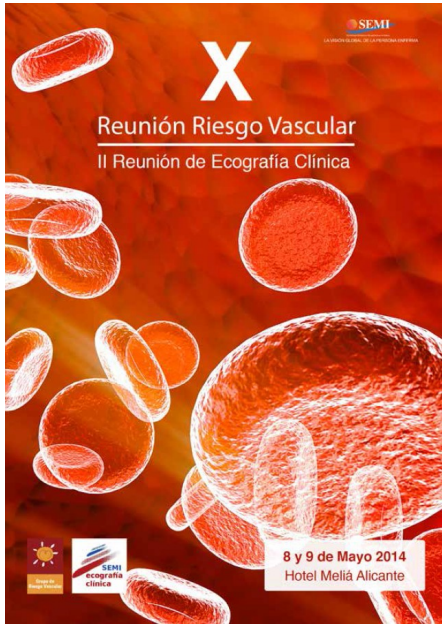


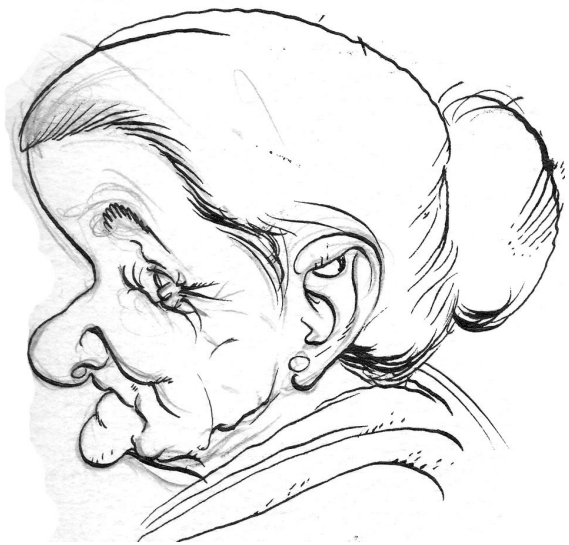
Universidad Zaragoza
1542

IACS Instituto Aragonés de Ciencias de la Salud

Desprescripción cardiovascular en el anciano

La asignatura pendiente

Jesús Díez Manglano
Medicina Interna. Hospital Royo Villanova. Zaragoza



82 años
Insuficiencia cardiaca clase III
Insuficiencia renal crónica estadio IV
Diabetes mellitus tipo 2
Obesidad mórbida
Hipertensión arterial
Hipertrigliceridemia
Anemia crónica

Darbepoetina alfa
Insulina glargina
Linagliptina
Bisoprolol
Furosemida
Clortalidona
Doxazosina
Pravastatina
Alopurinol
Paricalcitol
Calcifediol
Sevelámero
Omeprazol
Fentanilo transdérmico
Latanoprost colirio
Polividona iodada colirio

16 fármacos 23-26 dosis

- Pluripatología en el anciano
- Polifarmacia
- Desprescripción
- Desprescripción cardiovascular

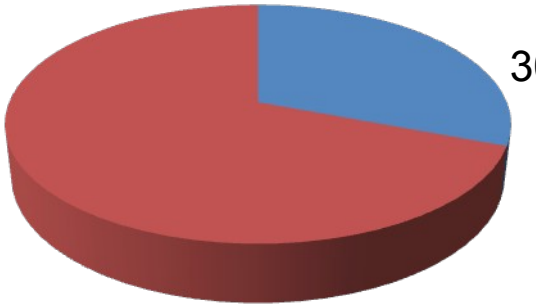
ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Pluripatología

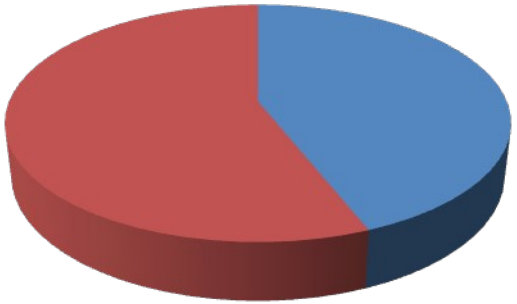
- Servicios de Medicina Interna y unidades de agudos de Geriatría de Aragón
- Pacientes pluripatológicos (criterios Junta de Andalucía)
- 13 hospitales y 60 investigadores
- 1870 ingresos, 1466 en Medicina Interna y 404 en Geriatría

