# Problem-based deprescribing

## Using your patients' clinical concerns to guide medication review

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## Clinical question

**How can I best approach deprescribing for my medically complex frail seniors?**

## Bottom line

A recently published article in the *Canadian Geriatrics Society Journal of CME* provides a practical approach to deprescribing with older patients who have complex health issues.[1] Many FPs take a problem-based approach to optimizing medications rather than doing medication reviews as a stand-alone activity.

## Evidence

- Polypharmacy, defined as using more medications or a higher dose than clinically indicated, is more common in the geriatric population and increases the risk of adverse drug events (ADEs).[2]
- Older patients are at greater risk of ADEs owing to body composition and physiology changes that result in altered pharmacokinetic and pharmacodynamic properties of medications, as well as owing to interactions with other medications.[3]
- These risks are sometimes not fully appreciated by clinicians, which is supported by the fact that ADEs contribute to up to 20% of hospitalizations in the elderly.[4-6]

## Approach

Seniors typically present to FPs for specific clinical or functional problems (eg, falls, incontinence, cognitive changes, weight loss) rather than to seek a general review of medications. With older patients, FPs should always consider medications as a primary or contributing factor in any clinical presentation and review the patient's medication list as a key part of care. Any new symptom a patient experiences should be screened as a possible ADE and as a potential opportunity to deprescribe.

While resources such as the Beers criteria[7] and the STOPP/START[8] (Screening Tool of Older People's Prescriptions and Screening Tool to Alert to Right Treatment) criteria promote a deprescribing approach, their focus is on the medications themselves and their appropriateness in the geriatric population in general terms. Problem-based deprescribing is a complementary strategy to enhance the use of these "optimal prescribing" criteria and help prioritize a deprescribing focus. **Box 1**[9] outlines the steps to promoting problem-based deprescribing.

**Box 1. Steps to problem-based deprescribing**

1. Routinely include ADEs in the differential diagnosis when a patient presents with a new symptom; this helps to recognize ADEs, as well as to avoid prescribing cascades
2. Prioritize clinical issues according to risk; start problem-based deprescribing by focusing on the highest-risk clinical issues (eg, delirium and falls)
3. When assessing concerning medications for deprescribing, weigh risk versus benefit of deprescribing and use evidence-based guidelines where available[9]
4. Forge a working partnership between the patient, caregiver, other physicians, and pharmacist to determine a plan for deprescribing and for monitoring outcomes

ADE—adverse drug event.

## Implementation

The most important step is to consider the role of medications in all concerns brought by your older patients (and younger ones, too!). For additional resources on problem-based deprescribing for common issues like incontinence, anorexia and weight loss, postural hypotension, and falls and delirium, visit **canadiangeriatrics.ca/wp-content/uploads/2018/10/5_Frank-Molnar-Article-Formatted-Final.pdf**.[1] Clinical practice guidelines for deprescribing benzodiazepines, proton pump inhibitors, and antipsychotics can be found at **deprescribing.org/resources/deprescribing-guidelines-algorithms**.[10-12]

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**Competing interests**
None declared

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