THE UNIVERSITY OF WESTERN AUSTRALIA

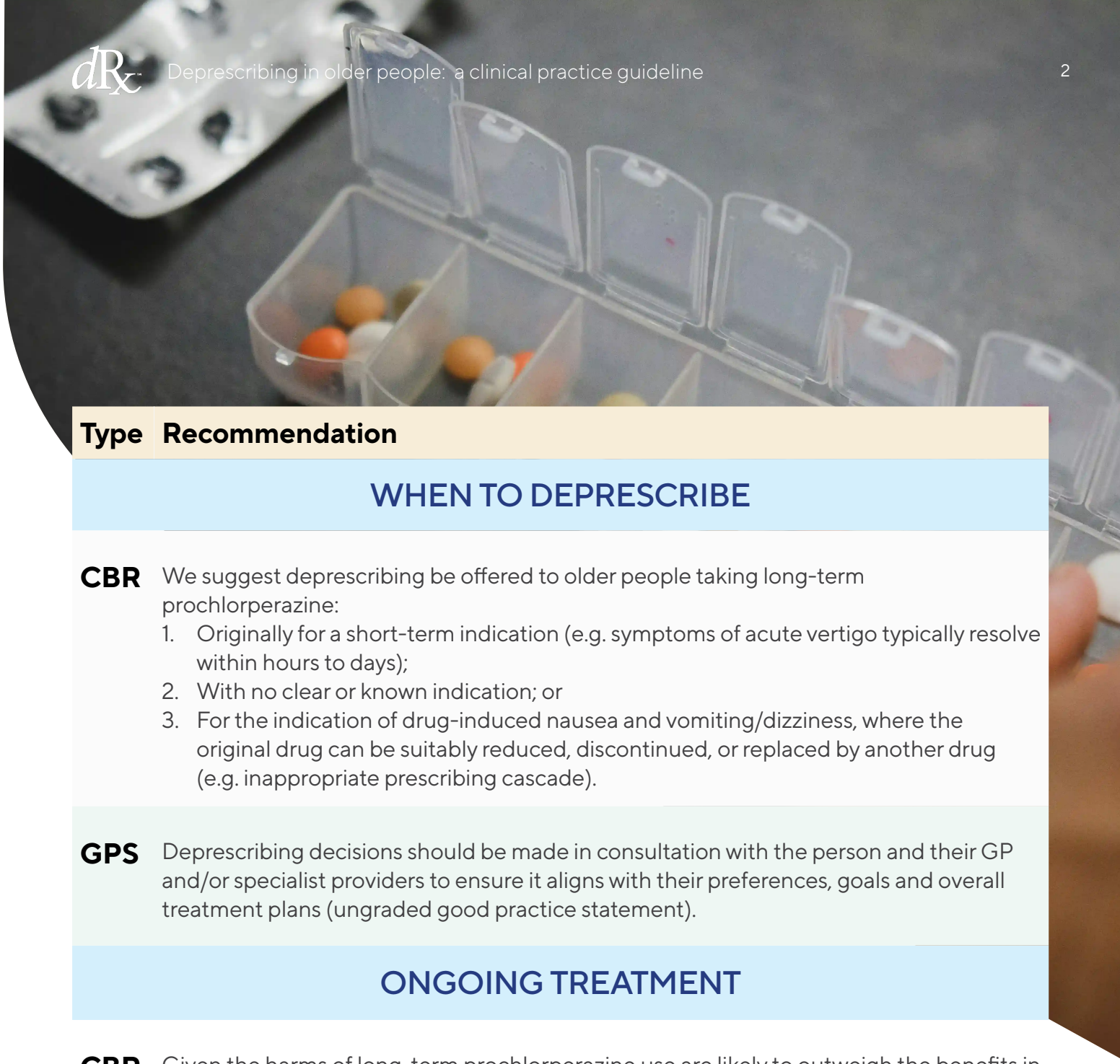
WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

PROCHLORPERAZINE

Deprescribing in older people: A clinical practice guideline

dRx™



Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking long-term prochlorperazine: 1. Originally for a short-term indication (e.g. symptoms of acute vertigo typically resolve within hours to days); 2. With no clear or known indication; or 3. For the indication of drug-induced nausea and vomiting/dizziness, where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade).
GPS	Deprescribing decisions should be made in consultation with the person 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	Given the harms of long-term prochlorperazine use are likely to outweigh the benefits in most cases, we generally suggest against the use of long-term prochlorperazine in older people and trial on-demand or intermittent use at the lowest effective dose in addition to appropriate investigation to identify and subsequently treat a cause. If symptoms are chronic and persistent, we suggest considering appropriate non-pharmacological therapies and/or safer alternatives for symptoms, provided this aligns with the individual's goals and preferences, following informed consent.

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

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting it according to the individual's response.

In general, given the likelihood of symptom recurrence in long-term users, we suggest reducing the dosing frequency every one to two weeks:

- For those on three times daily, reduce to twice daily, then once daily, then cease completely; or
- For those on twice daily, reduce to once daily, then cease completely;

and switch to on-demand or intermittent use at the lowest effective dose.

If symptoms recur during tapering, we suggest restarting at the previously tolerated tapered dose until symptoms resolve, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper.

MONITORING

CBR We suggest closely monitoring for disease exacerbations (e.g. symptom recurrence) or adverse drug withdrawal events (ADWEs, e.g. withdrawal-emergent abnormal movements), every 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.

For persistent ADWEs, we suggest collaborating with other relevant healthcare providers (e.g. physiotherapists, speech pathologists) to evaluate their impact and seriousness and develop strategies to resolve them.

If in-person visits are impractical, we suggest informing people to report symptom recurrence (e.g. dizziness) and/or any appearance of new symptoms 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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