Medicina Interna



30,8% PPP

Geriatría



44% PPP

ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Mortalidad en PP

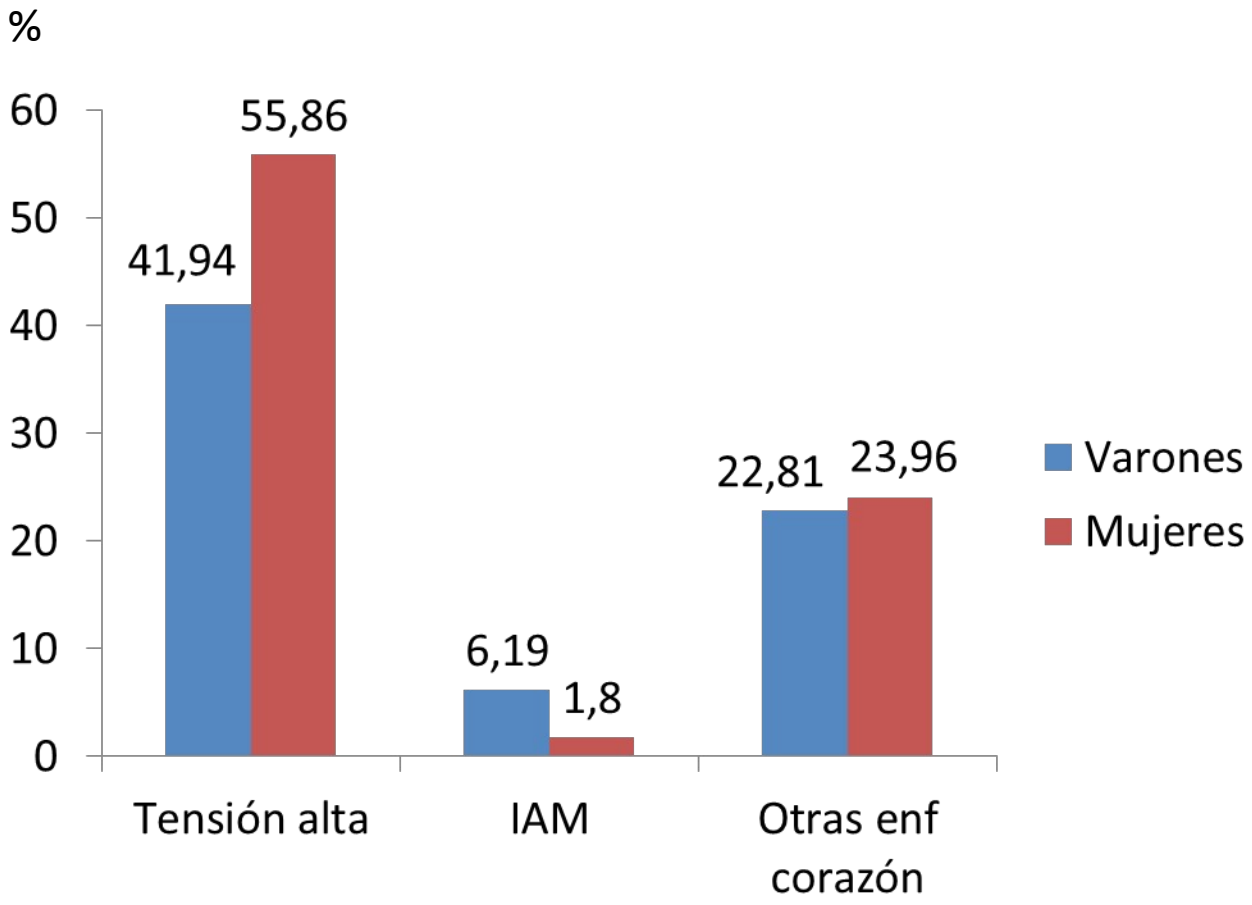
Ámbito	Mortalidad al año
Medicina Interna	35,7 %
Geriatría	44,4 %
Total	38,2 %
Cohorte PROFUND	**37,2 %**

Índice PROFUND	
Variable	Puntos
Edad ≥ 85	3
Rasgos clínicos Neoplasia activa Demencia Disnea clase III-IV NYHA o 3-4 mMRC Delirium en el último ingreso en el hospital	 6 3 3 3
Hb < 10 g/dL	3
Rasgos sociofamiliares Índice de Barthel < 60 Ausencia de cuidador u otro diferente del cónyuge	 4 2
≥ 4 ingresos hospitalarios en los últimos 12 meses	3

Estadio	Puntuación	Mortalidad (%)
1	0-2	14,6
2	3-6	24,4
3	7-10	46,6
4	≥ 11	61,3

Bernabeu M. Eur J Intern Med 2011; 22: 311.

Encuesta Nacional de Salud 2011-2012



Mayores de 85 años con enfermedad cardiovascular

- Pluripatología en el anciano
- Polifarmacia
- Desprescripción
- Desprescripción cardiovascular

Polifarmacia

Factores asociados a la polifarmacia en población anciana no institucionalizada. Análisis de la submuestra de la Encuesta Nacional de Salud 2006 para personas mayores de Castilla y León

Elisa Frutos Bernal [a,*], Juan Carlos Martín Corral [b] y Purificación Galindo Villardón [a]

