THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

ANTI-DEMENTIA MEDICINES

Deprescribing in older people: A clinical practice guideline

dRx™

ANTI-DEMENTIA MEDICINES

Cholinesterase inhibitors:

Donepezil*, galantamine, rivastigmine

Other medicines:

Memantine

*Common Pharmaceutical Benefits Scheme medicine

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking cholinesterase inhibitors for the cognitive symptoms of dementia: • For dementias other than Alzheimer's disease, dementia of Parkinson's disease, Lewy body dementia, or vascular dementia, due to limited evidence for efficacy; • For Alzheimer's disease, mixed dementia, dementia of Parkinson's disease, Lewy body dementia, or vascular dementia, if treatment has continued for more than 12 months without clear benefit or if dementia has progressed to a severe/end-stage; or • In the presence of significant side effects that impact their quality of life.
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose, but we suggest reassessing the need for long-term therapy periodically.
	HOW TO DEPRESCRIBE
CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest halving the daily dose every four weeks, ensuring the absence of withdrawal symptoms or worsening of global, cognitive, functional, or neuropsychiatric outcomes before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely.

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

CBR For people on combination therapy of cholinesterase inhibitors and medicines with anticholinergic properties, we suggest first considering the deprescribing of anticholinergics due to the potential adverse effects on cognitive function. Tapering of anticholinergics can generally follow the same approach as cholinesterase inhibitors tapering; however, we suggest individualising the tapering schedule and adjusting it as needed according to the individual's response. The dose for concomitant cholinesterase inhibitors may also need to be adjusted due to the reduction in opposing mechanisms of action following the dose reduction of anticholinergics.

GPS Healthcare providers should consider and offer adequate non-pharmacological management options to individuals and their families, care providers (e.g. verbal de-escalation, psychological intervention, engaging individuals in meaningful activities, increased staff-to-patient ratio, increased staff training in behaviour management) as appropriate to manage challenging behaviours in dementia (ungraded good practice statement).

MONITORING

CBR We suggest closely monitoring individuals for withdrawal symptoms or symptoms of disease exacerbation (e.g. worsening neuropsychiatric symptoms including agitation and apathy, cognitive decline, worsening behavioural symptoms, reduced ability in activities of daily living) every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to report symptoms and/or any appearance of new symptoms as needed.

GPS Healthcare providers should provide clear guidance to care providers on recognising withdrawal symptoms and symptoms of disease exacerbation, enabling them to seek timely medical advice (ungraded good practice statement).

GPS Healthcare providers should use validated assessment tools to evaluate changes in cognitive function, neuropsychiatric symptoms, functional status, and quality of life (e.g. Psychogeriatric Assessment Scales for cognitive function, Neuropsychiatric Inventory for neuropsychiatric symptoms, Functional Status Questionnaire for functional status, and EQ-5D for health-related quality of life) (ungraded good practice statement).

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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