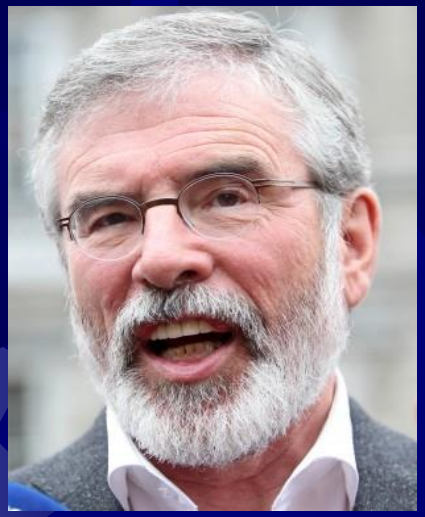
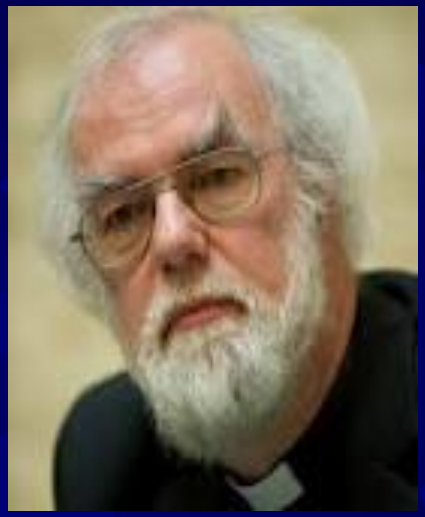
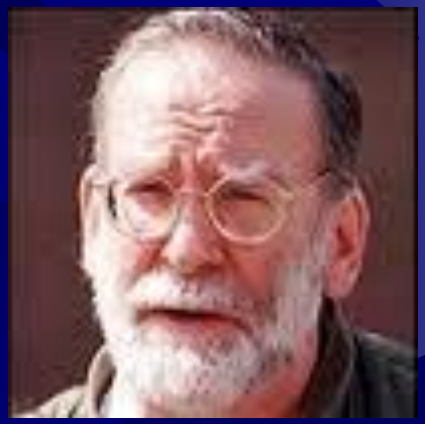
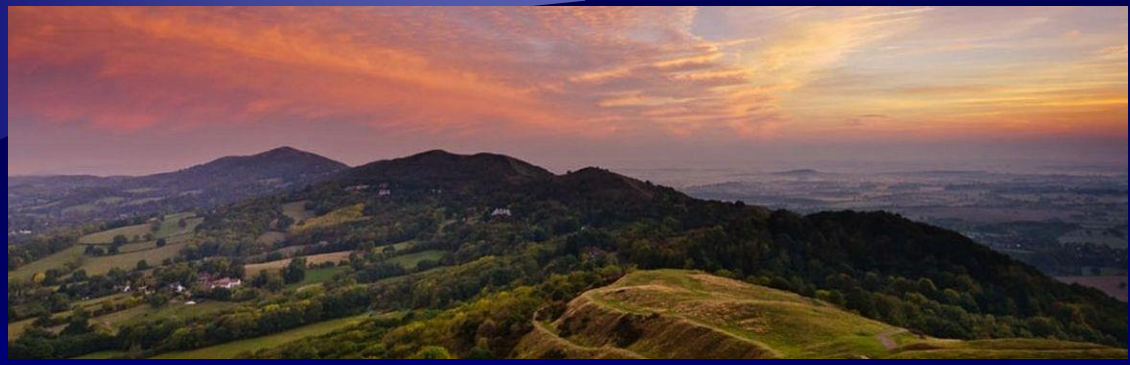
The Why, the How and the What of Deprescribing in Frailty/EOL

He comes from Wolverhampton and he is a lovely chap









Go To Your Happy Place

Mrs A, Age 84

- Previous MI (>1 year ago)
- Type 2 diabetes
- Osteoarthritis
- COPD FEV1=60%
- Depression

Mrs A's Baseline Meds

- Citalopram
- Omeprazole
- Metformin
- Inhaled Salbutamol
- LABA/LAMA or triple inhaler
- Aspirin
- Lisinopril
- Atorvastatin
- Bisoprolol
- ?Paracetamol
- NSAID gel

Mrs A's Extra Meds

- Gliptin
- Exanatide
- Insulin
- Opioids
- Steroid injections
- Tiotropium
- Combination steroid/LABA
- Amlodipine
- ?Alpha Blocker
- ?Spironolactone

But what about the function?

