Déprescription

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CTR de Gilly

17 décembre 2024

Adaptée d'une présentation de Corine Challet oct.2019

Pharmacie Interhospitalière de la Côte (PIC)- Morges

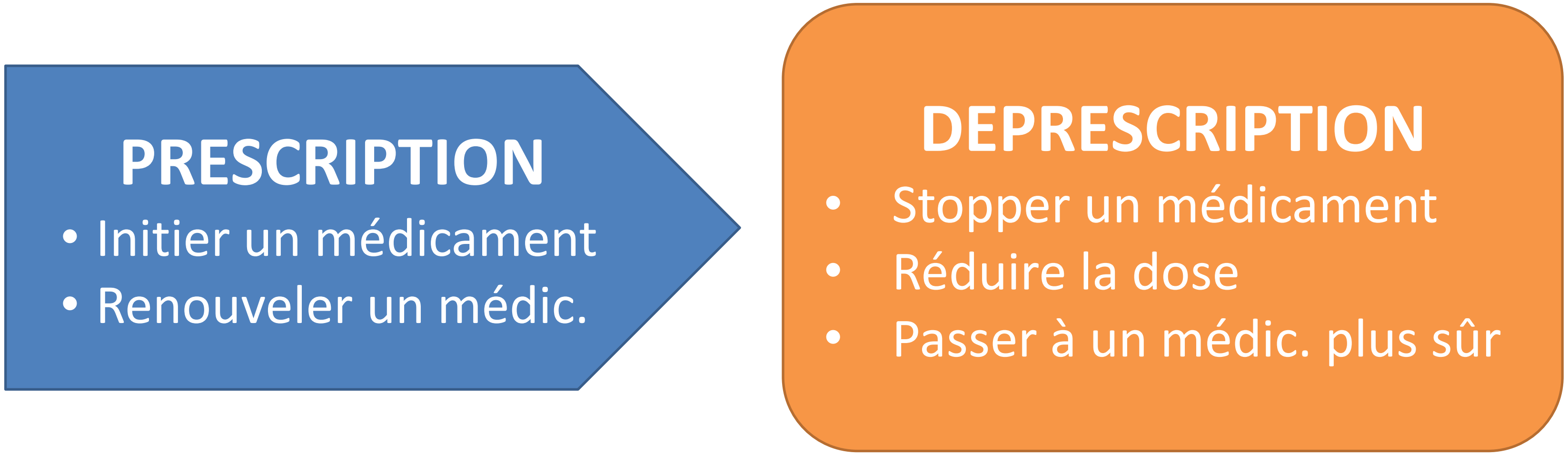
Plan de la présentation

- Définitions et généralités
- Prévalence
- Utilité
- Sécurité
- Outils

Définition

Deprescribing

Processus de retrait d'un **médicament inapproprié** supervisé par un professionnel de santé dans le but de minimiser la **polymédication** et d'améliorer les *résultats cliniques* et la qualité de vie du patient.



PRESCRIPTION

- Initier un médicament
- Renouveler un médic.

DEPRESCRIPTION

- Stopper un médicament
- Réduire la dose
- Passer à un médic. plus sûr

Tannenbaum et al, Can J on Aging, 2017, 36(1): 97-107
Scott et al, JAMA Int Med, 2015, 175(5): 827-34
Reeve et al, Br J Clin Pharmacol, 2015, 80: 1254-68

91 ans

Hosp. ↓ EG

- IC globale, FA
- IRC
- Hyperplasie bénigne de la prostate
- D2 NIR non tté
- Hypercholestérolémie
- Polyneuropathie, artériopathie
- TME d'origine multifactorielle
- Escarres des talons
- Polymyalgia rheumatica
- Malvoyance sur DMLA
- *sp:* MRSA, carcinome papillaire de la vessie, cataracte opérée, PTH droite en 1991
- ancien tabagisme

A l'arrivée à l'hôpital

- Perindopril 4mg 1-0-0
- Digoxine 0,125mg 1-0-0 sauf ve-sa-di
- Sintrom selon TP
- Torasémide 2,5mg 1-0-0
- Aspirine cardio 100mg 1-0-0
- Prednisone 5mg 1 ½ -0-0
- Co Dafalgan 1-0-1
- Simvastatine 20mg 0-0-1
- Calcium D3 sachet 1-0-1
- Alendron 70mg 1cp à 11 h le mardi
- Duofer 1-0-0
- Esoméprazole 20mg 1-0-0
- Finastéride 5mg 1-0-0
- Flavoxate 1-0-1
- Térazosine 5mg 0-0-1
- Movicol 1-0-0
- Supradyn 1-0-0

Source image: http://clipartix.com/old-man-clipart-image-44193/

Polymédication & causes

Vieillissement

Synergie médic.

Multimorbidité

Prévention 1aire/2aire

Maladie aiguë

POLYMEDICATION

(polypharmacy)

≥ 5 médicaments

appropriés *vs* inappropriés

Plusieurs prescripteurs

FR: femme
éducation↓
institution

Hospit. récente

y c. doublon sortie hôpital

Demandes du patient

Automédication

Plusieurs pharmacies

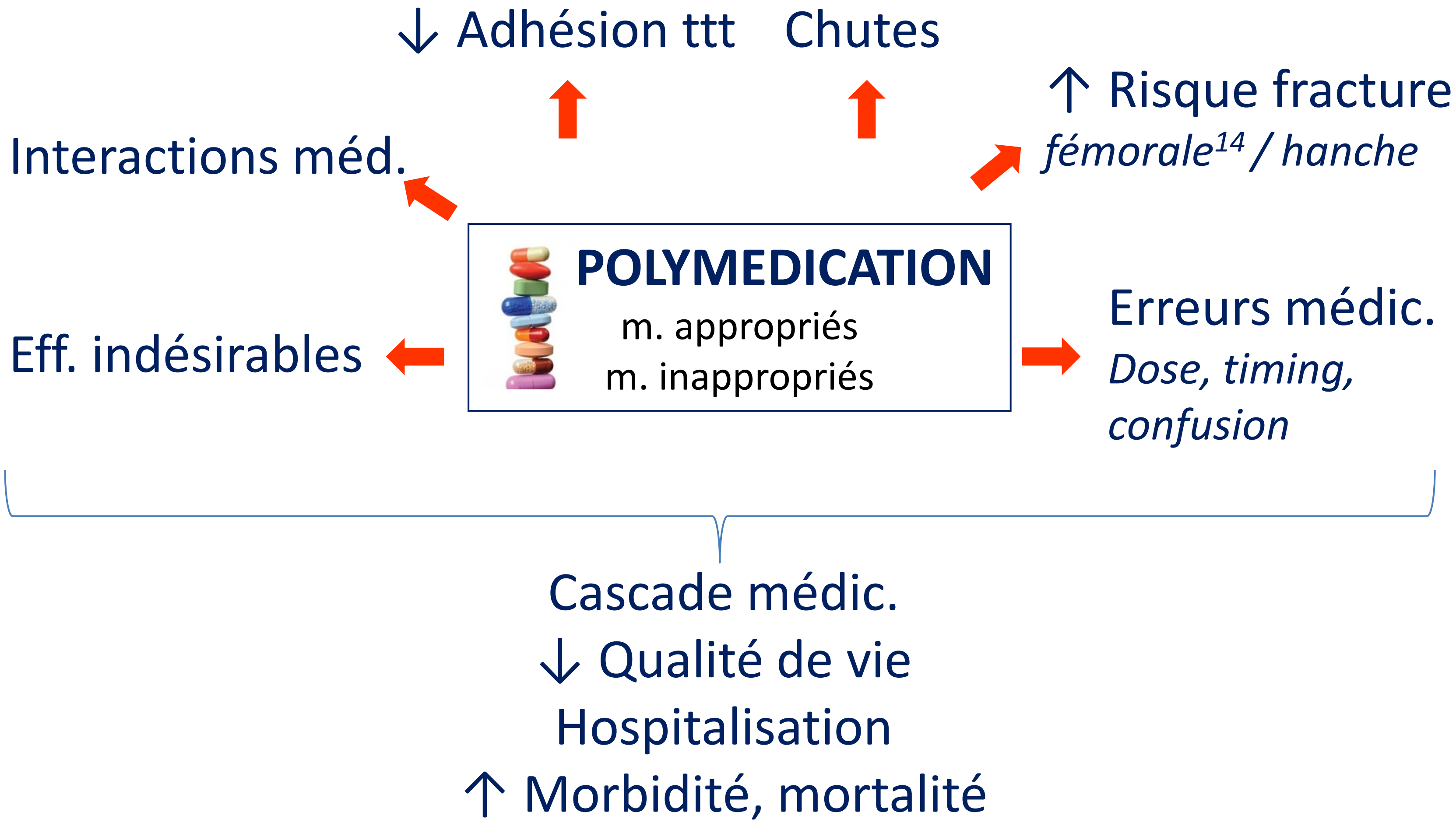
C. Mazzocato et al. Rev Med Suisse 2013, 9 : 1026-31

M. Herr et al. Pharmacoepidemiol. and drug safety, 2015, doi;10.1002/pds.3772

C. Sirois et al, Québec Pharmacie, 06.2014:29-37

Source image: www.divisionsbc.ca/kb/polypharmacy

Polymédication & risques



↓ Adhésion ttt

Chutes

↑ Risque fracture *fémorale[14] / hanche*

Interactions méd.

POLYMEDICATION
m. appropriés
m. inappropriés

Eff. indésirables

Erreurs médic.
Dose, timing, confusion

Cascade médic.
↓ Qualité de vie
Hospitalisation
↑ Morbidité, mortalité

C. Mazzocato et al. Rev Med Suisse 2013, 9 : 1026-31
M. Herr et al. Pharmacoepidemiol. and drug safety, 2015, doi;10.1002/pds.3772

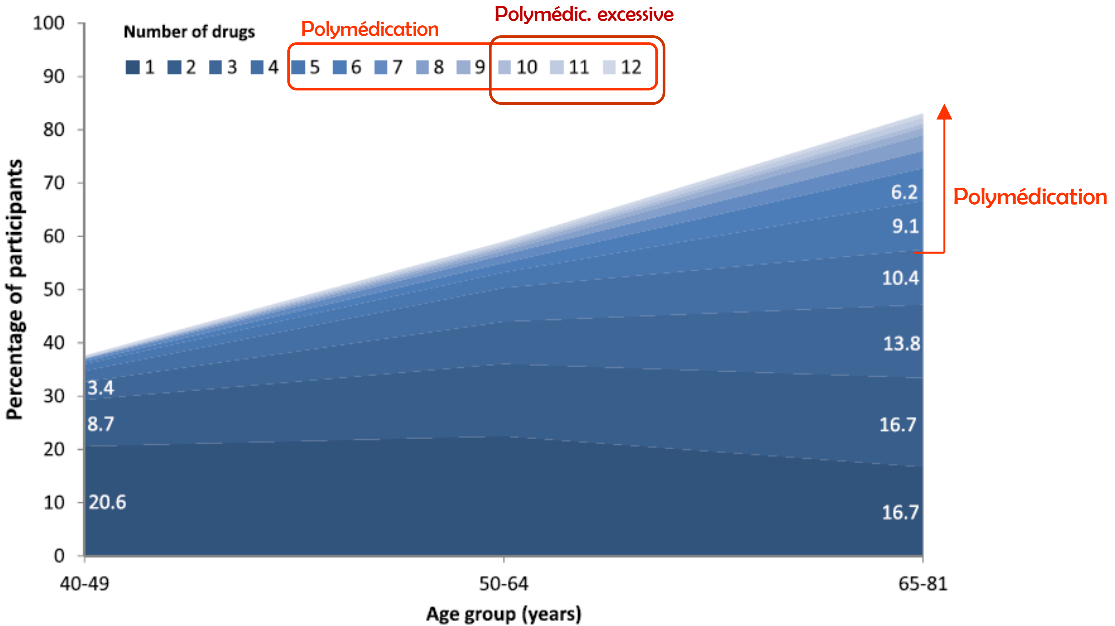
Source image: www.rpharms.com

Prévalence

Etude CoLaus – Suisse 2009-12 (n=4938, 40-81 ans)

11,8 % avec ≥ 5 médic., soit **1/9 participants**

1,4% avec ≥ 10 médic.



Castioni et al. BMC Health Services Research (2017) 17:840

Indicateurs des EMS suisses 2019-21 Rapport OFS, publié 05.2023

42% résidents avec ≥ 9 médic. dans les 7 derniers jours

Prévalence

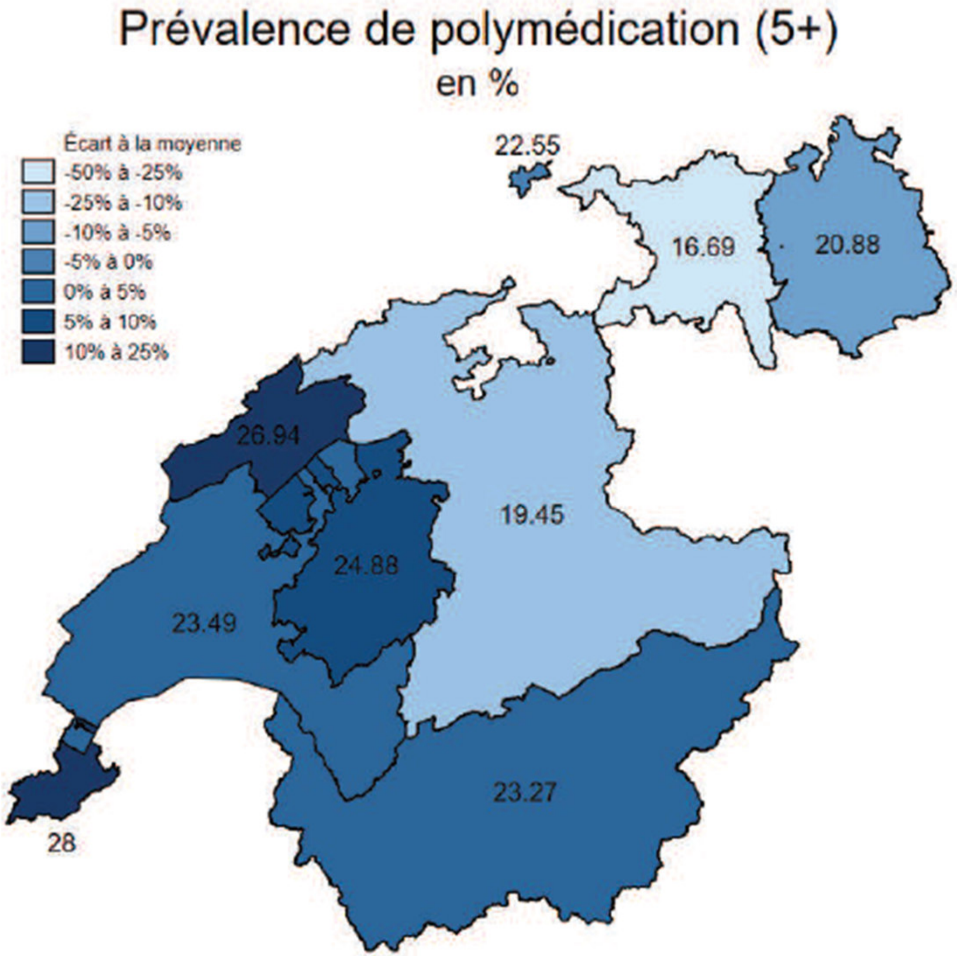

Prévalence de polymédication (5+)
en %
Écart à la moyenne
-50% à -25%
-25% à -10%
-10% à -5%
-5% à 0%
0% à 5%
5% à 10%
10% à 25%
22.55
16.69
20.88
26.94
19.45
24.88
23.49
23.27
28

Figure 1: Carte cantonale de la polymédication

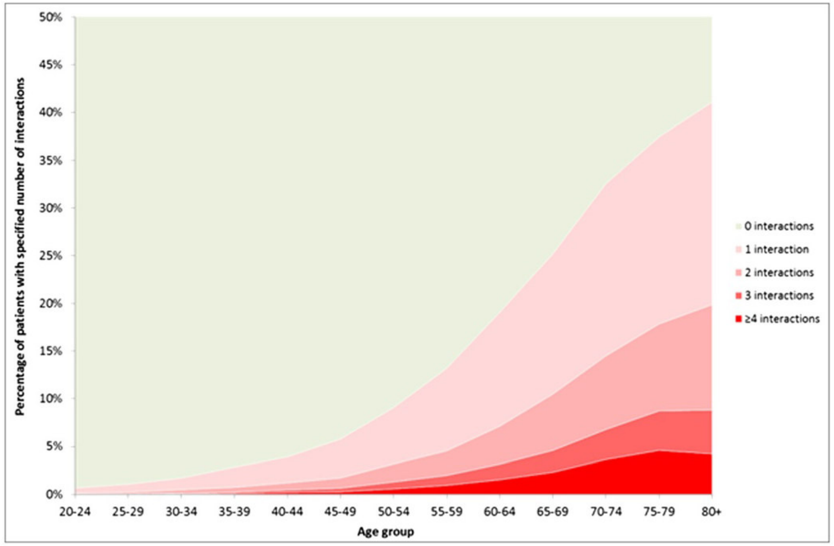
Vallon et al., rapport cantonal Valais 2024

Interactions médic.

- Risque d’**interaction médic.**
  - 13 % si 2 médic.
  - 38 % si 4 médic.
  - **82 %** si ≥ **7** médic.

Mazzocato et al., Revue médicale suisse (2013) 9: 1026-31

- Nbre d’interactions médic. potentiell. sévères⇧ **avec l’âge**



Guthrie et al., BMC Medicine (2015) 13: 74

Source image: https://reference.medscape.com/

Adhésion thérapeutique

- **Non-adhésion** au ttt resp. **10% hospitalisation** en gériatrie[15]
- ↓ adhésion ttt avec le **nombre de prises**[20]

79 % 1x / j	69 % 2x / j
65 % 3x / j	51 % 4x / j

- ↓ adhésion ttt avec le **nombre de médicaments**

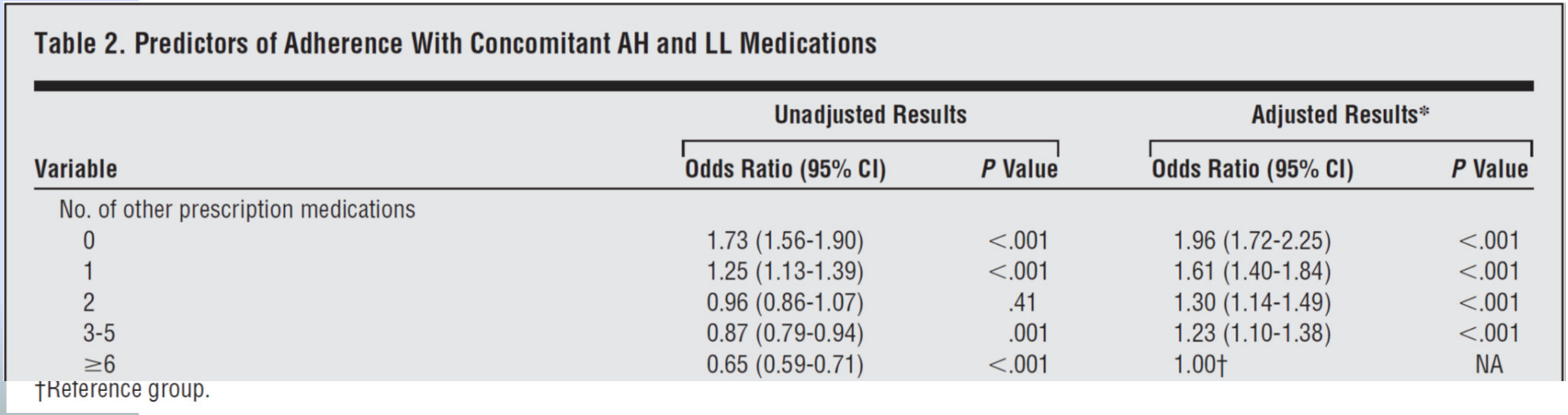


Table 2. Predictors of Adherence With Concomitant AH and LL Medications

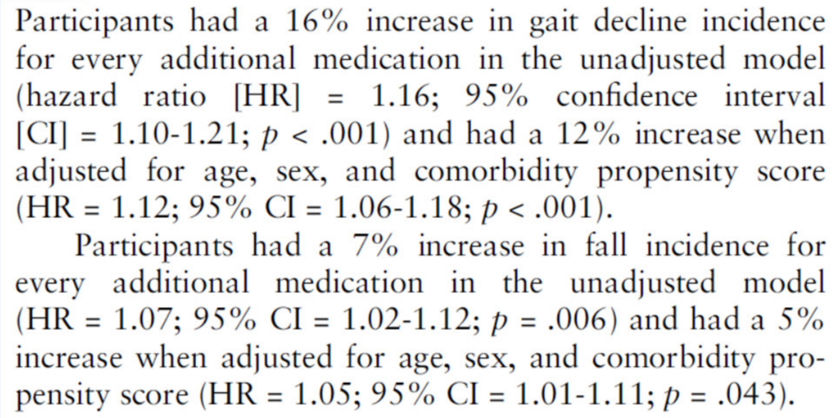
	Unadjusted Results		Adjusted Results*	
Variable	**Odds Ratio (95% CI)**	***P* Value**	**Odds Ratio (95% CI)**	***P* Value**
No. of other prescription medications				
0	1.73 (1.56-1.90)	<.001	1.96 (1.72-2.25)	<.001
1	1.25 (1.13-1.39)	<.001	1.61 (1.40-1.84)	<.001
2	0.96 (0.86-1.07)	.41	1.30 (1.14-1.49)	<.001
3-5	0.87 (0.79-0.94)	.001	1.23 (1.10-1.38)	<.001
≥6	0.65 (0.59-0.71)	<.001	1.00†	NA

†Reference group.

Chapman et al, Arch Intern Med, 2005, 165: 1147-52

Déclin de la marche & chutes

Etude canadienne
n= 249, patients ambulatoires
Âge: 76 ± 9 ans
63% femmes
Polymédication: ≥ 5 médic.
Suivi de 5 ans



Participants had a 16% increase in gait decline incidence for every additional medication in the unadjusted model (hazard ratio [HR] = 1.16; 95% confidence interval [CI] = 1.10-1.21; $p < .001$) and had a 12% increase when adjusted for age, sex, and comorbidity propensity score (HR = 1.12; 95% CI = 1.06-1.18; $p < .001$).

Participants had a 7% increase in fall incidence for every additional medication in the unadjusted model (HR = 1.07; 95% CI = 1.02-1.12; $p = .006$) and had a 5% increase when adjusted for age, sex, and comorbidity propensity score (HR = 1.05; 95% CI = 1.01-1.11; $p = .043$).