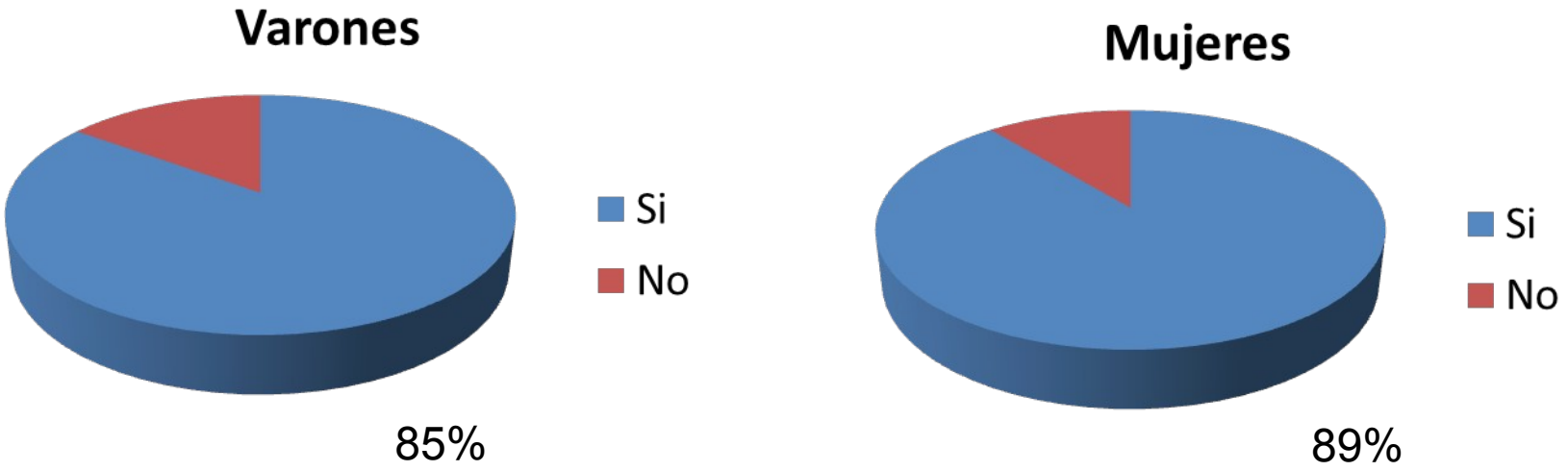
[a] Departamento de Estadística, Universidad de Salamanca, Salamanca, España
[b] Unidad de Cuidados Intensivos, Hospital Virgen de la Vega, Salamanca, España

Rev Esp Geriatr Gerontol. 2011;46(6):303–306

Resultados: El 86% de los entrevistados declaró consumir medicamentos y el 93,9% presenta alguna enfermedad crónica. Los problemas de salud más frecuentes son: artrosis, artritis o reumatismo (53,5%) e hipertensión (48,3%) y los medicamentos más consumidos son hipotensores (45%), medicamentos para el dolor (37,1%) y para el reumatismo (21,4%). Tanto la media de enfermedades presentadas como los fármacos consumidos son significativamente superiores en aquellos que dicen tener «mala o regular salud», los que frecuentan los servicios sanitarios, los que presentan déficit visual y auditivo y los que tienen dependencia para el cuidado personal, labores domésticas y movilidad ($p < 0,05$). Las variables asociadas a la polifarmacia son: 3 o más enfermedades crónicas (OR = 18,3), salud autopercibida regular-mala (OR = 3,4) y sexo femenino (OR = 1,9).

Conclusiones: Dada la magnitud del problema sería conveniente incluir en los exámenes de salud del anciano una revisión del consumo de fármacos, en particular en las mujeres mayores de 75 años, con regular o mal estado de salud autopercibido que presentan 3 o más enfermedades.

Encuesta Nacional de Salud 2011-2012



Consumo de medicamentos en las últimas 2 semanas en mayores de 85 años

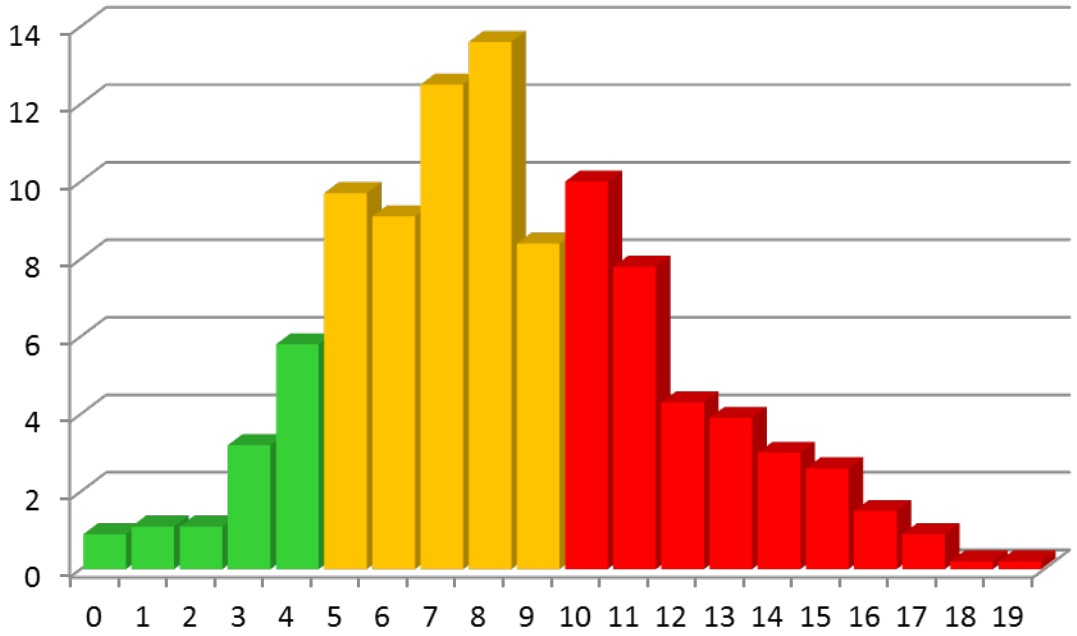
ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Polifarmacia y pluripatología en Aragón

