THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

MEDICINES FOR CHRONIC OBSTRUCTIVE AIRWAY DISEASES

Deprescribing in older people: A clinical practice guideline

dRx™

MEDICINES FOR CHRONIC OBSTRUCTIVE AIRWAY DISEASES

Beta$_2$ agonists:

Salbutamol, terbutaline, formoterol, indacaterol, olodaterol, salmeterol, vilanterol

Inhaled anticholinergics:

Ipratropium, aclidinium, glycopyrronium, tiotropium*, umeclidinium

Inhaled corticosteroids:

Beclomethasone, budesonide, ciclesonide, fluticasone furoate, fluticasone propionate

Xanthines:

Aminophylline, theophylline

Dual combination therapy (LAMA/ LABA)

- Tiotropium/ olodaterol
- Aclidinium/ formoterol
- Indacaterol/ glycopyrronium
- Umeclidinium/ vilanterol

Dual combination therapy (ICS/ LABA)

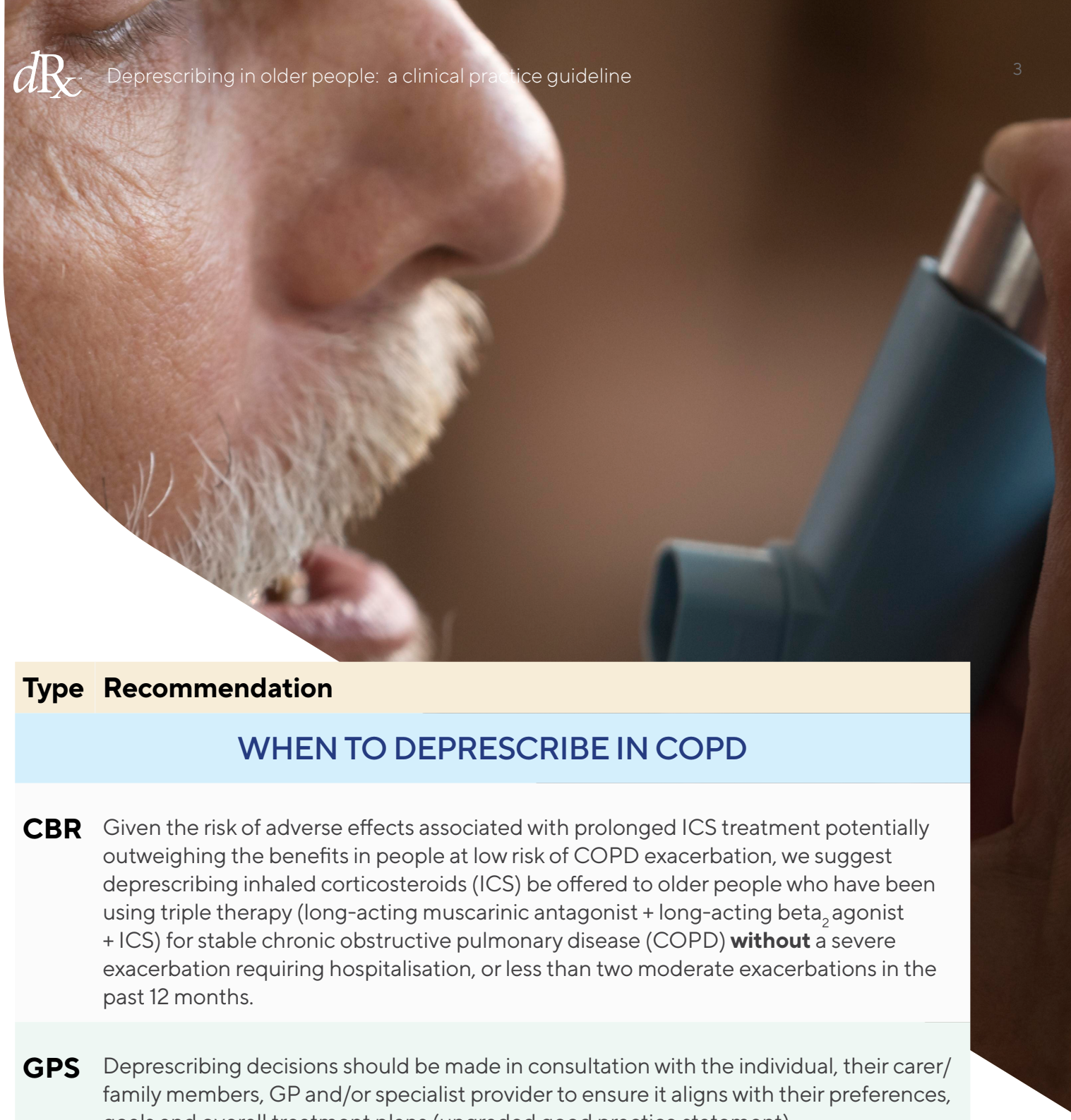
- Fluticasone propionate/ salmeterol*
- Fluticasone propionate/ formoterol
- Budesonide/ formoterol*
- Beclometasone/ formoterol
- Mometasone/ indacaterol
- Fluticasone furoate/ vilanterol

Triple therapy (ICS/ LAMA/ LABA)

- Fluticasone furoate/ umeclidinium/ vilanterol*
- Beclometasone/ glycopyrronium/ formoterol
- Budesonide/ glycopyrronium/ formoterol

*Common Pharmaceutical Benefits Scheme medicines

ICS, inhaled corticosteroids;
LABA, long-acting beta-agonists;
LAMA, long-acting muscarinic antagonists



Type	Recommendation
	WHEN TO DEPRESCRIBE IN COPD
CBR	Given the risk of adverse effects associated with prolonged ICS treatment potentially outweighing the benefits in people at low risk of COPD exacerbation, we suggest deprescribing inhaled corticosteroids (ICS) be offered to older people who have been using triple therapy (long-acting muscarinic antagonist + long-acting $beta_2$ agonist + ICS) for stable chronic obstructive pulmonary disease (COPD) **without** a severe exacerbation requiring hospitalisation, or less than two moderate exacerbations in the past 12 months.
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT IN COPD
CBR	We suggest continuing maintenance therapy as appropriate with a long-acting bronchodilator(s) (e.g. long-acting muscarinic antagonist, long-acting $beta_2$ agonist), either as monotherapy or in combination depending on symptomatic response.

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

HOW TO DEPRESCRIBE IN COPD

CBR We suggest individualised deprescribing based on the individual's preference. In general, we suggest discontinuing ICS without the need for tapering; however, some people may prefer a gradual stepwise reduction.

GPS Healthcare providers should regularly check inhaler techniques and adherence, especially if symptoms remain persistent (ungraded good practice statement).

GPS In severe disease, consideration should be given to which inhaler is used (i.e. insufficient airflow to utilise a dry powder Ellipta device vs. a jet Respimat device) (ungraded good practice statement).

GPS Healthcare providers should consider and offer adequate education on lifestyle interventions (e.g. smoking cessation, nutrition, alcohol, physical activity) to individuals as appropriate (ungraded good practice statement).

GPS Pulmonary rehabilitation should be offered to all people with COPD and may result in significant quality of life and symptom improvements to offset any anxiety around deprescribing (ungraded good practice statement).

MONITORING IN COPD

CBR We suggest monitoring lung function using a spirometry test three to six months after deprescribing, or sooner if clinical deterioration.

CBR We suggest closely monitoring for changes in symptoms and quality of life every six weeks for the first six months after deprescribing, then monitoring for exacerbation frequency every six months thereafter, with cough and shortness of breath most likely for the first three months of withdrawal.

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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