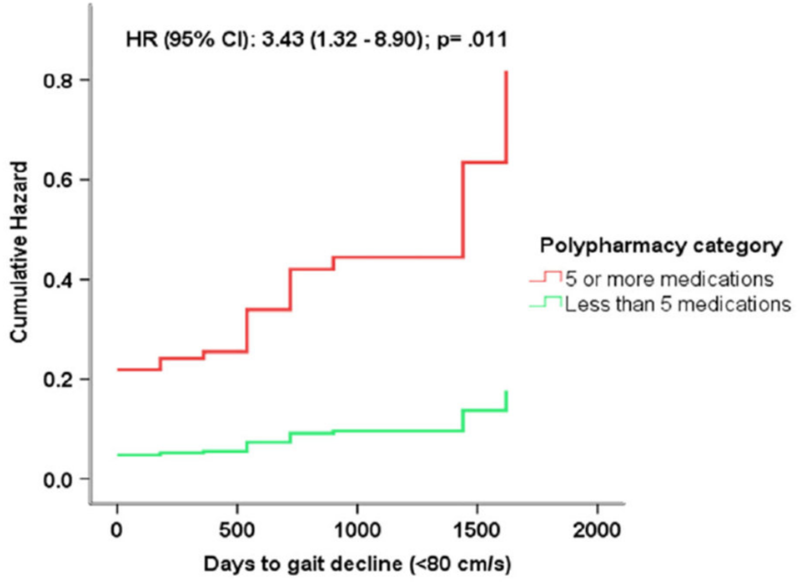
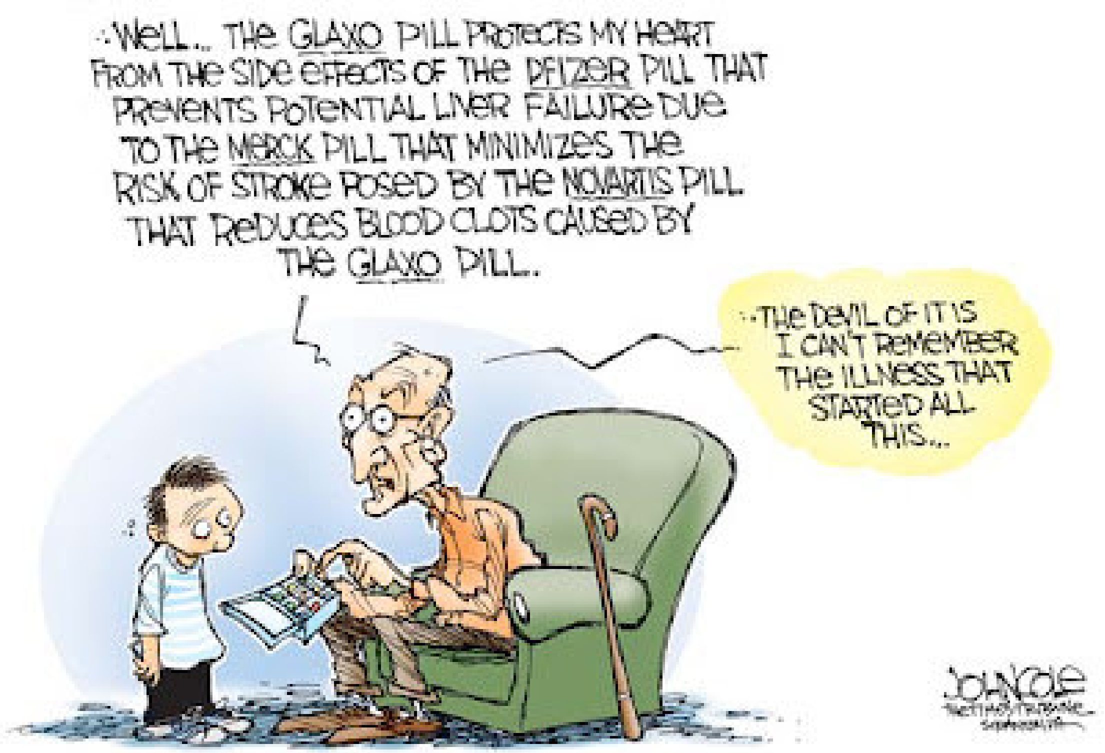


Figure 2. Risk of developing gait decline (<80 cm/s) from baseline to last visit, for participants taking less or more than five medications. CI, confidence interval; HR, hazard ratio.

Montero-Odasso et al, J Am Geriatr Soc, 2019, 67: 1182-8

Cascade médicamenteuse

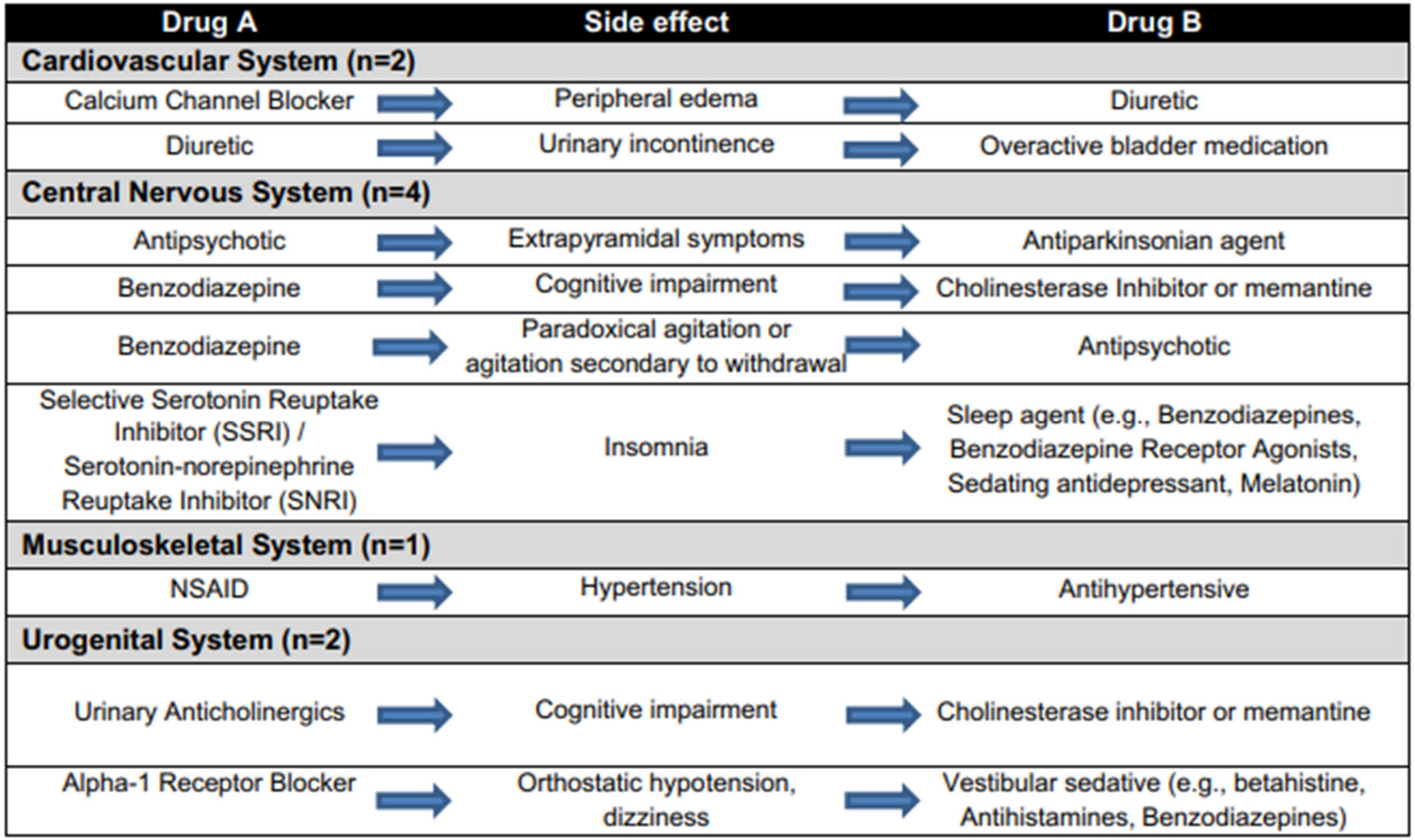
ou spirale médicamenteuse


WELL.. THE GLAXO PILL PROTECTS MY HEART FROM THE SIDE EFFECTS OF THE PFIZER PILL THAT PREVENTS POTENTIAL LIVER FAILURE DUE TO THE MERCK PILL THAT MINIMIZES THE RISK OF STROKE POSED BY THE NOVARTIS PILL THAT REDUCES BLOOD CLOTS CAUSED BY THE GLAXO PILL.
THE DEVIL OF IT IS I CAN'T REMEMBER THE ILLNESS THAT STARTED ALL THIS...
JOHN COLE

Source image:https://misfit120.files.wordpress.com/2012/05/prescription-old-guy-remembering.jpg

Cascades médic. fréquentes

Table 3 ThinkCascades: clinically important prescribing cascades affecting older people; by physiologic system

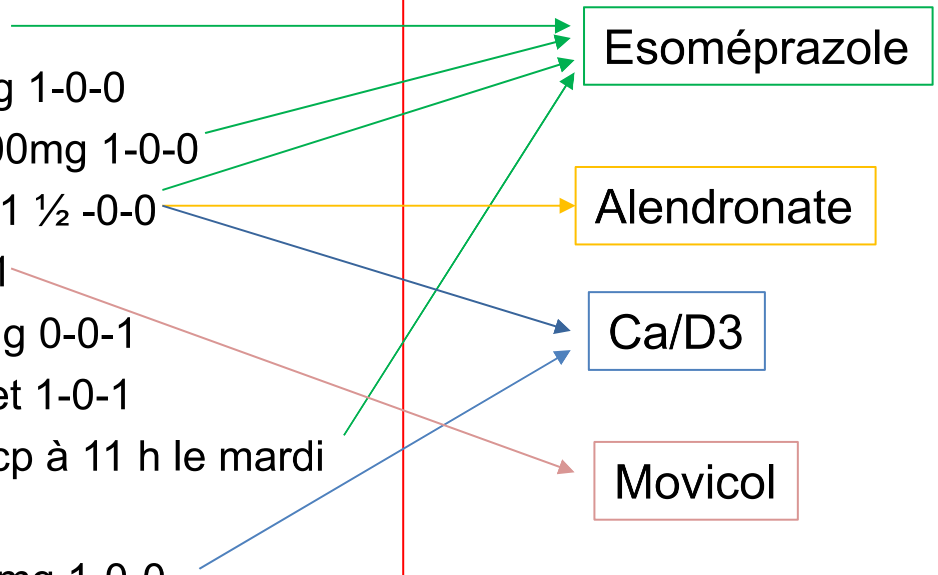


Drug A	Side effect	Drug B
Cardiovascular System (n=2)		
Calcium Channel Blocker	Peripheral edema	Diuretic
Diuretic	Urinary incontinence	Overactive bladder medication
Central Nervous System (n=4)		
Antipsychotic	Extrapyramidal symptoms	Antiparkinsonian agent
Benzodiazepine	Cognitive impairment	Cholinesterase Inhibitor or memantine
Benzodiazepine	Paradoxical agitation or agitation secondary to withdrawal	Antipsychotic
Selective Serotonin Reuptake Inhibitor (SSRI) / Serotonin-norepinephrine Reuptake Inhibitor (SNRI)	Insomnia	Sleep agent (e.g., Benzodiazepines, Benzodiazepine Receptor Agonists, Sedating antidepressant, Melatonin)
Musculoskeletal System (n=1)		
NSAID	Hypertension	Antihypertensive
Urogenital System (n=2)		
Urinary Anticholinergics	Cognitive impairment	Cholinesterase inhibitor or memantine
Alpha-1 Receptor Blocker	Orthostatic hypotension, dizziness	Vestibular sedative (e.g., betahistine, Antihistamines, Benzodiazepines)

NSAIDs non-steroidal anti-inflammatory drugs

Drugs & Aging (2022) 39:829–840

91 ans



A l'arrivée à l'hôpital

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- Digoxine 0,125mg 1-0-0 sauf ve-sa-di
- Sintrom selon TP
- Torasémide 2,5mg 1-0-0
- Aspirine cardio 100mg 1-0-0
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- Co Dafalgan 1-0-1
- Simvastatine 20mg 0-0-1
- Calcium D3 sachet 1-0-1
- Alendron 70mg 1cp à 11 h le mardi
- Duofer 1-0-0
- Esoméprazole 20mg 1-0-0
- Finastéride 5mg 1-0-0
- Flavoxate 1-0-1
- Térazosine 5mg 0-0-1
- Movicol 1-0-0
- Supradyn 1-0-0

Esoméprazole

Alendronate

Ca/D3

Movicol

Source image: http://clipartix.com/old-man-clipart-image-44193/

Emergency Hospitalizations for Adverse Drug Events in Older Americans

Budnitz et al, N Engl J Med, 2011, 365(21): 2002-12

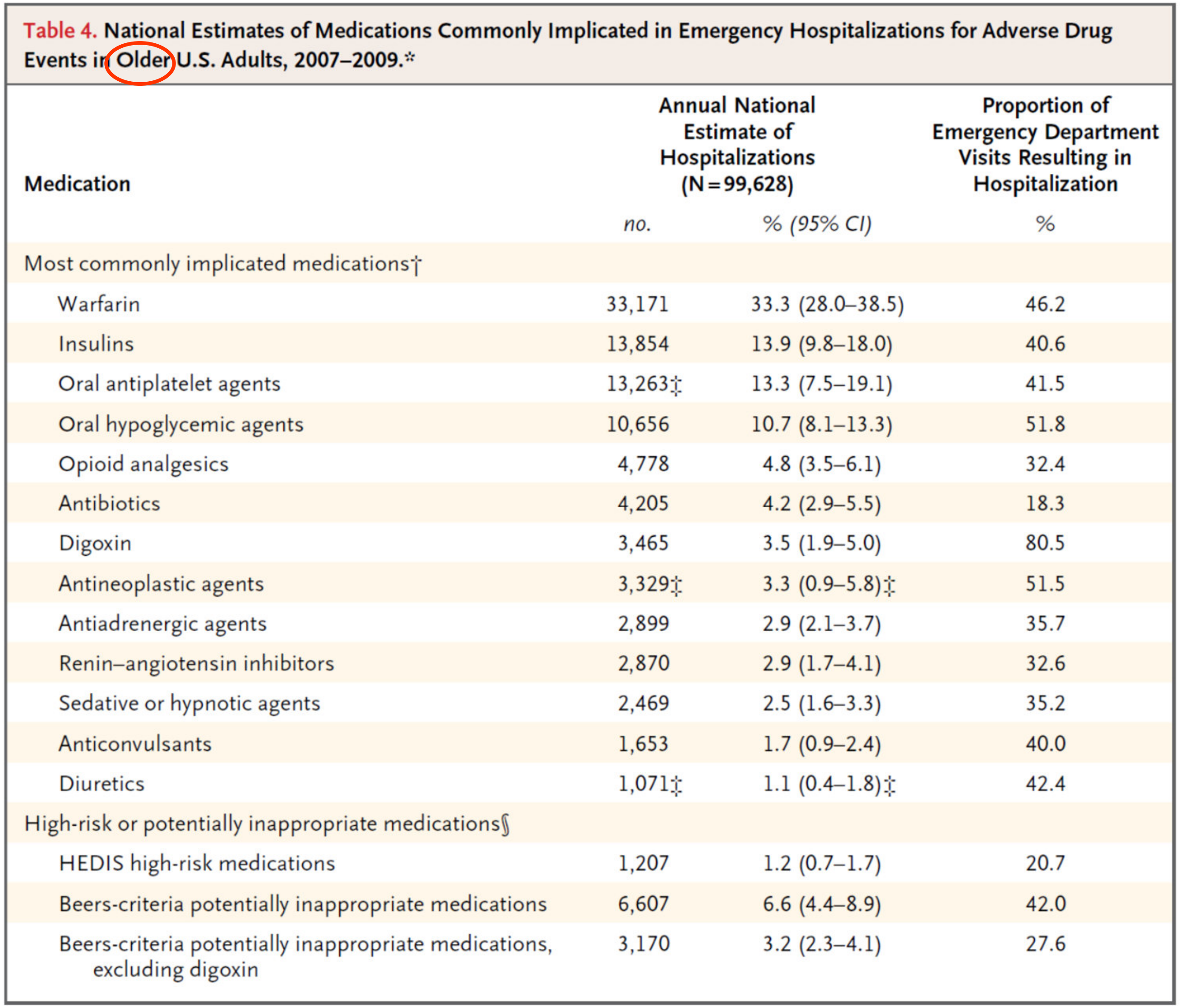
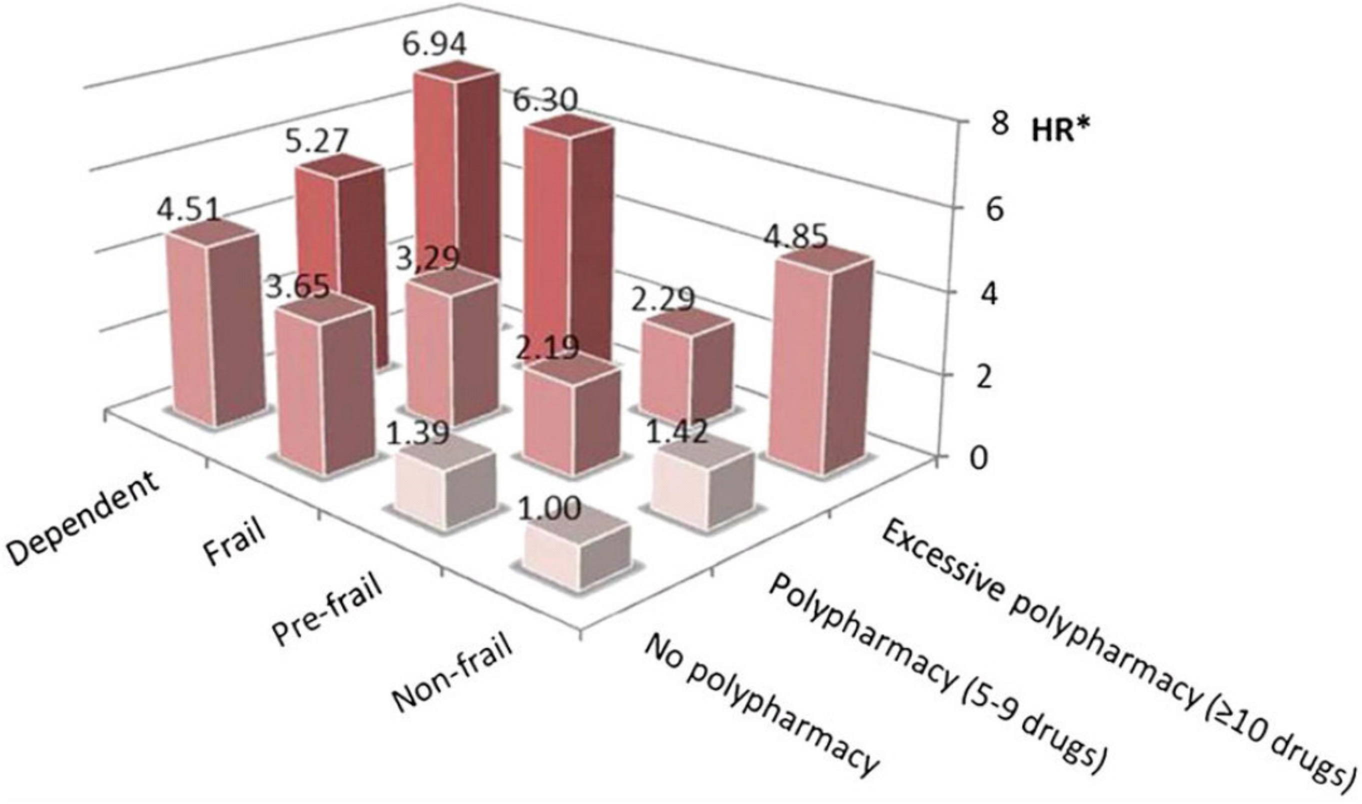


Table 4. **National Estimates of Medications Commonly Implicated in Emergency Hospitalizations for Adverse Drug Events in Older U.S. Adults, 2007–2009.**[*]

Medication	Annual National Estimate of Hospitalizations (N=99,628)		Proportion of Emergency Department Visits Resulting in Hospitalization
	no.	*% (95% CI)*	*%*
Most commonly implicated medications[†]			
Warfarin	33,171	33.3 (28.0–38.5)	46.2
Insulins	13,854	13.9 (9.8–18.0)	40.6
Oral antiplatelet agents	13,263[‡]	13.3 (7.5–19.1)	41.5
Oral hypoglycemic agents	10,656	10.7 (8.1–13.3)	51.8
Opioid analgesics	4,778	4.8 (3.5–6.1)	32.4
Antibiotics	4,205	4.2 (2.9–5.5)	18.3
Digoxin	3,465	3.5 (1.9–5.0)	80.5
Antineoplastic agents	3,329[‡]	3.3 (0.9–5.8)[‡]	51.5
Antiadrenergic agents	2,899	2.9 (2.1–3.7)	35.7
Renin–angiotensin inhibitors	2,870	2.9 (1.7–4.1)	32.6
Sedative or hypnotic agents	2,469	2.5 (1.6–3.3)	35.2
Anticonvulsants	1,653	1.7 (0.9–2.4)	40.0
Diuretics	1,071[‡]	1.1 (0.4–1.8)[‡]	42.4
High-risk or potentially inappropriate medications[§]			
HEDIS high-risk medications	1,207	1.2 (0.7–1.7)	20.7
Beers-criteria potentially inappropriate medications	6,607	6.6 (4.4–8.9)	42.0
Beers-criteria potentially inappropriate medications, excluding digoxin	3,170	3.2 (2.3–4.1)	27.6

Polymédication & mortalité

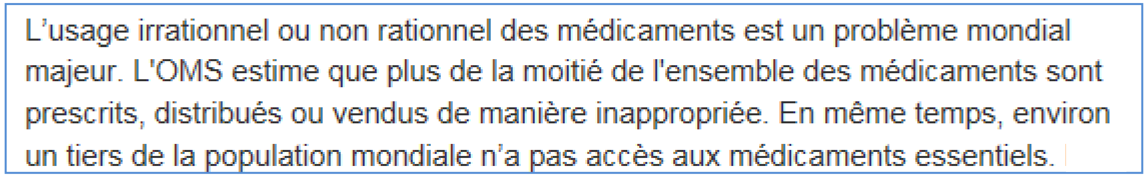
- Polymédic. ↑ risque de **mortalité** de qqn âgée fragile[16]



M. Herr et al, Pharmacoepidemiol. & Drug Saf, 2015

Médicaments inappropriés

Organisation mondiale de la Santé



L'usage irrationnel ou non rationnel des médicaments est un problème mondial majeur. L'OMS estime que plus de la moitié de l'ensemble des médicaments sont prescrits, distribués ou vendus de manière inappropriée. En même temps, environ un tiers de la population mondiale n'a pas accès aux médicaments essentiels.

