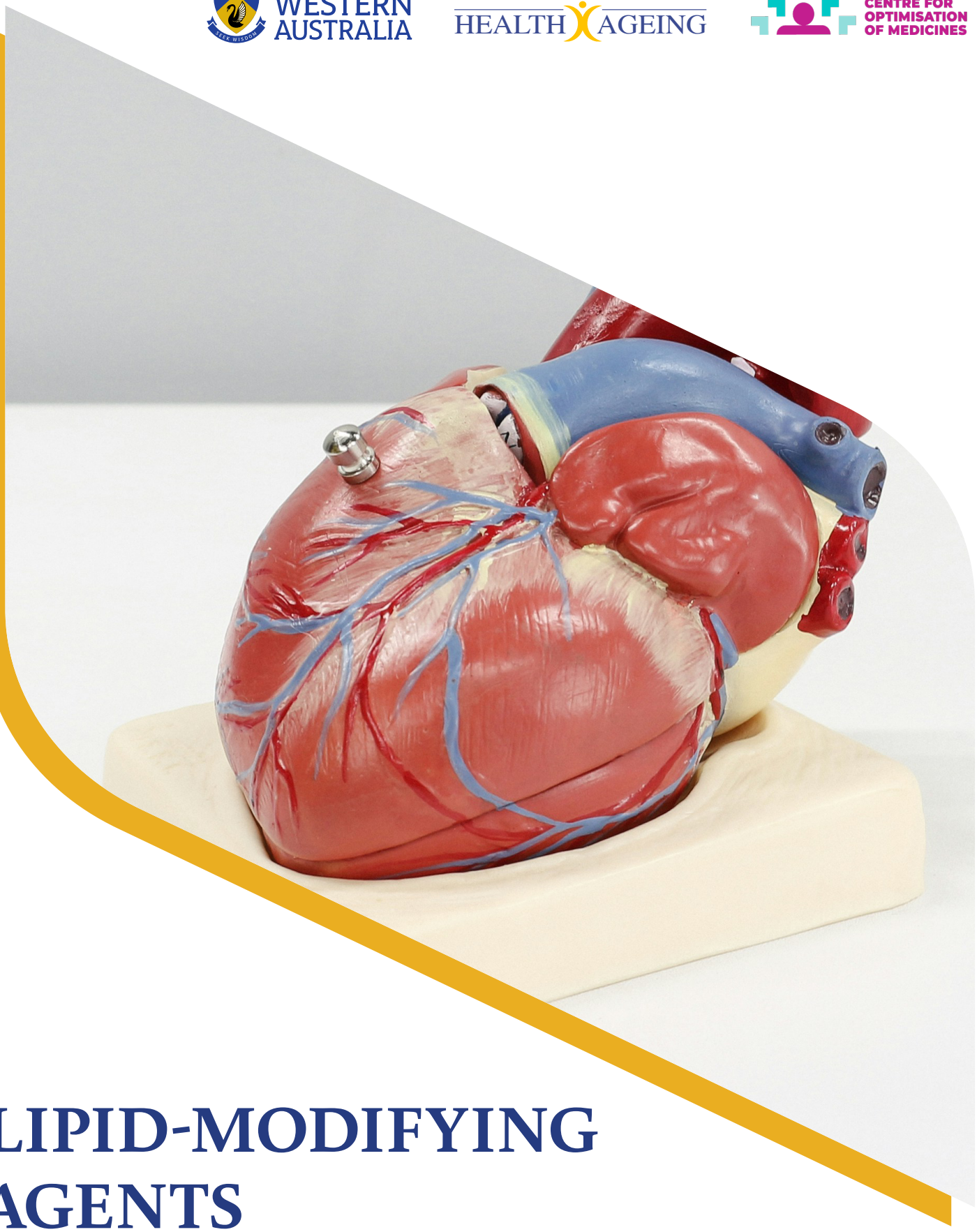
THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES



LIPID-MODIFYING AGENTS

Deprescribing in older people: A clinical practice guideline

dRx™

LIPID-MODIFYING AGENTS

HMG CoA reductase inhibitors (Statins):

Atorvastatin*, fluvastatin, pravastatin*, rosuvastatin*, simvastatin*

Fibrates:

Fenofibrate*, gemfibrozil

Bile acid sequestrants:

Colestyramine

PCSK9 (proprotein convertase subtilisin /kexin type 9) inhibitors:

Evolocumab, inclisiran

Combination lipid-modifying agents:

Ezetimibe with atorvastatin* or simvastatin* or rosuvastatin*

Lipid-modifying agents in combination with other drugs:

Atorvastatin with amlodipine*

Other drugs for dyslipidaemia:

Nicotinic acid, ezetimibe*

*Common Pharmaceutical Benefits Scheme medicines

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	Following a shared decision-making discussion in which potential benefits and harms are clearly communicated along with considerations of other individual factors, we suggest deprescribing be offered to older people taking lipid-modifying agents: 1. For primary prevention of cardiovascular diseases (CVD) and cerebrovascular diseases in people aged*: • 65-79 with CVD risk < 5% (over five years); • 65-79 with CVD risk between 5% and < 10% (over five years) and, if tested, a coronary artery calcium score of zero and/or no coronary artery disease shown on computed tomography (CT) or invasive coronary angiogram; or • ≥ 80 where the risk of adverse effects potentially outweighs the benefit. 2. For secondary prevention in people aged ≥ 80 years unable to tolerate high-intensity statin, moderate-intensity therapy can be considered; 3. For primary or secondary prevention in the context of frailty or advanced life-limiting illness (e.g. poor prognosis malignancies) with a life expectancy < 12 months when there are no recent active cardiovascular diseases to reduce risk of adverse effects, reduce medication burden, and improve quality of life; or 4. With possible adverse effects (e.g. statin-related muscle symptoms such as myalgia, myopathy, rhabdomyolysis). **See the GPS below on the suggestion to assess cardiovascular risk over five years*
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).
GPS	Healthcare providers should use the Australian CVD Risk Calculator* to assess cardiovascular risk over the next five years, as it accounts for the specific contexts of the Australian population and healthcare system (https://www.cvdcheck.org.au/calculator) (ungraded good practice statement). **Note that the Australian cardiovascular disease risk calculator is validated for use in people without known CVD aged 30 to 79 years who do not already meet high risk criteria.*

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

ONGOING TREATMENT

CBR We suggest considering ongoing statin therapy in individuals whose life expectancy is sufficient to allow time to benefit from continued treatment, and who are taking statins for:

1. Primary prevention of CVD and cerebrovascular disease in line with current treatment guidelines, e.g.
   - People aged 65-79 with a high CVD risk ≥ 10% (over 5 years);
   - With a coronary artery calcium score > 100;
   - With total cholesterol levels above 7.5mmol/L, independent of their CVD risk; or
   - With familial hypercholesterolaemia.
2. Secondary prevention of CVD and cerebrovascular disease;

provided this aligns with the individual's goals and preferences, following informed consent.

HOW TO DEPRESCRIBE

CBR We suggest discontinuing lipid-lowering agents without the need for tapering provided it aligns with the individual's wishes and goals.

MONITORING

CBR We suggest monitoring lipid concentrations annually.

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

Lipid-modifying agents

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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