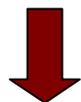
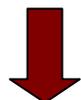


A practical guide to STOPPING MEDICATION in the elderly

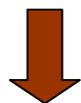
Recognise the need to stop a medicine



Reduce or stop one medicine at a time



Taper medicines when appropriate



Check for benefit or harm after each medicine has been stopped

A general guide to tapering medicine

Halve the dose. At the next scheduled visit review progress, then either:

- Maintain (at half dose)
- Continue to taper (e.g. quarter dose)
- Stop

Notes:

- View the discontinuation process as a trial
- Time taken to taper may vary from days to weeks to months

- Most medicines do not need to be used lifelong and their risk-benefit profile should be frequently reassessed by both primary and specialist prescribers
- Is there a medication that can that can be stopped?

- Try to reduce or stop only one medicine at one time. If problems develop it is then easier to identify the likely cause

- To reduce the likelihood of an adverse withdrawal event, some therapies should not be stopped abruptly following long-term use. The number of medicines to which this applies is relatively limited; important examples are seen below. (If in doubt taper, as it is safer)
- This should be done in a stepwise manner to establish if the patient's symptoms, conditions or risks can be managed with a lower dose or whether the medicine can be stopped completely

- Has the patient had any problems since the medicine has been stopped?
- Beneficial effects should be noted to reinforce that the decision to reduce or stop the medicine was correct.
- If symptoms of the initial condition return and are troublesome, despite gradual tapering, then it may be that the medicine cannot be stopped completely. The patient may however be able to be managed on a reduced dose.

Examples of drugs that require a cautious stepwise withdrawal

Drugs in this group may require specialist advice.

- Opioids/ Antidepressants / Antipsychotics / Anticonvulsants / Centrally acting antihypertensives/ Corticosteroids/ Hypnotics and tranquilisers

Antihypertensives

Why consider stopping?

- Check if there is a valid indication for prescribing- is the BP at a normal level or too low?
- Do the known possible adverse drug reactions outweigh the possible benefits? e.g. risk of falls; loop diuretic for ankle oedema – would compression hosiery be more appropriate?

General tapering guide

- If >1 antihypertensives are used, stop 1 at a time, maintaining the dose of the others without change. Restart antihypertensives if BP increases above 90 mm Hg diastolic and/or 150mm Hg systolic (160mm Hg if no organ damage).

Withdrawal effect:

- Wide range depending on the specific medicine and the condition being treated.
- Beta-blockers are often associated with adverse withdrawal events. Abrupt withdrawal may cause rebound hypertension, tachycardia, arrhythmia or angina. Gradual dose reduction is required

Reference: PrescQIPP

Benzodiazepines

Why consider stopping?

Regular and prolonged use should be avoided because of the risk of tolerance to effects, dependence and an increase risk of adverse effects

General tapering guide

- Withdrawal should be gradual in steps of about one-eighth (range one-tenth to one-quarter) of the daily dose every fortnight.
1. Transfer patient to equivalent daily dose of diazepam, preferably at night
 2. Reduce diazepam dose every 2–3 weeks; if withdrawal symptoms occur, maintain this dose until symptoms improve
 3. Reduce dose further, if necessary in smaller steps; it is better to reduce too slowly rather than too quickly
 4. Stop completely; period needed for withdrawal can vary from about 4 weeks to a year or more

Approximate equivalent doses, **diazepam 5mg**

- | | |
|---------------------------|------------------|
| • Chlordiazepoxide 15mg | • Nitrazepam 5mg |
| • Loprazolam 0.5mg – 1mg | • Oxazepam 15mg |
| • Lorazepam 0.5mg -1mg | • Temazepam 10mg |
| • Lormetazepam 0.5mg -1mg | |

Withdrawal effects

- This may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day in the case of a short-acting one.
- Characterised by insomnia, anxiety, loss of appetite and of body-weight, tremor, perspiration, tinnitus, and perceptual disturbances. Some symptoms may be similar to the original complaint and encourage further prescribing; some symptoms may continue for weeks or months after stopping benzodiazepines.

Reference: BNF 64, 2012

Useful link:

<http://www.wemerec.org/Documents/enotes/WithdrawingBenzodiazepine2009.pdf>

Oral corticosteroids

Why consider stopping?

- The consequences of the common adverse effects (such as osteoporosis, diabetes, glaucoma and gastrointestinal toxicity) may be more serious in elderly people, especially for those receiving long-term treatment

General tapering guide

The magnitude and speed of dose reduction should be determined on a case-by-case basis, taking into consideration the underlying condition that is being treated, the likelihood of relapse and the duration of corticosteroid treatment.

Gradual withdrawal should be considered in those whose disease is unlikely to relapse and have:

- received more than 40 mg prednisolone (or equivalent) daily for more than 1 week;
- been given repeat doses in the evening or received more than 3 weeks' treatment;
- recently received repeated courses (particularly if taken for longer than 3 weeks)/ taken a short course within 1 year of stopping long-term therapy;
- Other possible causes of adrenal suppression.

The dose may be reduced rapidly down to physiological doses (equivalent to prednisolone 7.5 mg daily) e.g. 2.5–5 mg every 1 to 3 days

Reduce more slowly initially if it is likely that the disease will relapse e.g. 2.5–5 mg every one to three weeks

Once the dose has reached 5–10 mg daily, reduce the dose more slowly, e.g. by 1 mg each week.

Patients on longer term treatment may require withdrawal at a more gradual rate over many months (such as a reduction of 1 mg every 1 to 4 weeks)

Withdrawal effects

Include:

Anorexia, hypotension, nausea, weakness, fever, myalgia, arthralgia, weight loss

Reference: BNF 64, 2012

Antidepressants

Why consider stopping?