Potentially **I**nappropiate **M**edications **PIMs**

- Médic. risqués
- Médic. inutiles, devenus superflus, changement guidelines
- Longue durée de ttt au lieu de courte
- Médic. inefficaces
- Médic. en non adéquation avec les buts du traitement
  - Ex. médic. préventif pour patient en soins palliatifs
- Médic. ne correspondant pas aux valeurs du patient
- Médic. inadaptés à une population de patients
  - Ex. IR, anticholinergiques chez âgés, dispositifs inhalation …

http://www.who.int/medicines/areas/rational_use/fr/

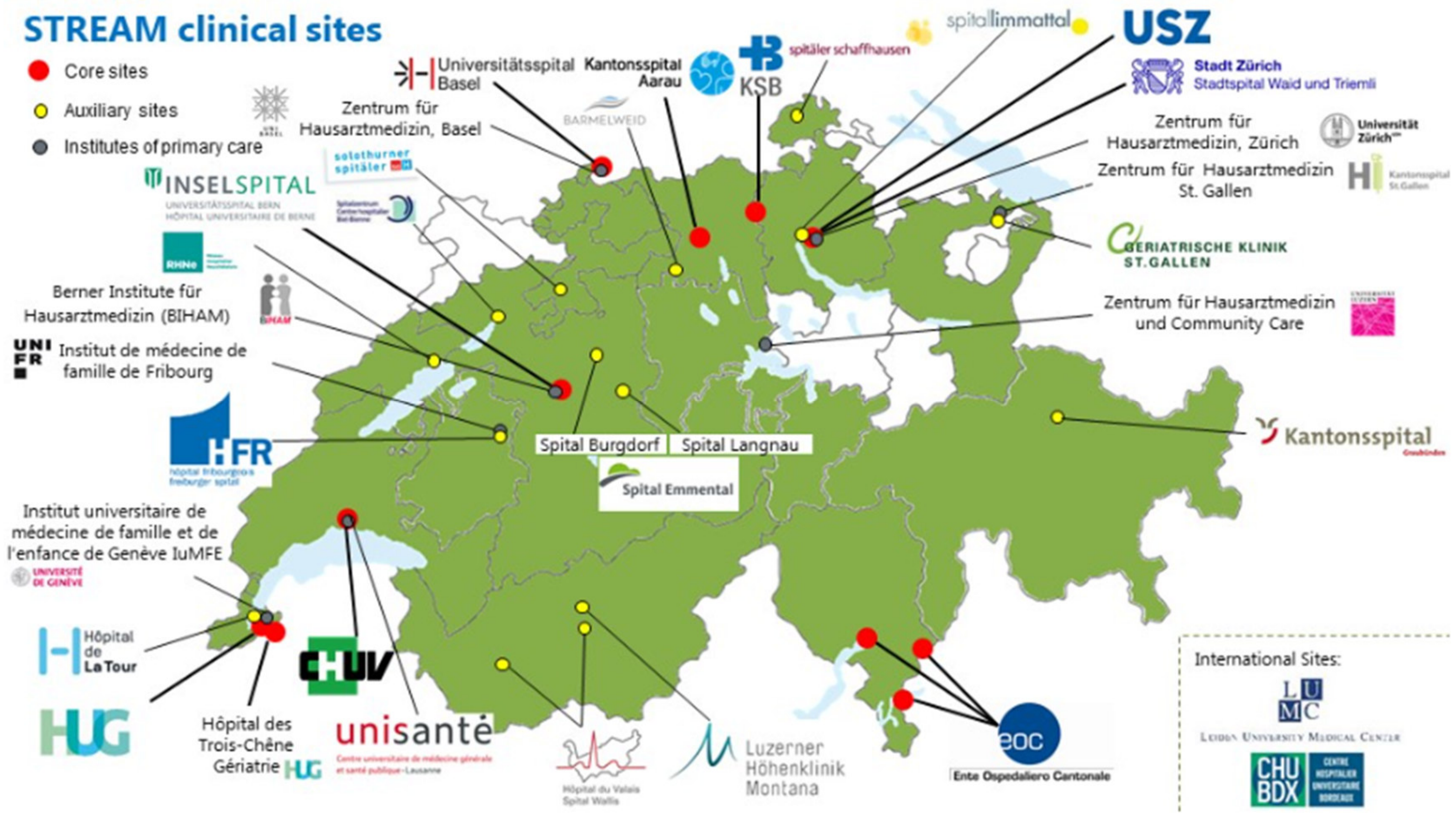
PIMs chez la personne âgée

- Prévalence des PIMS[19]
  - 20 % personnes âgées à domicile
  - 30 % personnes âgées hospitalisées
  - 50 % personnes âgées en EMS

- Manque d'études cliniques / guidelines avec ≥ 80 ans
  - 3 % seulement essais contrôlés randomisés avec ≥ 65 ans[14]
  - Patients 'très âgés' ou 'âgés et fragiles' exclus[19]
  - Extrapolations pour cette population

Source image: www.prioritesantemutualiste.fr/psm/bien-vieillir/polymedication-et-personne-agee

Etude STREAM


STREAM clinical sites
● Core sites
○ Auxiliary sites
● Institutes of primary care
Universitätsspital Basel
Kantonsspital Aarau
KSB
spitäler schaffhausen
spitallimmattal
USZ
Stadt Zürich Stadtspital Waid und Triemli
Zentrum für Hausarztmedizin, Basel
BARMELWEID
solothurner spitäler
INSELSPITAL UNIVERSITÄTSSPITAL BERN HÔPITAL UNIVERSITAIRE DE BERNE
RHNe
Berner Institute für Hausarztmedizin (BIHAM)
UNI FR
Institut de médecine de famille de Fribourg
HFR hôpital fribourgeois freiburger spital
Zentrum für Hausarztmedizin, Zürich
Universität Zürich
Zentrum für Hausarztmedizin St. Gallen
Kantonsspital St.Gallen
GERIATRISCHE KLINIK ST.GALLEN
Zentrum für Hausarztmedizin und Community Care
Spital Burgdorf
Spital Langnau
Spital Emmental
Kantonsspital Graubünden
Institut universitaire de médecine de famille et de l'enfance de Genève IuMFE
UNIVERSITÉ DE GENÈVE
Hôpital de La Tour
HUG
Hôpital des Trois-Chêne Gériatrie HUG
CHUV
unisanté Centre universitaire de médecine générale et santé publique - Lausanne
Hôpital du Valais Spital Wallis
Luzerner Höhenklinik Montana
eoc Ente Ospedaliero Cantonale
International Sites:
LUMC Leiden University Medical Center
CHU BDX Centre Hospitalier Universitaire Bordeaux

Accessible sur : www.statin-stream.ch/fr/localites/

Prévalence

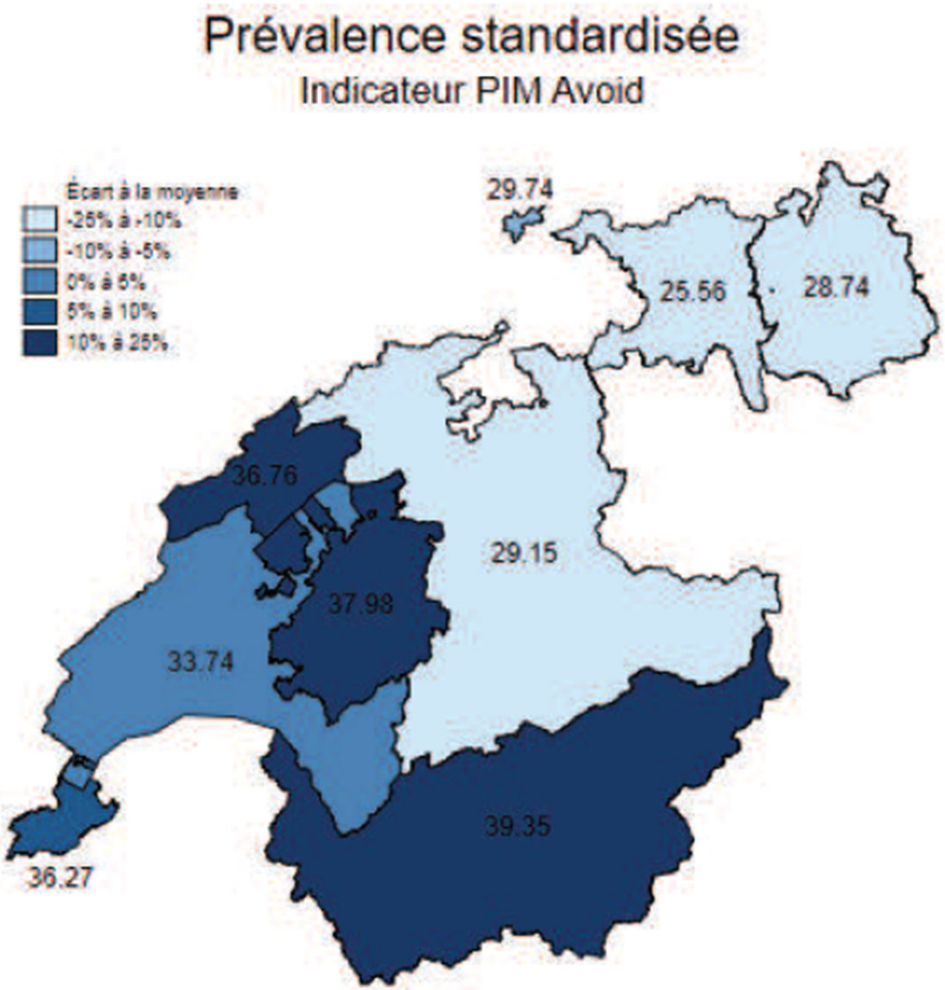
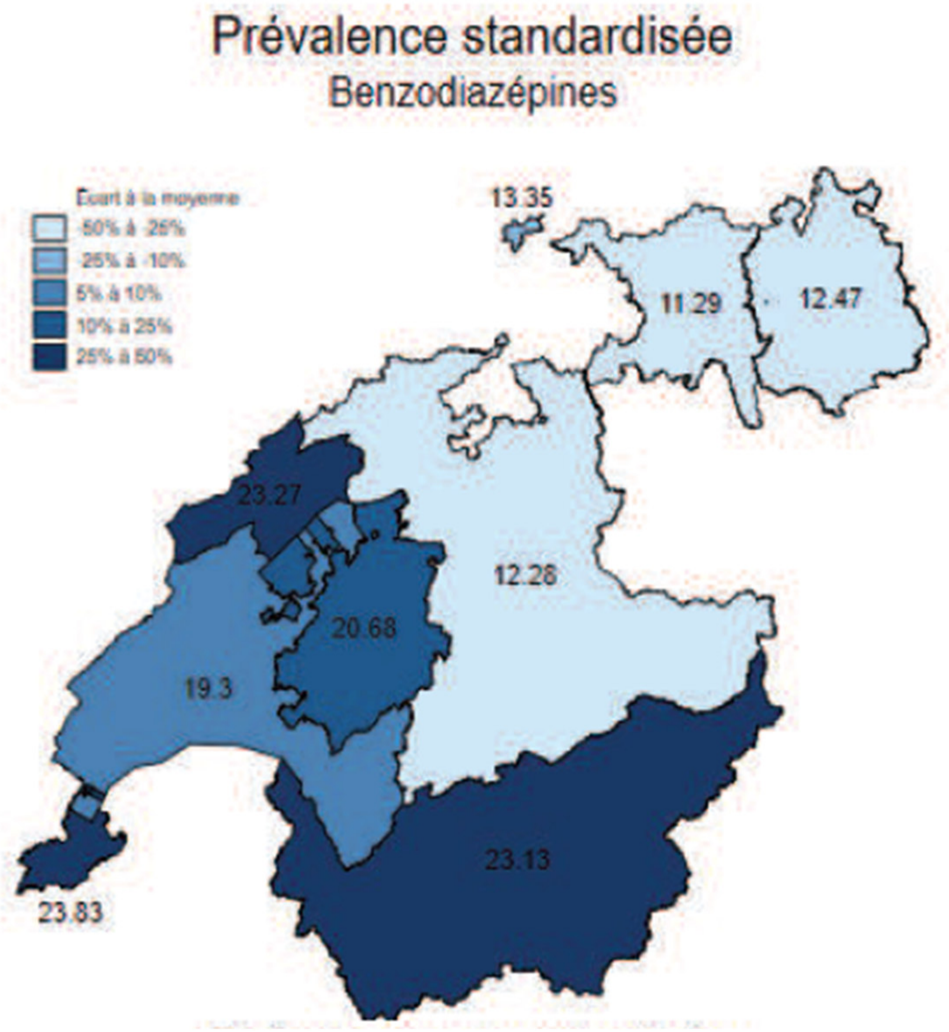

Prévalence standardisée
Indicateur PIM Avoid
Écart à la moyenne
-25% à -10%
-10% à -5%
0% à 5%
5% à 10%
10% à 25%
29.74
25.56
28.74
36.76
29.15
37.98
33.74
39.35
36.27

Figure 7: Prévalence standardisée des PIM à éviter par canton

Vallon et al., rapport cantonal Valais 2024

Prévalence


Prévalence standardisée
Benzodiazépines
Ecart à la moyenne
-50% à -25%
-25% à -10%
5% à 10%
10% à 25%
25% à 50%
13.35
11.29
12.47
23.27
12.28
20.68
19.3
23.13
23.83

Vallon et al., rapport cantonal Valais 2024

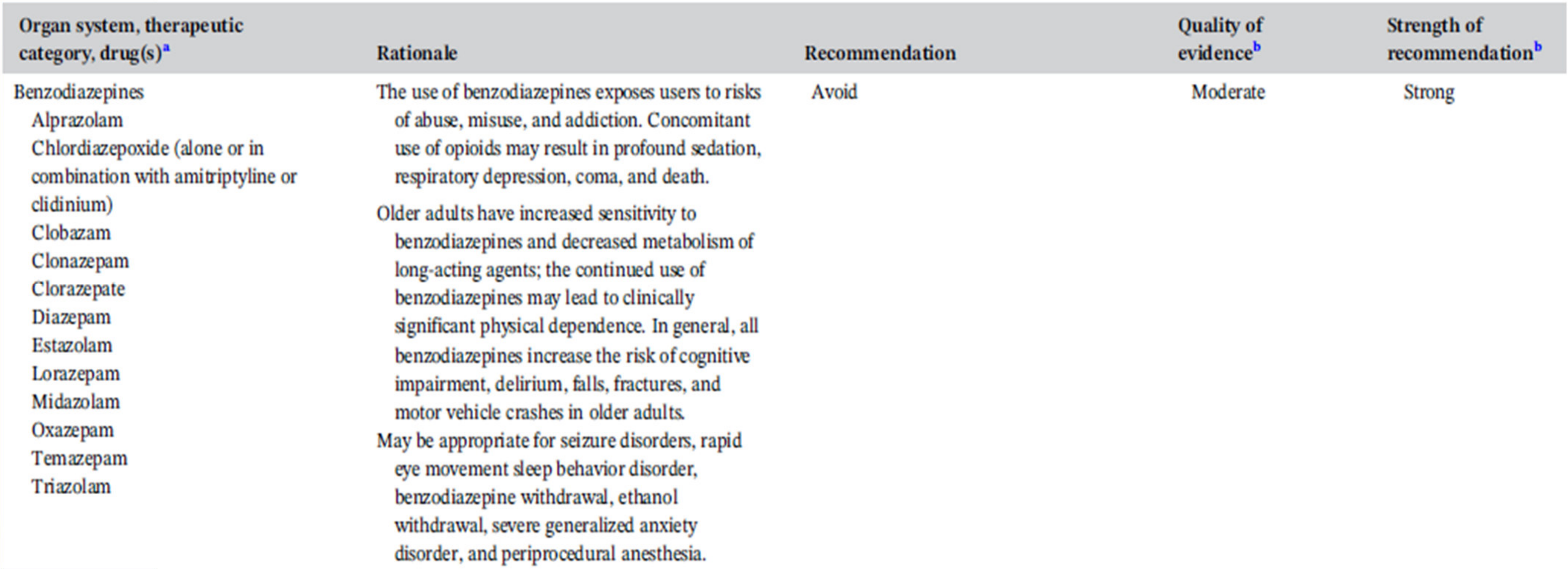
PIMs & outils

- **Critères de Beers** [22]
  - liste des PIMs à éviter c/o ≥ **65 ans**
  - 1991, puis m. à j régulières. **2023**
  - 53 médic. ou classes médic.
- **STOPP & START** [23,24]
  - outil pour patients ≥ **65 ans**
  - **S**creening **T**ool of **O**lder **P**ersons’ **P**rescriptions (133 cas) → PIMs
  - **S**creening **T**ool to **A**lert to **R**ight **T**reatment (57 cas)→ médic. essentiels omis
  - médic. classés par système
  - interactions médic. incluses
  - 2008, puis m. à j. **2023**

⇨ ***Ex. benzodiazépines***

Ex. Benzodiazépines

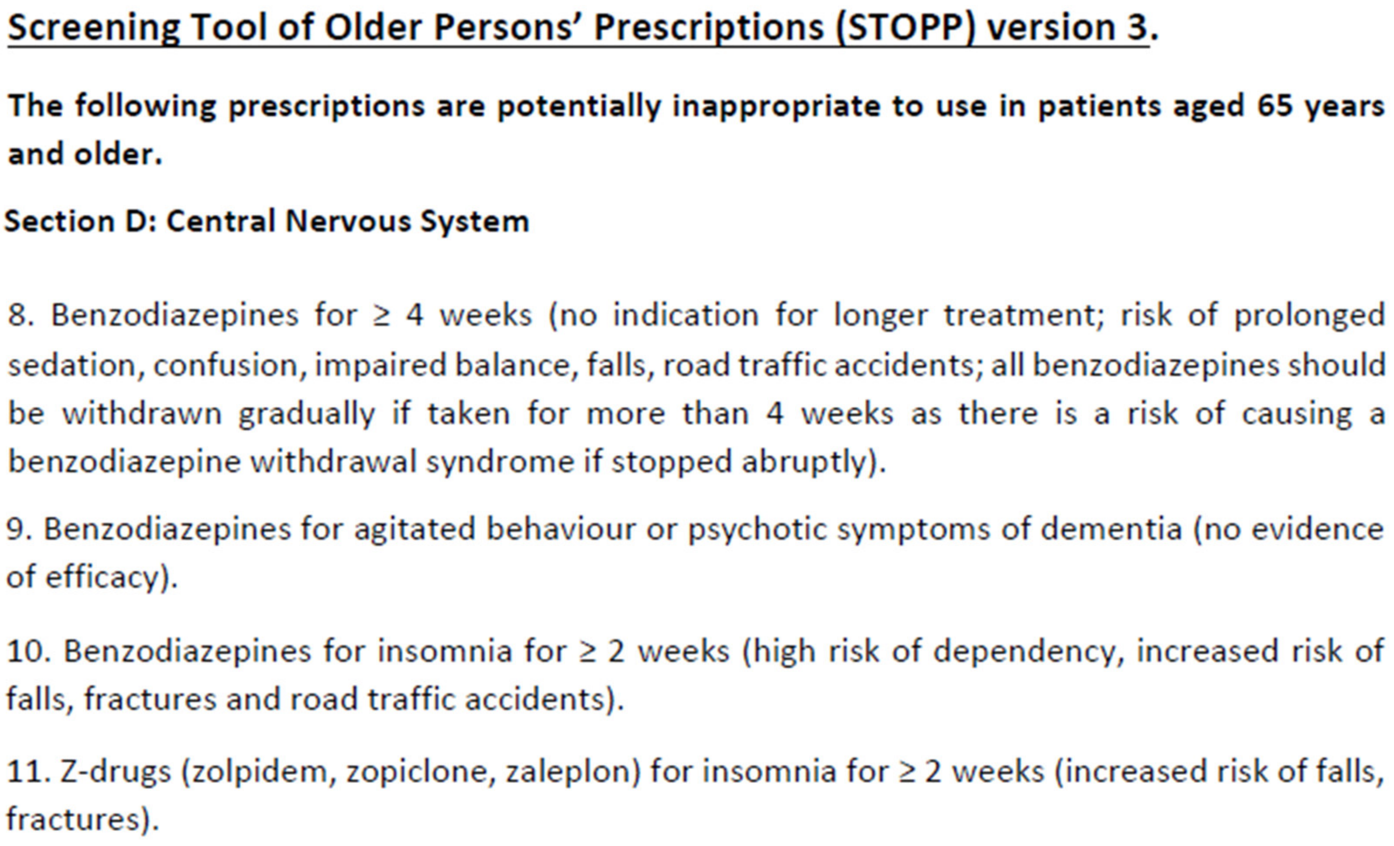
Liste de Beers 2023



Organ system, therapeutic category, drug(s)[a]	Rationale	Recommendation	Quality of evidence[b]	Strength of recommendation[b]
Benzodiazepines Alprazolam Chlordiazepoxide (alone or in combination with amitriptyline or clidinium) Clobazam Clonazepam Clorazepate Diazepam Estazolam Lorazepam Midazolam Oxazepam Temazepam Triazolam	The use of benzodiazepines exposes users to risks of abuse, misuse, and addiction. Concomitant use of opioids may result in profound sedation, respiratory depression, coma, and death. Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents; the continued use of benzodiazepines may lead to clinically significant physical dependence. In general, all benzodiazepines increase the risk of cognitive impairment, delirium, falls, fractures, and motor vehicle crashes in older adults. May be appropriate for seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, and periprocedural anesthesia.	Avoid	Moderate	Strong

J Am Geriatr Soc. 2023;1–30.

Ex. Benzodiazépines



Screening Tool of Older Persons' Prescriptions (STOPP) version 3.

The following prescriptions are potentially inappropriate to use in patients aged 65 years and older.

Section D: Central Nervous System

8. Benzodiazepines for ≥ 4 weeks (no indication for longer treatment; risk of prolonged sedation, confusion, impaired balance, falls, road traffic accidents; all benzodiazepines should be withdrawn gradually if taken for more than 4 weeks as there is a risk of causing a benzodiazepine withdrawal syndrome if stopped abruptly).

9. Benzodiazepines for agitated behaviour or psychotic symptoms of dementia (no evidence of efficacy).

10. Benzodiazepines for insomnia for ≥ 2 weeks (high risk of dependency, increased risk of falls, fractures and road traffic accidents).

11. Z-drugs (zolpidem, zopiclone, zaleplon) for insomnia for ≥ 2 weeks (increased risk of falls, fractures).

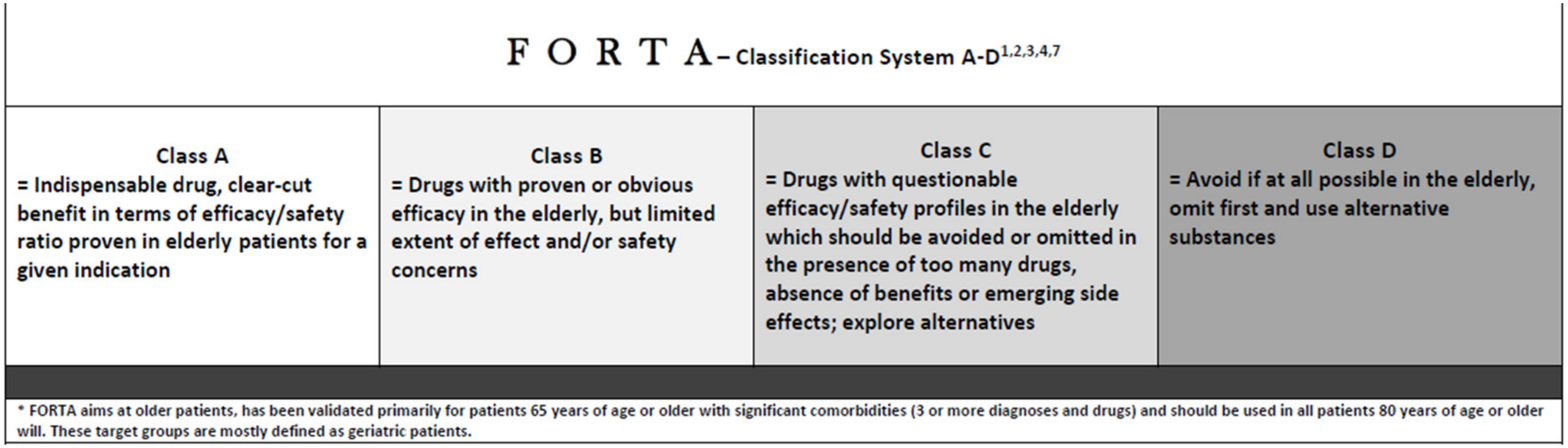
European Geriatric Medicine (2023) 14:625–632

PIMs & outils

- Critères de Beers 2023 🇺🇸
- STOPP/START 2023 🇮🇪
- EU(7) PIM Liste 2015 et EuroFORTA liste 🇪🇺
- Priscus Liste 2023 🇩🇪
- NORGEP-NH 2017 🇳🇴
- Liste de Morin 2018 🇫🇷
- StoppFrail liste 2017 🇮🇪

PIMs & outils

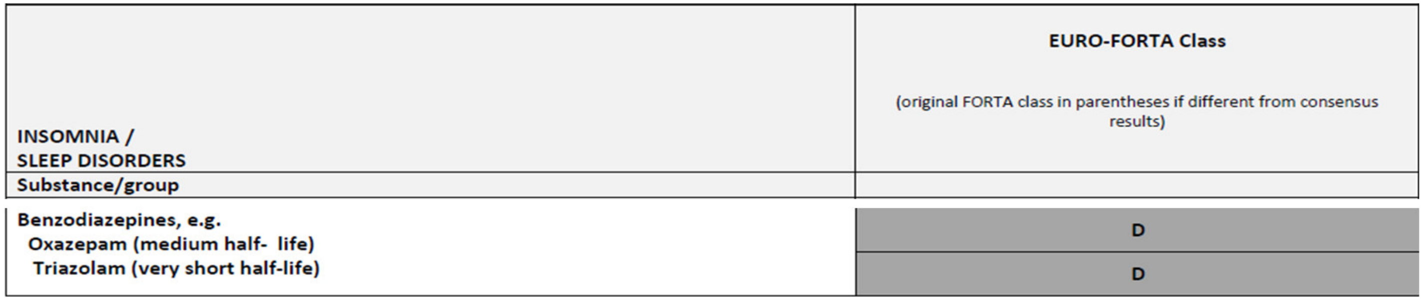
- EuroFORTA liste



FORTA – Classification System A-D[1,2,3,4,7]

Class A	Class B	Class C	Class D
= Indispensable drug, clear-cut benefit in terms of efficacy/safety ratio proven in elderly patients for a given indication	= Drugs with proven or obvious efficacy in the elderly, but limited extent of effect and/or safety concerns	= Drugs with questionable efficacy/safety profiles in the elderly which should be avoided or omitted in the presence of too many drugs, absence of benefits or emerging side effects; explore alternatives	= Avoid if at all possible in the elderly, omit first and use alternative substances

* FORTA aims at older patients, has been validated primarily for patients 65 years of age or older with significant comorbidities (3 or more diagnoses and drugs) and should be used in all patients 80 years of age or older will. These target groups are mostly defined as geriatric patients.

