consider if patient has: <ul style="list-style-type: none"> <li>➤ high risk of gastrointestinal bleeding.</li> <li>➤ low risk of cardiovascular event.</li> <li>➤ has limited prognosis.</li> </ul> </li> <li>Patients receiving dual antiplatelet therapy should have one agent ceased within 12 months of the acute event.</li> <li>Consider associated adverse effects of agents.</li> <li>Can usually be ceased without tapering.</li> </ul>

	KEY POINTS	FACTORS TO CONSIDER	STRATEGY
ANTIPSYCHOTICS	<ul style="list-style-type: none"> <li>Effective in 1 in 5 dementia patients for short term management of symptoms.</li> <li>Less effective for some types of behavioural problems.</li> <li>Non-pharmacologic therapy is as effective as antipsychotics in many patients.</li> <li>May contribute to adverse effects which mimic symptoms of dementia.</li> <li>Adverse effects may include falls, increased mortality and increased risk of stroke.</li> <li>Most patients on long term antipsychotics for BPSD can have their antipsychotics ceased.</li> <li>Discontinuation should be gradual.</li> </ul>	<ul style="list-style-type: none"> <li>Patients with adverse effects will be likely to benefit from dose reduction or cessation.</li> <li>Some patients have higher risk of adverse effects. See Antipsychotics Guide for detail.</li> <li>Patients with more severe BPSD may develop worse behaviour if dose reduction or cessation is attempted.</li> <li>Patients with a pre-dementia history of psychosis or other psychiatric disorder may worsen their underlying psychiatric condition by reduction or cessation.</li> </ul>	<ul style="list-style-type: none"> <li>Patients whose behavioural symptoms are unchanged or improving over weeks or months may benefit from trial reduction.</li> <li>Patients who no longer have troublesome BPSD may benefit from trial reduction.</li> <li>Consider a trial cessation if a person has been symptom/target behaviour free for three to six months.</li> <li>Withdrawal should be considered at least annually in all cases.</li> <li>Withdrawal should be done gradually, eg. reduce the dose by 50% every two weeks; cease after two weeks on minimum dose.</li> </ul>
BENZODIAZEPINES	<ul style="list-style-type: none"> <li>1 in 6 patients treated will have an adverse effect.</li> <li>Treating 13 patients will improve sleep quality in one.</li> <li>Non-pharmacological methods are often as effective.</li> <li>Discontinuation may result in short term changes to sleep architecture.</li> <li>Some patients may develop true withdrawal symptoms and will require more gradual dose reduction.</li> <li>Deprescribing of long term benzodiazepines may take at least 6-8 weeks.</li> </ul>	<ul style="list-style-type: none"> <li>Some patients may be aware of being dependent on benzodiazepines for insomnia and may be amenable to a weaning regimen.</li> <li>Short term benzodiazepine use may be appropriate for patients with a self-limiting stressor.</li> <li>Patients receiving benzodiazepines for other significant indications (anxiety, muscle spasm) may require continuation of the agents.</li> </ul>	<ul style="list-style-type: none"> <li>Consider if patient has overt adverse effects or has been taking benzodiazepines long term.</li> <li>A tapering strategy should be used for all patients, but the duration and amount of tapering is variable.</li> <li>Most patients will tolerate tapering by 15-20% per step over 6-8 weeks.</li> <li>If patient has withdrawal or discontinuation symptoms, return to previous tapering step for a longer period of time.</li> </ul>
BISPHOSPHONATES	<ul style="list-style-type: none"> <li>Effective in prevention of secondary fractures; one fracture avoided for every 40-90 patients treated for 1-3 years.</li> <li>Patients with 5 years of continuous oral bisphosphonate treatment will have ongoing benefit for a further 5 years after cessation.</li> <li>Where ongoing osteoporosis treatment is required, safer options should be considered.</li> </ul>	<ul style="list-style-type: none"> <li>In patients with low falls risk, there may not be ongoing benefit.</li> <li>In patients with non-vertebral fractures, and T score above -2.5, there is little ongoing benefit in the 5 years after an initial 5 years of treatment.</li> <li>Patients with a high risk of fractures eg. T score at -2.5 or below, may have ongoing benefit from treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Patients with a history of osteoporosis who have had 5 years of bisphosphonate treatment and whose risk of fracture is now low should have their bisphosphonate ceased for 5 years.</li> <li>A plan for regular monitoring of bone mineral density may be of benefit to monitor for any decline.</li> <li>Bisphosphonates can usually be ceased without the need for tapering.</li> </ul>
STATINS	<ul style="list-style-type: none"> <li>Effective for secondary prevention of cerebral and cardiac events.</li> <li>Less effective for primary prevention of cardiac and cerebral events with numbers needed to treat of the order of 70-130.</li> <li>Adverse effects are related to dose and are more frequent in patients with interacting drugs.</li> <li>The majority of the reduction of LDL in all available statins is achieved at the minimum dose.</li> </ul>	<ul style="list-style-type: none"> <li>Short estimated life expectancy.</li> <li>Poor overall functional status.</li> <li>Low cardiovascular event risk.</li> <li>Presence of suspected adverse effects.</li> <li>Life expectancy of 5 years or greater.</li> <li>High risk of recurrent events.</li> </ul>	<ul style="list-style-type: none"> <li>Minimise adverse effects by using the minimum dose of the statin.</li> <li>In patients with reduced life expectancy, a relatively low risk of cardiovascular events or with possible adverse effects, a trial cessation may be considered.</li> <li>In patients with a limited prognosis, statins should be stopped.</li> <li>Statins can usually be stopped without the need for tapering.</li> </ul>
VITAMIN D AND CALCIUM	<ul style="list-style-type: none"> <li>The combination of vitamin D and calcium is effective for non-vertebral fracture reduction.</li> <li>The combination of vitamin D and calcium reduces falls more effectively than either calcium alone or placebo.</li> <li>Calcium supplements without vitamin D are unlikely to provide benefit unless dietary calcium intake is very low.</li> <li>Vitamin D and calcium supplementation optimises the efficacy of other osteoporosis prevention strategies.</li> </ul>	<ul style="list-style-type: none"> <li>Patients with low falls risk are unlikely to benefit in reduction of fall frequency.</li> <li>It is not established that a low vitamin D level alone is an indication for supplementation.</li> <li>Severe vitamin D deficiency may contribute to osteomalacia.</li> <li>For patients receiving active osteoporosis treatment, calcium and vitamin D supplementation is likely to be required.</li> <li>Very low levels of vitamin D are associated with significant bone metabolic changes.</li> </ul>	<ul style="list-style-type: none"> <li>Assess the patient for risk of falls.</li> <li>Assess the patient's dietary intake of calcium.</li> <li>Patients should be considered for cessation if they: <ul style="list-style-type: none"> <li>have adequate dietary intake of calcium</li> <li>have low falls risk.</li> </ul> </li> <li>Vitamin D and calcium treatment can usually be ceased without the need for tapering.</li> </ul>

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