SPRING - 2024 - Issue 54

Regional Palliative Care Services

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Medication Deprescribing in Palliative Care

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Introduction

Deprescribing is a patient-centered process of identifying and stopping inappropriate or unnecessary medications with the goal of improving patient outcomes.[1,2,3] Polypharmacy, or the use of multiple medications, is common in palliative care patients who are often taking medications for their life limiting condition, chronic comorbid conditions, and symptom management.[1] Polypharmacy can lead to high pill burden and medication cost, as well as increased risk of side effects and drug interactions.[1,2,4]

Optimal deprescribing should utilize shared decision making between the patient, family, and care team and include careful consideration of each medication's potential benefits and risks.[3] Using an interdisciplinary approach, such as involvement of a pharmacist, can further contribute to optimization of deprescribing decisions.[3]

Stepwise Approach to Deprescribing

Utilizing a stepwise approach can help simplify the sometimes daunting task of deprescribing (see figure 1). The first step is to compile an accurate and comprehensive list of medications (prescription, non-prescription, vitamins and minerals).[1] This should include gathering information about indications, perceived effectiveness, side effects, adherence, and duration of use.

The next step is to weigh the benefit and risk of each medication. One way to help determine the likelihood of benefit is to compare a patient's estimated life expectancy to the time until benefit of a particular medication.[5] For example, medications used to prevent long-term risks of asymptomatic

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conditions (e.g. hypertension, dyslipidemia, osteoporosis) have little benefit in the short term and should be considered for deprescription in patients with limited life expectancy.[1,6] Medications intended for symptom relief should generally be continued, as long as the symptom is ongoing, and the medication has proved effective. When assessing harms of each medication, consider presence and severity of side effects as well as risk of potential harms in the future. If a patient has poor adherence to one or more of their medications, determine and address the reasoning (e.g. perceived lack of effectiveness, side effects, difficultly swallowing).

The third step is to create a deprescribing plan. This involves prioritizing what to stop first.

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Figure 1: Stepwise Approach to Deprescribing