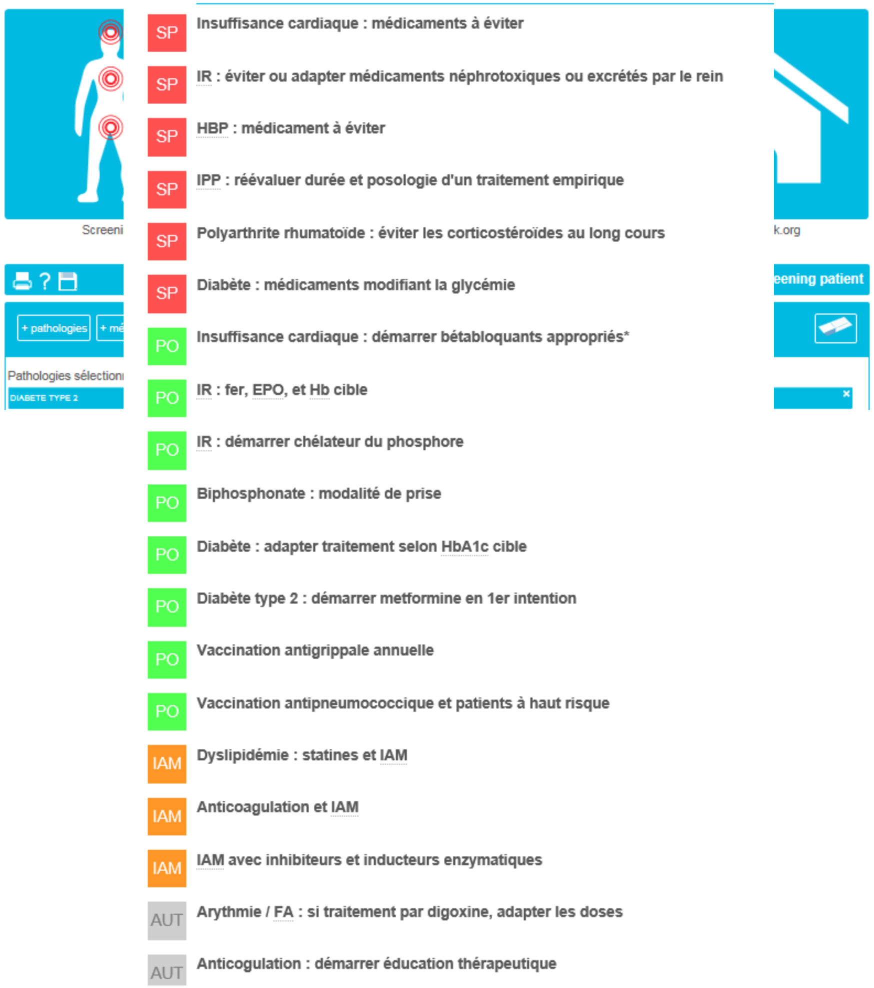


INSOMNIA / SLEEP DISORDERS	EURO-FORTA Class (original FORTA class in parentheses if different from consensus results)
Substance/group	
Benzodiazepines, e.g.	
Oxazepam (medium half- life)	D
Triazolam (very short half-life)	D

https://forta.umm.uni-heidelberg.de/ pour CH/A/D

PIMs & outils

- www.pimcheck.org
- HUG, en coll. avec médecins, pharmaciens suisses, français, belges et canadiens
- > 1600 médic.
- tient compte des comorbidités
- Intègre les guidelines internationales et des soc. savantes



SP	Insuffisance cardiaque : médicaments à éviter
SP	IR : éviter ou adapter médicaments néphrotoxiques ou excrétés par le rein
SP	HBP : médicament à éviter
SP	IPP : réévaluer durée et posologie d'un traitement empirique
SP	Polyarthrite rhumatoïde : éviter les corticostéroïdes au long cours
SP	Diabète : médicaments modifiant la glycémie
PO	Insuffisance cardiaque : démarrer bétabloquants appropriés*
PO	IR : fer, EPO, et Hb cible
PO	IR : démarrer chélateur du phosphore
PO	Biphosphonate : modalité de prise
PO	Diabète : adapter traitement selon HbA1c cible
PO	Diabète type 2 : démarrer metformine en 1er intention
PO	Vaccination antigrippale annuelle
PO	Vaccination antipneumococcique et patients à haut risque
IAM	Dyslipidémie : statines et IAM
IAM	Anticoagulation et IAM
IAM	IAM avec inhibiteurs et inducteurs enzymatiques
AUT	Arythmie / FA : si traitement par digoxine, adapter les doses
AUT	Anticogulation : démarrer éducation thérapeutique

91 ans

A l'arrivée à l'hôpital

- Perindopril 4mg 1-0-0
- **Digoxine** 0,125mg 1-0-0 sauf ve-sa-di
- Sintrom selon TP
- Torasémide 2,5mg 1-0-0
- Aspirine cardio 100mg 1-0-0
- **Prednisone** 5mg 1 ½ -0-0
- **Co**-Dafalgan 1-0-1
- Simvastatine 20mg 0-0-1
- Calcium D3 sachet 1-0-1
- *Alendron* 70mg 1cp à 11 h le mardi
- **Duofer** 1-0-0
- Esoméprazole 20mg 1-0-0
- Finastéride 5mg 1-0-0
- **Flavoxate** 1-0-1
- **Térazosine** 5mg 0-0-1
- Movicol 1-0-0
- **Supradyn** 1-0-0

PIMs (Beers, ST-ST)

Toxicité si > 0,125 mg/j & IR

delirium, EI long terme

pas long terme si dlr faible-modérée

Indication?

antichol.: delirium, démence/tbles cognitifs, péjor. constip. chronique

Hypotension orthostat., bradycardie

Utile?

Nouvelle culture

Choosing wisely
2011 - USA

Smarter medicine

Slow medicine

LESS
is
MORE

Stratégie Santé 2020
Qualité des prestations et des soins

↓ nombre de prestations, de processus et de médicaments **inefficients et inefficaces**

smartermedicine.ch

Top 5 listes
Méd. ambulatoire, hospitalière, intensive, néphrologie, gériatrie, …

Deprescribing **N**etworks: ADeN, CaDeN, …

Source image: www.123rf.com

Santé 2020, rétrospectives 2016, perspectives pour 2017 et législature 2016-2019, rapport OFSP, 06.2017

Déprescrire: les + et les -

Avantages
Simplification du traitement
Disparition d’effets indésirables
↑ Qualité de vie
↑ Adhésion thérapeutique
↓ Coûts liés aux médic. et à la prise en charge des EI
↓ Interactions médicamenteuses
Opportunité d’une réévaluation du ttt et d’une décision partagée avec le patient

Inconvénients
Risque de récurrence des conditions médicales
Réactions de sevrage du médicament ou de rebond
Renversement d’une interaction médicamenteuse

Utilité?

↓ **Mortalité** à 1 an *(45% vs 21%)* après arrêt 2,8 médic. moyenne/patient *vs* sans chgt ttt chez patients EMS israëliens , ↓ **transferts en soins aigüs** *(11.8% vs 30%),* pas de différence d'EI, 18% patients avec échec d'arrêt et réintroduction du médic. (antidépresseurs, antipsych, …)

Garfinkel et al, IMAJ, 2007, 9:430.34

↑ **PIMs stoppés** chez résidents EMS hollandais , mais pas de différence d'EI ou d'impact sur *outcomes* 2^{aires} (sympt. neuropsychiatr. , fonction cognitive, qlté de vie)

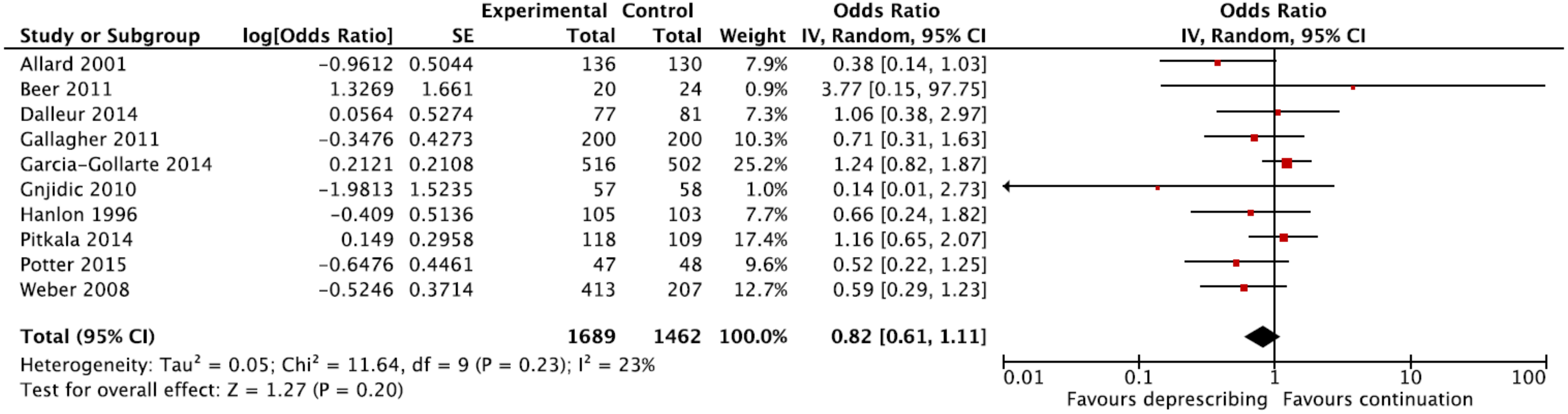
Wouters et al, Ann Intern Med, 2017, 167(9):609-17

Utilité?

The feasibility and effect of deprescribing in older adults on mortality and health: a systematic review and meta-analysis

- Mean follow-up duration: 9,6 +/- 3,9 mo
- Settings: community, hospitals, nursing homes

Figure 3 Mortality associated with deprescribing interventions to reduce polypharmacy (randomized studies)



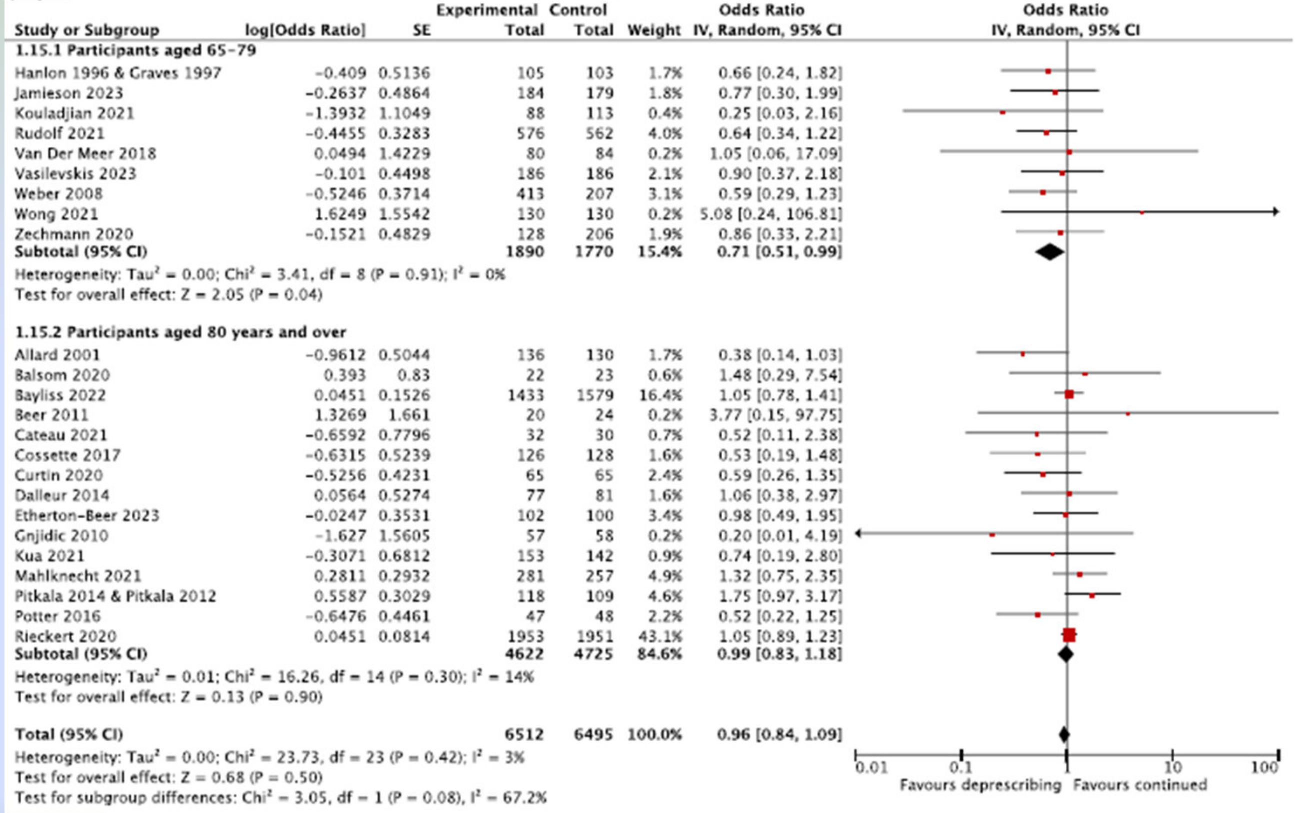
Study or Subgroup	log[Odds Ratio]	SE	Experimental Total	Control Total	Weight	Odds Ratio IV, Random, 95% CI
Allard 2001	−0.9612	0.5044	136	130	7.9%	0.38 [0.14, 1.03]
Beer 2011	1.3269	1.661	20	24	0.9%	3.77 [0.15, 97.75]
Dalleur 2014	0.0564	0.5274	77	81	7.3%	1.06 [0.38, 2.97]
Gallagher 2011	−0.3476	0.4273	200	200	10.3%	0.71 [0.31, 1.63]
Garcia–Gollarte 2014	0.2121	0.2108	516	502	25.2%	1.24 [0.82, 1.87]
Gnjidic 2010	−1.9813	1.5235	57	58	1.0%	0.14 [0.01, 2.73]
Hanlon 1996	−0.409	0.5136	105	103	7.7%	0.66 [0.24, 1.82]
Pitkala 2014	0.149	0.2958	118	109	17.4%	1.16 [0.65, 2.07]
Potter 2015	−0.6476	0.4461	47	48	9.6%	0.52 [0.22, 1.25]
Weber 2008	−0.5246	0.3714	413	207	12.7%	0.59 [0.29, 1.23]
Total (95% CI)			**1689**	**1462**	**100.0%**	**0.82 [0.61, 1.11]**

Heterogeneity: Tau^2 = 0.05; Chi^2 = 11.64, df = 9 (P = 0.23); I^2 = 23%
Test for overall effect: Z = 1.27 (P = 0.20)

Page et al, Br J Clin Pharmacol, 2016, 82: 583-623

Utilité?

The effect of deprescribing interventions on mortality and health outcomes in older people: An updated systematic review and meta-analysis



Study or Subgroup	log[Odds Ratio]	SE	Experimental Total	Control Total	Weight	Odds Ratio IV, Random, 95% CI
1.15.1 Participants aged 65–79						
Hanlon 1996 & Graves 1997	−0.409	0.5136	105	103	1.7%	0.66 [0.24, 1.82]
Jamieson 2023	−0.2637	0.4864	184	179	1.8%	0.77 [0.30, 1.99]
Kouladjian 2021	−1.3932	1.1049	88	113	0.4%	0.25 [0.03, 2.16]
Rudolf 2021	−0.4455	0.3283	576	562	4.0%	0.64 [0.34, 1.22]
Van Der Meer 2018	0.0494	1.4229	80	84	0.2%	1.05 [0.06, 17.09]
Vasilevskis 2023	−0.101	0.4498	186	186	2.1%	0.90 [0.37, 2.18]
Weber 2008	−0.5246	0.3714	413	207	3.1%	0.59 [0.29, 1.23]
Wong 2021	1.6249	1.5542	130	130	0.2%	5.08 [0.24, 106.81]
Zechmann 2020	−0.1521	0.4829	128	206	1.9%	0.86 [0.33, 2.21]
Subtotal (95% CI)			**1890**	**1770**	**15.4%**	**0.71 [0.51, 0.99]**
Heterogeneity: Tau² = 0.00; Chi² = 3.41, df = 8 (P = 0.91); I² = 0%						
Test for overall effect: Z = 2.05 (P = 0.04)						
1.15.2 Participants aged 80 years and over						
Allard 2001	−0.9612	0.5044	136	130	1.7%	0.38 [0.14, 1.03]
Balsom 2020	0.393	0.83	22	23	0.6%	1.48 [0.29, 7.54]
Bayliss 2022	0.0451	0.1526	1433	1579	16.4%	1.05 [0.78, 1.41]
Beer 2011	1.3269	1.661	20	24	0.2%	3.77 [0.15, 97.75]
Cateau 2021	−0.6592	0.7796	32	30	0.7%	0.52 [0.11, 2.38]
Cossette 2017	−0.6315	0.5239	126	128	1.6%	0.53 [0.19, 1.48]
Curtin 2020	−0.5256	0.4231	65	65	2.4%	0.59 [0.26, 1.35]
Dalleur 2014	0.0564	0.5274	77	81	1.6%	1.06 [0.38, 2.97]
Etherton-Beer 2023	−0.0247	0.3531	102	100	3.4%	0.98 [0.49, 1.95]
Gnjidic 2010	−1.627	1.5605	57	58	0.2%	0.20 [0.01, 4.19]
Kua 2021	−0.3071	0.6812	153	142	0.9%	0.74 [0.19, 2.80]
Mahlknecht 2021	0.2811	0.2932	281	257	4.9%	1.32 [0.75, 2.35]
Pitkala 2014 & Pitkala 2012	0.5587	0.3029	118	109	4.6%	1.75 [0.97, 3.17]
Potter 2016	−0.6476	0.4461	47	48	2.2%	0.52 [0.22, 1.25]
Rieckert 2020	0.0451	0.0814	1953	1951	43.1%	1.05 [0.89, 1.23]
Subtotal (95% CI)			**4622**	**4725**	**84.6%**	**0.99 [0.83, 1.18]**
Heterogeneity: Tau² = 0.01; Chi² = 16.26, df = 14 (P = 0.30); I² = 14%						
Test for overall effect: Z = 0.13 (P = 0.90)						
Total (95% CI)			**6512**	**6495**	**100.0%**	**0.96 [0.84, 1.09]**
Heterogeneity: Tau² = 0.00; Chi² = 23.73, df = 23 (P = 0.42); I² = 3%						
Test for overall effect: Z = 0.68 (P = 0.50)						
Test for subgroup differences: Chi² = 3.05, df = 1 (P = 0.08), I² = 67.2%						

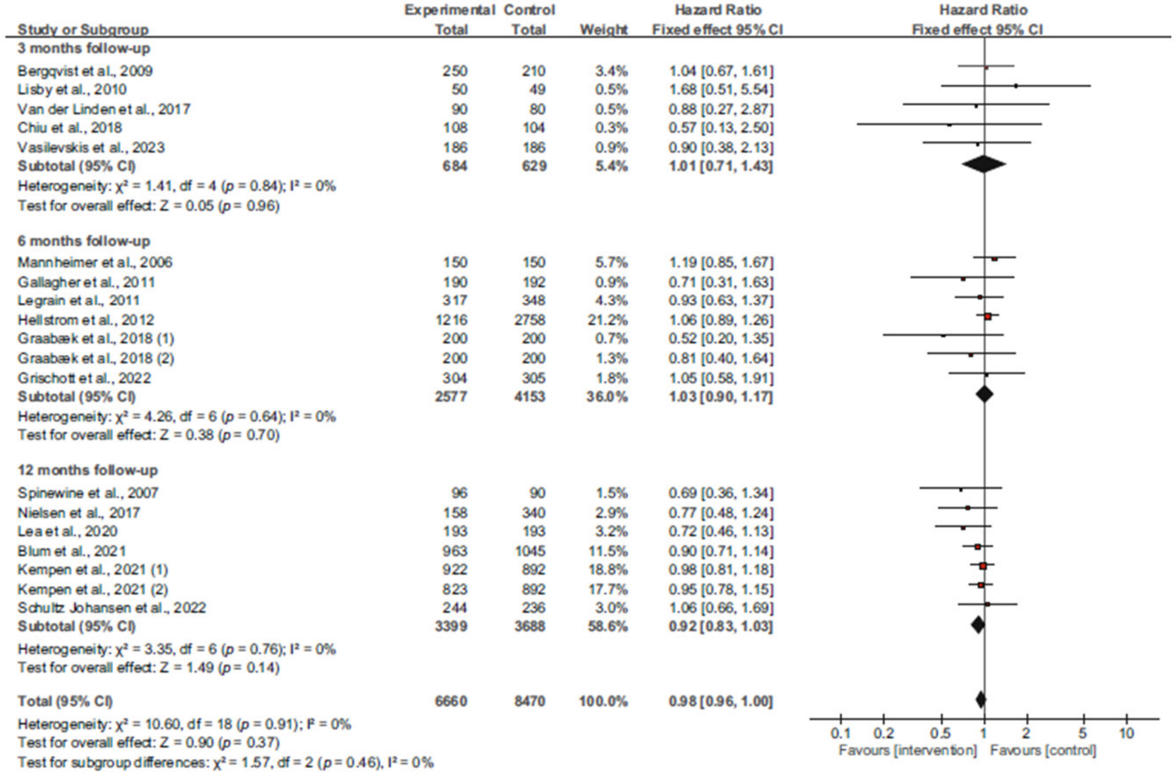
Update 2024

- Mean follow-up duration: 15.1 +/- 12.4 mo
- Settings: community, hospitals, nursing homes
- Participants: 78.0 ± 6.7 years

Br J Clin Pharmacol. 2024;90:2409–2482.

