THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

ANTIEPILEPTICS

Deprescribing in older people: A clinical practice guideline

dRx™

ANTIEPILEPTICS

Barbiturates and derivatives:

Phenobarbital, primidone

Hydantoin derivatives:

Phenytoin

Succinimide derivatives:

Ethosuximide

Benzodiazepine derivatives:

Clonazepam, nitrazepam

Carboxamide derivatives:

Carbamazepine, oxcarbazepine, rufinamide

Fatty acid derivatives:

Valproate, vigabatrin, tiagabine

Other antiepileptics:

Brivaracetam, cannabidiol, gabapentin, lacosamide, lamotrigine, levetiracetam, perampanel, stiripentol, sulthiame, topiramate, zonisamide

Note: Please refer to the sedative hypnotics section for benzodiazepine derivatives used as sedative hypnotics (flunitrazepam, midazolam, nitrazepam, temazepam) and anxiolytics section for benzodiazepine derivatives used as anxiolytics (alprazolam, bromazepam, clobazam, diazepam, lorazepam, oxazepam).

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	**Epilepsy indication** We suggest deprescribing can be considered if preferred by the individual, provided they have been seizure-free for at least two years, and the risks (e.g. seizure recurrence implications such as driving license implications) and benefits (e.g. reduced adverse effects, interactions or treatment burden) are clearly communicated following an individualised risk assessment, and individual values, preferences, and goals are considered.
CBR	**Non-epilepsy indications** We suggest deprescribing be offered to older people taking antiepileptics for non-epilepsy indications (e.g. neuropathic pain or behavioural and psychological symptoms of dementia) when there is no evidence of therapeutic benefit after a reasonable trial at an optimal dose (e.g. ≥ two to three months) or when the treatment is poorly tolerated.
GPS	**Epilepsy and non-epilepsy indication** Deprescribing decisions should be made in consultation with the individual and their neurologist to ensure alignment with the individual's preferences, goals, and overall treatment plan (ungraded good practice statement).
	ONGOING TREATMENT
CBR	**Epilepsy indication** We suggest continuing antiepileptics for the indication of epilepsy for a minimum of two years without a seizure, or longer (as every additional year of seizure freedom reduces the risk of seizure recurrence), balanced by the individualised risk-benefit assessment.
CBR	**Non-epilepsy indication** We suggest continuing antiepileptics for non-epileptic indications (e.g. primidone for essential tremor) when the benefit clearly outweighs the risk.

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

HOW TO DEPRESCRIBE

CBR For all indications, we suggest individualising the tapering schedule and adjusting it according to the individual's response.

CBR **Epilepsy indication**
For epilepsy, we suggest reducing the dose of antiepileptics by 10-25% monthly, with close monitoring for breakthrough seizures. If seizure activity occurs, we suggest returning to the previous effective dose. However, we suggest the speed of tapering be guided by the person by taking into consideration other factors such as driving implications.

CBR **Non-epilepsy indications**
In general, we suggest reducing the dose gradually by 25% of the previous dose every week initially. If there is any indication of symptom recurrence (e.g. anxiety, restlessness, pain) or if used for longer than a month consider tapering more gradually (up to 6 months may be preferred for a barbiturate or clonazepam).

MONITORING

CBR **Epilepsy and non-epilepsy indication**
We suggest closely monitoring for symptom recurrence (e.g. seizure recurrence or changes in psychological symptoms for non-epilepsy indications) and whether other concurrent medicines require adjustments due to changes in drug-drug interactions when tapering antiepileptics. Monitoring should ideally occur 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 **Epilepsy indication**
For individuals with epilepsy, healthcare providers should ensure a seizure action plan is in place in case breakthrough seizures occur and encourage individuals to track any seizure activities (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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