


## Deprescribing in the Elderly

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1



## Dr Vicki's First Rule of Geriatrics

- If a bad thing is happening to a patient, a drug did it until proven otherwise

2



### Age Dependent Changes in Body Composition

3


## MRS B.

- "Tennessee Triad" with STEMI 2 months ago
- In and out of the hospital
- Her PCP asked her to bring in her medication bottles to her next appointment...





4

### Do the Brown Bag Test: have your patients bring all their meds in!





- Go through
  - Medicine cabinets
  - Bedside tables
  - Kitchen table
- Include
  - Rx
  - OTC
  - Vitamins
  - Supplements



5

### Mrs. B's pill bottles

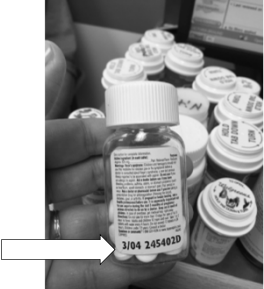



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**Brown Bag Review pays off...**

**Two months after her bare metal stent:**

- *Wonder if her cardiologist knows that her aspirin expired 11 years ago....*



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**And then, there is my dad who just puts all his pills in one bottle...**



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**So let's chat about POLYPHARMACY!**

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**Factors Contributing to Polypharmacy**

- Increasing age
- Multiple symptoms
- Multiple medical problems
- Copious prescribing
- Multiple providers
  - specialists, the VA, etc.

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**Factors Contributing to Polypharmacy (continued)**

- Lack of primary care provider to coordinate
- Use of multiple pharmacies
- Drug regimen changes
- Hoarding of medications
- Self-treatment
  - OTCs, supplements, online

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Deprescribing Step 1

**WHAT ARE THEY ACTUALLY TAKING???**

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# Annual Wellness Visit???

## ARE THEY ACTUALLY TAKING???

13

## Do the Brown Bag Test: bring the meds to the doctor



- So important that I will say it twice!!!

14

### Get one good Medication List

- Make sure you know what medications you are on and why \*
- Make sure all interested persons have a copy of the medication list
  - Electronic tools help

Medications and Allergy Information

Name of Medication*	Dose	How often taken	Last time taken

\*Include all over the counter medications and herbal supplements

Allergic to	Reaction

15

### Get one good Medication List

- Make sure you know what medications you are on and why \*
- Make sure all interested persons have a copy of the medication list
  - Electronic tools help
- **Remember, doctors can add but they can't subtract!**

Medications and Allergy Information

Name of Medication*	Dose	How often taken	Last time taken


\*Include all over the counter medications and herbal supplements

Allergic to	Reaction

16


### Encourage pill box use!

- Use a pill box if they have more than a few pills
  - Even for vitamins
- Use one pharmacy!
- Encourage your patients to get to know the pharmacist



17

### Jasper loves his pill box



18

Deprescribing Step 2!

## LOW HANGING FRUIT!!!



19

## Medication Issues: Nonessential



20

## No Geriatrics lecture is complete without a Benadryl® slide!

- Benadryl® (diphenhydramine) is Bad!
- And ubiquitous!



21

## Benadryl® (diphenhydramine)

- Anticholinergic medications
  - Dry eyes, dry mouth, constipation, urinary retention, mental confusion
  - Big cause of side effects in seniors
- It's really an allergy med!
  - Not indicated for sleep...that's just a side effect!

Should not be used routinely for sleep!



22

## Better recommendations for sleep ...



- Melatonin
  - Take after supper, before HS
- Sleep apps on phones
- CBT
- Trazodone
  - Start 25 mg qHS



