# DEPRESCRIBING IN PALLIATIVE CARE

*"Reignite, Reconnect and Rebuild; Strengthening Palliative Care"*

Madeleine James

# CONFLICTS OF INTEREST

# OBJECTIVES

1. Define deprescribing in the context of palliative care
2. Appreciate the impact of polypharmacy on optimal palliative care
3. Recognize barriers to deprescribing
4. Develop a stepwise deprescribing approach
5. Identify medications that can be considered for deprescribing
6. Understand practical considerations for deprescribing
7. Apply the above concepts to patient cases

"The planned and supervised process of dose reduction or stopping of medication that might be causing harm, or no longer be of benefit. Deprescribing is part of good prescribing"[1]

"The systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patients' goals, current level of functioning, life expectancy, values and preferences"[2]

# POLYPHARMACY[3,4,5]

- Excessive number of medications
- Average of 10 medications at end of life
- Unnecessary/inappropriate drugs often only discontinued in final days

**Higher Symptom Burden**

**Lower Quality of Life**

**Increased Risks of Adverse Events**

**Increased Costs**

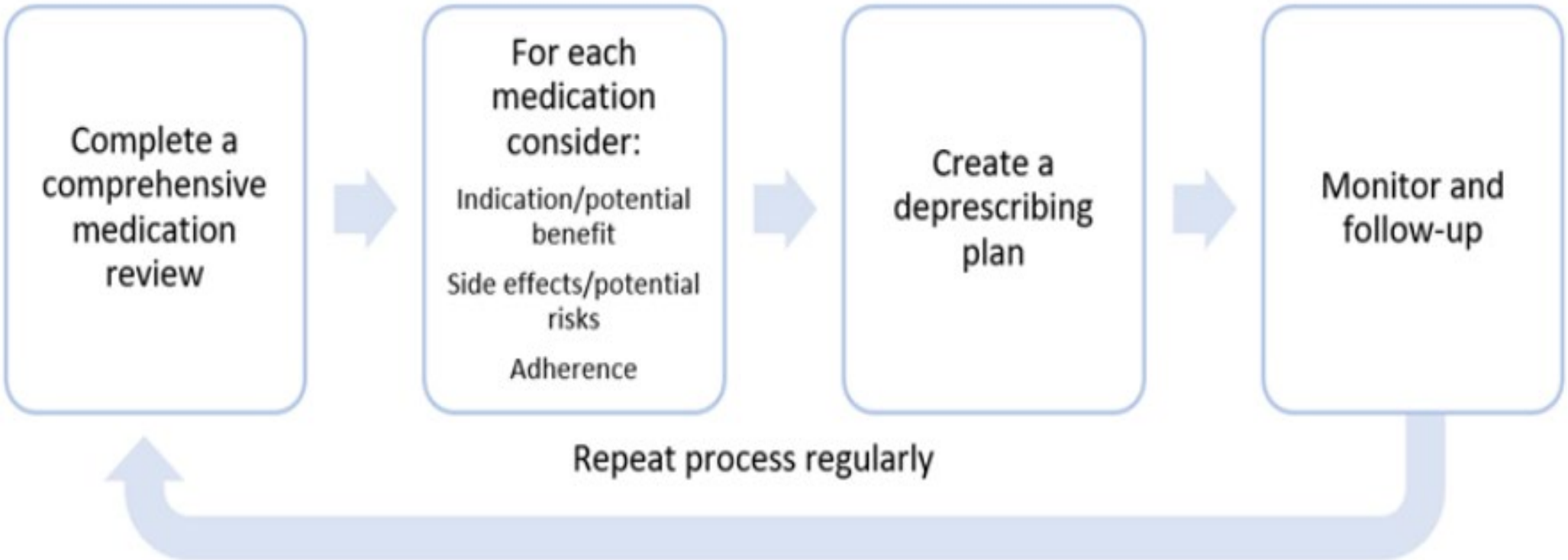
# BARRIERS TO DEPRESCRIBING[5]

- Stability
- Time
- Role Clarification
- Lack of Guidelines
- Risk of Withdrawal
- Unclear Prognosis
- Difficult Conversations

# OPTIMAL DEPRESCRIBING

- Comprehensive
- Individualized
- Patient-Centred
- Interdisciplinary
- Stepwise
- Continuous

# STEPWISE APPROACH[5]



# WITHDRAWAL/TAPERING

Examples:

- Antidepressants
- Anticonvulsants
- Acetylcholinesterase Inhibitors
- Benzodiazepines
- Beta Blockers
- Corticosteroids
- Opioids
- Proton Pump Inhibitors