Se han incluido 462 PP, 253 (54,8%) mujeres, con una edad media de 81,0±8.8. Las mujeres eran de mayor edad (83±9 vs 79±8; p=0,0003).

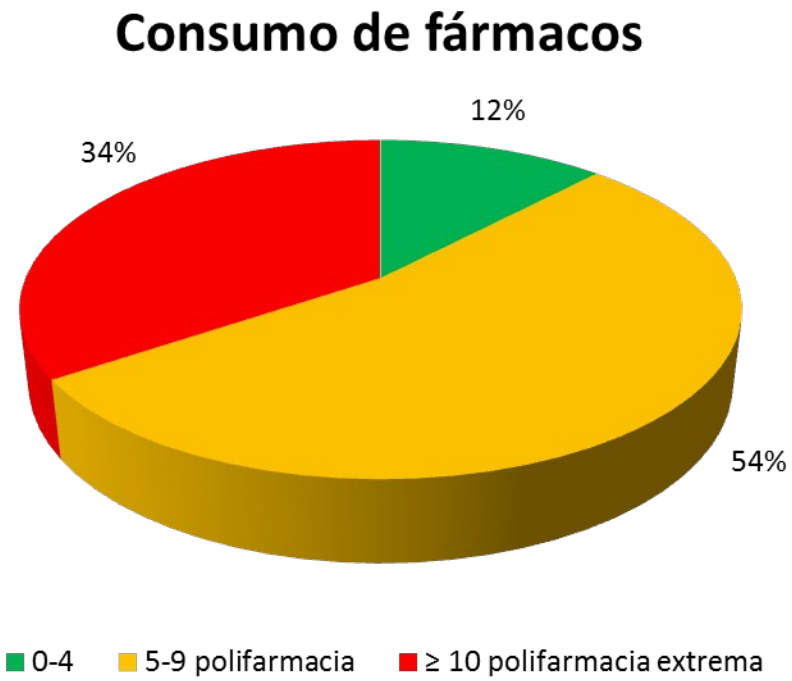
El consumo de medicamentos oscilaba entre 0-19 fármacos.



ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Polifarmacia y pluripatología en Aragón



ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Polifarmacia extrema en PP en Aragón

Análisis multivariable		
Variable	OR (IC 95)	p
Enf. Cardiacas (A)	2,33 (1,40-3,87)	0,001
Enf. Respiratorias (C)	1,87 (1,13-3,09)	0,01
Arteriopatía periférica y DM (F)	2,02 (1,17-3,50)	0,01
Delirium	0,48 (0,25-0,91)	0,02
Nº ingresos año previo	1,21 (1,01-1,14)	0,04