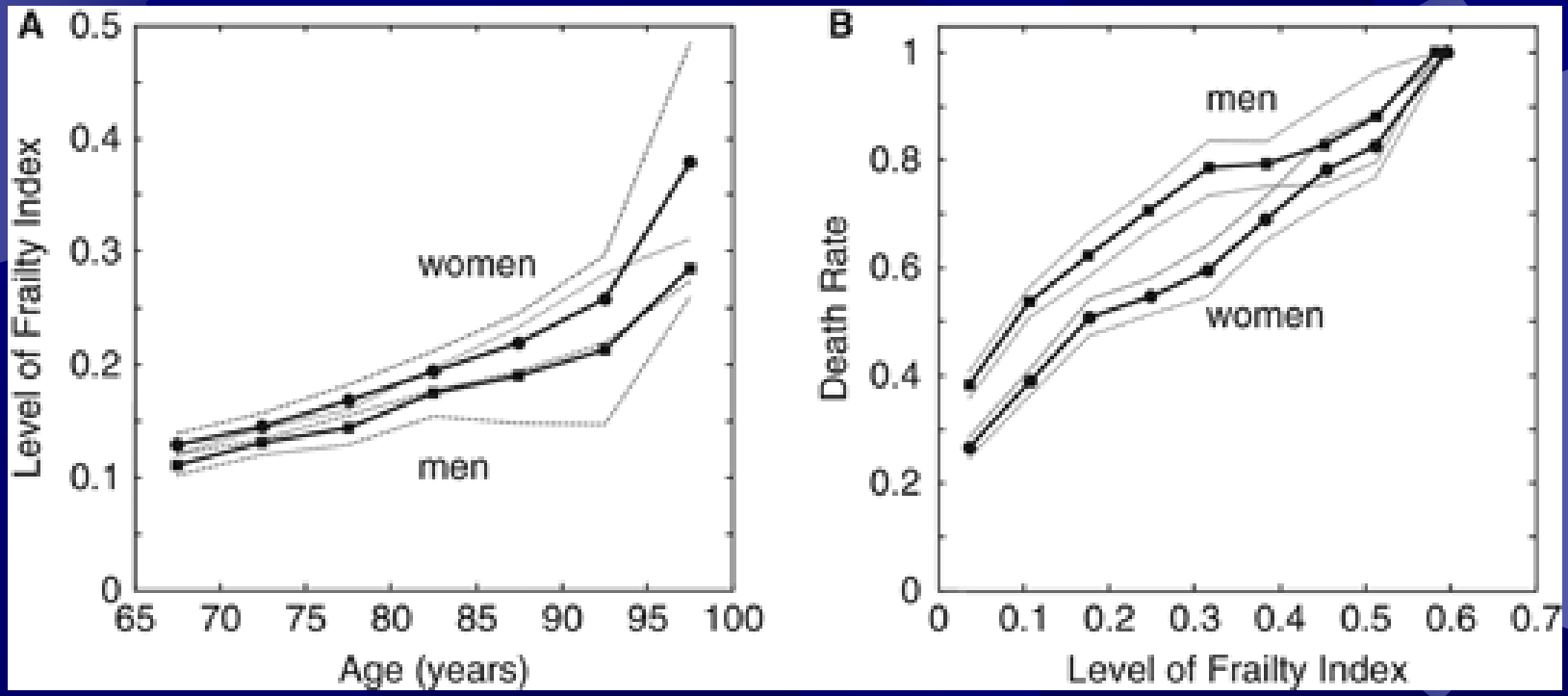
- What is the commonest reason for admission to a care home? Dementia
- What proportion of women can expect to enter a care home at some point? 1 in 3
- How many care home places are there in the UK? 500 000ish, 100 000ish nursing
- Average age of the residents? 88
- Median life expectancy in nursing care? 10 months
- Median life expectancy in residential care? 30 months