# DISCUSSING DEPRESCRIBING[6]

**B**uild a foundation of trust and respect

**U**nderstand what is known about medications

**I**nform about benefits and risks

**L**isten to goals and expectations

**D**evelop a plan of care in collaboration

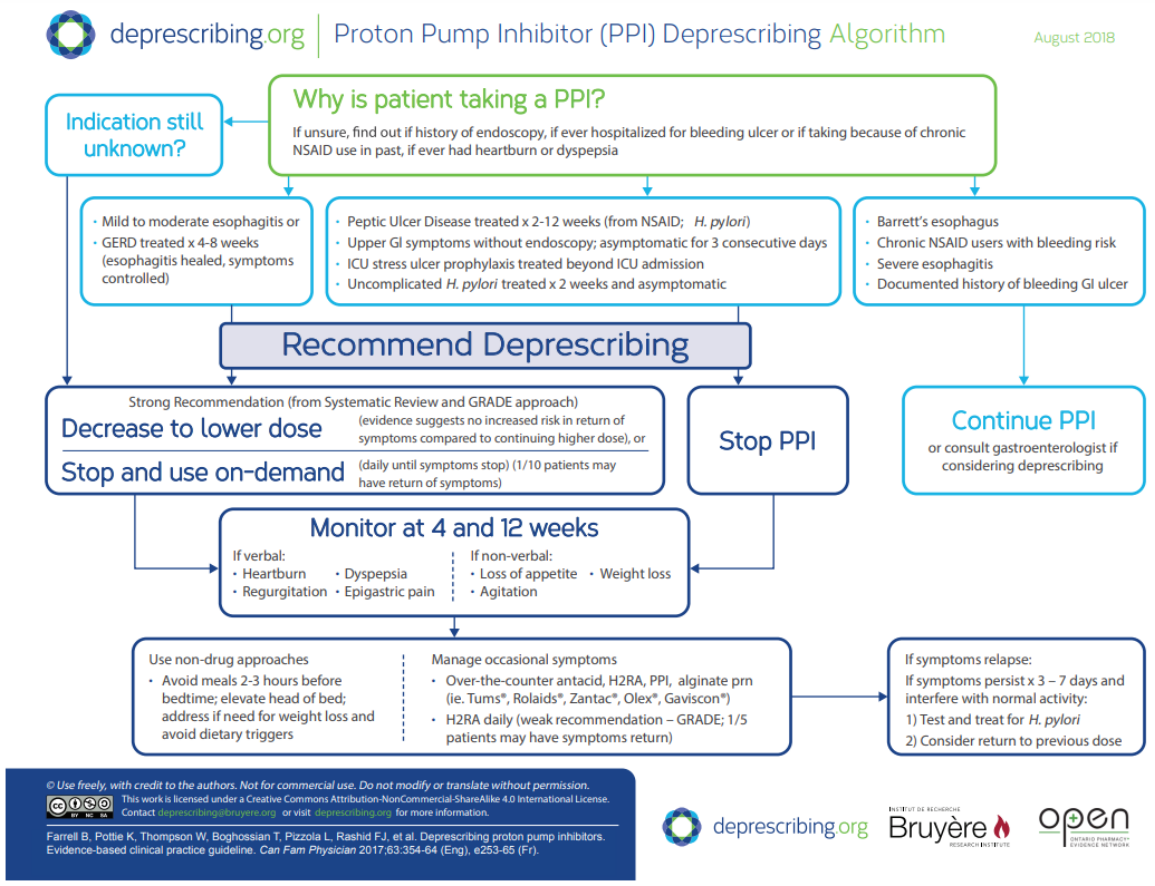
# DEPRESCRIBING TOOLS

STOPPFrail

Deprescribing.org

Medstopper.com

# DEPRESCRIBING.ORG[1]



# MEDSTOPPER.COM[7]

| Stopping Priority RED=Highest GREEN=Lowest | Medication/ Category/ Condition | May Improve Symptoms? | May Reduce Risk for Future Illness? | May Cause Harm? | Suggested Taper Approach | Possible Symptoms when Stopping or Tapering | Beers/ STOPP Criteria |
|---|---|---|---|---|---|---|---|
| | diphenhydramine (Benadryl) / Antihistamine / **allergies** |  |  |  | If used daily for more than 3-4 weeks. Reduce dose by 50% every 1 to 2 weeks. Once at 25% of the original dose and no withdrawal symptoms have been seen, stop the drug. If any withdrawal symptoms occur, go back to approximately 75% of the previously tolerated dose. | return of symptoms, runny nose, hives, itching | Details |

# STOPPFRAIL[8]

**STOPPFrail is a list of potentially inappropriate prescribing indicators designed to assist physicians with stopping such medications in older patients (≥65 years) who meet ALL of the criteria listed below:**