Utilité?

Clinical impact of medication review and deprescribing in older inpatients: A systematic review and meta-analysis



Study or Subgroup	Experimental Total	Control Total	Weight	Hazard Ratio Fixed effect 95% CI
3 months follow-up				
Bergqvist et al., 2009	250	210	3.4%	1.04 [0.67, 1.61]
Lisby et al., 2010	50	49	0.5%	1.68 [0.51, 5.54]
Van der Linden et al., 2017	90	80	0.5%	0.88 [0.27, 2.87]
Chiu et al., 2018	108	104	0.3%	0.57 [0.13, 2.50]
Vasilevskis et al., 2023	186	186	0.9%	0.90 [0.38, 2.13]
Subtotal (95% CI)	**684**	**629**	**5.4%**	**1.01 [0.71, 1.43]**
Heterogeneity: $\chi^2 = 1.41$, df = 4 ($p = 0.84$); $I^2 = 0\%$				
Test for overall effect: Z = 0.05 ($p = 0.96$)				
6 months follow-up				
Mannheimer et al., 2006	150	150	5.7%	1.19 [0.85, 1.67]
Gallagher et al., 2011	190	192	0.9%	0.71 [0.31, 1.63]
Legrain et al., 2011	317	348	4.3%	0.93 [0.63, 1.37]
Hellstrom et al., 2012	1216	2758	21.2%	1.06 [0.89, 1.26]
Graabæk et al., 2018 (1)	200	200	0.7%	0.52 [0.20, 1.35]
Graabæk et al., 2018 (2)	200	200	1.3%	0.81 [0.40, 1.64]
Grischott et al., 2022	304	305	1.8%	1.05 [0.58, 1.91]
Subtotal (95% CI)	**2577**	**4153**	**36.0%**	**1.03 [0.90, 1.17]**
Heterogeneity: $\chi^2 = 4.26$, df = 6 ($p = 0.64$); $I^2 = 0\%$				
Test for overall effect: Z = 0.38 ($p = 0.70$)				
12 months follow-up				
Spinewine et al., 2007	96	90	1.5%	0.69 [0.36, 1.34]
Nielsen et al., 2017	158	340	2.9%	0.77 [0.48, 1.24]
Lea et al., 2020	193	193	3.2%	0.72 [0.46, 1.13]
Blum et al., 2021	963	1045	11.5%	0.90 [0.71, 1.14]
Kempen et al., 2021 (1)	922	892	18.8%	0.98 [0.81, 1.18]
Kempen et al., 2021 (2)	823	892	17.7%	0.95 [0.78, 1.15]
Schultz Johansen et al., 2022	244	236	3.0%	1.06 [0.66, 1.69]
Subtotal (95% CI)	**3399**	**3688**	**58.6%**	**0.92 [0.83, 1.03]**
Heterogeneity: $\chi^2 = 3.35$, df = 6 ($p = 0.76$); $I^2 = 0\%$				
Test for overall effect: Z = 1.49 ($p = 0.14$)				
Total (95% CI)	**6660**	**8470**	**100.0%**	**0.98 [0.96, 1.00]**
Heterogeneity: $\chi^2 = 10.60$, df = 18 ($p = 0.91$); $I^2 = 0\%$				
Test for overall effect: Z = 0.90 ($p = 0.37$)				
Test for subgroup differences: $\chi^2 = 1.57$, df = 2 ($p = 0.46$), $I^2 = 0\%$				

Réduction significative (8%) des réadmissions hospitalières après déprescription/revue médication

Pas d'impact sur la mortalité

Diminution des ADE/ADR

- Population: 59-86 ans
- Suivi 1-40 mois après hospitalisation

J Am Geriatr Soc. 2024;72:3219-3238.

Utilité?

Peu d'évidences de bénéfices sur les outcomes cliniques

- Taille d'échantillon trop petite
- Durée du follow-up trop courte
- Dégâts causés par polymédication ou PIMs réversibles?
- Polymédication et PIMs: plutôt des marqueurs de sévérité des comorbidités que les responsables directs des dégâts associés

Reeve et al, Eur J Intern Med, 2017, 38: 3-11

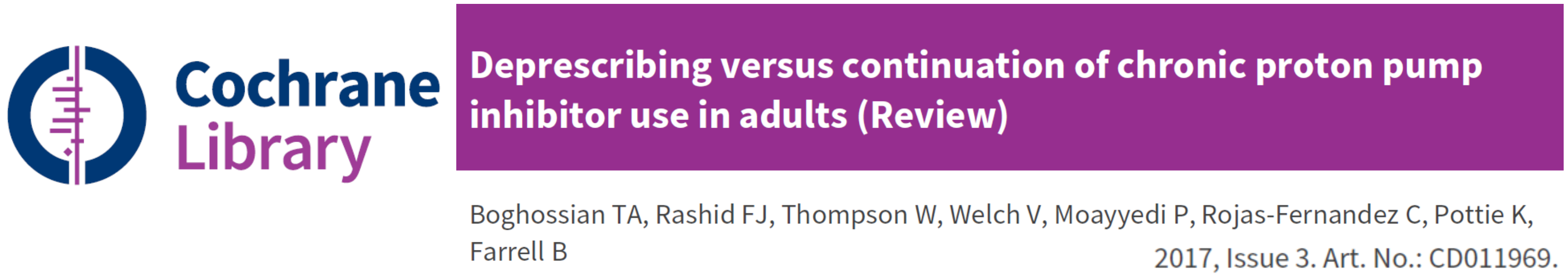
Sécurité?

Déprescrire sans nuire au patient

- n=70 patients âgés ambulatoires (moyennes: 82,8 +/- 6,9 ans, 7,7 +/- 3,7 médic.)
- Algorithme des médic. à stopper
- Suivi moyen de 19 mois
- 82% (256/311) médic. stoppés (c/o 64 patients)
- 2% (6/311) médic. repris car **récurrence** de l'indication initiale
- Pas d'EI significatifs ou décès en lien avec déprescrip.
- 88% patients rapportent une amélioration de santé globale

Garfinkel et al, Arch Intern Med. 2010 Oct 11;170(18):1648-54

Sécurité?

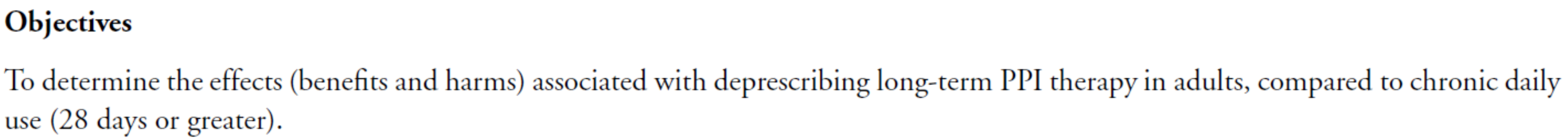


Cochrane Library

Deprescribing versus continuation of chronic proton pump inhibitor use in adults (Review)

Boghossian TA, Rashid FJ, Thompson W, Welch V, Moayyedi P, Rojas-Fernandez C, Pottie K, Farrell B

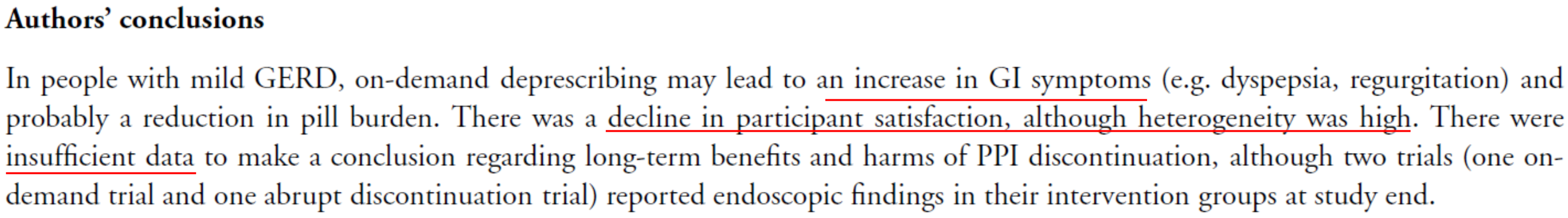
2017, Issue 3. Art. No.: CD011969.



Objectives

To determine the effects (benefits and harms) associated with deprescribing long-term PPI therapy in adults, compared to chronic daily use (28 days or greater).

6 trials retenues pour l'analyse
Outpatient settings



Authors' conclusions

In people with mild GERD, on-demand deprescribing may lead to an increase in GI symptoms (e.g. dyspepsia, regurgitation) and probably a reduction in pill burden. There was a decline in participant satisfaction, although heterogeneity was high. There were insufficient data to make a conclusion regarding long-term benefits and harms of PPI discontinuation, although two trials (one on-demand trial and one abrupt discontinuation trial) reported endoscopic findings in their intervention groups at study end.

Sécurité?

Antidépresseurs: Influence de l’âge

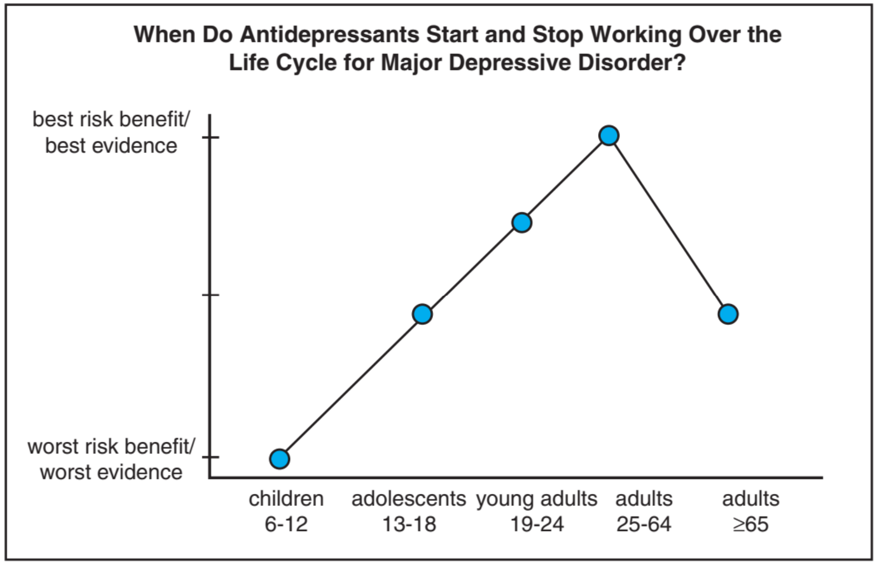
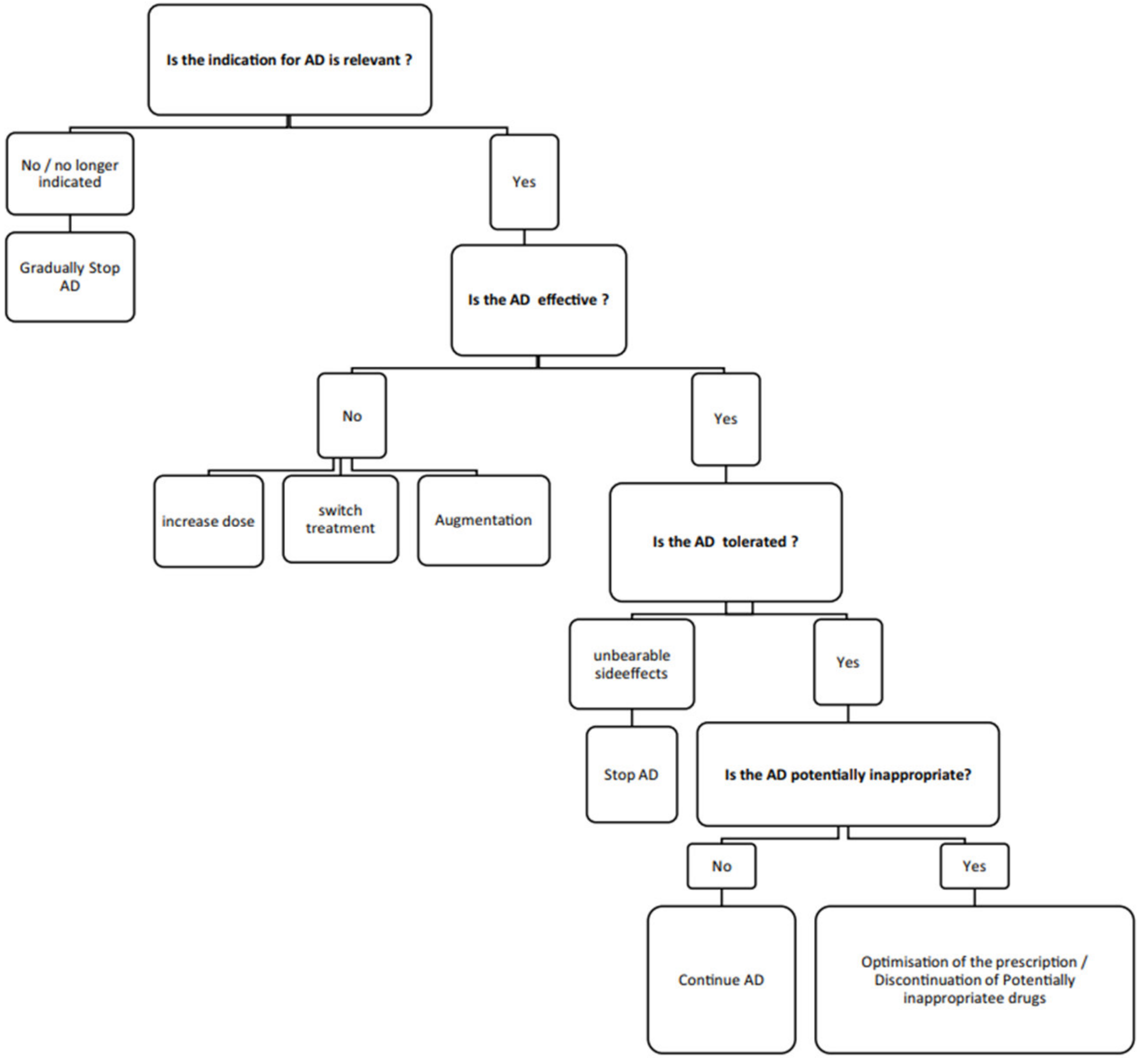


Figure 7-7. Antidepressants over the life cycle. The efficacy, tolerability, and safety of antidepressants have been studied mostly in individuals between the ages of 25 and 64. Existing data across all age groups suggest that the risk–benefit ratio is most favorable for adults between the ages of 25 and 64 and somewhat less so for adults between the ages of 19 and 24, due to a possibly increased risk of suicidality in younger adults. Limited data in children and adolescents also suggest increased risk of suicidality; this, coupled with a lack of data demonstrating clear antidepressant efficacy, gives children between the ages of 6 and 12 the worst risk–benefit ratio, with adolescents intermediate between young adults and children. Elderly patients, 65 years of age and older, may not respond as well or as quickly to antidepressants as other adults and may also experience more side effects than younger adults.

Sécurité? Antidépresseurs


Is the indication for AD is relevant ?
No / no longer indicated
Gradually Stop AD
Yes
Is the AD effective ?
No
increase dose
switch treatment
Augmentation
Yes
Is the AD tolerated ?
unbearable sideeffects
Stop AD
Yes
Is the AD potentially inappropriate?
No
Continue AD
Yes
Optimisation of the prescription / Discontinuation of Potentially inappropriatee drugs

- → Indication
- → Efficacité
- →Tolérance
- →PIM

Therapeutics and Clinical Risk Management 2023:19 291–299

Déprescription antidépresseurs

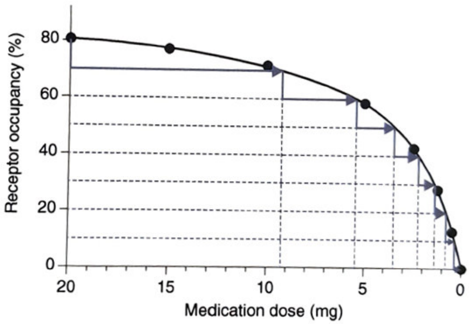
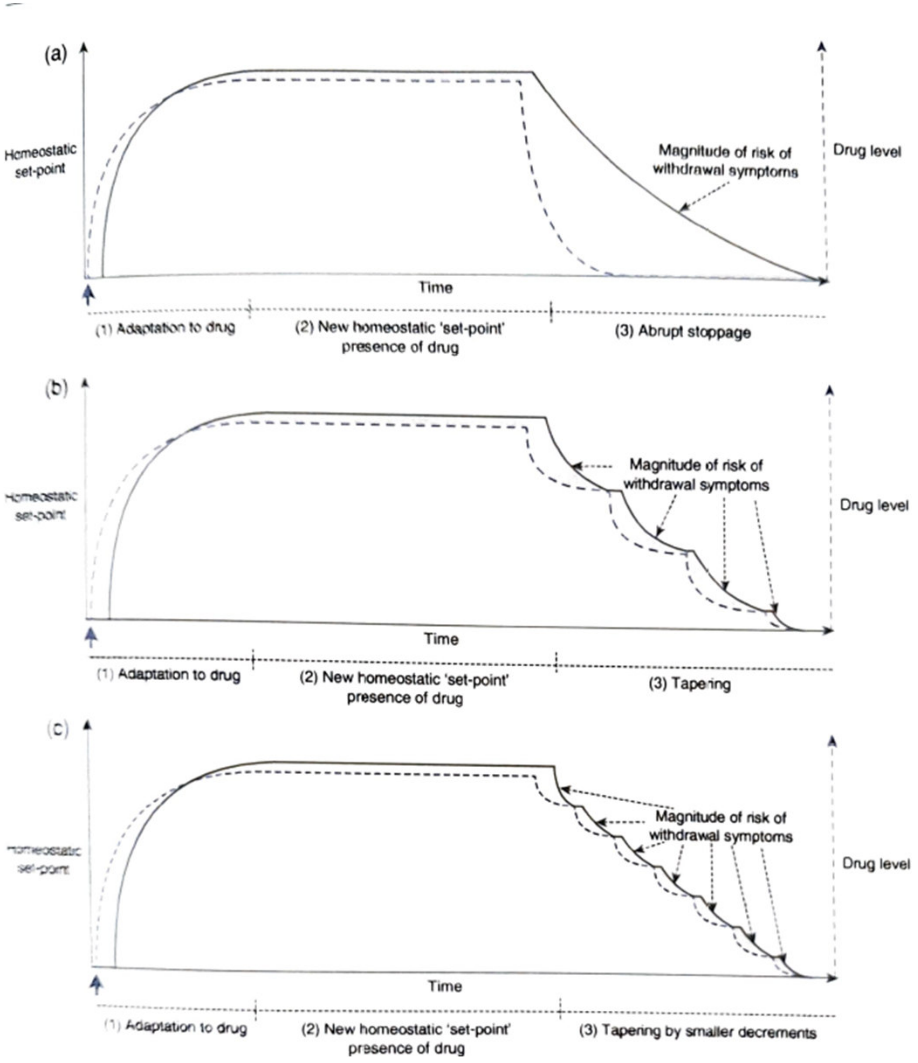


Figure 1.2 Example of hyperbolic tapering of a psychiatric medication. Dose reductions are shown on the x-axis, with increasingly small reductions producing equal-sized reductions in receptor occupancy (on the y-axis).


(a)
Homeostatic set-point
Magnitude of risk of withdrawal symptoms
Drug level
Time
(1) Adaptation to drug
(2) New homeostatic 'set-point' presence of drug
(3) Abrupt stoppage
(b)
Homeostatic set-point
Magnitude of risk of withdrawal symptoms
Drug level
Time
(1) Adaptation to drug
(2) New homeostatic 'set-point' presence of drug
(3) Tapering
(c)
Homeostatic set-point
Magnitude of risk of withdrawal symptoms
Drug level
Time
(1) Adaptation to drug
(2) New homeostatic 'set-point' presence of drug
(3) Tapering by smaller decrements

M Horowitz, D.Taylor, The Maudsley, Deprescribing guidelines, Wiley Blackwell 2024

Déprescription antidépresseurs

Fréquences et sévérité de symptômes de sevrage	**Antidépresseur**
Sévère et fréquent	**SNRI**: (des)venlafaxine, duloxetine **SSRI**: paroxétine **MAOi**: moclobemide **Autre**: mirtazapine
Modérément fréquent/sévère	**SSRI**: (es)citalopram, sertraline, fluvoxamine, fluoxétine **TCA**: nortriptyline, clomipramine, imipramine, amitriptyline **Autres**: trazodone, milnacipran, réboxétine, bupropion
Moins fréquent/sévère	Vortioxétine, miansérine, trimipramine
Le moins fréquent/faible risque	Agomélatine

M Horowitz, D.Taylor, The Maudsley, Deprescribing guidelines, Wiley Blackwell 2024

Déprescription antidépresseurs

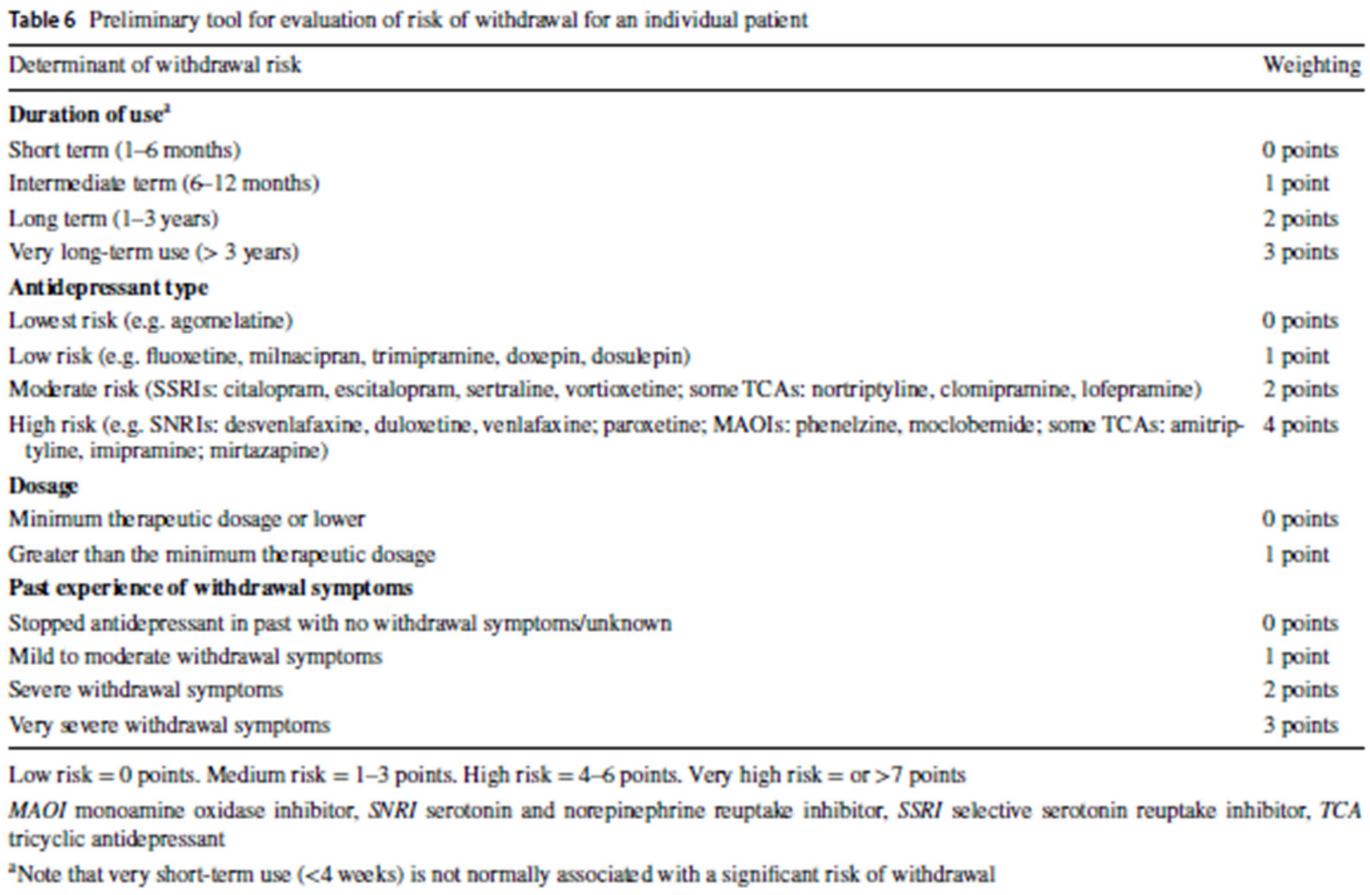


Table 6 Preliminary tool for evaluation of risk of withdrawal for an individual patient