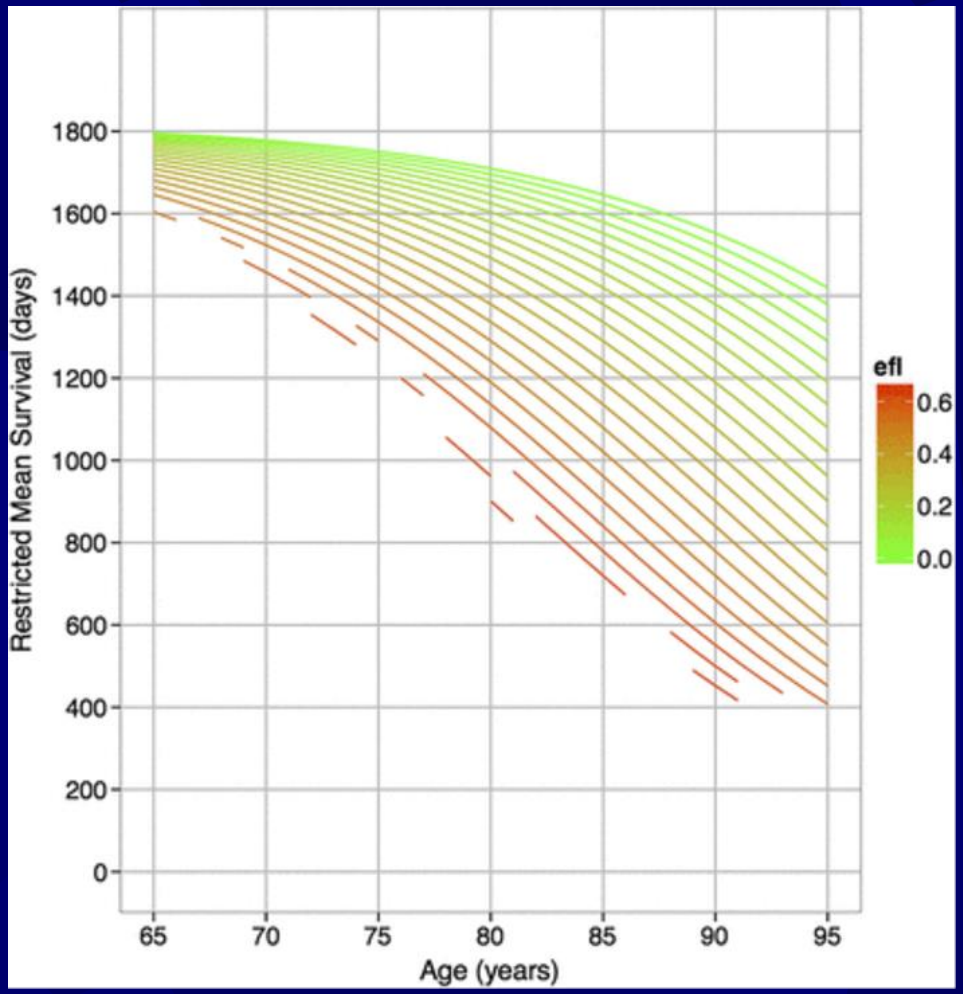
People at Home

- Same principles
- Relatives will be more aware
- May start an EOL discussion

eFI

- 100% mortality at certain scores?




Restricted Mean Survival (days)
1800
1600
1400
1200
1000
800
600
400
200
0
65
70
75
80
85
90
95
Age (years)
efl
0.6
0.4
0.2
0.0

The How of deterioration

- Severe infection
- Fading

- It's not usually the classic chronic conditions eg LVF, COPD, DM
- The "innocent" bystander

Ethical interlude

- There is no difference ethically between not starting something, and stopping it once it has been started.
- It just feels a bit different

- OR, ask yourself, “If this person was not on this medication, would I be starting it”

Not forgetting

- There's almost certainly no convincing evidence base for any medication in the scenario you find yourself in…….
- Age, multi-morbidity, function etc
- NICE multimorbidity, rather than NICE disease specific guidelines

But won’t they die if we stop the meds?