1. End-stage irreversible pathology
2. Poor one year survival prognosis
3. Severe functional impairment or severe cognitive impairment or both
4. Symptom control is the priority rather than prevention of disease progression

**The decision to prescribe/not prescribe medications to the patient, should also be influenced by the following issues:**

1. Risk of the medication outweighing the benefit
2. Administration of the medication is challenging
3. Monitoring of the medication effect is challenging
4. Drug adherence/compliance is difficult

# OPTIMAL MEDICATION USE[1]

- Focus more on symptom management and quality of life
- Focus less on prevention and quantity of life
- Benefits outweigh risks
- Realistic time to benefit
- Flexible administration
- Reduced pill burden
- Reduced risk of withdrawal

# ESSENTIAL MEDICATIONS[9]

| Essential Medications | Previously Thought To Be Essential Medications | Non-Essential Medications |
|---|---|---|
| Analgesics | Antiarrhythmics | Antibiotics |
| Antiemetics | Anticonvulsants | Anticoagulants |
| Antipsychotics | Antihypertensives | Antiplatelets |
| Anxiolytics | Antiparkinsonian medications | Antidepressants |
| Sedatives | Corticosteroids | Antisecretory agents |
| | Diuretics | Bisphosphonates |
| | Immunosuppressants | Hormone replacement therapy |
| | Insulin | Iron supplements |
| | NSAIDs | Vitamins |
| | Oral hypoglycemics | Lipid-lowering agents |

# CASES

# CASE #1: MRS. A

85-year-old female with metastatic breast cancer to liver and bone. From home with husband. Patient is no longer receiving curative treatment and focus is on quality of life. You are in today to visit the couple at home. Patient reports more fatigue and progressively spending more time napping. Appetite has remained low. Patient feels she is taking a lot of medications and asks if all of them are still required. She admits to missing medications frequently.

**Past Medical History**

- Metastatic Breast Cancer
- Diabetes
- Hypertension
- Dyslipidemia
- Osteoporosis
- Hip Fracture
- Anxiety
- Gout

**Relevant History**

- Blood Pressure = 110-130/50-70s (last 3 months)
- HBA1C = 7.2 (2 months ago)
- Does not do regular glucose checks
- LDL = 1.8 (6 months ago)
- Weight = 50 kg
- Creatinine = 75, Na = 134, K = 4.0 (1 month ago)
- Urate = 365 (1 month ago)
- Known for frequent gout attacks

# CASE #1 MEDICATION LIST

| Medication | Indication |
|---|---|
| Hydromorph Contin 3 mg PO BID | Pain/Dyspnea |
| Hydromorphone 0.5 mg PO Q2H PRN | Pain/Dyspnea |
| Metoclopramide 5 mg PO Q6H PRN | Nausea |
| Sennosides 17.2 mg PO QHS | Constipation |
| PEG 17 grams PO daily | Constipation |
| Escitalopram 10 mg PO daily | Anxiety |
| Lorazepam 0.5 mg PO BID PRN | Anxiety/Dyspnea |
| Rosuvastatin 10 mg PO QHS | Dyslipidemia |
| Hydrochlorothiazide 25 mg PO daily | Hypertension |
| Metformin 500 mg PO BID meals | Diabetes |
| Calcium Carbonate 1000 mg PO daily | Osteoporosis |
| Cholecalciferol 1000 units PO daily | Osteoporosis |
| Risedronate 35 mg PO QSaturdays | Osteoporosis |
| Allopurinol 200 mg PO daily | Gout |