- Check if there is a valid indication for prescribing. For a single episode of depression treat for 6-9 months; for multiple episodes, treat for at least 2 years, no upper duration of treatment has been identified.
- Dosulepin should not be prescribed.
- Do the known possible adverse drug reactions outweigh the possible benefits? e.g. TCAs can worsen dementia, glaucoma, constipation, urinary retention; SSRIs may induce clinically significant hyponatraemia.
- Are TCAs being taken with other medicines that have anticholinergic activity and can increase risk of cognitive impairment e.g. chlorpromazine, oxybutynin, chlorphenamine?

General tapering guide

- Dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge

For people with severe adverse reactions to treatment (e.g. cardiac arrhythmia with a tricyclic antidepressant) — a more abrupt discontinuation may be necessary.

For people on shorter half-life drugs such as paroxetine or venlafaxine a longer period is needed

For people who have been receiving longer-term maintenance treatment — may need to be tapered for much longer e.g. over 6 months.

Fluoxetine has a long half life and active metabolites therefore can be stopped abruptly. Patients taking higher doses (40 mg to 60 mg daily) may require a more gradual withdrawal.

Withdrawal effects

- Discontinuation symptoms include dizziness, nausea, paraesthesiae, anxiety, diarrhoea, flu-like symptoms, and headache. They may occur when stopping or reducing the dose of any antidepressant.
- Onset is usually around 5 days of stopping therapy. Occasionally, symptoms occur during tapering or after missed doses.
- These symptoms are usually mild and self-limiting, rarely lasting for more than 1–2 weeks. However, occasionally they can be severe, particularly if the drug is stopped abruptly.
- Discontinuation symptoms are more likely with antidepressants with a short half-life, in people who developed anxiety symptoms at the start of treatment, and in people taking other centrally-acting drugs.

Reference: BNF 64, 2012/ PrescQIPP

Useful link: <http://www.wemerec.org/Documents/enotes/Stoppingantidepressantse-notes.pdf>

Acid suppressants

Why consider stopping?

- PPIs have been implicated with an increased risk of infection including pneumonia and *clostridium difficile*.
- More recently reports have also highlighted potential increases in bone fracture rates and hypomagnesaemia seen in patients taking long-term PPIs

General tapering guide

- Tapering the dose of an acid suppressant (both PPIs and H₂RAs) is recommended because of the risk of rebound hypersecretion of gastric acid.
- A step down approach can be employed for certain patients, alongside recommendations for appropriate trials of antacids or alginates and lifestyle changes.
- Halve the dose for four to eight weeks then stop (or step down to a less potent agent)

Withdrawal effects

- Rebound hypersecretion (which may last up to 6-8weeks)
- If rebound hyperacidity is mistaken for a return of the underlying condition then acid suppressants may be restarted unnecessarily

Useful link: <http://www.wemerec.org/Documents/enotes/StoppingPPIsenotes.pdf>

Bisphosphonates

Why consider stopping?

- Check if there is a valid indication for prescribing.
- Has treatment been taken for 5 years or more?
- Do the known possible adverse drug reactions outweigh the possible benefits?
- If the patient is at low risk of falls, are these still needed?
- Prolonged immobility is a risk factor for low BMD
- Compliance is often poor

- Alendronate can be stopped abruptly without the need for tapering.

Useful link:

<http://www.wemerec.org/Documents/enotes/Stoppingbisphosphonates-notes.pdf>

Reference: PrescQIPP

Statins

Why consider stopping?

- The decision to stop a statin is based on an assessment of individual benefits and risks.
 - Stopping may be justified in a person at relatively low risk of a cardiovascular event, who is also poorly compliant or experiencing troublesome adverse effects.
 - Statins should be stopped in palliative patients
- In most cases statins can be stopped without the need for tapering

Transdermal opioids (patches)

- Strong opioids are well established in the management of cancer pain and there is increasing use in non cancer pain in primary care.
- Modified release morphine is the recommended first choice strong opioid
- There is increasing prescribing of opioid transdermal preparations, which has both safety and cost implications. (Perhaps it's because patches seem simple that we get complacent about the potential risks)

Is a transdermal patch appropriate? Can the patient be switched to oral medication?

- Patches are only for patients with **stable** pain AND significant side effects to morphine or when the oral route is unacceptable e.g. dysphagia
- They are NOT suitable for patients with unstable pain.

What are the problems associated with transdermal patches?

- Analgesic patches are all similar in their indications but vary greatly in their potency. Fever or external heat, e.g. a hot bath or sauna may increase absorption and hence increased risk of adverse effects
- Transdermal Adhesion Problems - patches do not always stay tightly bound to the skin's surface e.g. during excessive sweating

When is a transdermal patch appropriate?

- Stable analgesia requirements and swallowing difficulties or compliance issues

Note: these conversions are provided only as an approximate guide to equivalences and individual patient variability needs to be considered when switching from one opioid to another

DRUG NAME	APPROXIMATE CODEINE EQUIVALENCE	APPROXIMATE ORAL MORPHINE EQUIVALENCE
BuTrans 5micrograms/hour	60mg/24hours	10mg/24hours
BuTrans 10micrograms/hour	120mg/24hours	20mg/24hours
BuTrans 20micrograms/hour	240mg/24hours	40mg/24hours

DRUG NAME	APPROXIMATE ORAL MORPHINE EQUIVALENCE
Fentanyl 25micrograms/hour	30mg to 134mg/24hours
Fentanyl 50 micrograms/hour	135mg to 224mg/24hours
Fentanyl 75 micrograms/hour	225mg to 314mg/24hours
Fentanyl 100 micrograms/hour	315mg to 404mg/24hours

Reference: ABHB Opioid Conversion doses