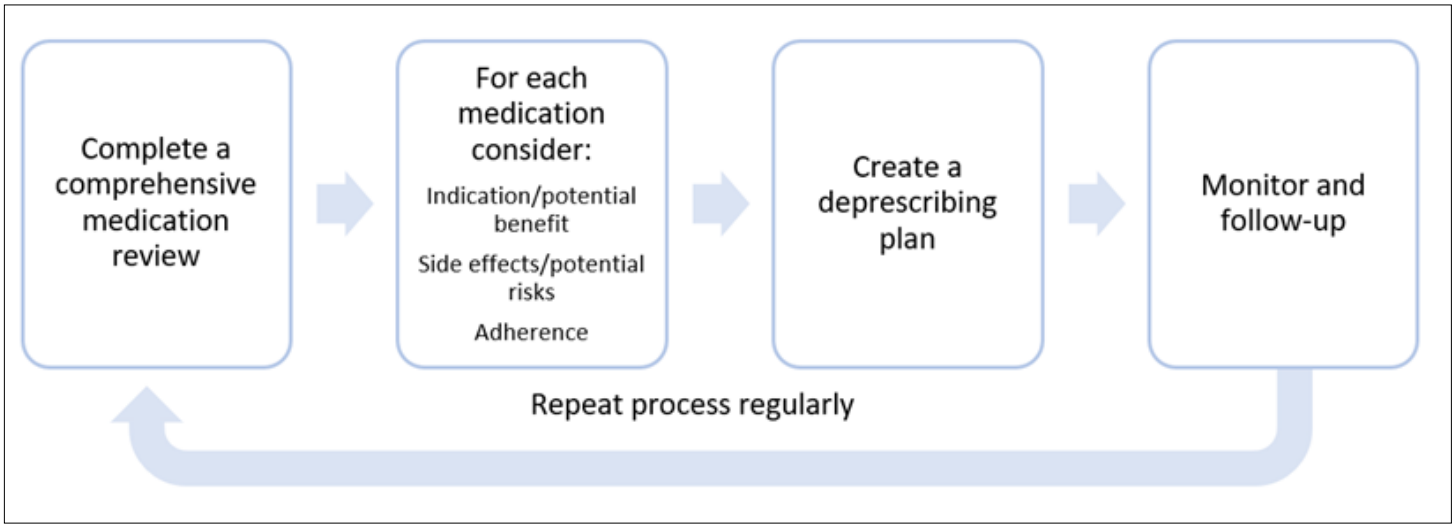

Table 1: Adapted OncPal Deprescribing Guideline (Thompson 2019)

Class of medication	Medication	Situations of limited benefit
Aspirin	Aspirin	Primary prevention
Lipid lowering medications	Statins Fibrates Ezetimibe	All indications
Blood pressure lowering medications	ACE inhibitors Sartans Beta blockers Calcium channel blockers Thiazide Diuretics	Mild to moderate hypertension Secondary prevention of cardiovascular events Management of stable coronary artery disease
Anti-ulcer medications	Proton pump inhibitors H2 antagonists	All indications unless recent history of gastrointestinal bleeding, peptic ulcer, gastritis, GORD, or the concomitant use of NSAIDs and steroids
Oral hypoglycaemics	Metformin Sulfonylureas Thiazolidinediones DPP-4 inhibitors GLP-1 analogues Acarbose	Mild hyperglycaemia (prevention of diabetic complications)
Osteoporosis medications	Bisphosphonates Raloxifene Strontium Denosumab	All indications except hypercalcaemia
Vitamins	n/a	All except treatment of low serum concentrations
Minerals	n/a	All except treatment of low serum concentrations
Complementary therapies	n/a	All indications

Table 2: STOPPFrail version 2 (Curtin et. al. 2021)

Appropriate candidates for STOPPFrail-guided deprescribing typically meet ALL of the following criteria:
1. ADL dependency (i.e. assistance with dressing, washing, transferring, walking) and/or severe chronic disease and/or terminal illness.
2. Severe irreversible frailty, i.e. high risk of acute medical complications and clinical deterioration.
3. Physician overseeing care of patient would not be surprised if the patient died in the next 12 months.