# CASE #1 QUESTION

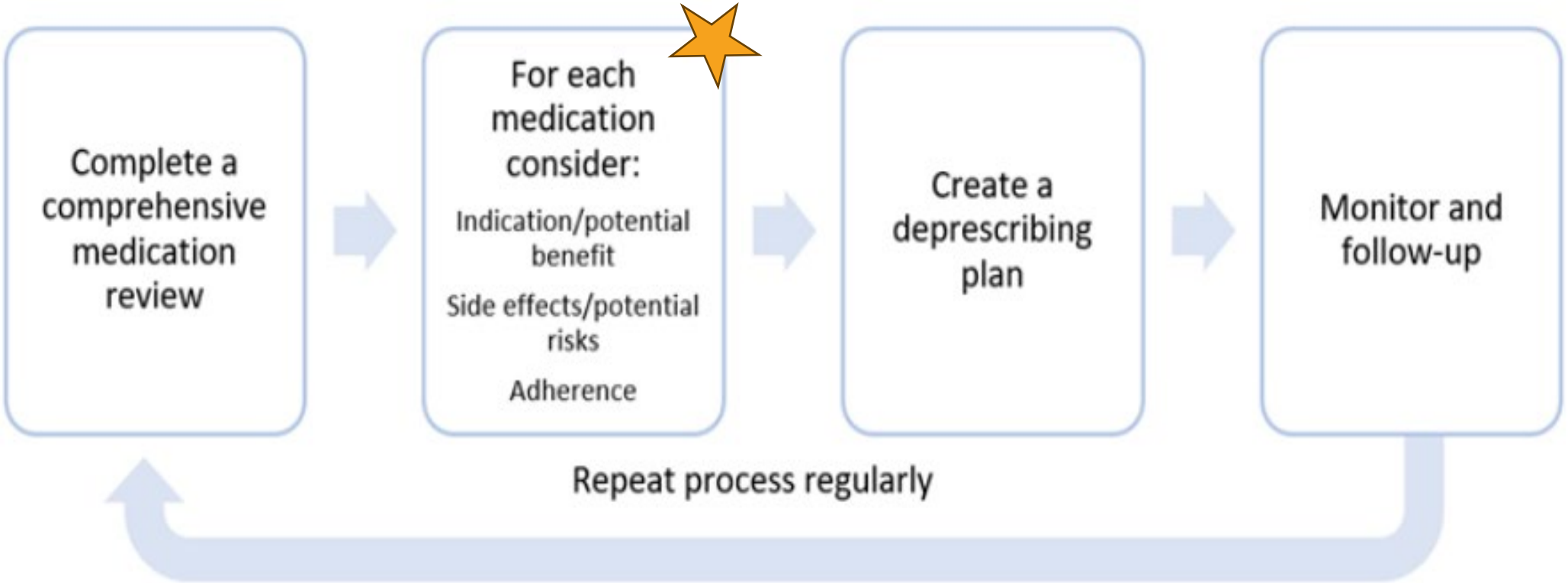
What medications would you consider deprescribing at this time?

A. Rosuvastatin
B. Escitalopram
C. Risedronate
D. Allopurinol
E. Cholecalciferol
F. Calcium Carbonate
G. Hydrochlorothiazide
H. Metformin

Go to **wooclap.com** and use the code **MTJQBX**

# CASE #1 LINK

# STEPWISE APPROACH[5]



# CASE #1 REVIEW

| Medication | Indication/Benefits | Side Effects/Risks | History/Factors | Plan |
|---|---|---|---|---|
| Rosuvastatin | Cardiovascular Prevention | Muscle Pain | Target LDL<br>Liver Metastases | |
| Hydrochlorothiazide | | Hypotension/Falls<br>Dehydration/Electrolyte Abnormalities<br>Hyperuricemia | Tight Blood Pressure Control<br>Low Intake/Renal Function<br>Low Sodium<br>Frequent Gout Attacks | |
| Metformin | Glucose Management | Hypoglycemia<br>GI Symptoms | Target HBA1C<br>Liver Metastases<br>Low Intake/Renal Function | |
| Calcium Carbonate | Fracture Prevention | Constipation<br>Hypercalcemia | Cost | |
| Cholecalciferol | | - | Cost | |
| Risedronate | | Esophageal/GI Irritation | Function/Mobility<br>Renal Function<br>Long Half-Life | |
| Escitalopram | Anxiety Symptoms | Various Side Effects<br>Risk of Withdrawal | Trajectory/Prognosis | |
| Allopurinol | Gout Attack Prevention | - | Target Urate<br>Frequent Attacks | |

# CASE #2 MR. B

Mr. B is a 75-year-old male with metastatic prostate cancer extensive to bone. Admitted to hospital for anticipated end-of-life care with focus on comfort. Dexamethasone was stopped two weeks ago due to increasing agitation at home. Patient is eating 25% or less of meals. Wife has informed you that medications are now needing to be crushed in applesauce. Patient is functionally bedbound and a foley catheter was inserted two days ago due to urinary retention.

