Deprescribing

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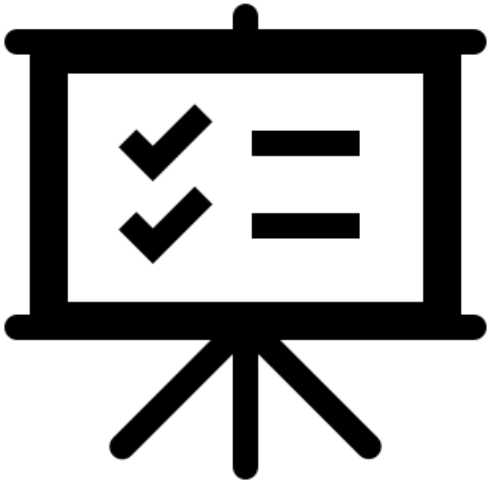
Wisconsin Alzheimer's Institute
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Learning objective



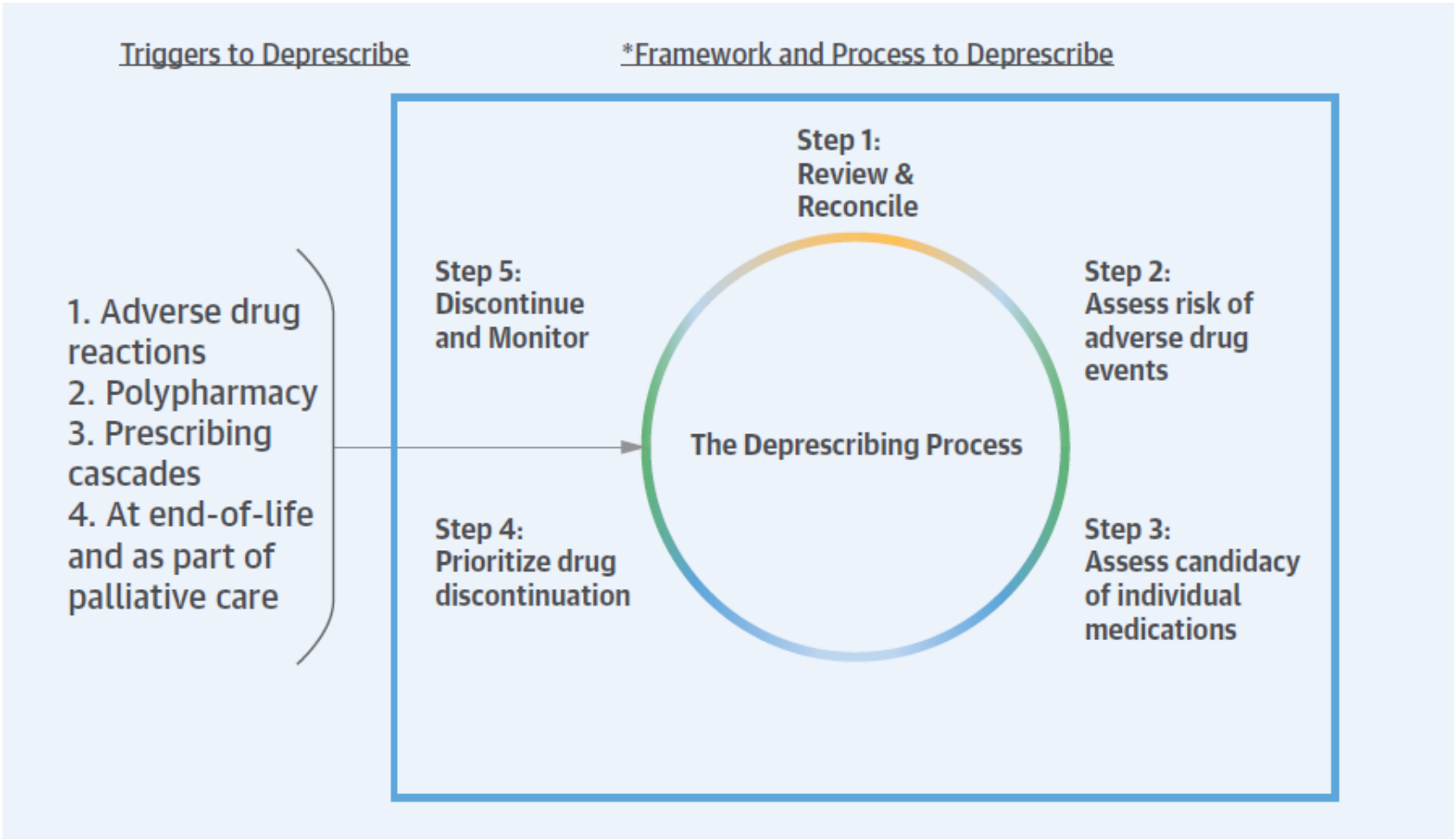
- Describe a strategy for gradual dose reductions of medications

Dose reductions of medications

- which medications should be discontinued
  - antipsychotics → benzodiazepines → other sedating medications
- how should medications be discontinued?
  - abrupt: most often studied, but would not recommend unless side effects are the reason for discontinuation
  - taper: less well studied, but seems to be expert consensus
    - antipsychotics: incremental reductions every 1-2 weeks until off
    - benzodiazepines: 10% per week
    - antidepressants: reverse of how they were initiated
- what if the target symptoms return?

Van Leeuwen at al., *JAMDA* 2018; *The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia* 2016.

Framework for deprescribing



Krishnaswami et al *J Am Coll Cardiol* 2019

Dose reductions of medications: case

- 82-yo with dementia due to Alzheimer's disease whose agitation and paranoia have improved
- citalopram 20 mg qam, quetiapine 25 mg qam & 75 mg qhs, lorazepam 1 mg qhs, melatonin 5 mg qhs
- step 1: wean off quetiapine
  - d/c morning dose (sedation, risk of falls)
  - weekly intervals: 50 qhs → 25 qhs → d/c
- step 2: wean off lorazepam
  - weekly intervals: 0.5 qhs → (0.25 qhs) → d/c
- continue citalopram (unless side effects)
- d/c melatonin (unlikely effective)