Deprescribing Guide: Dementia Medications

INTRODUCTION TO DEMENTIA MEDICATION DEPRESCRIBING

Despite a lack evidence to support sustained efficacy, especially in the setting of terminal dementia, family and caregivers may resist when deprescribing dementia medications is discussed. In a 2009 survey of hospice medical directors, approximately 80% recommended deprescribing.[1] However, the negative feelings encountered when entering into discussions with families and caregivers on the topic has contributed to variability in how dementia medications are managed in the hospice setting. This reference will serve as a resource to guide clinical decision-making when considering deprescribing of these medications and provide techniques to support hospice staff when initiating these conversations.

DEMENTIA MEDICATIONS

Acetylcholinesterase Inhibitors (AChEIs)	NDMA Receptor Antagonist	Combination Products
donepezil (Aricept®) rivastigmine (Exelon®) galantamine (Razadyne®)	memantine (Namenda®)	memantine and donepezil (Namzaric®)

RATIONAL FOR DEMENTIA MEDICATION DEPRESCRIBING

Clinical practice guidelines are utilized by medical professionals for clinical decision-making when adhering to evidence-based medicine. A recent review reported that more than 66% of guidelines advised the deprescribing of acetylcholinesterase inhibitors in the presence of certain clinical scenarios. These recommendations are highlighted in the tablet below. It is important to remember these recommendations do not supersede the clinical judgement of the medical provider caring for the patient or the hospice agency medical director, but simply serve as a tool to support hospice staff.

Recommend deprescribing in the following circumstances[5]:	
Lack of response/Loss of effectiveness	• Can be difficult to gauge, especially with long-term RX • Family/caregiver may fear significant decline when stopped

Adverse effects	• Acetylcholine inhibitor use can result in excess cholinergic activity which may include:
	  ○ diarrhea
	  ○ nausea/vomiting
	  ○ bradycardia
	  ○ bronchospasm
	  ○ incontinence
	  ○ weight loss
	  ○ peptic ulcer disease
	• Some patients may experience improve quality of life/symptom management following AChEI discontinuation

Severity of cognitive/ functional impairment	• Mini Mental Status Exam < 10 • Functional Assessment Staging Test (FAST) score worse than 7A
Institutionalization	• No longer needed to prevent heightened level of care • Symptoms/behavioral disturbances can be addressed from a comfort/quality of life approach
Medical status	• Recommended to stop in patients who are terminally ill, actively dying, with a new fracture or active infection • Continuing medications that are not relieving any symptoms (i.e. not palliative), may be outside the goals of care
Family/caregiver preference	• Due to lack of anticipated palliative benefit of medications from this class, recommend stopping if patient, family or caregiver express concern with continued use
Drug-drug interactions	• May interfere with anticholinergic medications such as ipratropium, tiotropium or glycopyrrolate
Inconsistent adherence	• Discontinue if patient unable/unwilling to take regularly

PATIENT & CAREGIVER DISCUSSION POINTS:

- Acknowledge the family's concerns about discontinuing medications for dementia
- Discuss how increased cholinergic activity resulting form acetylcholine inhibitor use can contribute to undesirable side effects negatively impacting patient quality of life, such as incontinence, diarrhea, nausea/vomiting
- Center conversation patient comfort and quality of life
- Discuss progression of dementia symptoms with family/caregiver(s), and if worsening, how medications used for dementia may not provide any additional benefit.

HOW TO DEPRESCRIBE

- Deprescribing guidelines typically recommend a tapered discontinuation, when possible, to reduce risk of withdrawal symptoms that may occur after abrupt withdrawal. Tapering schedules of up to 50% per week over 2-4 weeks have been proposed, especially after long-term use.[2,10,11]
- AChEI discontinuation syndromes have been reported but usually in patients with mild to moderate dementia.[2,10,12-14] Dementia's effects on individual patients are inherently unpredictable; changes following discontinuation may not be related to deprescribing. Case reports of clinical deterioration describe changes following discontinuation. A meta-analysis found the rate of cognitive decline to occur in the 6 weeks following discontinuation.[2] Patients with baseline psychosis may be more prone to decline.[10] New onset of agitation, anxiety, delirium, tearfulness, mood changes, insomnia, or paralytic ileus that are reasonably attributed to AChEI withdrawal should prompt an evaluation that considers AChEI reintroduction, or if a AChEI taper is still in progress, to taper at a slower rate.[12-14]

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