**Past Medical History**

- Metastatic Prostate Cancer
- Benign Prostatic Hyperplasia
- Anemia
- Hypertension
- Hypothyroidism

# CASE #2 MEDICATION LIST

| Medication | Indication |
|---|---|
| Morphine 5 mg PO or 2 mg subcut Q4H | Pain/Dyspnea |
| Morphine 5 mg PO or 2 mg subcut Q2H PRN | Pain/Dyspnea |
| Haloperidol 0.5 mg subcut Q4H PRN | Nausea/Agitation |
| Glycopyrrolate 0.4 mg subcut Q4H PRN | Secretions |
| Moi-Stir Spray 2 sprays PO PRN | Dry Mouth |
| Lactulose 30 mL PO BID | Constipation |
| Bisacodyl 10 mg PR daily PRN | Constipation |
| Tamsulosin 0.4 mg PO QHS | Benign Prostatic Hyperplasia |
| Dutasteride 0.5 mg PO daily | Benign Prostatic Hyperplasia |
| Levothyroxine 100 mcg PO daily | Hypothyroidism |
| Ferrous Fumarate 300 mg PO QHS | Anemia |
| Pantoprazole 40 mg PO daily | Unclear |

# CASE #2 QUESTION

What medications would you consider deprescribing at this time?

A. Tamsulosin
B. Dutasteride
C. Levothyroxine
D. Ferrous Fumarate
E. Pantoprazole

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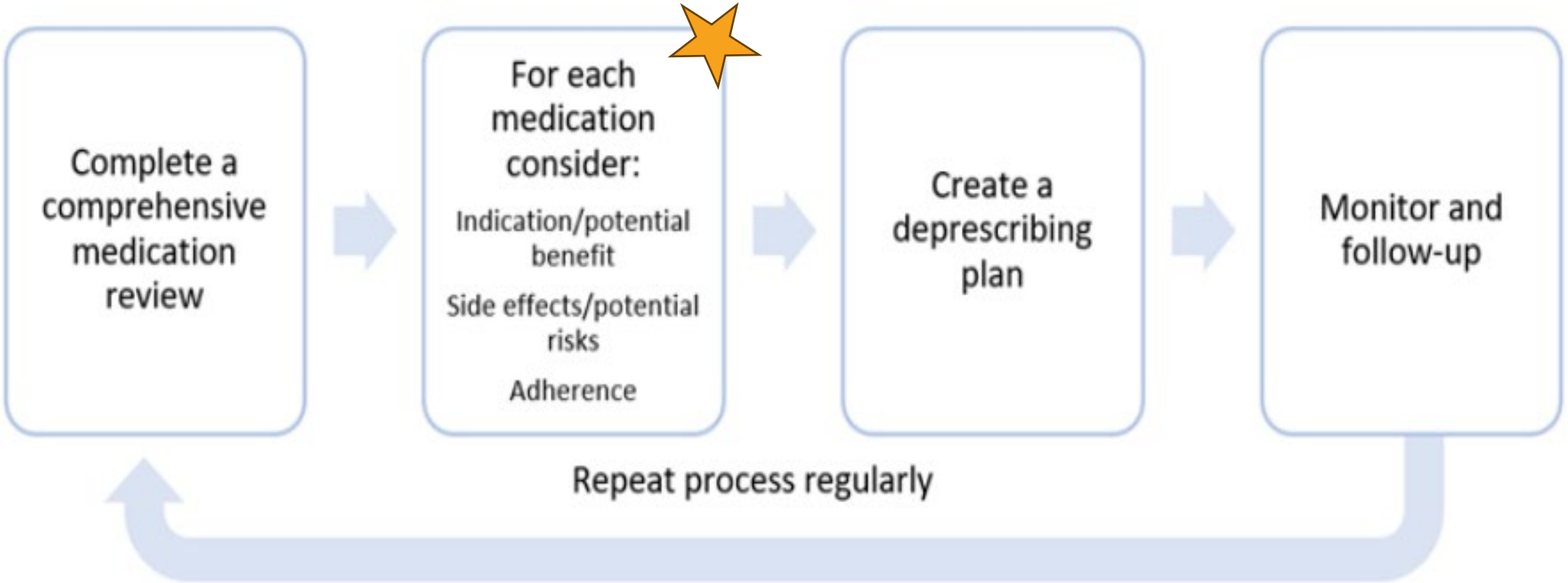
# CASE #2 LINK

# STEPWISE APPROACH[5]



# CRUSHING MEDICATIONS[10]

- Enteric/Extended-Release Coatings
- Taste
- Gastrointestinal Irritation
- Occupational Hazard

# CASE #2 REVIEW

| Medication | Indication | Administration | Factors | Plan |
|---|---|---|---|---|
| Tamsulosin | BPH Symptoms | Do not crush | Foley Catheter | |
| Dutasteride | BPH Symptoms | Do not crush | | |
| Ferrous Fumarate | Chronic Anemia | Do not crush | Liquid Available<br>Goals/Trajectory<br>Constipation/GI Upset | |
| Pantoprazole | Unclear | Do not crush | Unknown Indication<br>(Dexamethasone History) | |
| Levothyroxine | Hypothyroidism | Can crush | Unknown TSH<br>Hypothyroidism Symptoms | |

# CASE #3 MRS. C PART I

Mrs. C is an 83-year-old female with end-stage COPD. From home with daughter and grandchildren. Admitted to hospital due to failure to cope and ongoing dyspnea. Mostly bedbound but still able to get to bathroom with assistance. No issues taking oral medications and still eating 50% of meals. Family visits often and patient is enjoying meaningful time with them. Focus is primarily on comfort and quality of life.

