THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

CORTICOSTEROIDS, PLAIN (EYE)

Deprescribing in older people: A clinical practice guideline

dRx™

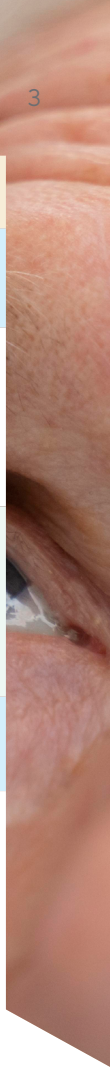
CORTICOSTEROIDS, PLAIN (EYE)

Ophthalmic anti-inflammatory agents include corticosteroids

such as dexamethasone*, fluorometholone*, hydrocortisone, and prednisolone (alone or in combination with phenylephrine).

*Common Pharmaceutical Benefits Scheme medicines

Note: For corticosteroids used on the skin, refer to the Corticosteroids (skin) section; for systemic corticosteroids, see the Prednisone / Prednisolone section.



Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people using ophthalmic corticosteroids for over 6 to 8 weeks whose symptoms have resolved or are stable and are unlikely to recur (e.g. after post-operative healing).
GPS	Deprescribing decisions should be made in consultation with the person and their treating ophthalmologist and/or optometrist to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	We suggest continuing ophthalmic corticosteroids in older people who have chronic steroid-responsive sight-threatening ophthalmic diseases (e.g. uveitis or chronic cystoid macular oedema) or who have previous corneal transplants or glaucoma incisional surgery to prevent corneal graft rejection and manage wound healing, with treatment and duration guided by the treating ophthalmologist and regular monitoring to balance benefits and risks.
	HOW TO DEPRESCRIBE
CBR	We suggest tapering ophthalmic corticosteroids in proportion to the duration of use and clinical indication. Short-term use (< 3 weeks) at usual doses generally does not require tapering. For treatment lasting three weeks or more, we suggest a gradual reduction in dosing frequency each week. If used for more than three months or in refractory disease, tapering should be even slower, by reducing frequency every two to four weeks. Tapering should be carried out by reducing the frequency of use rather than the number of drops, as patients should only instil one drop at a time. If rebound of inflammation or symptoms occur, return to approximately 75% of the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient.
	MONITORING
CBR	We suggest close monitoring by the treating ophthalmologist and/or optometrist for rebound intraocular inflammation or symptom recurrence for two to four weeks after discontinuing ophthalmic corticosteroids, with longer monitoring for those with refractory disease or prolonged use. Beyond this period, ongoing monitoring should be determined using shared decision-making based on the severity of their condition and/or symptoms. We suggest advising patients to inform their healthcare providers of any concerning symptoms.

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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