- Well yes, but no quicker than they would if they take them
- Evidence from several studies. Longer survival in non-randomised studies, no worse in randomised studies
- Hilmer S, Gnjdic D Age and Ageing (2018) **47 638-640**


FINE FOOD
WHAT IS FAR BETTER
THAN WINNING THE
LOTTERY,

Advice from a friend

- That's the difference between you and me Stuart. I would start everything and you would stop it again……
- Thanks Richard

Principles of prescribing

- Only give what they need
- Only treat symptoms
- Remember that some things are difficult to give

How

- Get residents list
- Do reviews
- Document changes
- Send letters
- Total home changes

A Word on Anticholinergic Scores

DON’T

The other organisational bits

- Leave GPs in charge
- Sell to nursing homes as “win-win”
- Practice pharmacist involvement
- Let the relatives have a say if they want – Notice in home – Few do in practice

What does matter

Dr S Hutchinson
Consultant Physician
Medicine & Elderly Care

How to do a review

- Diagnoses
- Medications, theoretical and actual
- Function – Mobility, continence, weight, behaviour +/- BP
- Maybe blood results

- Mostly about care plans and MAR charts

Cardiology

- Statins. Secondary prevention only
- Aspirin/Clopidogrel. Secondary prevention only
- Anti-anginals. Generally don’t get angina. Immobility.
- Warfarin/DOACs. Think fairly hard. Use HASBLED as well as CHADSVASC

Cardiology

- ACE/ARB. Probably no role unless blood pressure is very poorly controlled
- Bisoprolol rather than Digoxin – Watch the pulse – Low dose combinations

Diuretics

- What are they for
  - Keep for failure
  - Review for hypertension
  - Stop for swollen ankles

Respiratory

- Ask what the function is
- “Exacerbations” may be an indication that control is poor. History may not be your friend
- LAMAs, LABAs, combinations are OK for symptom relief. Review in the immobile/asymptomatic/no deterioration in the COPD element

Respiratory

- If moderate/severe dementia, then most inhalers are useless
- If no spacer, MDIs are useless

- So, if not short of breath – Stop.
- If short of breath, nebulisers/oral therapy - Prednisolone
- Carbocysteine is expensive cough medicine

Gastro

- The source of PPIs is a problem – the BOGOF phenomenon
  - Always with a PEG
  - Long term with GI bleeds
  - Care stopping in other situations
- Lactulose is evil
- Macrogols (Laxido) as default

Urinary

- Anticholinergics in the always incontinent
- Catheterised patients

Diabetes

- Aim for fasting glucose of 7-10.
- Remember that intake is erratic
- HBA1c 8.5% in old money

- Metformin can cause weight loss
- Sulphonylureas cause hypos and weight gain
- Avoid short acting insulins, alone or in combination use Insulatard in preference

Mental Health

- Anti-depressants – A problem
- Sleepers – A bigger problem
- Anti-psychotics – Much less of a problem. Don’t touch if under secondary care psychiatry
- Donepezil – Stop if MMSE patently <10
- Memantine – A problem

HOWEVER

- If old age psychiatry are involved, walk away from the psychotropic meds

Vitamins and Supplements

- Thiamine/Vit B. 28 days
- Iron. 3 months and recheck
- Folate. ????
- Calcium/Vit D. Not in those who can't stand
- B12 tablets. 1mg or bust
- Fortithing. Only from dieticians…..

Wolverhampton oddments

- DMARDS and no monitoring.
- Buprenorphine patches – Sedatives for the 2010s.

Administration

- Big pills…….
- Multiple tablets
- Expensive liquids…..

- Quantity management

No Really, How Much

- Annualised £87 000 - £100 000per year
- 85% uptake rate from GPs

- Evidence is that the savings are largely recurring – No carried over learning

Counting

- 20% reduction in pill count.
- Or around 300 000 doses per year
- No wonder the homes want us back.

NEWT

What a wonderful resource……..

Thanks

Any Questions