**Past Medical History**

- Chronic obstructive pulmonary disease (COPD)
- Ex-Smoker
- Heart Failure (preserved EF)
- Atrial Fibrillation
- Stroke (3 years ago)
- Hypertension
- Dyslipidemia
- Anemia
- GERD

**Relevant History**

- Blood Pressure = 121/72 (on admission)
- Heart Rate = 71 (on admission)
- Creatinine = 86 (2 months ago)
- Hgb = 95, Plt = 256 (2 months ago)
- Weight = 65 kg
- Minor bruising but no bleeding
- On home oxygen

# CASE #3 MEDICATION LIST

| Medication | Indication |
|---|---|
| M-ESLON 30 mg PO BID | Dyspnea |
| Morphine 5 mg PO or 2 mg subcut Q2H PRN | Pain/Dyspnea |
| PEG 17 grams PO BID | Constipation |
| Prednisone 20 mg PO daily | COPD |
| Trelegy Ellipta 1 inhalation daily | COPD |
| Salbutamol MDI 2 inhalations Q4H PRN | COPD |
| Furosemide 40 mg PO BID (QAM/Noon) | Heart Failure |
| Spironolactone 25 mg PO daily | Heart Failure |
| Bisoprolol 5 mg PO daily | Atrial Fibrillation |
| Apixaban 5 mg PO BID | Atrial Fibrillation |
| Pantoprazole 40 mg PO daily | Gastroprotection/Reflux |

# CASE #3 PART I QUESTION

Would you recommend to discontinue anticoagulation at this time?

A. Yes

B. No

Would you recommend to discontinue the beta-blocker at this time?

A. Yes

B. No

# ANTICOAGULATION II


**PERCENT PER YEAR**

| **therapy option** | **net clinical benefit** (strokes prevented per major bleed caused) | annual risk of **stroke/embolism** | annual risk of **major bleeding** (intracranial bleeding, bleeding requiring hospitalization, HgB decrease of > 20 g/L, or need for transfusion) |
|---|---|---|---|
| no therapy | n/a | 12.9% | 0.4% |
| apixaban | 3.9 | 3.4% | 2.8% |

# RATE CONTROL

- Symptom Management
  - Palpitations
  - Chest pain
  - Dizziness
- Side Effects
- Withdrawal Considerations

# CASE #3 PART 2

Mrs. C has remained on the unit for the last month with a gradual overall decline. Multiple falls during admission due to attempting to get out of bed without assistance. Recently declining more rapidly with confusion and somnolence. Family has decided on no further investigations or active management. Focus is on comfort. Now bedbound and mostly only taking sips of liquids. Still able to take oral medications but with increasing difficulty.

**Past Medical History**

- Chronic obstructive pulmonary disease (COPD)
- Ex-Smoker
- Heart Failure (preserved EF)
- Atrial Fibrillation
- Stroke (3 years ago)
- Hypertension
- Dyslipidemia
- Anemia
- GERD

# CASE #3 MEDICATION LIST

| Medication | Indication |
|---|---|
| Hydromorphone CADD subcut rate: 0.5 mg/hour + PCA 0.5 mg Q1H PRN | Dyspnea |
| Methotrimeprazine 5 mg subcut Q2H PRN | Agitation/Nausea |
| Midazolam 1 mg subcut Q1H PRN | Agitation/Dyspnea |
| Scopolamine 0.4 mg subcut Q4H PRN | Secretions |
| Sennosides 17.2 mg PO QHS | Constipation |
| Moi-Stir Spray 2 sprays PO PRN | Dry Mouth |
| Dexamethasone 3 mg subcut daily | COPD |
| Trelegy Ellipta 1 inhalation daily | COPD |
| Salbutamol MDI 2 inhalations Q4H PRN | COPD |
| Furosemide 20 mg subcut daily | Heart Failure |
| Famotidine 10 mg subcut BID | Gastroprotection/Reflux |
| Apixaban 5 mg PO BID | Atrial Fibrillation |
| Bisoprolol 2.5 mg PO daily | Atrial Fibrillation |

