THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

POTASSIUM

Deprescribing in older people: A clinical practice guideline

dRx™

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	To minimise potential prescribing cascades and risk of adverse outcomes associated with electrolyte imbalance, especially in people with an increased risk of hyperkalaemia (e.g. renal impairment, concurrent use of medicines affecting serum potassium levels), we suggest deprescribing be offered to older people taking long-term potassium: 1. Without an ongoing indication (e.g. past use for diuretic-induced hypokalaemia and current normal serum potassium) 2. For drug-induced hypokalaemia where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade) 3. With no clear or known indication (e.g. prophylaxis in people with a low risk of hypokalaemia)
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	We suggest continuing potassium in older people with persistent potassium depletion due to causes that cannot be resolved: • Advanced liver disease; or • Secondary hyperaldosteronism with renovascular hypertension; or • Gastrointestinal losses; or • Concomitant medicines known to affect potassium status adversely that cannot be deprescribed provided treatment 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 discontinuing potassium without the need for tapering with the possibility of restarting if needed.

If tapering is preferred [e.g. for people taking a high dose (i.e. > 1200 mg three times daily) prior to deprescribing], we suggest reducing the dose by 50%* every two weeks to minimise the risk of hypokalaemia. Once the lowest dose is reached, we suggest discontinuing potassium completely.

**Tapering can be performed by reducing the dosing frequency. Effervescent tablet formulation is available, presenting additional options for tapering doses.*

MONITORING

CBR We suggest closely monitoring serum potassium concentration with the time frame to be determined by the baseline dose. In general, we suggest reassessing serum potassium concentration once, one week after deprescribing.

We suggest periodic monitoring for dietary changes (i.e. intake of potassium-containing foods), and symptoms or signs attributable to hypokalaemia (e.g. muscle weakness, cramps, spasms, fatigue, and palpitations).

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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