Deprescribing & Polypharmacy

Stopping a drug needs the same rigor as starting one · and it is the decision least often made

Could a drug be doing this?
ask before writing another

⚠ THE TWO IDEAS THAT DO MOST OF THE WORK

⚠ THE PRESCRIBING CASCADE

An adverse effect is **misread as a NEW medical problem** and a second drug is added to treat it. **CCB → ankle edema → diuretic. Metoclopramide or antipsychotic → parkinsonism → levodopa. Cholinesterase inhibitor → urinary urgency → anticholinergic that worsens the very cognition the first drug was for.** NSAID → raised BP → antihypertensive. **Invisible unless you look for it. The habit that prevents it: ask of EVERY new symptom, could a drug be doing this?** -before reaching for the pad.

TIME TO BENEFIT

What makes deprescribing **defensible rather than arbitrary**. Preventive drugs -statins, bisphosphonates, tight glycemic control- take **YEARS** to produce benefit, while harms and burdens start **IMMEDIATELY**. **When remaining life expectancy is shorter than the time to benefit, the drug is cost, side effects and pill burden with no realistic prospect of the outcome it was prescribed for.** Not giving up -matching treatment to the horizon, and it turns "too many tablets" into a concrete decision.

IT IS NOT ONLY ABOUT STOPPING

Under-prescribing is equally common and equally harmful, which is why the tool has two halves: **STOPP** flags inappropriate drugs, **START** flags **indicated treatments that were OMITTED**. Common omissions in exactly these patients: **anticoagulation in AF withheld over fall risk that is usually overstated**, statins where genuinely indicated, **bone protection after a fragility fracture**, ACEi/ARB in proteinuric CKD. **A review that only ever subtracts is as incomplete as one that only adds.**

HIGH-YIELD TARGETS

Class	Why, and the catch
⚠ Benzodiazepines & Z-drugs	Falls, fractures, cognitive impairment, dependence, dangerous with opioids. **Often started for a transient problem years ago and never reviewed.** Must be tapered
⚠ Anticholinergics	**Burden is CUMULATIVE** -no single drug looks dramatic, but a bladder antimuscarinic + antihistamine + tricyclic + sedating antiemetic together cause confusion, falls, retention, constipation. **Total it across the WHOLE list.** Many are over the counter, so **patients do not report them as medications -ask specifically**
⚠ Antipsychotics in dementia	**Boxed warning for INCREASED MORTALITY** in older adults with dementia-related psychosis. Reserve for genuine danger after non-drug approaches, lowest dose, and **set a review date AT prescribing** -these are the drugs most often continued indefinitely by default
Sulfonylureas & tight A1c targets	**Hypoglycemia causes falls, confusion and admissions NOW**, while the benefit of tight control takes years. **Relax the target and simplify the regimen in frailty** -an A1c that would be inadequate at 55 may be entirely appropriate at 88
PPIs · NSAIDs	PPIs started for a short course or stress-ulcer prophylaxis and continued for years -**check the original indication still applies**. NSAIDs: GI bleeding, kidney injury, heart failure decompensation, raised BP; especially hazardous with anticoagulation, renal impairment or RAAS blockade
Antihypertensives · opioids & gabapentinoids	Do not reflexively stop antihypertensives, but **reassess targets with frailty, orthostasis or falls -check LYING AND STANDING BP**, not the seated reading. Opioids and gabapentinoids: sedation, falls, cognitive effects, dependence, compounding together

THE TOOLS & WHERE THE OPPORTUNITY IS

Item	Detail
Tools	**AGS Beers Criteria (2023)** -over three dozen drugs/classes to avoid in most older people, plus 40+ to use with caution or avoid in specific conditions. **STOPP/START version 3 (2023)**, by system. **⚠ Both are prompts for thought, NOT prohibitions** -a listed drug can still be right with an explicit rationale. **Polypharmacy (commonly ≥ 5 drugs) is a risk marker, not a diagnosis**: eight appropriate drugs beat three of which two are harming, so **count to prompt the review, then judge each drug individually**
⚠ Hospital: both ways	**Admission is the best moment** -the full list is visible, and an adverse drug effect may be why they are there. **But hospital is also where lists GROW**: a PPI, an antipsychotic for one night of delirium, a laxative or a hypnotic gets carried onto the discharge summary and continued for years. **Anything started in hospital needs an explicit STOP DATE or plan in the discharge letter**
The sequence	**Get a genuinely accurate list** -ask patients to bring everything in, including OTC products, supplements, topicals, inhalers and eye drops. For each drug: **what is it for, is that indication still valid, is it working, do harms now outweigh benefit? Change ONE drug per review** so any consequence is attributable -stopping four at once and watching the patient decline tells you nothing about which one mattered

RUNNING THE TAPER · AND WHAT CHANGES NEAR THE END OF LIFE

Situation	Approach
Taper pace	**Slower than feels necessary, and slower the longer it has been taken.** A common approach is **reducing by ~a quarter of the dose at a time, holding several weeks at each step**, slowing further as the dose gets low -the last reductions are hardest. **⚠ If withdrawal symptoms appear, HOLD at the current dose rather than reversing**; returning to the starting dose surrenders the progress made
PPI step-down	Halve the dose, then **alternate days** before stopping. **Tell the patient rebound heartburn is expected for a week or two and is NOT the original disease returning** -that warning prevents an immediate self-restart. An as-needed antacid or H2 blocker covers the gap
⚠ Limited prognosis	**Time-to-benefit bites hardest here. Preventive therapy goes first** -statins, bisphosphonates, tight glycemic and BP targets- while **symptom control is protected and often expanded. The goal shifts from preventing a distant event to how the patient feels this month**, and families hear stopping a statin as abandonment unless that is said out loud
Follow up	**Book the review at the time you stop the drug**, not vaguely -deprescribing without follow-up is how a taper fails silently

⚠ WHAT MUST BE TAPERED, AND HOW TO SAY IT

⚠ NEVER STOP THESE ABRUPTLY

Benzodiazepines and Z-drugs (rebound insomnia and anxiety; seizures at higher doses), **beta-blockers** (rebound tachycardia, ischemia), **corticosteroids** (adrenal insufficiency after prolonged use), **SSRIs/SNRIs** (discontinuation syndrome, worst with short half-lives such as paroxetine and venlafaxine), **gabapentinoids and opioids**, **clonidine** (rebound hypertension), and **PPIs** (rebound acid hypersecretion). **⚠ Warn that transient symptoms are EXPECTED** -otherwise the first bad night is read as proof the drug was necessary, and it is restarted permanently.

THE CONVERSATION

Frame it as active care, not withdrawal of care. "This was right when it was started, and may now be doing more harm than good" lands very differently from "you don't need this." **Name the SPECIFIC harm** -the fall, the confusion, the bleed- because a general worry about too many tablets does not persuade. **Offer a time-limited trial, not a verdict**: "let us stop it for a month and see, and we can restart it" preserves control and is usually accepted where a permanent stop is refused. **Say explicitly you are not giving up on them. ⚠ Document WHY it was stopped** -or the next clinician restarts it.

References: American Geriatrics Society 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults · STOPP/START criteria version 3 (2023) for potentially inappropriate prescribing in older people · FDA boxed warning on antipsychotics and mortality in dementia-related psychosis.

Educational aid; verify against current guidance, local formulary and patient factors.