1,50€

el Periódico de Aragón

29 viernes

ESTUDIO SOBRE LOS HÁBITOS SANITARIOS DE LOS ESPAÑOLES

Los aragoneses son los que más medicinas consumen

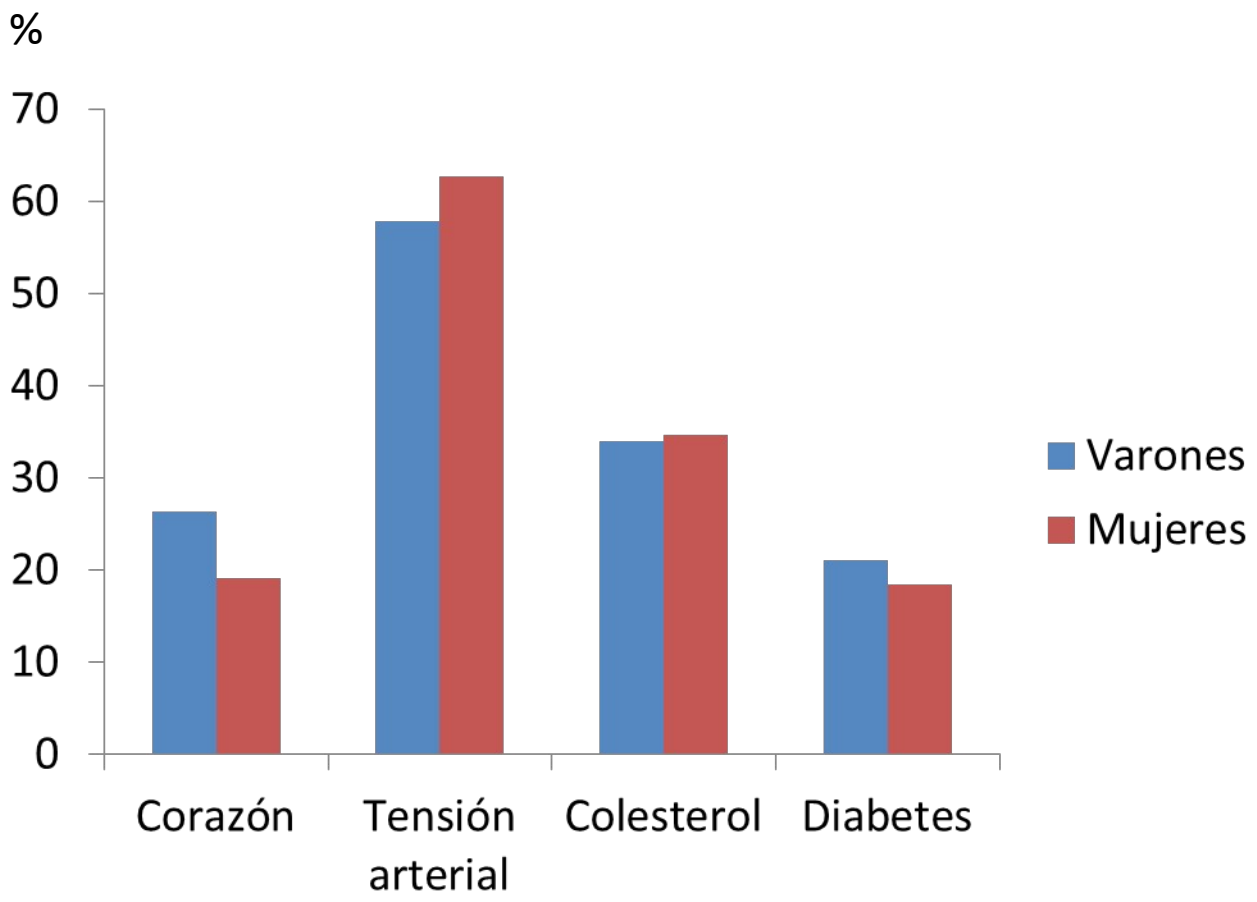
Los pacientes de la comunidad son también los que más veces acuden al médico al año

Artrosis y cataratas son las principales patologías que sufren los enfermos en Aragón