Determinant of withdrawal risk	Weighting
Duration of use[a]	
Short term (1–6 months)	0 points
Intermediate term (6–12 months)	1 point
Long term (1–3 years)	2 points
Very long-term use (> 3 years)	3 points
Antidepressant type	
Lowest risk (e.g. agomelatine)	0 points
Low risk (e.g. fluoxetine, milnacipran, trimipramine, doxepin, dosulepin)	1 point
Moderate risk (SSRIs: citalopram, escitalopram, sertraline, vortioxetine; some TCAs: nortriptyline, clomipramine, lofepramine)	2 points
High risk (e.g. SNRIs: desvenlafaxine, duloxetine, venlafaxine; paroxetine; MAOIs: phenelzine, moclobemide; some TCAs: amitriptyline, imipramine; mirtazapine)	4 points
Dosage	
Minimum therapeutic dosage or lower	0 points
Greater than the minimum therapeutic dosage	1 point
Past experience of withdrawal symptoms	
Stopped antidepressant in past with no withdrawal symptoms/unknown	0 points
Mild to moderate withdrawal symptoms	1 point
Severe withdrawal symptoms	2 points
Very severe withdrawal symptoms	3 points

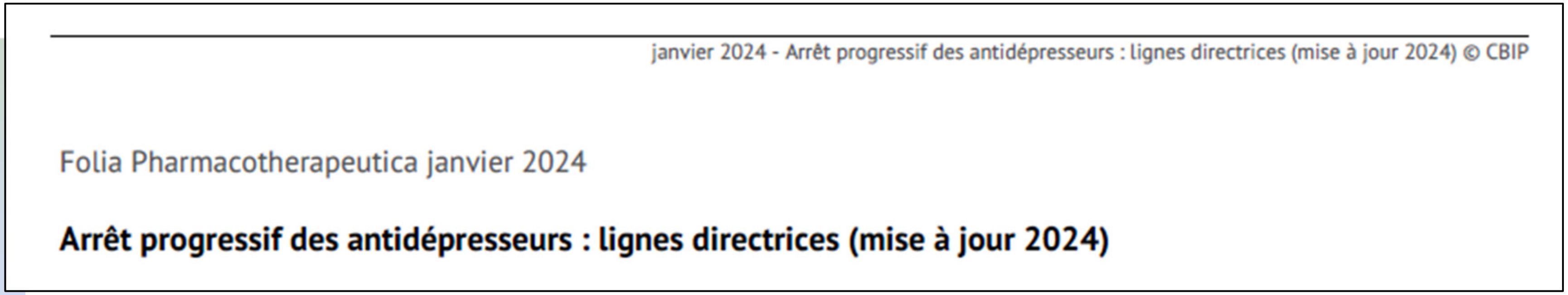
Low risk = 0 points. Medium risk = 1–3 points. High risk = 4–6 points. Very high risk = or >7 points

MAOI monoamine oxidase inhibitor, *SNRI* serotonin and norepinephrine reuptake inhibitor, *SSRI* selective serotonin reuptake inhibitor, *TCA* tricyclic antidepressant

[a] Note that very short-term use (<4 weeks) is not normally associated with a significant risk of withdrawal

CNS Drugs (2023) 37:143–157

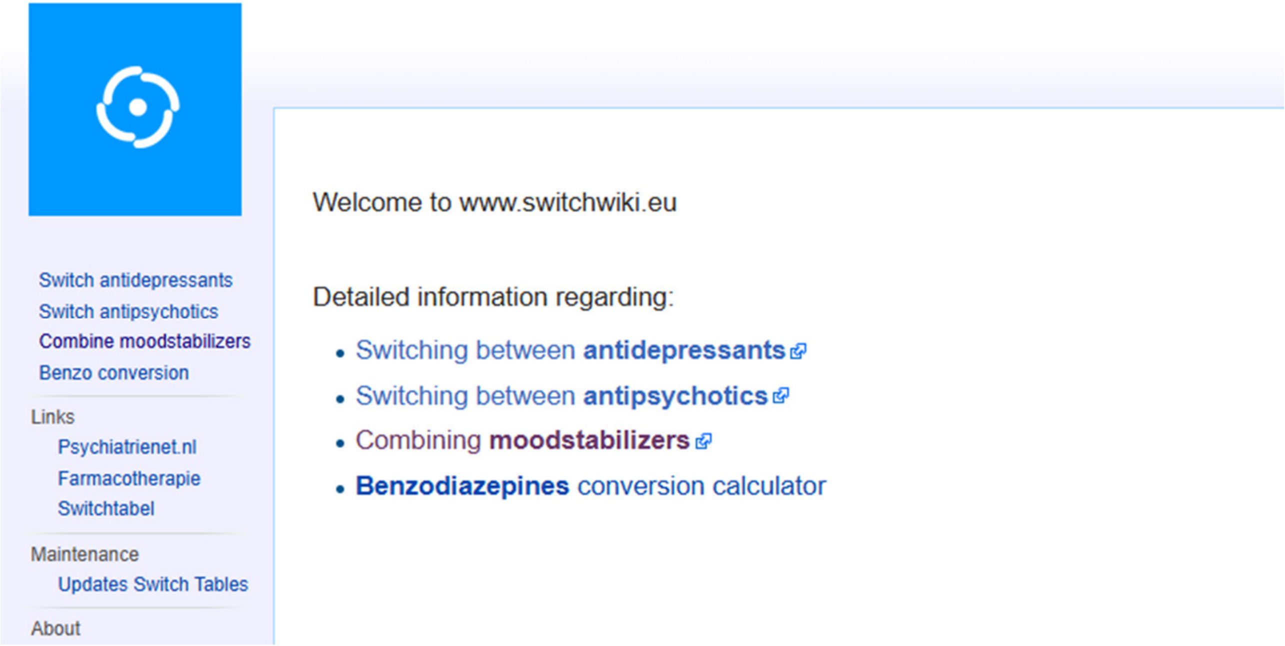
Déprescription antidépresseurs
Outils



janvier 2024 - Arrêt progressif des antidépresseurs : lignes directrices (mise à jour 2024) © CBIP

Folia Pharmacotherapeutica janvier 2024

Arrêt progressif des antidépresseurs : lignes directrices (mise à jour 2024)


Switch antidepressants
Switch antipsychotics
Combine moodstabilizers
Benzo conversion
Links
Psychiatrienet.nl
Farmacotherapie
Switchtabel
Maintenance
Updates Switch Tables
About

Welcome to www.switchwiki.eu

Detailed information regarding:

- Switching between **antidepressants**
- Switching between **antipsychotics**
- Combining **moodstabilizers**
- **Benzodiazepines** conversion calculator

DEPRESCRIPTION

1. **Anamnèse médicamenteuse exhaustive**
    - Chronologie (cascade?)
    - Allergies médic.
    - Complexité: ‘fardeau’ pharmacologique
    - **Opinion du patient** sur ses médic. et la déprescrip.
2. **Détecter les PIMs** et évaluer les risques/bénéfices
    - Âge, IR, interactions méd.
3. **Choisir quels médic. stopper**
    - 1 médic. à la fois (prioriser)
    - Choisir le moment (stable cliniquement)
    - Chances de succès (patient, tentatives antérieures?)
    - Sevrage progressif?
    - Simplifier le ttt (nbre de prises, médic. combinés)
4. **Planifier le retrait et le suivi**
    - Explications et **consentement du patient**
5. **Retrait, suivi et soutien du patient**
    - Documenter, informer les autres profess. de santé

Déprescription - Outils

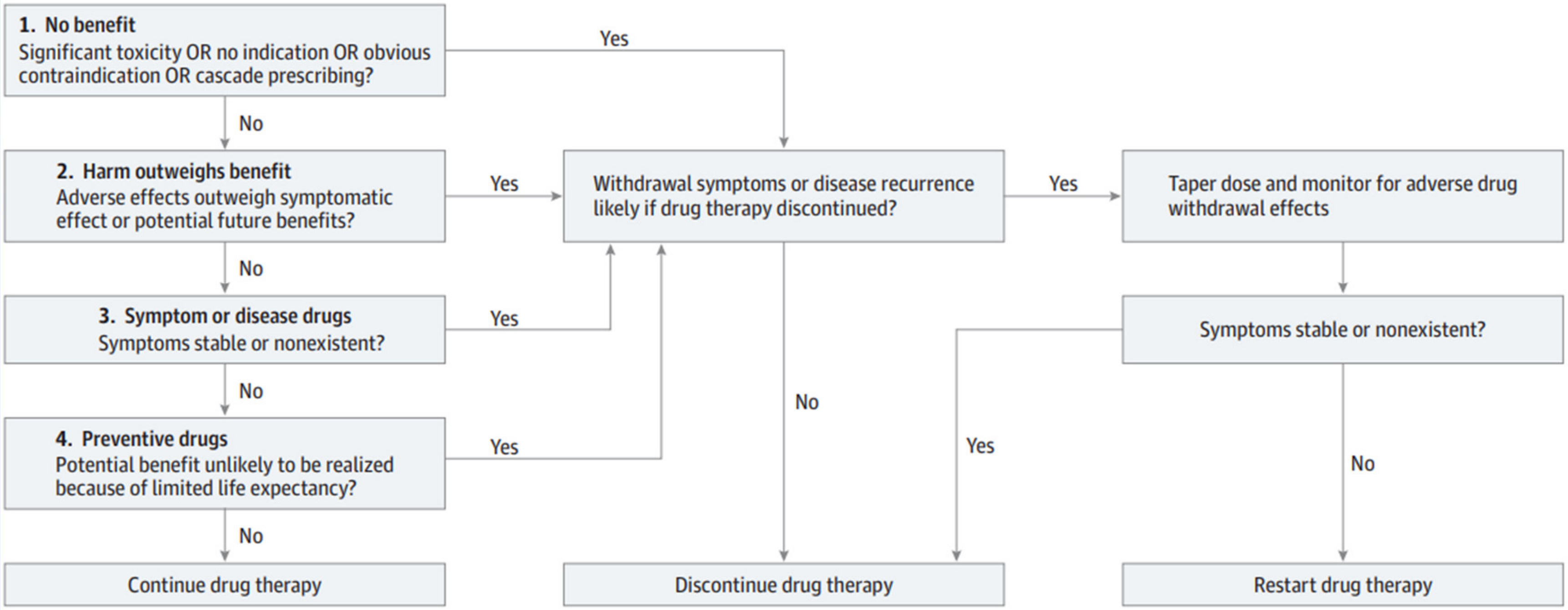


Figure. Algorithm for Deciding Order and Mode in Which Drug Use Could Be Discontinued

1. No benefit
Significant toxicity OR no indication OR obvious contraindication OR cascade prescribing?

2. Harm outweighs benefit
Adverse effects outweigh symptomatic effect or potential future benefits?

3. Symptom or disease drugs
Symptoms stable or nonexistent?

4. Preventive drugs
Potential benefit unlikely to be realized because of limited life expectancy?

Continue drug therapy

Withdrawal symptoms or disease recurrence likely if drug therapy discontinued?

Discontinue drug therapy

Taper dose and monitor for adverse drug withdrawal effects

Symptoms stable or nonexistent?

Restart drug therapy

JAMA Intern Med. 2015;175(5):827-834

Approches

Intervention multi-facettes (revue médicamenteuse) ↔ **1 médic.** ou **1 classe thérap.** spécifique

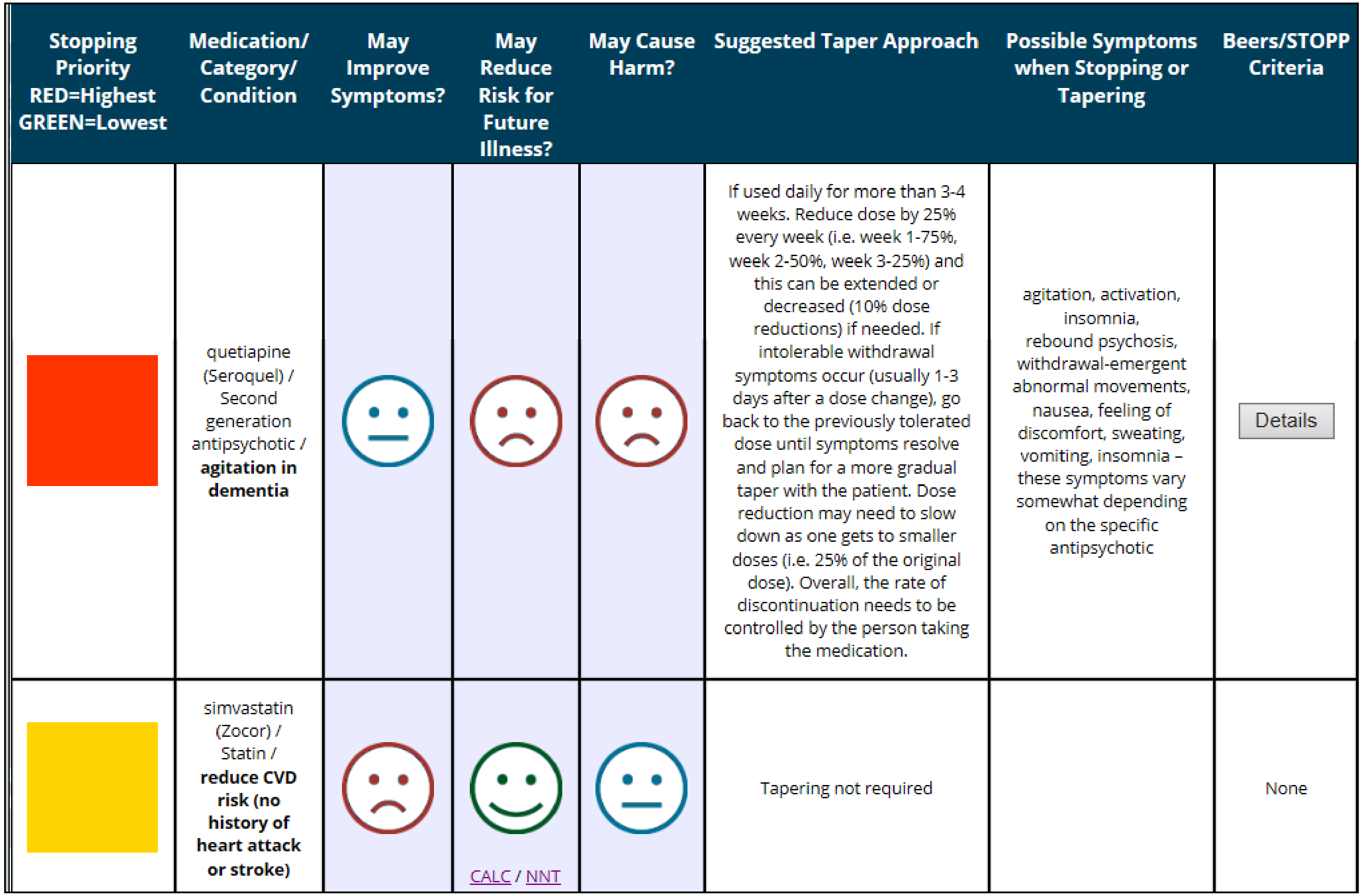
Patients individuels ↔ **Population** de patients

Démarche du **prescripteur** ↔ Démarche **globale**, p.ex. programme santé publique

- Algorithmes & guidelines si existants
- Interdisciplinarité

E. Reeve et al, Eur J Intern Med, 2017, 38: 3-11
E. Reeve et al, J Am Geriat Soc, 2013, 61: 1508-14
C. Sirois et al, Québec Pharmacie, 06.2014, 29-37

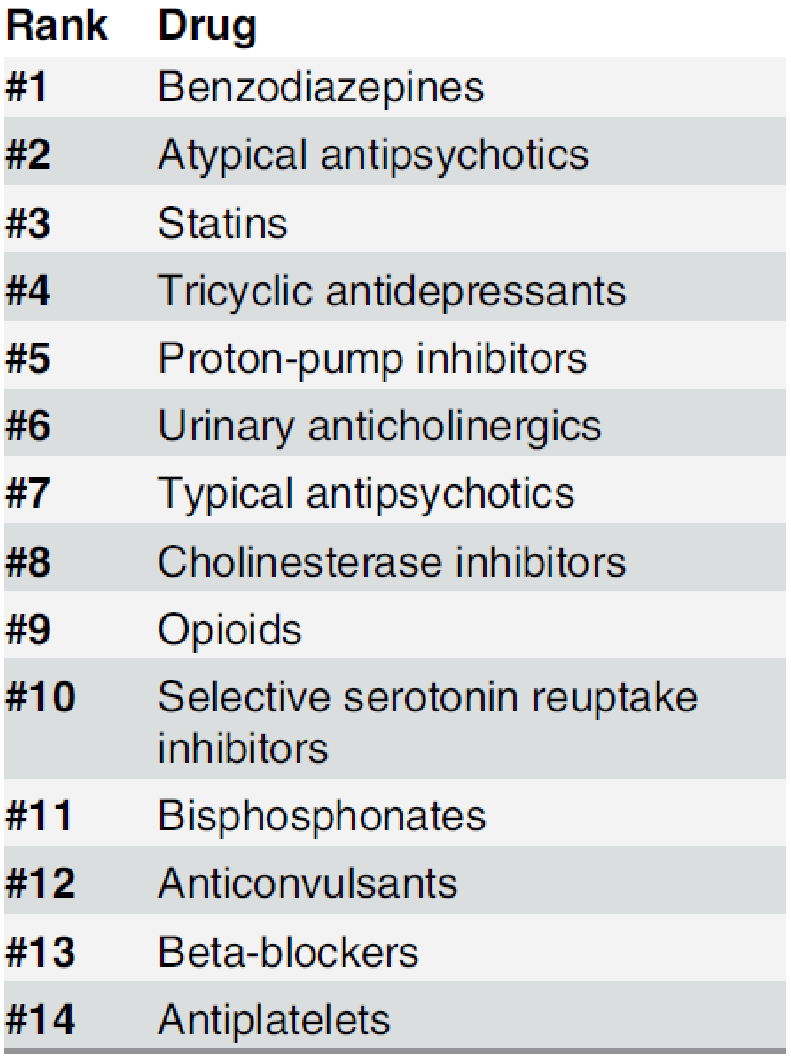
Medstopper plan



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
🟥	quetiapine (Seroquel) / Second generation antipsychotic / **agitation in dementia**	😐	☹	☹	If used daily for more than 3-4 weeks. Reduce dose by 25% every week (i.e. week 1-75%, week 2-50%, week 3-25%) and this can be extended or decreased (10% dose reductions) if needed. If intolerable withdrawal symptoms occur (usually 1-3 days after a dose change), go back to the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient. Dose reduction may need to slow down as one gets to smaller doses (i.e. 25% of the original dose). Overall, the rate of discontinuation needs to be controlled by the person taking the medication.	agitation, activation, insomnia, rebound psychosis, withdrawal-emergent abnormal movements, nausea, feeling of discomfort, sweating, vomiting, insomnia – these symptoms vary somewhat depending on the specific antipsychotic	Details
🟨	simvastatin (Zocor) / Statin / **reduce CVD risk (no history of heart attack or stroke)**	☹	🙂 CALC / NNT	😐	Tapering not required		None

medstopper.com

Médicaments visés



Rank	Drug
#1	Benzodiazepines
#2	Atypical antipsychotics
#3	Statins
#4	Tricyclic antidepressants
#5	Proton-pump inhibitors
#6	Urinary anticholinergics
#7	Typical antipsychotics
#8	Cholinesterase inhibitors
#9	Opioids
#10	Selective serotonin reuptake inhibitors
#11	Bisphosphonates
#12	Anticonvulsants
#13	Beta-blockers
#14	Antiplatelets

B Farrell et al, PLOS One, 2015, 10(4): e0122246. doi:10.1371/journal.pone.0122246

Médic. & smartermedicine.ch

Classe thérap.	Top 5 (24) listes*	
	à éviter	dans liste de
Benzodiazépines	☹ c/o âgé avec insomnie, agitation, ECA ☹ à la sortie de l'H	Méd. int. hôpital Gériatrie
IPP à long terme	☹ en systématique aux SI ☹ à long terme à haute D	SI Méd. int. ambulatoire
Antibiotiques	☹ large spectre si pas évalué avant et pendant (désescalade) ☹ si infections v. aériennes sup. sans gravité ☹ bactériurie asympt. c/o âgé	SI Méd. int. ambulatoire Gériatrie
Antipsychotiques	☹ 1^{ère} intention dans démence	Gériatrie
Sulfonylurées	☹ CTR strict Glc & Hb1Ac	Gériatrie
AINS	☹ si HTA, IC, IR chronique	Néphrologie
Opioïdes	☹ sortie H chez patients naïfs	Anesth.
Antiplaquettaires	☹ En prév. Primaire	Angiologie

www.smartermedicine.ch

* Non exhaustif

Guidelines

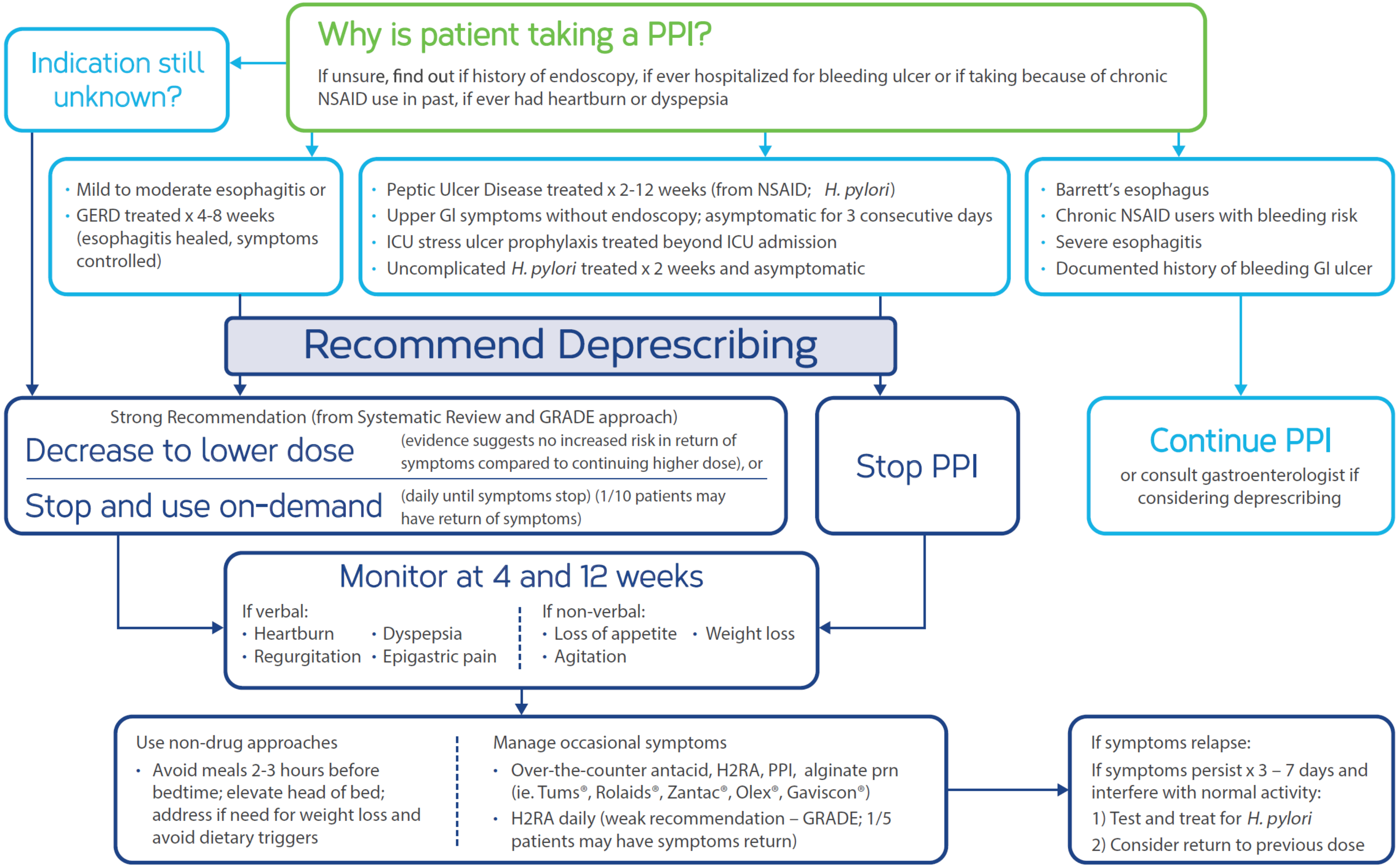
deprescribing.org

Guidelines & algorithmes

- IPP
- Hypoglycémiants
- BZD & analogues
- Antipsychotiques
- Inhibiteurs de la cholinestérase & mémantine

September 2016

deprescribing.org | Proton Pump Inhibitor (PPI) Deprescribing Algorithm



Why is patient taking a PPI?

