



Deprescribing: When trying for less is more

I often hear patients plead, “I take so many pills! Can’t any be stopped?” These patients can be of any age, but most are older. As I scroll through their listed medications, attempting to reconcile the list with reality, it seems that many patients have accumulated medications the same way an old barge has accumulated barnacles, port by port, doctor visit by doctor visit. In some cases, I have to ask the patient or search the electronic medical record (EMR) to understand why a drug was prescribed by another physician. Was that antidepressant for depression, anxiety, poor sleep, or restless legs? Is it working? For medications I may have added in the past, I ask if the drug is still doing what I prescribed it for. If the patient’s answer leaves me unsure of the drug’s ongoing efficacy, I question the patient further about any minor ill effects or financial burdens from continuing the medication.

Sometimes the answer is straightforward—the pills were started to reduce knee pain, but the pain is still there. But sometimes if I suggest stopping a drug, I get surprising pushback from the patient: “But the pain may be worse without those pills.” And it can be hard to assess whether a medication has attained its therapeutic goal, such as when a drug is given to prevent or reduce the occurrence of intermittent events (eg, hydroxychloroquine to reduce flares in lupus, aspirin to prevent transient ischemic attacks). Unless a medication has been given sufficient time to have its effect and has clearly failed, we often have to trust its efficacy because those events might be more frequent if the drug were stopped.

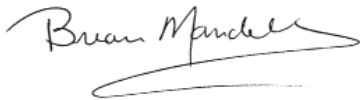
In this issue of the *Journal* (page 209), Kim and Factora discuss a difficult scenario—discontinuing cognitive-enhancing therapy in patients with Alzheimer dementia. The stakes, hopes, and anxiety are high for the patient and caregivers. These drugs have only modest efficacy, and it is often difficult to know if they are working. To complicate matters, dementia is progressive, but the rate of progression differs among individuals, making it harder to be convinced that the drugs have lost their efficacy and that discontinuation is warranted in order to reduce the side effects, cost, and pill burden. Similar challenges arise for similar reasons when considering discontinuation of antipsychotics or other drugs given for behavioral reasons to elderly patients with dementia.¹

The issues surrounding downsizing medication lists—or *deprescribing*—extend far beyond patients with Alzheimer dementia. A disease may have progressed beyond the point where the drug can make a significant impact. Patients often develop tachyphylaxis to the newer protein drugs (biologics for rheumatoid arthritis, inflammatory bowel disease, psoriasis, or gout) due to the generation of neutralizing antidrug antibodies. At some point the patient’s life expectancy becomes a factor when considering medications directed at preventing long-term complications of a disease and the increased likelihood of significant adverse effects in patients as they age (eg, from aggres-

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sively prescribed antihypertensive and antidiabetic drugs). For drugs such as bisphosphonates, alkylating agents, and metoclopramide, complications of cumulative dosing over time should be considered a reason to discontinue therapy.

The take-home message from this article is to create opportunities to periodically revisit the rationale for all of a patient's prescriptions, and to make sure patients are comfortable knowing why they should keep taking each of their medications. While revisiting a patient's prescriptions may indeed reduce the medication burden, I believe it also enhances adherence to the remaining prescribed medications. The medication reconciliation process requires more than simply checking off the box in the EMR to indicate that the medications were "reviewed."



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1. Bjerre LM, Farrell B, Hogel M, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia: evidence-based clinical practice guideline. *Can Fam Physician* 2018; 64(1):17–27.