THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

DIURETICS

Deprescribing in older people: A clinical practice guideline

dRx™

DIURETICS

Low-ceiling diuretics, thiazides:
Hydrochlorothiazide#

Low-ceiling diuretics, excluding thiazides:
Chlortalidone, indapamide#

Loop diuretics:
Furosemide*, bumetanide

Aldosterone antagonists and other potassium-sparing agents:
Eplerenone, spironolactone*, finerenone

Combination drugs:
Amiloride with hydrochlorothiazide

*Common Pharmaceutical Benefits Scheme (PBS) medicines
#Common PBS medicines (as combination products)

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	Following shared decision-making, we suggest deprescribing diuretics be offered to older people with: 1. No current indication (i.e. heart failure, renal failure, or hypertension); 2. Adverse effects potentially outweigh benefits (e.g. with urinary incontinence symptoms that significantly affect quality of life); 3. When the diuretic was prescribed solely for hypertension and the criterion for deprescribing antihypertensive medications as outlined in the antihypertensives section is met; or 4. A relative contraindication, such as: • Potassium-sparing diuretics in people with hyperkalaemia; • Loop/thiazide diuretics in people with gout, refractory symptomatic hyponatremia, or diabetes mellitus; or • Diuretics for drug-induced oedema (e.g. calcium channel blockers).
GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers (e.g. cardiologist or nephrologist) to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	We suggest continuing diuretics in older people taking long-term diuretics for persistently symptomatic fluid overload due to cardiac, renal, or liver failure, despite optimal management being in place.
CBR	We suggest continuing aldosterone antagonists in people with heart failure, especially if reduced ejection fraction (HFrEF), given their benefit in reducing mortality and hospitalisation.
CBR	We suggest continuing finerenone in chronic kidney disease (with albuminuria) in people with type 2 diabetes.
CBR	If deprescribing is unsuccessful despite two attempts, we suggest maintaining the lowest effective dose, but reassessing the need for long-term therapy periodically.

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

HOW TO DEPRESCRIBE

CBR If complete cessation is considered appropriate, we suggest for furosemide:

- If daily doses < 40mg, discontinue without tapering
- If daily doses amount to 40mg, halve the dose for one week before complete cessation
- If daily doses amount to 80mg, halve the dose for two weeks before complete cessation
- If daily doses are between 80mg and 160mg, reduce the dose by 40 mg every two weeks until it reaches 40 mg, then discontinue completely.

For other diuretics, we suggest tapering the dose with monitoring of fluid status, with daily weight monitoring for potential weight gain following down titration of dosing.

For combination of thiazide and loop diuretic, we suggest first tapering thiazide diuretic.

CBR If potassium supplements are being used alongside thiazide or loop diuretics, we suggest adjusting or discontinuing potassium supplements in coordination with any changes to the diuretic therapy.

For potassium-sparing diuretics, we suggest reviewing and adjusting other medicines and/or lifestyle factors that affect potassium levels in coordination with any changes to the diuretic therapy.

MONITORING

CBR We suggest closely monitoring for blood pressure, signs of exacerbations (e.g. peripheral oedema, signs of heart failure), and changes in body weight weekly during tapering for at least three months following deprescribing. After this initial period, we suggest monthly monitoring for ongoing risk factors for at least three months, followed by monitoring every six months thereafter.

If in-person visits are impractical, we suggest advising people to self-monitor blood pressure and body weight at home by using a blood pressure monitor and weighing scales respectively, as well as reporting any significant changes to their healthcare provider as needed.

CBR When discontinuing or changing the dose of diuretics, we suggest closely monitoring for changes in serum potassium and renal function (blood urea nitrogen, serum creatinine and eGFR).

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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