# CASE #3 PART 2 QUESTION

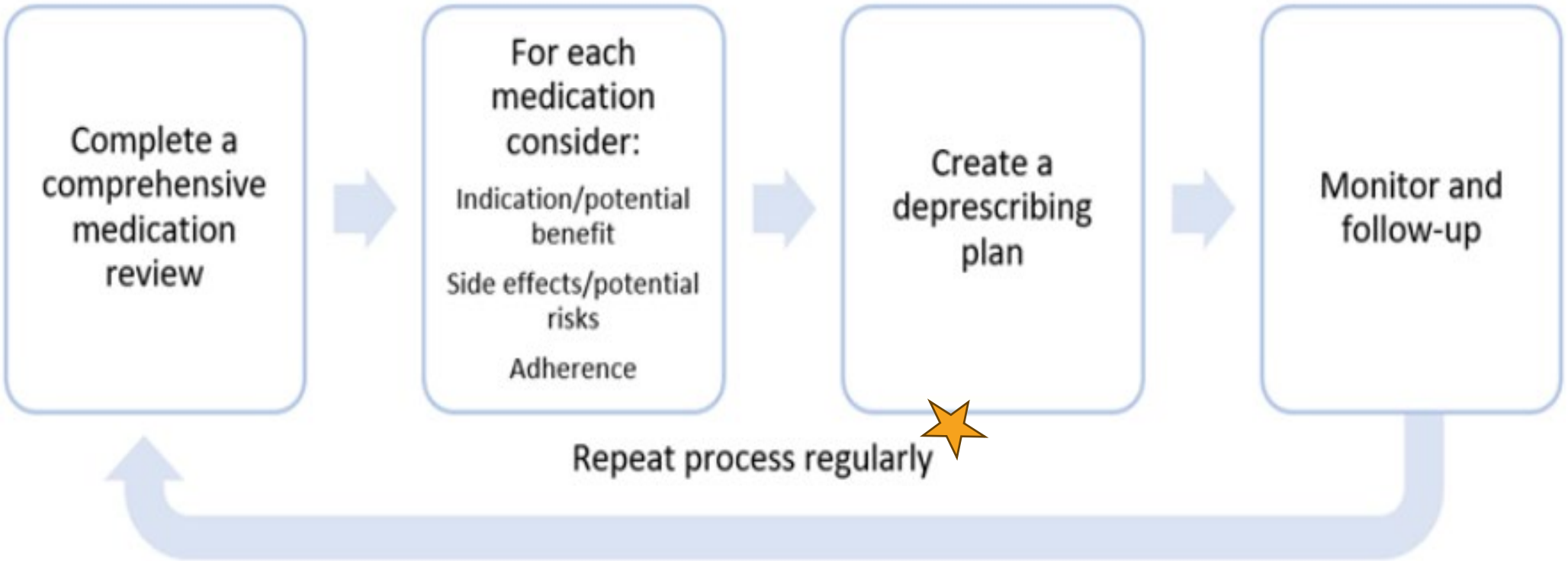
What would you recommend regarding the anticoagulation at this time?

A. Stop Apixaban
B. Continue Apixaban
C. Stop Apixaban and start Dalteparin

Would you recommend to discontinue the beta-blocker at this time?

A. Yes
B. No

# STEPWISE APPROACH[5]



# CASE #3 PART 2 REVIEW

- Goals/Prognosis
- Benefits/Risks
- Medication Administration

| Medication | Plan |
| --- | --- |
| Apixaban | |
| Bisoprolol | |

# CASE #4 MR. D

Mr. D is a 92-year-old male with severe dementia and recent admission to acute care for recurrent aspiration pneumonia. Ongoing decline despite antibiotics and family decided on transition to comfort care. Patient remains bedbound. Only taking sips of liquids and intermittently able to take oral medications. No meaningful interactions with visiting family. Ongoing confusion and agitation at times.

**Past Medical History**

- Dementia
- Behavioral and Psychological Symptoms in Dementia (BPSD)
- Degenerative Disc Disease
- Chronic Back Pain
- Osteoarthritis
- Hypertension
- Urinary Incontinence

# CASE #4 MEDICATION LIST

| Medication | Indication |
|---|---|
| Acetaminophen 650 mg PR Q4H PRN | Pain/Fever |
| Morphine 1 mg subcut Q6H | Pain/Dyspnea |
| Morphine 1 mg subcut Q2H PRN | Pain/Dyspnea |
| Haloperidol 0.5 mg subcut Q4H PRN | Nausea/Agitation |
| Midazolam 0.5 mg subcut Q1H PRN | Agitation/Dyspnea |
| Sennosides 17.2 mg PO QHS | Constipation |
| Bisacodyl 10 mg PR daily PRN | Constipation |
| Glycopyrrolate 0.4 mg subcut Q4H PRN | Secretions |
| Donepezil 10 mg PO daily | Dementia |
| Risperidone 0.25 mg PO BID | BPSD |
| Pregabalin 50 mg PO BID | Pain |

# CASE #4 QUESTION

Which medications would be ideal to taper at this time?