If unsure, find out if history of endoscopy, if ever hospitalized for bleeding ulcer or if taking because of chronic NSAID use in past, if ever had heartburn or dyspepsia

Indication still unknown?

- Mild to moderate esophagitis or
- GERD treated x 4-8 weeks (esophagitis healed, symptoms controlled)

- Peptic Ulcer Disease treated x 2-12 weeks (from NSAID; *H. pylori*)
- Upper GI symptoms without endoscopy; asymptomatic for 3 consecutive days
- ICU stress ulcer prophylaxis treated beyond ICU admission
- Uncomplicated *H. pylori* treated x 2 weeks and asymptomatic

- Barrett's esophagus
- Chronic NSAID users with bleeding risk
- Severe esophagitis
- Documented history of bleeding GI ulcer

Recommend Deprescribing

Strong Recommendation (from Systematic Review and GRADE approach)

Decrease to lower dose (evidence suggests no increased risk in return of symptoms compared to continuing higher dose), or

Stop and use on-demand (daily until symptoms stop) (1/10 patients may have return of symptoms)

Stop PPI

Continue PPI

or consult gastroenterologist if considering deprescribing

Monitor at 4 and 12 weeks

If verbal:
- Heartburn
- Dyspepsia
- Regurgitation
- Epigastric pain

If non-verbal:
- Loss of appetite
- Weight loss
- Agitation

Use non-drug approaches
- Avoid meals 2-3 hours before bedtime; elevate head of bed; address if need for weight loss and avoid dietary triggers

Manage occasional symptoms
- Over-the-counter antacid, H2RA, PPI, alginate prn (ie. Tums®, Rolaids®, Zantac®, Olex®, Gaviscon®)
- H2RA daily (weak recommendation – GRADE; 1/5 patients may have symptoms return)

If symptoms relapse:

If symptoms persist x 3 – 7 days and interfere with normal activity:

1) Test and treat for *H. pylori*

2) Consider return to previous dose

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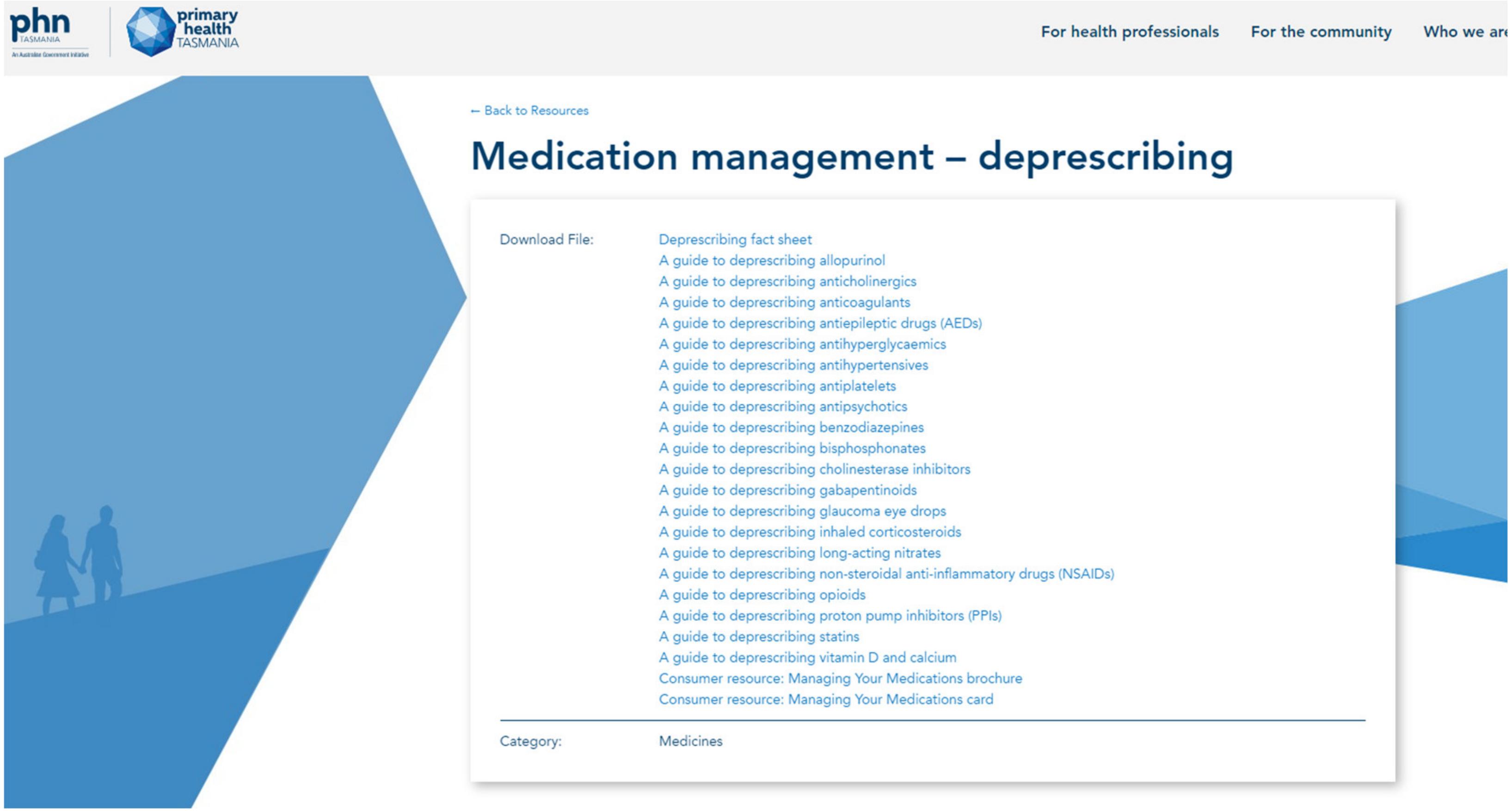
Contact deprescribing@bruyere.org or visit deprescribing.org for more information.

Farrell B, Pottie K, Thompson W, Boghossian T, Pizzola L, Rashid FJ, et al. Deprescribing proton pump inhibitors. Evidence-based clinical practice guideline. *Can Fam Physician* 2017;63:354-64 (Eng), e253-65 (Fr).

deprescribing.org
Institut de recherche Bruyère Research Institute
open Ontario Pharmacy Research Collaboration

Déprescription - Outils

- Primary Health Tasmania


phn TASMANIA
An Australian Government Initiative
primary health TASMANIA
For health professionals
For the community
Who we ar
← Back to Resources

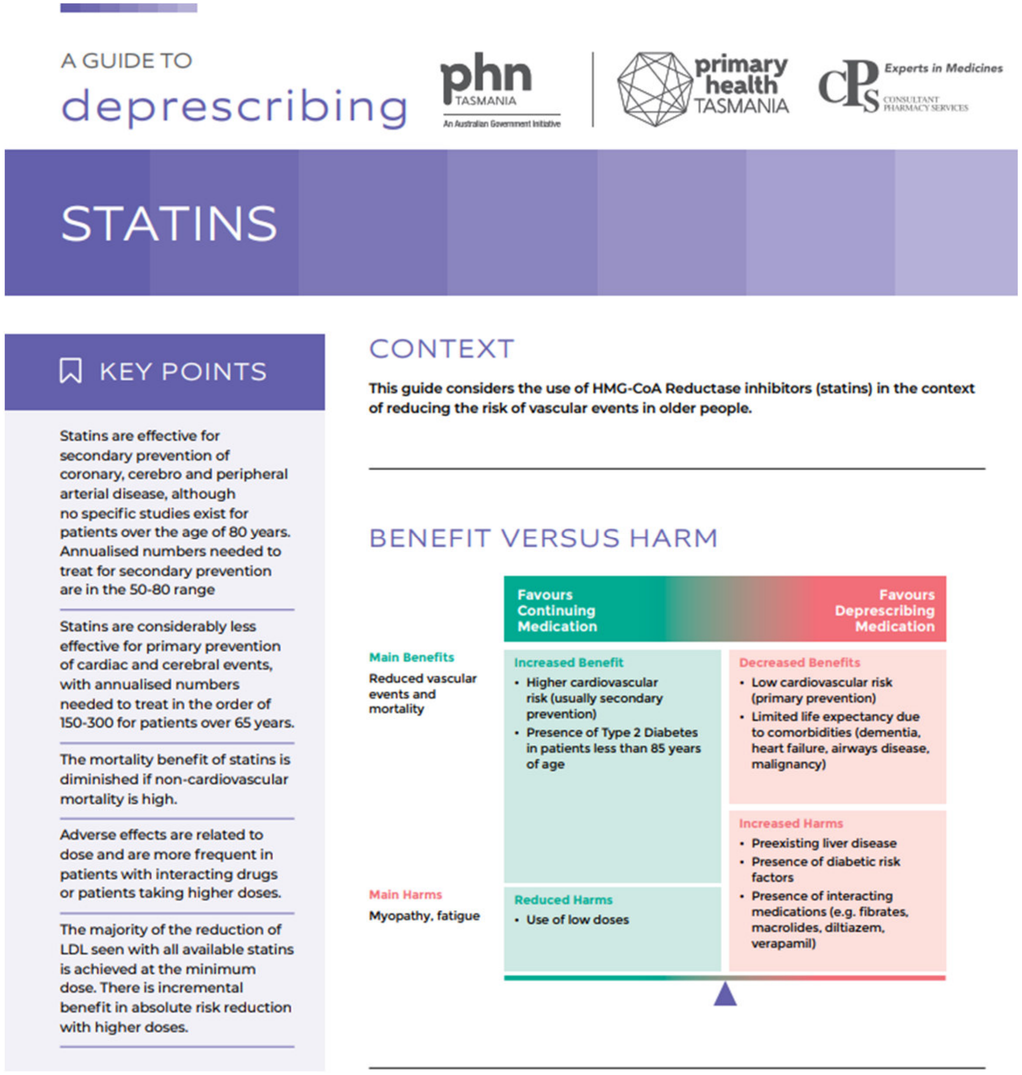
Medication management – deprescribing

Download File:	Deprescribing fact sheet A guide to deprescribing allopurinol A guide to deprescribing anticholinergics A guide to deprescribing anticoagulants A guide to deprescribing antiepileptic drugs (AEDs) A guide to deprescribing antihyperglycaemics A guide to deprescribing antihypertensives A guide to deprescribing antiplatelets A guide to deprescribing antipsychotics A guide to deprescribing benzodiazepines A guide to deprescribing bisphosphonates A guide to deprescribing cholinesterase inhibitors A guide to deprescribing gabapentinoids A guide to deprescribing glaucoma eye drops A guide to deprescribing inhaled corticosteroids A guide to deprescribing long-acting nitrates A guide to deprescribing non-steroidal anti-inflammatory drugs (NSAIDs) A guide to deprescribing opioids A guide to deprescribing proton pump inhibitors (PPIs) A guide to deprescribing statins A guide to deprescribing vitamin D and calcium Consumer resource: Managing Your Medications brochure Consumer resource: Managing Your Medications card
Category:	Medicines

https://www.primaryhealthtas.com.au/resources/deprescribing-resources/

Déprescription - Outils

- Primary Health Tasmania



A GUIDE TO
deprescribing

phn TASMANIA
An Australian Government Initiative

primary health TASMANIA

CPS Experts in Medicines
CONSULTANT PHARMACY SERVICES

STATINS

KEY POINTS

Statins are effective for secondary prevention of coronary, cerebro and peripheral arterial disease, although no specific studies exist for patients over the age of 80 years. Annualised numbers needed to treat for secondary prevention are in the 50-80 range

Statins are considerably less effective for primary prevention of cardiac and cerebral events, with annualised numbers needed to treat in the order of 150-300 for patients over 65 years.

The mortality benefit of statins is diminished if non-cardiovascular mortality is high.

Adverse effects are related to dose and are more frequent in patients with interacting drugs or patients taking higher doses.

The majority of the reduction of LDL seen with all available statins is achieved at the minimum dose. There is incremental benefit in absolute risk reduction with higher doses.

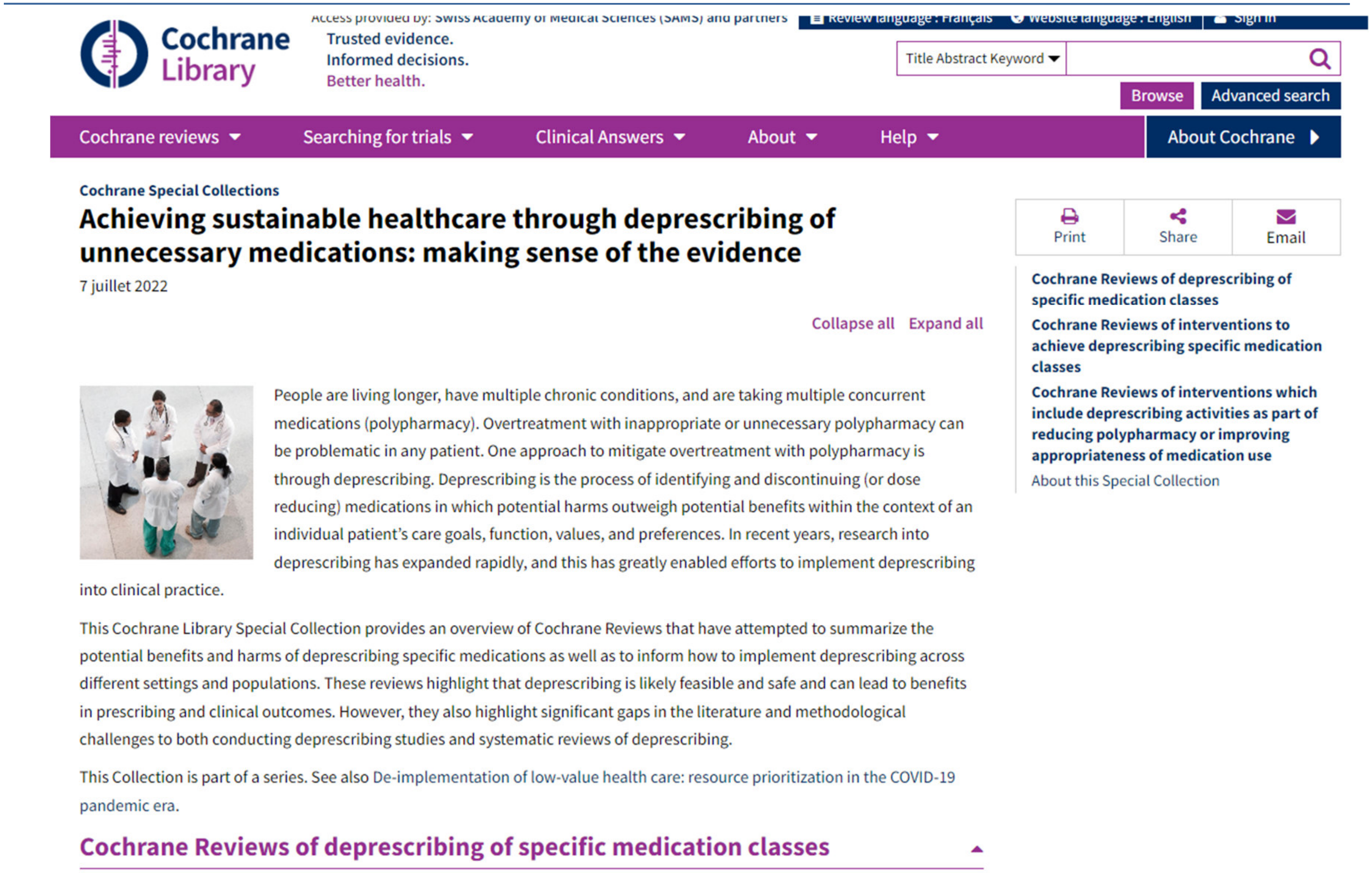
CONTEXT

This guide considers the use of HMG-CoA Reductase inhibitors (statins) in the context of reducing the risk of vascular events in older people.

BENEFIT VERSUS HARM

	Favours Continuing Medication	**Favours Deprescribing Medication**
Main Benefits Reduced vascular events and mortality	**Increased Benefit** • Higher cardiovascular risk (usually secondary prevention) • Presence of Type 2 Diabetes in patients less than 85 years of age	**Decreased Benefits** • Low cardiovascular risk (primary prevention) • Limited life expectancy due to comorbidities (dementia, heart failure, airways disease, malignancy)
Main Harms Myopathy, fatigue	**Reduced Harms** • Use of low doses	**Increased Harms** • Preexisting liver disease • Presence of diabetic risk factors • Presence of interacting medications (e.g. fibrates, macrolides, diltiazem, verapamil)

Cochrane - outils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Informed decisions.
Better health.
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Cochrane Special Collections

Achieving sustainable healthcare through deprescribing of unnecessary medications: making sense of the evidence

7 juillet 2022

People are living longer, have multiple chronic conditions, and are taking multiple concurrent medications (polypharmacy). Overtreatment with inappropriate or unnecessary polypharmacy can be problematic in any patient. One approach to mitigate overtreatment with polypharmacy is through deprescribing. Deprescribing is the process of identifying and discontinuing (or dose reducing) medications in which potential harms outweigh potential benefits within the context of an individual patient's care goals, function, values, and preferences. In recent years, research into deprescribing has expanded rapidly, and this has greatly enabled efforts to implement deprescribing into clinical practice.

This Cochrane Library Special Collection provides an overview of Cochrane Reviews that have attempted to summarize the potential benefits and harms of deprescribing specific medications as well as to inform how to implement deprescribing across different settings and populations. These reviews highlight that deprescribing is likely feasible and safe and can lead to benefits in prescribing and clinical outcomes. However, they also highlight significant gaps in the literature and methodological challenges to both conducting deprescribing studies and systematic reviews of deprescribing.

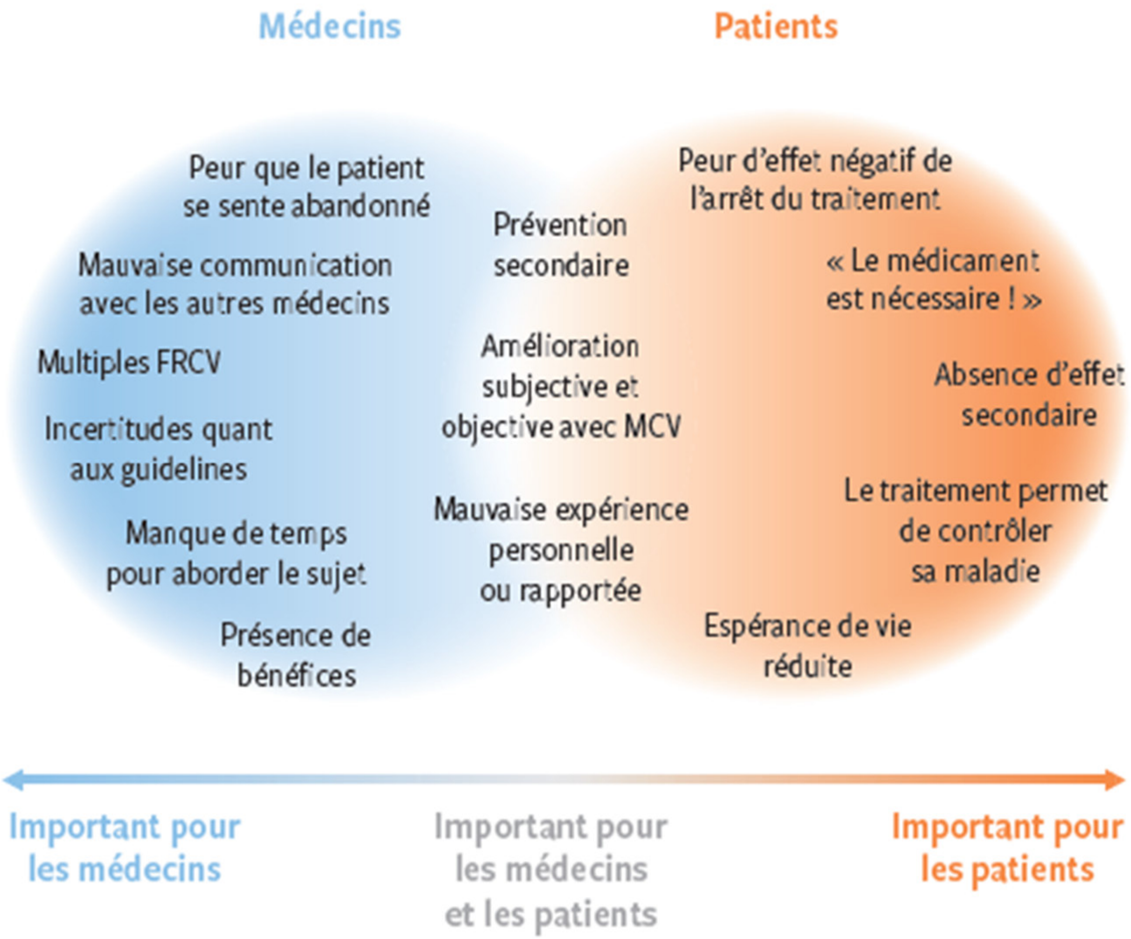
This Collection is part of a series. See also De-implementation of low-value health care: resource prioritization in the COVID-19 pandemic era.