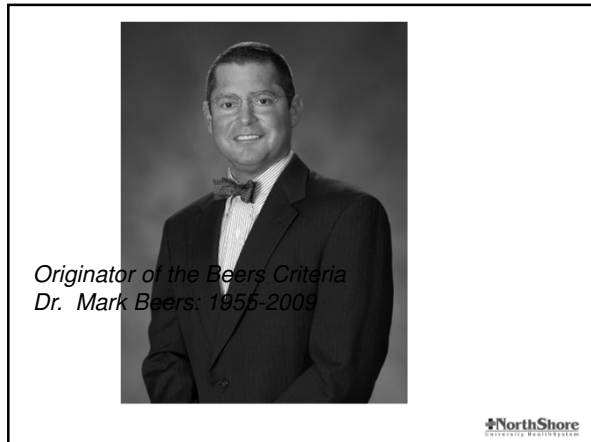
23

Deprescribing Step 2

## CLEAN UP THOSE MEDS!!!



24



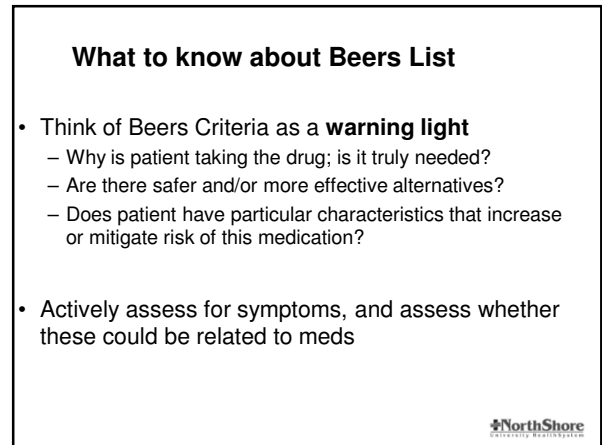
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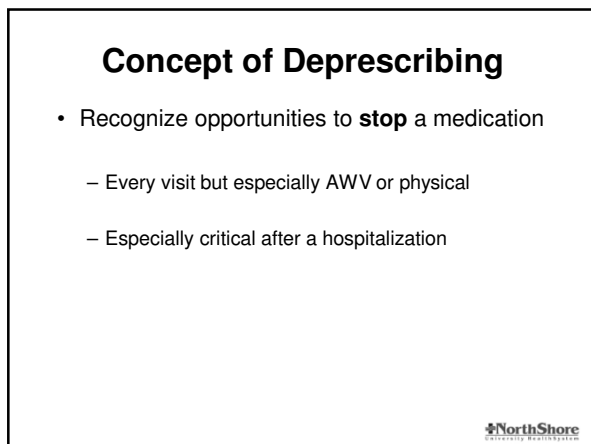
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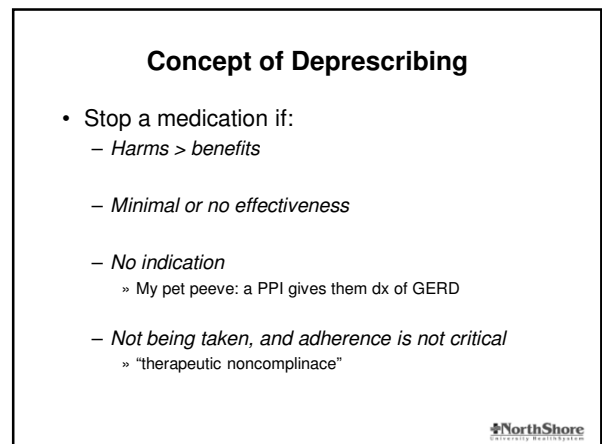
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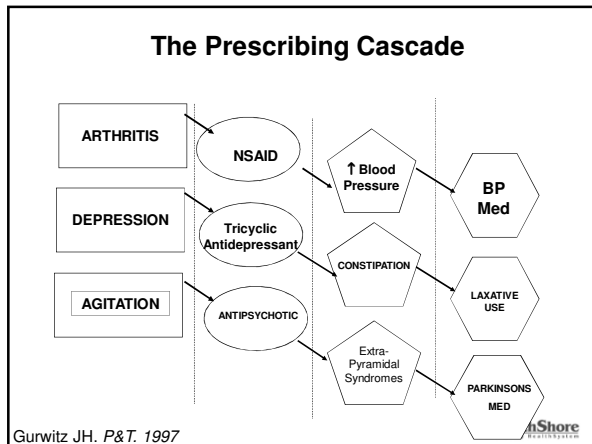
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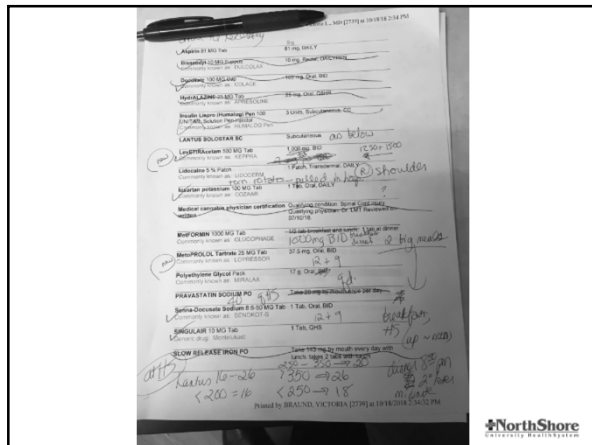
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31

- ### Examples of Medications Eligible for Deprescribing
- Bisphosphonates
    - After 5+ years or if CKD
  - Anti-allergy
    - Older folks generally outgrow allergies
  - PPIs and H<sub>2</sub> antagonists
    - A marker of a hospitalization
  - AChEI (donepezil) and memantine
    - Are they really doing anything?
  - Iron
    - Do they have IDA? Have you checked ?
  - Antipsychotics
    - Are they really “psychotic”?

