Tests and Medications I Wish You'd Never Ordered 2019

"Here We Go Again!!!"

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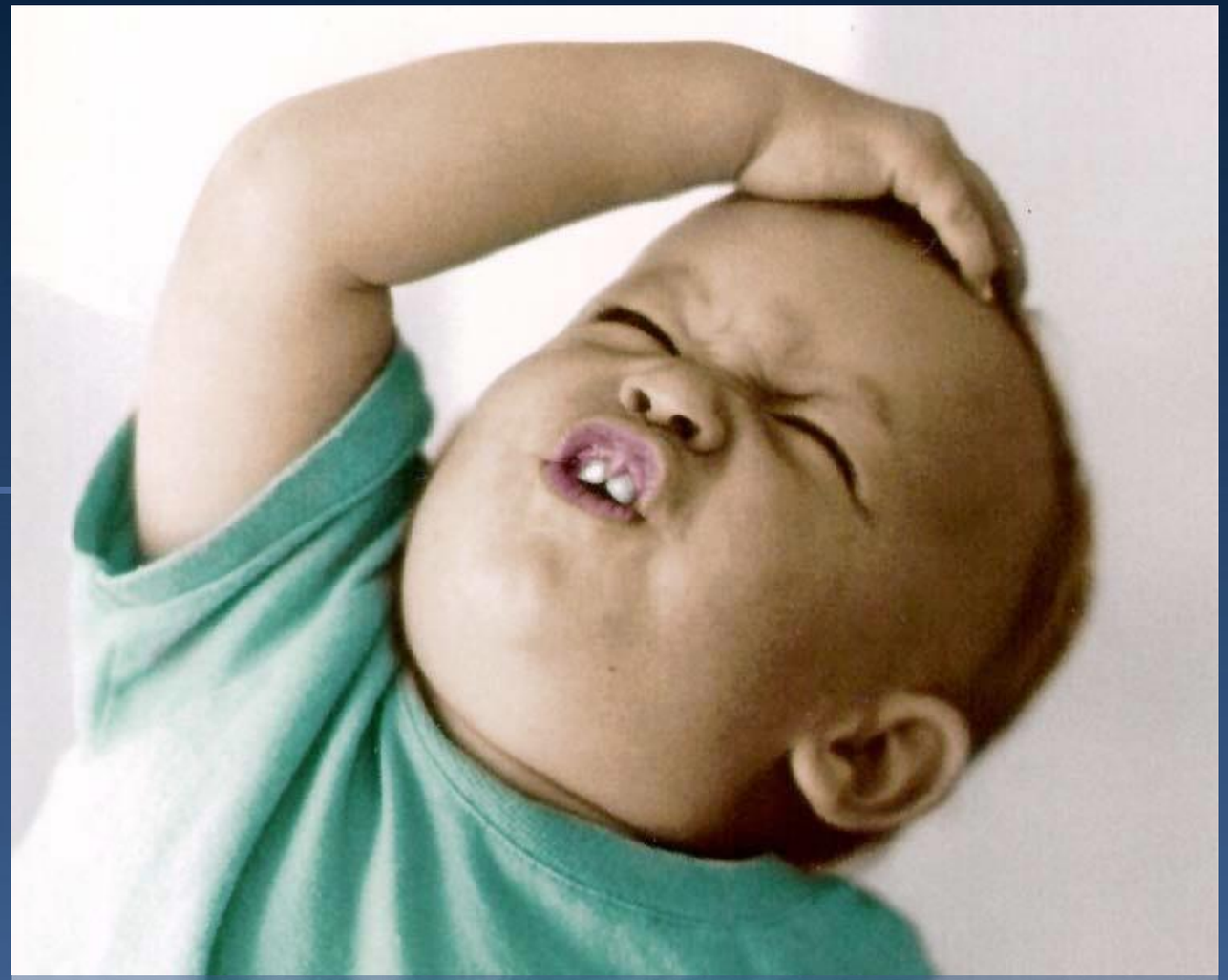


Disclosure of Financial Relationships

I have no conflict of interest with the information presented herein.

Case History

- 89 y/o woman with Alzheimer dementia, Type II DM, HTN, A-fib on anticoagulants, GERD, chronic insomnia, multiple falls; family desiring to pursue comfort care with hospice
- Resides at ECF, primary care physician group with expertise in geriatrics oversees care, along with team of mid-levels
- BMI 25.31 (down from 32.06 six months ago; lost 21% of TBW); eating <50% of meals
- FAST 6e (fecal/urinary incontinence), sleeps 12-16 hours/day; total dependence in all ADLs, PPS=40% (50% six months ago)

Case History

- Medications
  - Omeprazole
  - Chlorthalidone
  - Citalopram
  - Lorazepam
  - Lovastatin
  - Ranitidine
  - Metoprolol
  - Trazodone
  - Donepezil
  - Metformin
  - Oxybutynin
  - Apixaban
  - Diphenoxylate/Atropine
  - Hydrocodone/APAP
  - APAP
  - Ondansetron

Case History

- Patient had consistent hypotension during initial time on service, along with frequent falls
- Patient lethargic much of the time, unable to say more than a few words

“Can we de-prescribe some of her meds?”

Case History

- Recommendations
  - Change apixaban to aspirin
    - Rationale: CHA_2DS_2-VASc Score is 5 (6% annual stroke risk) vs HAS-BLED score of 3 (high risk for bleeding)
      - This is a hospice patient…would ASA be “good enough” for the last six months of life?

Case History

- Recommendations
  - Discontinue chlorthalidone
    - Rationale: the patient has no edema or outward manifestations of CHF, has hypotension and frequent falls. Diuretics can cause electrolyte disturbances and can contribute to delirium.