Section A: General	• Any drug that the patient persistently fails to take or tolerate despite adequate education and consideration of all appropriate formulations. • Any drug without a clear clinical indication. • Any drug for symptoms which have now resolved (e.g. pain, nausea, vertigo, pruritus)
Section B: Cardiology system	• Lipid-lowering therapies (statins, ezetimibe, bile acid sequestrants, fibrates, nicotinic acid, lomitapide). • Antihypertensive therapies: Carefully reduce or discontinue these drugs in patients with systolic blood pressure (SBP) persistently <130 mmHg. An appropriate SBP target in frail older people is 130–160 mmHg. Before stopping, consider whether the drug is treating additional conditions (e.g. beta-blocker for rate control in atrial fibrillation, diuretics for symptomatic heart failure). • Anti-anginal therapy (specifically nitrates, nicorandil, ranolazine): None of these anti-anginal drugs have been proven to reduce cardiovascular mortality or the rate of myocardial infarction. Aim to carefully reduce and discontinue these drugs in patients who have had no reported anginal symptoms in the previous 12 months AND who have no proven or objective evidence of coronary artery disease.
Section C: Coagulation system	• Anti-platelets: No evidence of benefit for primary (as distinct from secondary) cardiovascular prevention. • Aspirin for stroke prevention in atrial fibrillation: Aspirin has little or no role for stroke prevention in frail older people who are not candidates for anticoagulation therapy and may significantly increase bleeding risk.
Section D: Central nervous system	• Neuroleptic antipsychotics in patients with dementia: Aim to reduce dose and discontinue these drugs in patients taking them for longer than 12 weeks if there are no current clinical features of behavioural and psychiatric symptoms of dementia (BPSD). • Memantine: Discontinue and monitor in patients with moderate to severe dementia, unless memantine has clearly improved BPSD.
Section E: Gastrointestinal system	• Proton pump Inhibitors: Reduce dose of proton pump inhibitors when used at full therapeutic dose ≥8 weeks, unless persistent dyspeptic symptoms at lower maintenance dose. • H2 receptor antagonist: Reduce dose of H2 receptor antagonists when used at full therapeutic dose for ≥8 weeks, unless persistent dyspeptic symptoms at lower maintenance dose.
Section F: Respiratory system	• Theophylline and aminophylline: These drugs have a narrow therapeutic index, have doubtful therapeutic benefit and require monitoring of serum levels and interact with other commonly prescribed drugs putting patients at an increased risk of ADEs. • Leukotriene antagonists (montelukast, zafirlukast): These drugs have no proven role in chronic obstructive pulmonary disease; they are indicated only in asthma.
Section G: Musculoskeletal system	• Calcium supplements: Unlikely to be of any benefit in short-term unless proven, symptomatic hypocalcaemia. • Vitamin D (ergocalciferol and cholecalciferol): Lack of clear evidence to support the use of vitamin D to prevent falls and fractures, cardiovascular events or cancers. • Anti-resorptive/bone anabolic drugs *for osteoporosis* (bisphosphonates, strontium, teriparatide, denosumab) • Long-term oral nonsteroidal anti-inflammatory drugs: Increased risk of side effects (e.g. peptic ulcer disease, bleeding, worsening heart failure) when taken regularly for ≥2 months. • Long-term oral corticosteroids: Increased risk of major side effects (e.g. fragility fractures, proximal myopathy, peptic ulcer disease) when taken regularly for ≥2 months. Consider careful dose reduction and discontinuation.
Section H: Urogenital system	• Drugs for benign prostatic hyperplasia (5-alpha reductase inhibitors and alpha-blockers) in catheterised male patients: No benefit with long-term bladder catheterisation. • Drugs for overactive bladder (muscarinic antagonists and mirabegron): No benefit in patients with persistent, irreversible urinary incontinence unless clear history of painful detrusor hyperactivity.
Section I: Endocrine system	• Anti-diabetic drugs: De-intensify therapy. Avoid HbA1c targets (HbA1C <7.5% [58 mmol/mol] associated with net harm in this population). The goal of care is to minimise symptoms related to hyperglycaemia (e.g. excessive thirst, polyuria).
Section J: Miscellaneous	• Multivitamin combination supplements: Discontinue when prescribed for prophylaxis rather than treatment of hypovitaminosis. • Folic acid: Discontinue when treatment course is completed. The usual treatment duration is 1–4 months unless malabsorption, malnutrition or concomitant methotrexate use. • Nutritional supplements: Discontinue when prescribed for prophylaxis rather than treatment of malnutrition.

Disclaimer (STOPPFrail): While every effort has been made to ensure that the potentially inappropriate deprescribing criteria listed in STOPPFrail are accurate and evidence-based, it is emphasised that the final decision to deprescribe any drug referred to in these criteria rests entirely with the prescriber. It is also to be noted that the evidence base underlying certain criteria in STOPPFrail may change after the time of publication of these criteria. Therefore, it is advisable that deprescribing decisions should take account of current published evidence in support of or against the use of drugs or drug classes described in STOPPFrail.

Medications should usually be stopped one at a time so the effect can be accurately monitored.[1] It is also important to consider how you should stop the medication. Some medications need to be slowly tapered to avoid rebound effects (e.g. beta blockers, proton pump inhibitors) or withdrawal syndromes (e.g. corticosteroids, antidepressants).[2] The final step is to create a follow-up plan in collaboration with the patient to monitor the effect of the changes.[1] This stepwise process should be repeated regularly until all harmful and unnecessary medications have been stopped.