32



33

- ### Concept of Deprescribing
- Plan, communicate, and coordinate:
    - Include patient, caregiver, and other healthcare providers
    - What to expect/intent
    - Instructions, e.g., how to taper
  - Monitor and follow-up
    - Withdrawal reactions
    - Exacerbation of underlying conditions

34

Deprescribing Step 3  
**SPECIFIC RESOURCES**

35

- ### Resources for Deprescribing
- Deprescribing.org**
- Algorithms
    - Benzodiazepines
    - PPIs
    - Antipsychotics
    - Antihyperglycemic agents
- Choosing Wisely**
- FOR FUN; YouTube
    - Bohemian Polypharmacy

36

## Choosing Wisely.org

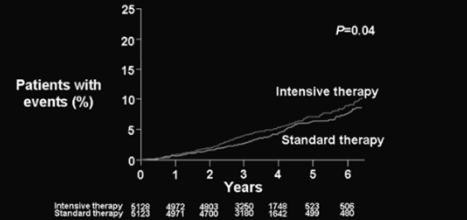
### Avoid using medications other than metformin to achieve hemoglobin A1c <7.5% in most older adults; moderate control is generally better.

There is no evidence that using medications to achieve tight glycemic control in most older adults with type 2 diabetes is beneficial. Among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycolated hemoglobin levels less than 7% is associated with harms, including higher mortality rates. Tight control has been consistently shown to produce higher rates of hypoglycemia in older adults. Given the long time frame to achieve theorized microvascular benefits of tight control, glycemic targets should reflect patient goals, health status and life expectancy. Reasonable glycemic targets would be 7.0–7.5% in healthy older adults with long life expectancy, 7.5–8.0% in those with moderate comorbidity and a life expectancy < 10 years, and 8.0–9.0% in those with multiple morbidities and shorter life expectancy.



37

## ACCORD: Death from Any Cause



ACCORD=Action to Control Cardiovascular Risk in Diabetes

ACCORD Study Group. *N Engl J Med.* 2008;358(24):2545-2559.



38

## DM Targets should reflect patient goals, health status, and life expectancy!

### • New goals:

- 7-7.5% in healthy older adults with longer life expectancies
- 7.5-8% in those with moderate co-morbidities and life expectancy <10 years
- 8-9% in those with multiple co-morbidities and short life expectancy



39

### Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.

In randomized controlled trials, some patients with mild-to-moderate and moderate-to-severe Alzheimer's disease (AD) achieve modest benefits in delaying cognitive and functional decline and decreasing neuropsychiatric symptoms. The impact of cholinesterase inhibitors on institutionalization, quality of life and caregiver burden are less well established. Clinicians, caregivers and patients should discuss cognitive, functional and behavioral goals of treatment prior to beginning a trial of cholinesterase inhibitors. Advance care planning, patient and caregiver education about dementia, diet and exercise and non-pharmacologic approaches to behavioral issues are integral to the care of patients with dementia, and should be included in the treatment plan in addition to any consideration of a trial of cholinesterase inhibitors. If goals of treatment are not attained after a reasonable trial (e.g., 12 weeks), then consider discontinuing the medication. Benefits beyond a year have not been investigated and the risks and benefits of long-term therapy have not been well-established.

ChoosingWisely.org



40

## Acetylcholinesterase Inhibitors

- Donepezil (Aricept®)
- Galantamine (Razadyne®)
- Rivastigmine (Exelon® patch, pills)



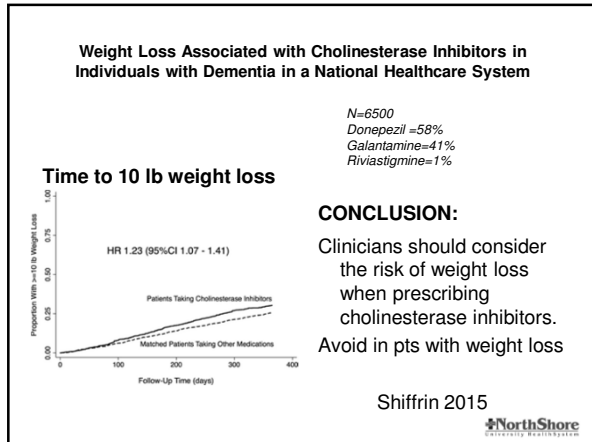
41

## Are these meds useful??

- They improve cognitive tests modestly
- All were only tested for < two years
- These outcomes are not established
  - Quality of life
  - Caregiver burden
  - Time to institutionalization
- VB notes: some families need to try these at first...
  - But don't leave the patient on forever



42



43

## Deprescribing.org

### deprescribing.org | Is a Proton Pump Inhibitor still needed?

August 2018

**What are Proton Pump Inhibitors (PPIs)?**  
Proton Pump Inhibitors, or PPIs, are a class of drugs that are used to treat problems such as heartburn or stomach acids. There are many different types of PPI drugs.