ACUERDO EN EL ERE

Ibercaja pacta la salida de 275 trabajadores, la mayoría prejubilados

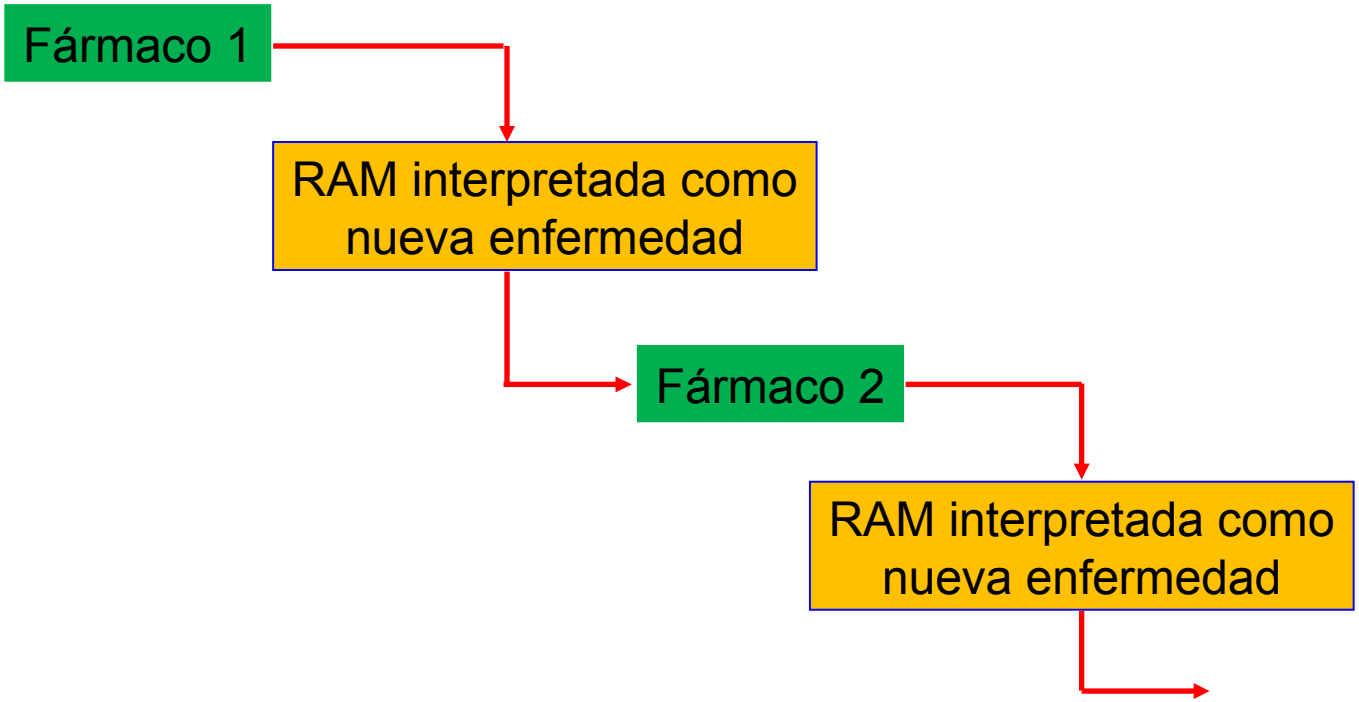
Encuesta Nacional de Salud 2011-2012



Consumo de medicamentos en mayores de 65 años

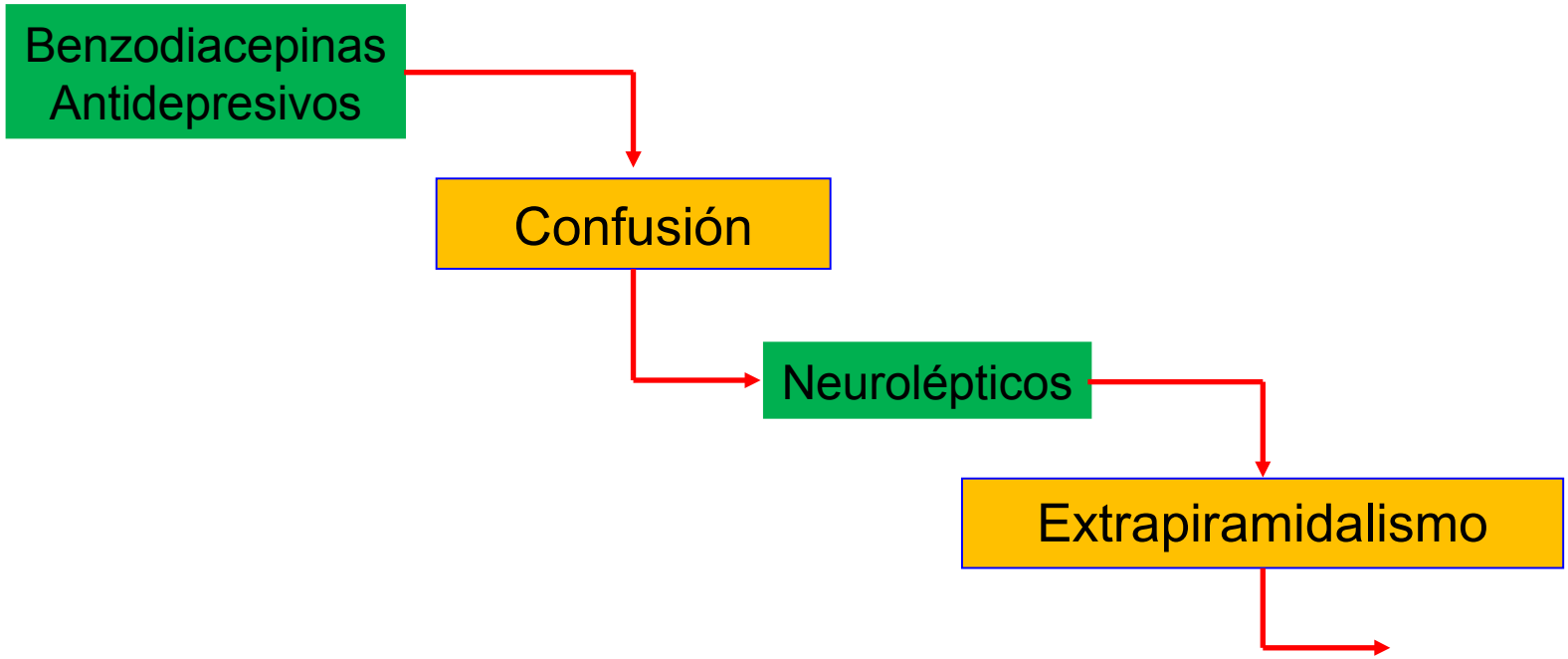
Polifarmacia

Cascada de la prescripción



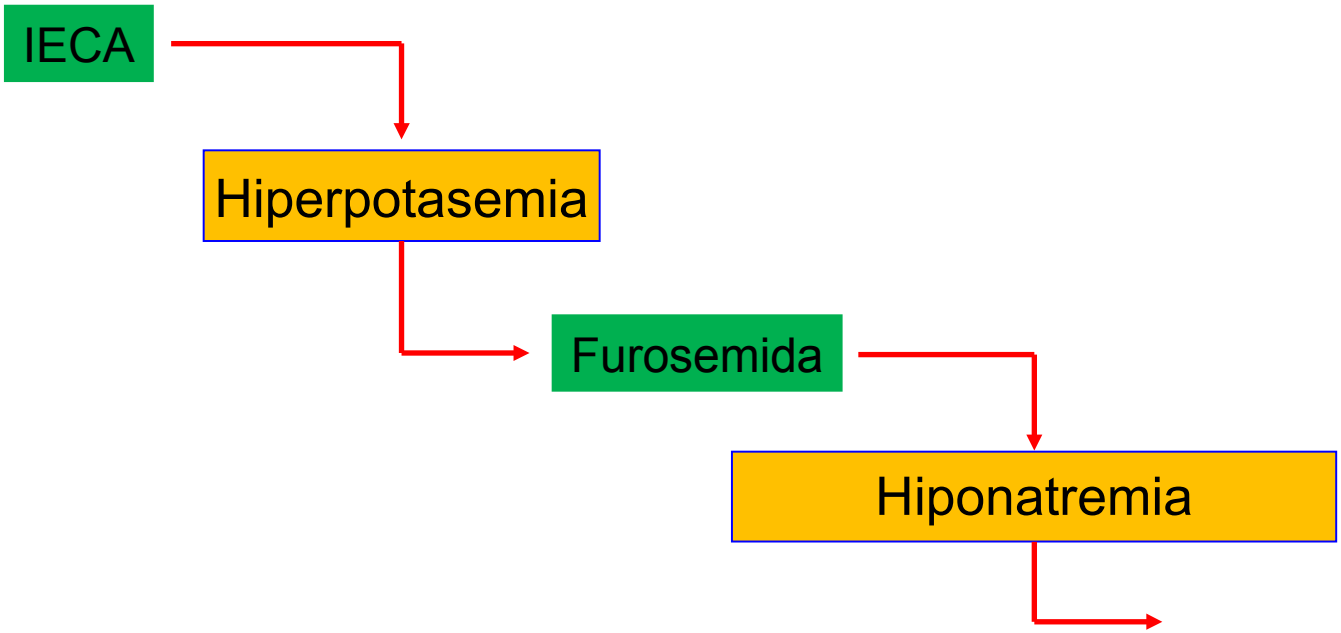
Polifarmacia

Cascada de la prescripción



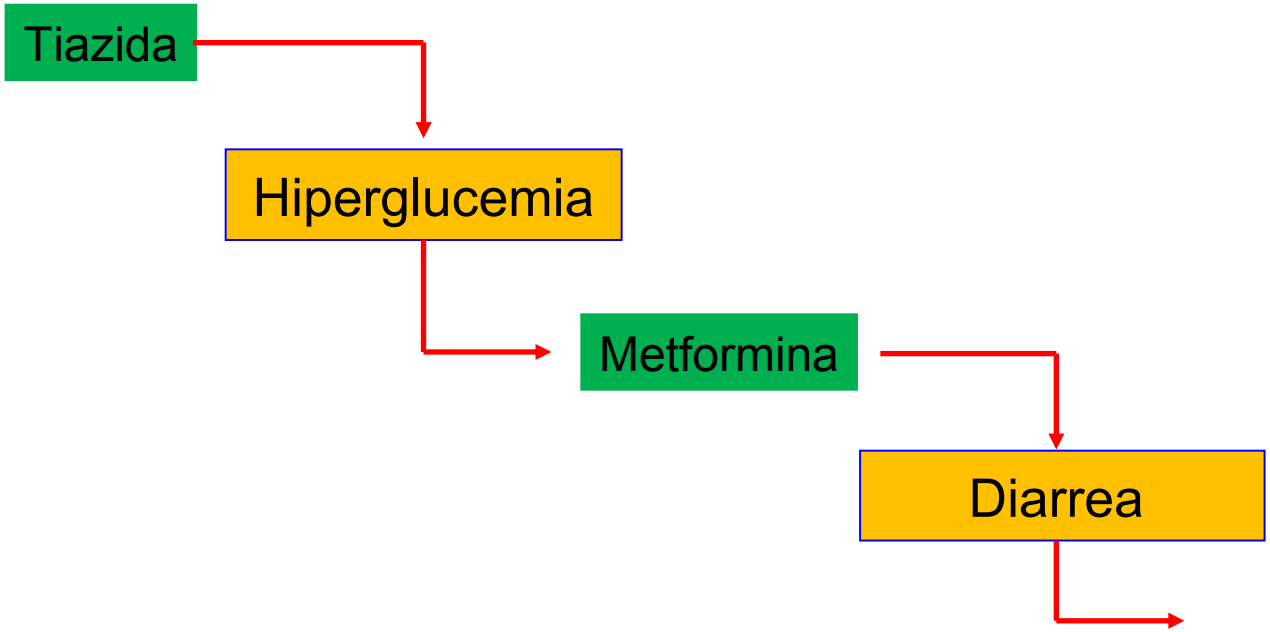
Polifarmacia