A. Donepezil

B. Pregabalin

C. Risperidone

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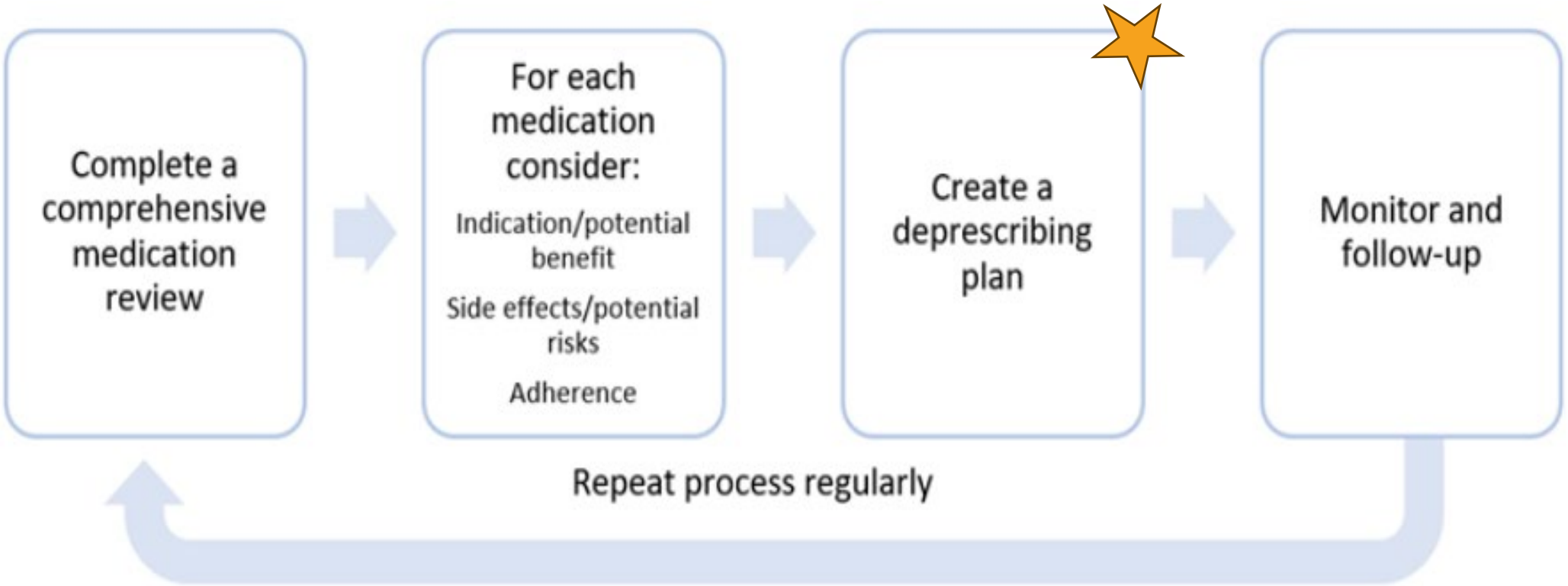
# CASE #4 LINK

# STEPWISE APPROACH[5]



# WITHDRAWAL[9]

| Pregabalin | Acetylcholinesterase Inhibitors |
| --- | --- |
| Insomnia | Agitation |
| Nausea/Vomiting | Aggression |
| Diarrhea | Hallucinations |
| Encephalopathy | Altered Level of Consciousness |

# ANTIPSYCHOTIC EQUIVALENCY[12]

| Antipsychotic | Dose Equivalency |
|---|---|
| Haloperidol | 2 mg |
| Olanzapine | 5 mg |
| Quetiapine | 75 mg |
| Risperidone | 1 mg |
| Aripiprazole | 7.5 mg |

# CASE #4 REVIEW

| Medication | Plan |
| --- | --- |
| Pregabalin | |
| Donepezil | |
| Risperidone | |

# TAKE AWAY POINTS

1. Polypharmacy is common and impacts quality palliative care
2. Deprescribing is the process of discontinuing unnecessary/inappropriate medications
3. Consider goals, level of functioning, life expectancy, values, and preferences
4. Utilize a stepwise approach with help of resources/tools
5. Target non-essential medications
6. Consider practical factors like medication administration and tapering

# ACKNOWLEDGEMENTS


- Amanda Wolfe, Pharmacist
- Staff on Bruyère Palliative Care Unit

# QUESTIONS?

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