Cochrane Reviews of deprescribing of specific medication classes

Cochrane Reviews of deprescribing of specific medication classes
Cochrane Reviews of interventions to achieve deprescribing specific medication classes
Cochrane Reviews of interventions which include deprescribing activities as part of reducing polypharmacy or improving appropriateness of medication use
About this Special Collection

Disponible: https://www.cochranelibrary.com/collections/doi/SC000054/full/fr?contentLanguage=fr

Déprescription: barrières



Médecins

Patients

Peur que le patient se sente abandonné

Mauvaise communication avec les autres médecins

Multiples FRCV

Incertitudes quant aux guidelines

Manque de temps pour aborder le sujet

Présence de bénéfices

Prévention secondaire

Amélioration subjective et objective avec MCV

Mauvaise expérience personnelle ou rapportée

Peur d'effet négatif de l'arrêt du traitement

« Le médicament est nécessaire ! »

Absence d'effet secondaire

Le traitement permet de contrôler sa maladie

Espérance de vie réduite

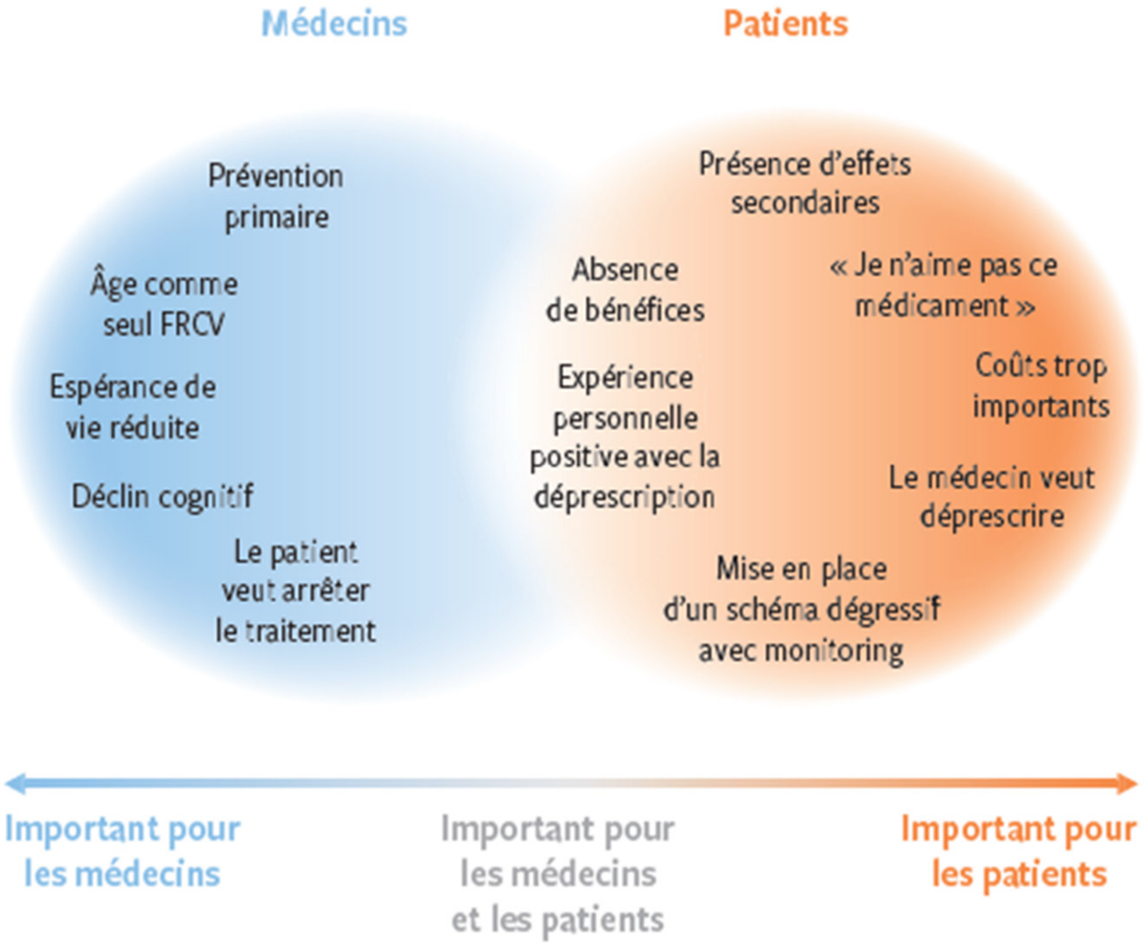
Important pour les médecins

Important pour les médecins et les patients

Important pour les patients

Rev Med Suisse 2024 ; 20 : 480-5

Déprescription: aspects facilitateurs



Médecins

Patients

Prévention primaire

Âge comme seul FRCV

Espérance de vie réduite

Déclin cognitif

Le patient veut arrêter le traitement

Absence de bénéfices

Expérience personnelle positive avec la déprescription

Présence d'effets secondaires

« Je n'aime pas ce médicament »

Coûts trop importants

Le médecin veut déprescrire

Mise en place d'un schéma dégressif avec monitoring

Important pour les médecins

Important pour les médecins et les patients

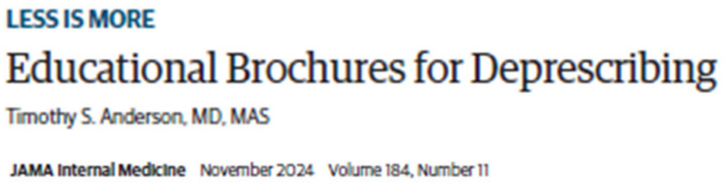
Important pour les patients

Rev Med Suisse 2024 ; 20 : 480-5

Réussir à déprescrire

« Cela fait des années que je prends ces médicaments, pourquoi devrais-je changer? »

- Physiologie & âge
- PIMs
- Syndrome gériatrique
- Interactions médic.



LESS IS MORE

Educational Brochures for Deprescribing

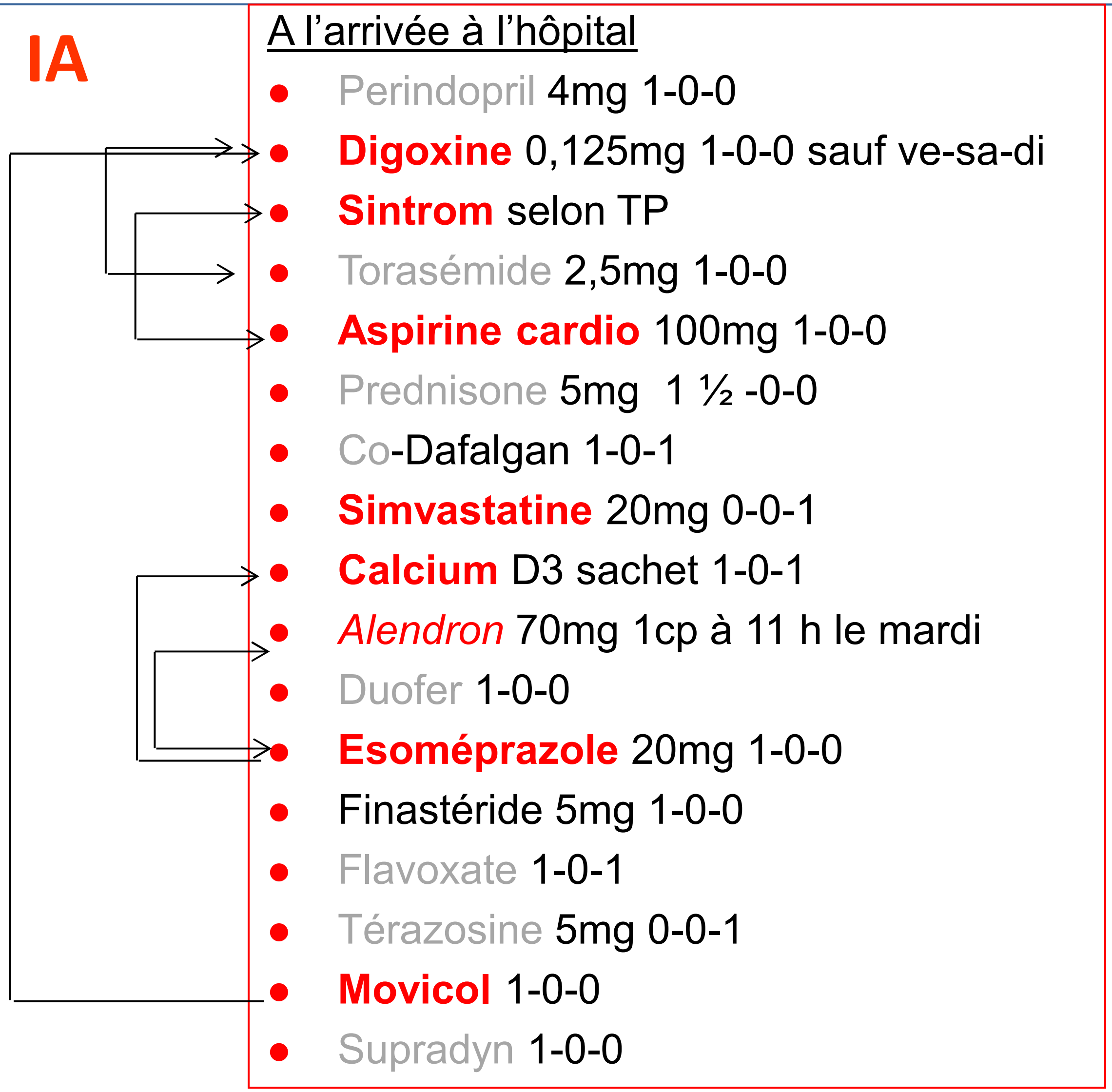
Timothy S. Anderson, MD, MAS

JAMA Internal Medicine November 2024 Volume 184, Number 11

Source image: www.myneworleans.com

91 ans

IA



A l'arrivée à l'hôpital

- Perindopril 4mg 1-0-0
- **Digoxine** 0,125mg 1-0-0 sauf ve-sa-di
- **Sintrom** selon TP
- Torasémide 2,5mg 1-0-0
- **Aspirine cardio** 100mg 1-0-0
- Prednisone 5mg 1 ½ -0-0
- Co-Dafalgan 1-0-1
- **Simvastatine** 20mg 0-0-1
- **Calcium** D3 sachet 1-0-1
- *Alendron* 70mg 1cp à 11 h le mardi
- Duofer 1-0-0
- **Esoméprazole** 20mg 1-0-0
- Finastéride 5mg 1-0-0
- Flavoxate 1-0-1
- Térazosine 5mg 0-0-1
- **Movicol** 1-0-0
- Supradyn 1-0-0

Risques

↑ Mortalité

Saignements

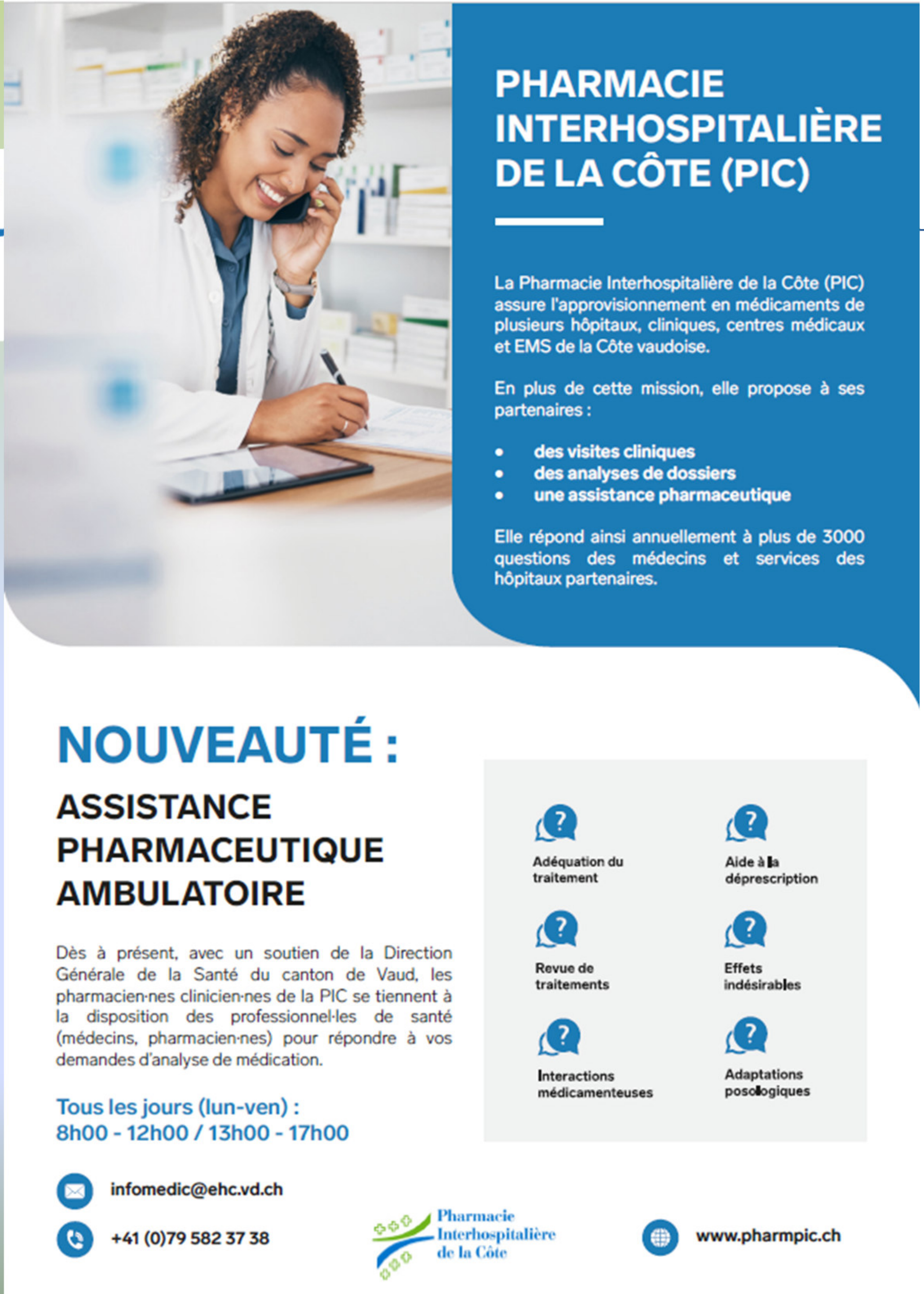
Ostéoporose

- Fractures
- Pneumonie
- *Cl. difficile*
- Déficit B12
- HypoMg
- …

Take home message

- ↓ nombre de médicaments n’est pas le but en soi
- Déprescrire pour **moins d’effets néfastes** et pour de **meilleurs *outcomes***
- Remettre en question le traitement médicamenteux du patient **avec sa participation** tout au long de son parcours clinique, y compris à la sortie de l’hôpital
- Opportunité d’une approche interdisciplinaire
- Impacts à long terme de la déprescription: à suivre

Assistance pharmaceutique: 021 804 21 46



PHARMACIE INTERHOSPITALIÈRE DE LA CÔTE (PIC)

La Pharmacie Interhospitalière de la Côte (PIC) assure l'approvisionnement en médicaments de plusieurs hôpitaux, cliniques, centres médicaux et EMS de la Côte vaudoise.

En plus de cette mission, elle propose à ses partenaires :

- **des visites cliniques**
- **des analyses de dossiers**
- **une assistance pharmaceutique**

Elle répond ainsi annuellement à plus de 3000 questions des médecins et services des hôpitaux partenaires.

NOUVEAUTÉ :

ASSISTANCE PHARMACEUTIQUE AMBULATOIRE

Dès à présent, avec un soutien de la Direction Générale de la Santé du canton de Vaud, les pharmacien·nes clinicien·nes de la PIC se tiennent à la disposition des professionnel·les de santé (médecins, pharmacien·nes) pour répondre à vos demandes d'analyse de médication.

Tous les jours (lun-ven) :
8h00 - 12h00 / 13h00 - 17h00

- Adéquation du traitement
- Aide à la déprescription
- Revue de traitements
- Effets indésirables
- Interactions médicamenteuses
- Adaptations posologiques

infomedic@ehc.vd.ch

+41 (0)79 582 37 38

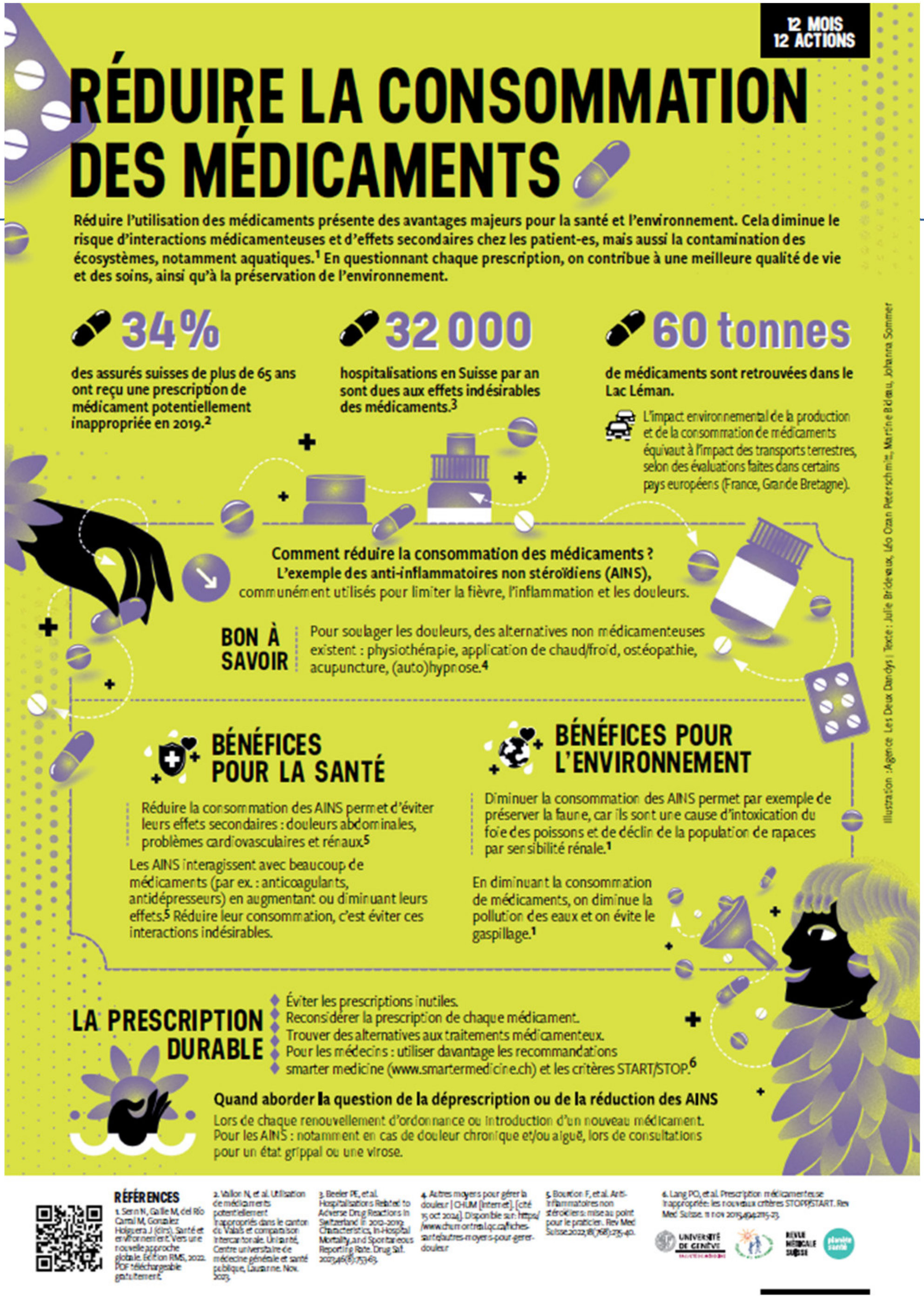
Pharmacie
Interhospitalière
de la Côte

www.pharmpic.ch

FORMATION

mercredi 15 janvier 2025
(19h30 à 21h)

Thème: hypnotiques



12 MOIS
12 ACTIONS

RÉDUIRE LA CONSOMMATION DES MÉDICAMENTS

Réduire l'utilisation des médicaments présente des avantages majeurs pour la santé et l'environnement. Cela diminue le risque d'interactions médicamenteuses et d'effets secondaires chez les patient-es, mais aussi la contamination des écosystèmes, notamment aquatiques.[1] En questionnant chaque prescription, on contribue à une meilleure qualité de vie et des soins, ainsi qu'à la préservation de l'environnement.

34%

des assurés suisses de plus de 65 ans ont reçu une prescription de médicament potentiellement inappropriée en 2019.[2]

32 000

hospitalisations en Suisse par an sont dues aux effets indésirables des médicaments.[3]

60 tonnes

de médicaments sont retrouvées dans le Lac Léman.

L'impact environnemental de la production et de la consommation de médicaments équivaut à l'impact des transports terrestres, selon des évaluations faites dans certains pays européens (France, Grande Bretagne).

Comment réduire la consommation des médicaments ?
L'exemple des anti-inflammatoires non stéroïdiens (AINS),
communément utilisés pour limiter la fièvre, l'inflammation et les douleurs.

BON À SAVOIR

Pour soulager les douleurs, des alternatives non médicamenteuses existent : physiothérapie, application de chaud/froid, ostéopathie, acupuncture, (auto)hypnose.[4]

BÉNÉFICES POUR LA SANTÉ

Réduire la consommation des AINS permet d'éviter leurs effets secondaires : douleurs abdominales, problèmes cardiovasculaires et rénaux.[5]

Les AINS interagissent avec beaucoup de médicaments (par ex. : anticoagulants, antidépresseurs) en augmentant ou diminuant leurs effets.[5] Réduire leur consommation, c'est éviter ces interactions indésirables.

BÉNÉFICES POUR L'ENVIRONNEMENT

Diminuer la consommation des AINS permet par exemple de préserver la faune, car ils sont une cause d'intoxication du foie des poissons et de déclin de la population de rapaces par sensibilité rénale.[1]

En diminuant la consommation de médicaments, on diminue la pollution des eaux et on évite le gaspillage.[1]

LA PRESCRIPTION DURABLE

- Éviter les prescriptions inutiles.
- Reconsidérer la prescription de chaque médicament.
- Trouver des alternatives aux traitements médicamenteux.
- Pour les médecins : utiliser davantage les recommandations
- smarter medicine (www.smartermedicine.ch) et les critères START/STOP.[6]

Quand aborder la question de la déprescription ou de la réduction des AINS

Lors de chaque renouvellement d'ordonnance ou introduction d'un nouveau médicament. Pour les AINS : notamment en cas de douleur chronique et/ou aiguë, lors de consultations pour un état grippal ou une virose.

Illustration : Agence Les Deux Dandys | Texte : Julie Brideaux, Léo Ozan Peterschmitt, Martine Bideau, Johanna Sommer

RÉFÉRENCES

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