Resources and Tools for Deprescribing

Several guidelines and tools have been created to assist clinicians with deprescribing, including two intended for palliative care patients. The OncPal Deprescribing Guideline targets patients with advanced cancer with a life expectancy of less than 6 months.[3] It lists specific classes of medications and the indications where there is solid evidence for deprescription (see table 1).[2] The Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy (STOPPFrail) is a deprescribing guide aimed at older people with limited life expectancy where the focus of care is on quality of life.[6] This tool was first developed in 2017 and has since been updated to a second version.[6] It includes 25 deprescribing criteria as well as guidance on appropriate patient selection (see table 2).[6]

Barriers to Deprescribing

There are many potential barriers to deprescribing which can occur at the patient, prescriber, or organizational level.[1] Patients or their families may have previously had bad experiences with deprescribing, be reluctant to make changes, or have fears of withdrawal effects or worsening condition upon stopping a medication.[1,3] Some patients also have strong attachments to their chronic medications and see them as necessary for their long-term health.[4] Additionally, prescribers may be concerned that patients will perceive deprescribing as them "giving up hope".[1] Thorough discussions with an emphasis on shared decision making may improve patient insight and understanding, subsequently alleviating these concerns. These discussions can also prompt broader conversations about goals of care and advance care planning.[3] Some additional barriers prescribers may encounter include lack of time, fear of negative outcomes, hesitancy to stop medications initiated by specialists, and limited experience or knowledge around deprescribing.[1,3] Utilizing a stepwise approach and available deprescribing tools may help overcome some of these barriers. Lastly organizational barriers can include limited staffing and lack of easily accessible resources.[3]

Conclusion

Decisions around deprescribing require careful weighing of the potential benefits and risks of medications at the end of life. Utilizing a stepwise approach and available guidelines can help prescribers with these decisions. It is critical that all deprescribing decisions are individualized and take into account the values, preferences, goals of care, and prognosis of the patient.[3]

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Please Welcome Our Newest Palliative Care Nurse Consultants

Welcome:
Chris Robberts
Chris brings many years of clinical experience in Terrace as well as Prince George; he also has experience in teaching at post secondary institutions in Terrace and Prince George.

Welcome:
Brandi Blevins
Brandi brings general palliative care experience from working at UHNBC as well as hospice experience. Brandi is excited to start in her consultant role March 4.

Upcoming Palliative Care Education

The Northern Health Palliative Care Consultation Team is excited to offer a variety of upcoming palliative care education in both in person and online formats. If you are interested or have questions about our upcoming training please e-mail Palliative.Care.Consult.Team@northernhealth.ca.

In Person

Session:	Date:	Time:	Location:	Who can register:
LEAP Core—Learning Essential Approaches to Palliative Care	May 14 & 15, 2024	08:00 to 16:30	Prince George	Physicians, Pharmacists, Social Workers, RNs & LPNs
LEAP Core—Learning Essential Approaches to Palliative Care	May 27 & 28, 2024	08:00 to 16:30	Fort St John	Physicians, Pharmacists, Social Workers, RNs & LPNs

Online

Session:	Date:	Time:	Who can register:
ECHO—Basic	Sessions monthly until June	12:00 to 13:00 PST	Primary Care Providers
ECHO—LTC Community & Facility	Sessions bi-monthly	13:30 to 14:00 PST	Those working Long Term Care in both facility and community
Essentials in Hospice and Palliative Care: A Practical Resource for Every Nurse	Start anytime– self-paced	Online	RNs and LPNs
Serious Illness Conversation Guide Training	April 29, 2024	13:00 to 15:00 PST	Primary Care Providers

In partnership with Pallium Canada, the BC Centre for Palliative Care serves as the Provincial Hub for the Palliative Care ECHO Project in British Columbia.

For more on ECHO sessions facilitated by the BC Centre for Palliative Care, please click here.

BC Centre for Palliative Care

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