Case History

- Recommendations
  - Taper and discontinue donepezil
    - Rationale: the patient has had a rapid functional decline and is now sleeping over 75% of each day. Her appetite is declining and she is now hospice eligible. A trial off therapy seems reasonable.

Case History

- Recommendations
  - Discontinue lovastatin
    - Rationale: Two major points…
      - Prospective trial of statin use in hospice patients…stopping statins led to higher QOL scores, fewer meds for management of side effects, and lower cost. (Kutner JS, et al; *JAMA Intern Med*. 2015 May; 175(5): 691–700)
      - If you only had six months left to live, would it matter what your cholesterol is?

Case History

- Recommendations
  - Discontinue metformin
    - Rationale: FSBS have been lower now that patient isn’t eating as much. We can monitor BS and re-start metformin if trending upward.

Case History

- Recommendations
  - Discontinue oxybutynin
    - Rationale: patient was now incontinent of both urine and feces, necessitating use of an adult diaper. Medication was no longer needed. Oxybutynin is associated with lethargy and delirium in older patients
    - Potential interaction between this med and donepezil (both are anticholinergics)

Case History

- Recommendations
  - Discontinue omeprazole
    - Rationale: patient on both H_2 blocker and PPI. No hx of bleeding, and GERD was managed well. Beers list 2019 indicated PPIs were potentially problematic in elderly. In 2015, H_2 blockers were as well, but subsequent data indicates no risk

Case History

- Medications De-prescribed…
  - Chlorthalidone
  - Lovastatin
  - Donepezil
  - Apixaban changed to ASA
  - Metformin
  - Oxybutynin

Outcome

- During the 90 day benefit period, the patient became more interactive, improved her PPS (from 40% to 50%), and gained 7 pounds of weight.
  - She was discharged from service toward the end of the first benefit period as she no longer met eligibility criteria for hospice
- Given her diagnosis, she will likely become eligible as her dementia progresses.

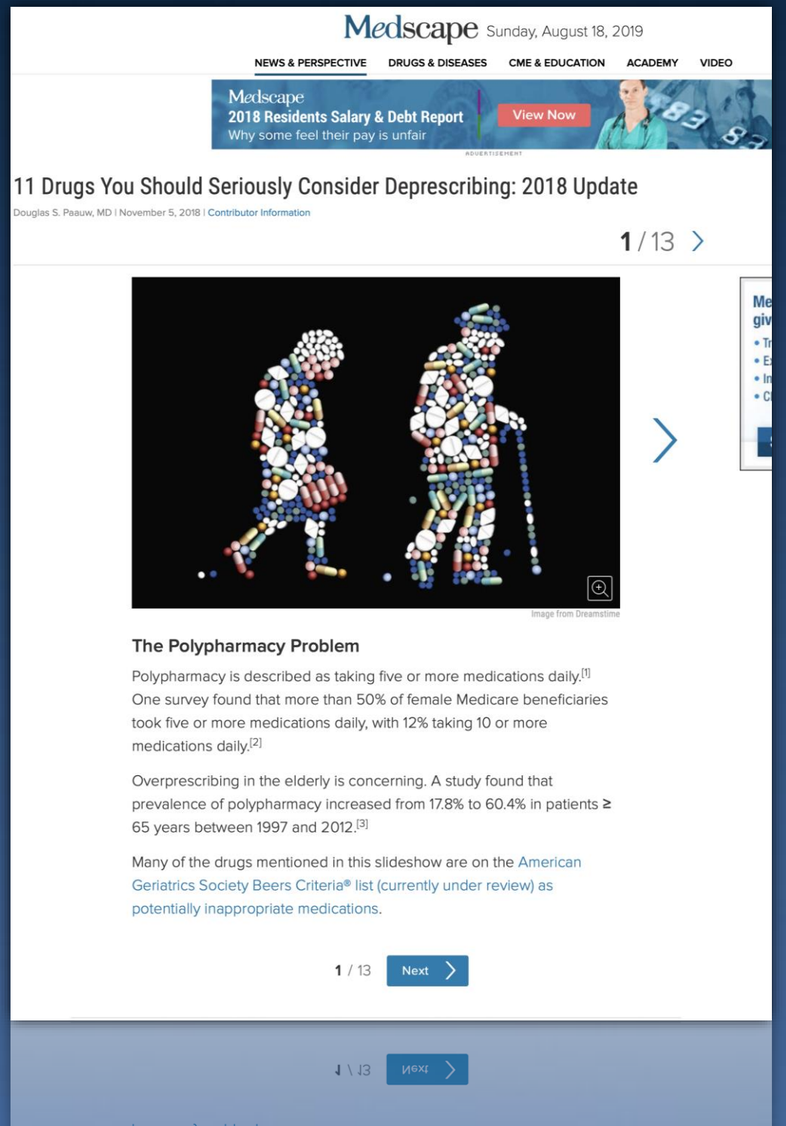
From the “Choosing Wisely” campaign…

- American Geriatrics Society
  - Don’t prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects

From the Medical Press…

Medscape November 5, 2018

- On the list (elderly):
  1. Proton pump inhibitors.
  2. Statins (>75 years old).
  3. Benzodiazepines.
  4. Antimuscarinics for urinary incontinence.
  5. Cholinesterase inhibitors for Alzheimer dementia.
  6. Muscle relaxants for back pain.
  7. Supplements.



Takeaways

- De-prescribing is part of the ongoing management of the patient
- Some patients may enjoy a substantial improvement in their quality of life with de-prescribing
- It isn’t an option for every patient, but every patient ought to be evaluated for the possibility
- Helpful algorithms: https://deprescribing.org/resources/deprescribing-guidelines-algorithms/

“To find health should be the object of the doctor. Anyone can find disease.”

~A.T. Still MD, DO Philosophy of Osteopathy