THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

OCULAR LUBRICANTS

Deprescribing in older people: A clinical practice guideline

dRx™

OCULAR LUBRICANTS (OTHER OPHTHALMOLOGICALS)

- Carbomer 980
- Carmellose (alone or with glycerin)
- Carmellose with glycerin and polysorbate 80/ sodium hyaluronate
- Hypromellose (alone or with carbomer 980/ dextran 70)
- Hydroxypropyl guar with macrogol 400 and propylene glycol
- Hydroxypropyl guar with macrogol 400, propylene glycol and sorbitol/ sodium hyaluronate
- Hydroxypropyl guar with mineral oil, propylene glycol and sorbitol
- Liquid paraffin + glycerol + tyloxapol + poloxamer-188 + trometamol hydrochloride + trometamol + cetalkonium chloride (Cationorm®)*
- Macrogol 400 with sodium hyaluronate/ propylene glycol
- Polyvinyl alcohol (alone or with povidone)
- Paraffin (alone or with lanolin)
- Perfluorohexyloctane
- Phospholipid liposomes
- Retinol palmitate with paraffin and lanolin

*Common Pharmaceutical Benefits Scheme medicine

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking long-term ocular lubricants whose symptoms have resolved or are stable and are unlikely to recur, particularly if an avoidable or modifiable risk factor (e.g. drug-induced dry eyes) has been addressed.
GPS	Deprescribing decisions should be made in consultation with the person and their treating ophthalmologist and/or optometrist where appropriate to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	We suggest continuing long-term ocular lubricants (preservative-free if possible) at the lowest effective dose and with appropriate formulations, particularly if other non-pharmacological strategies are less effective, environmental triggers cannot be avoided (e.g. living conditions), or if patients have concurrent ocular conditions/taking concomitant medicines which are known to cause dry/irritated eyes.
	HOW TO DEPRESCRIBE
CBR	We suggest gradually tapering doses before ceasing if more than daily administration (e.g. twice or three times daily), then switching to "as required" use at the lowest effective dose as well as providing advice for alternative management strategies, provided this aligns with the individual's goals and preferences, following informed consent.
	MONITORING
CBR	We suggest ongoing monitoring for any ocular symptoms such as dry eyes, redness, and discomfort in the eyes for three to six months after deprescribing by advising patients to report to their healthcare providers any concerning symptoms in between appointments. If symptoms are persistent, we suggest adequate investigation (including administration technique) and differential diagnoses and considering appropriate non-pharmacological therapies.

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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