THE UNIVERSITY OF WESTERN AUSTRALIA

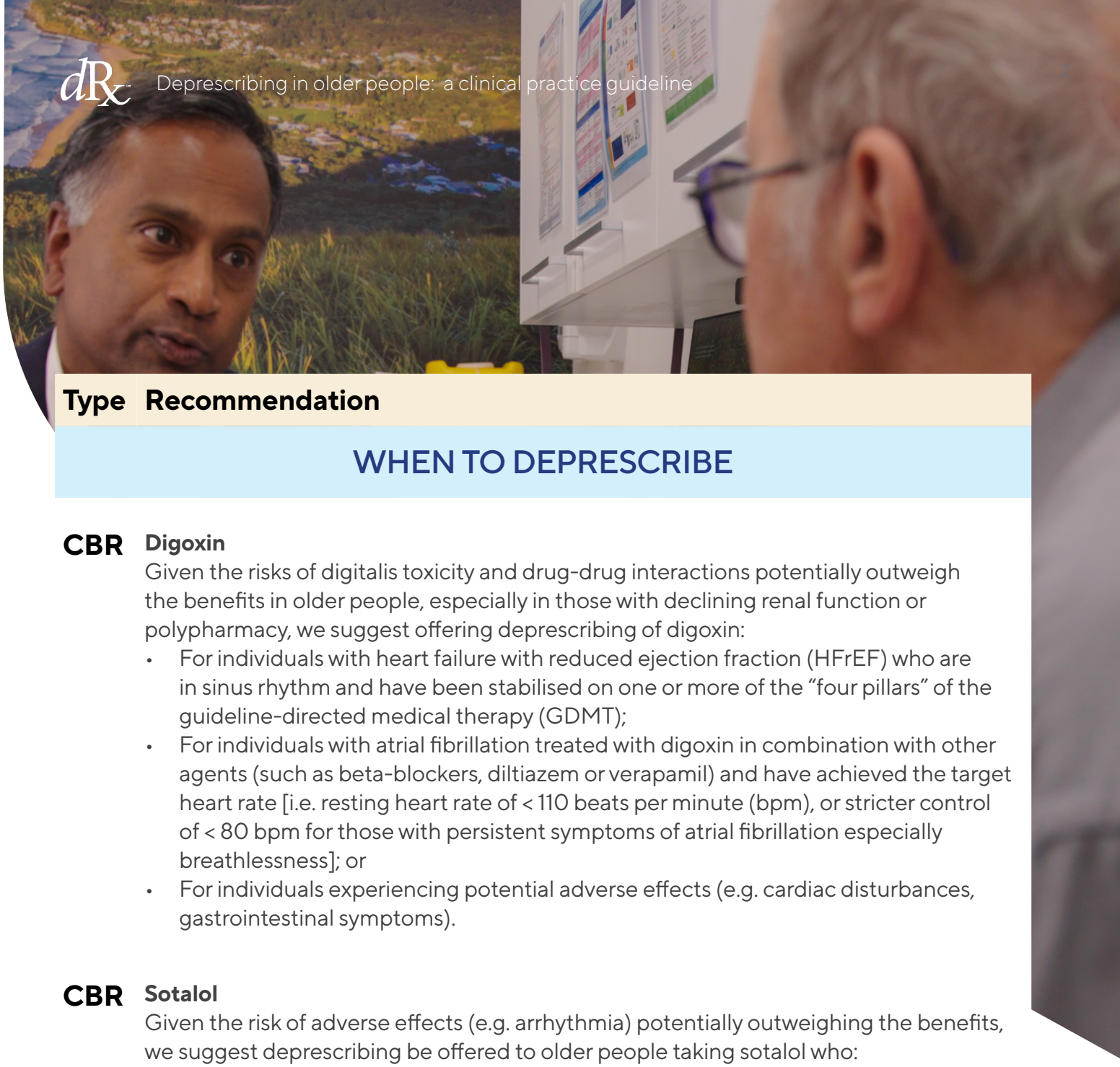
WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

DIGOXIN/SOTALOL

Deprescribing in older people: A clinical practice guideline

dRx™



Type	Recommendation

WHEN TO DEPRESCRIBE

CBR **Digoxin**

Given the risks of digitalis toxicity and drug-drug interactions potentially outweigh the benefits in older people, especially in those with declining renal function or polypharmacy, we suggest offering deprescribing of digoxin:

- For individuals with heart failure with reduced ejection fraction (HFrEF) who are in sinus rhythm and have been stabilised on one or more of the "four pillars" of the guideline-directed medical therapy (GDMT);
- For individuals with atrial fibrillation treated with digoxin in combination with other agents (such as beta-blockers, diltiazem or verapamil) and have achieved the target heart rate [i.e. resting heart rate of < 110 beats per minute (bpm), or stricter control of < 80 bpm for those with persistent symptoms of atrial fibrillation especially breathlessness]; or
- For individuals experiencing potential adverse effects (e.g. cardiac disturbances, gastrointestinal symptoms).

CBR **Sotalol**

Given the risk of adverse effects (e.g. arrhythmia) potentially outweighing the benefits, we suggest deprescribing be offered to older people taking sotalol who:

- Have permanent atrial fibrillation without an intention to restore or maintain sinus rhythm; or
- Have been stabilised and in normal sinus rhythm for at least two to three months

GPS Deprescribing decisions should be made in consultation with the individual and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).

ONGOING TREATMENT

CBR We suggest continuing GDMT for heart failure or beta-blockers for atrial fibrillation.

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

HOW TO DEPRESCRIBE

CBR **Digoxin**

We suggest individualising the tapering schedule based on the individual's clinical context. When digoxin is identified as being suitable for deprescribing, we suggest abrupt cessation if the serum level is subtherapeutic.

We suggest abrupt cessation when clinically indicated, such as in cases of digitalis toxicity (e.g. bradycardia), and introducing an alternative agent for rate control if indicated. If tapering is preferred and the individual is experiencing symptoms of tachycardia, we suggest reducing the dose by 50% every two weeks until the dose reaches ≤ 62.5 micrograms, then cease completely.

CBR **Sotalol**

We suggest gradual tapering of the dose by 25% every one to two weeks, ensuring individuals remain symptom-free before initiating each tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. If clinically indicated, consider an alternative for rate control, preferably a beta-blocker.

Note: This suggestion does not apply to cases of sotalol poisoning, where urgent procedures are required to monitor and treat QT-interval prolongation and torsades de pointes. Refer to relevant clinician resources, such as the Therapeutic Guidelines toxicology section (https://www.tg.org.au/content-updates/toxicologyandtoxinology/).

MONITORING

CBR **Digoxin/Sotalol**

We suggest closely monitoring for changes in heart rate and/or signs of cardiac decompensation (e.g. shortness of breath) including addressing electrolyte disturbances, every one to two weeks until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monitoring at three and six months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their other medications, preferences, responses, and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to self-monitor symptoms using pulse monitors and report to their healthcare providers as needed.

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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