- Lansoprazole (Prevacid)
- Omeprazole (Losec)
- Pantoprazole (Protonix)
- Raboprazole (Aciphex)
- Esomeprazole (Nexium)
- Dexlansoprazole (Dexlans)
- Omeprazole (Prilosec)

**Why use less of, or stop using a Proton Pump Inhibitor?**  
While PPIs are effective at treating many stomach problems, such as heartburn, they are often only needed for a short period of time. Despite this, many people take PPIs for longer than they may need. Research shows that for some people, downs can be safely lowered or the drug used just when needed for symptoms relief. PPIs are generally a safe group of medications. However, they can cause headache, nausea, diarrhea and rash. They may also increase risk of:

- Low vitamin B12 and magnesium blood levels

**How to safely reduce a Proton Pump Inhibitor**  
People over the age of 65 who have been taking a PPI for more than 4 to 6 weeks should talk to a doctor, nurse practitioner or pharmacist about whether stopping a PPI is the right choice for them. Doctors, nurse practitioners or pharmacists can help to decide on the best approach to stop use of a PPI. They can advise on how to reduce the dose, whether to stop completely, or how to make lifestyle changes that can prevent heartburn symptoms from returning. Reducing the dose might involve taking the PPI once daily instead of twice daily, lowering the number of mg in a dose from 40mg to 20mg, or taking 20mg or 10mg for 3 days before stopping the drug, or taking the PPI every second day for some time before stopping.

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44

### deprescribing.org | Is a Benzodiazepine or Z-Drug still needed for sleep?

August 2018

**What are Benzodiazepine & Z-Drugs (BZRA)s?**  
Benzodiazepine receptor agonists & Z-Drugs, or BZRAs, are a class of drugs that are used to treat problems such as anxiety or difficulty sleeping. There are many different types of BZRA drugs.

- Alprazolam (Xanax)
- Bromazepam (Lexapro)
- Chlordiazepoxide (Librium)
- Clobazam (Rivotril)
- Clozapem (Doralene)
- Diazepam (Valium)
- Eszopiclone (Lunesta)
- Lorazepam (Ativan)
- Nimetazepam (Mogadon)
- Oxazolam (Serax)
- Tetrazepam (Briquetol)
- Tiazolam (Miltiject)
- Zolpidem (Ambien)
- Zolpidem CR (Ambien CR)

**Why use less of, or stop using a BZRA?**  
BZRAs used as sleeping pills are usually only helpful for a short period (around a week) of nightly use. After a few weeks, the brain gets used to the effects of the BZRA and it may not work as well as it did at first, but can still cause side effects. BZRAs can cause dependence, memory problems and daytime fatigue. They are also associated with dementia and falls (sometimes resulting in broken bones). The chance of experiencing these effects may be higher as people get older. Many countries recommend against using BZRAs for sleep in older people. Because BZRAs don't work as well after a few weeks and because they can cause side effects, it's important for many people, especially older people, to try and stop taking them and learn to fall asleep on their own again.

**Stopping a BZRA is not for everyone**  
Some people may need to stay on a BZRA for a very specific reason. However, most need a BZRA for a short period of time. People who may need to continue on a BZRA include those with any of the following:

- Demerged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- Anxiety that has been successfully and effectively managed with the BZRA
- Alcohol withdrawal

**How to safely reduce a BZRA**  
People between 65 and 84 years of age who have been taking a BZRA for insomnia more than a few weeks, and people 65 years of age or older taking a BZRA for insomnia regardless of how long, should talk to their health care provider about whether stopping a BZRA is the right choice for them. Doctors, nurse practitioners or pharmacists can help to decide on the best approach to using less of a BZRA. They can advise on how to reduce the dose, when to use sleep hygiene, and when to stop the drug altogether. They can also give advice on how to make lifestyle changes that can manage insomnia. Slowly reducing the dose of the BZRA helps to reduce the severity of withdrawal effects. People are more successful in stopping their BZRA if they slowly reduce the dose instead of just suddenly stopping it. Some people can reduce the dose over the course of a few weeks; others need several months. Switching from a short-acting BZRA to a long-acting one has been recommended in the past but has not been shown to be more effective than slowly lowering the dose of a short-acting drug.

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45



46



47



48