THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

PREDNISONE / PREDNISOLONE

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 oral corticosteroids for: • Chronic obstructive pulmonary disease (COPD) as long-term oral corticosteroids are not indicated for this condition; • Autoinflammatory or autoimmune conditions, once clinical remission or sustained low disease activity has been achieved; or • Polymyalgia rheumatica, after at least 12 months of therapy and lack of signs and symptoms of an active disease.
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 that ongoing treatment with oral corticosteroids may be necessary for some people with autoimmune diseases who experience a relapse after attempts to deprescribe, despite concurrent use of disease-modifying agents. In such cases, we suggest maintaining long-term oral corticosteroids at the lowest effective dose.

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

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting the schedule based on individual preferences, overall risk of withdrawal effects, risk of glucocorticoid-induced adrenal insufficiency, risk of relapse, adverse drug effects, disease activity, the initial dose, and duration of use.

In general, we suggest reducing the dose by prednisone equivalent of 10-20% per week; however, some people may require very gradual tapering such as 1 mg every four to eight weeks, especially when approaching physiological glucocorticoid dosing.

MONITORING

CBR We suggest advising patients to report to their healthcare providers symptoms of potential signs and symptoms of glucocorticoid withdrawal syndrome (e.g. sleep disturbance and mood changes), glucocorticoid-induced adrenal insufficiency (e.g. myalgias, fatigue, and muscle weakness) and recurrence of underlying conditions (e.g. breathlessness for COPD or arthralgias in rheumatoid arthritis).

We suggest monthly monitoring of erythrocyte sedimentation rate and C-reactive protein 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.

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:

THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

Suggested citation: Quek HW, Reus X, Lee K, Etherton-Beer C, Page A on behalf of the Guideline Development Group. Deprescribing in older people: A clinical practice guideline. Perth: The University of Western Australia; 2025.