Cascada de la prescripción



Polifarmacia

Cascada de la prescripción



Consecuencias de la polimedicación

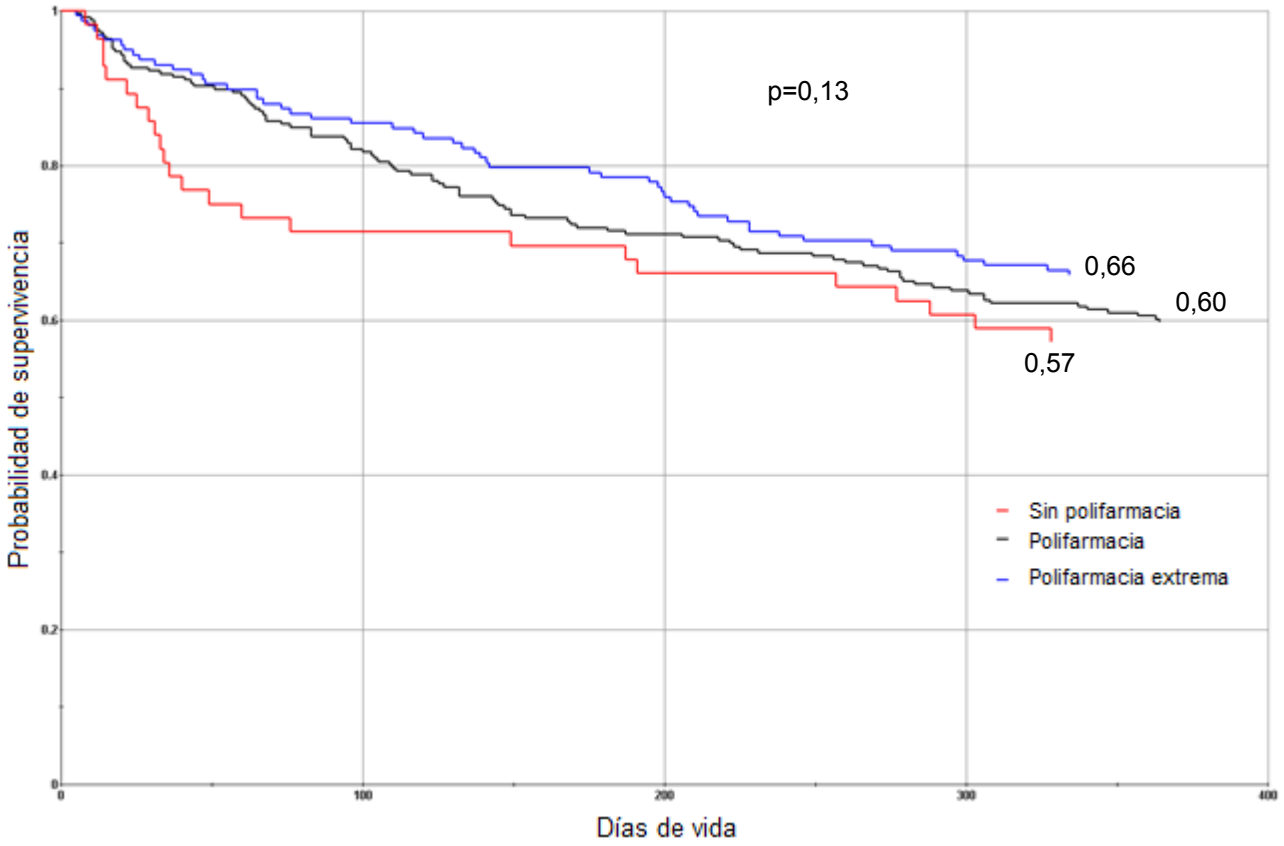
- Incremento del riesgo de efectos adversos
- Disminución de los beneficios de los fármacos adecuados
- Menor cumplimiento de los tratamientos adecuados
- Aumento de los costes

Queneau. Bull Acad Natl Med 2007; 191:271

ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Polifarmacia y mortalidad en PP



Polifarmacia

Polimedicación adecuada: el paciente toma muchos fármacos, pero todos ellos tienen indicación clínica.

Adecuación

Polimedicación inadecuada: cuando se toman más medicamentos de los clínicamente necesarios.

Reducción

Pseudopolimedicación: cuando en la historia están registrados más fármacos de los que realmente toma el paciente.

Actualización

CONCILIACION

Adecuación

- Criterios de Beers
- Criterios STOP-START

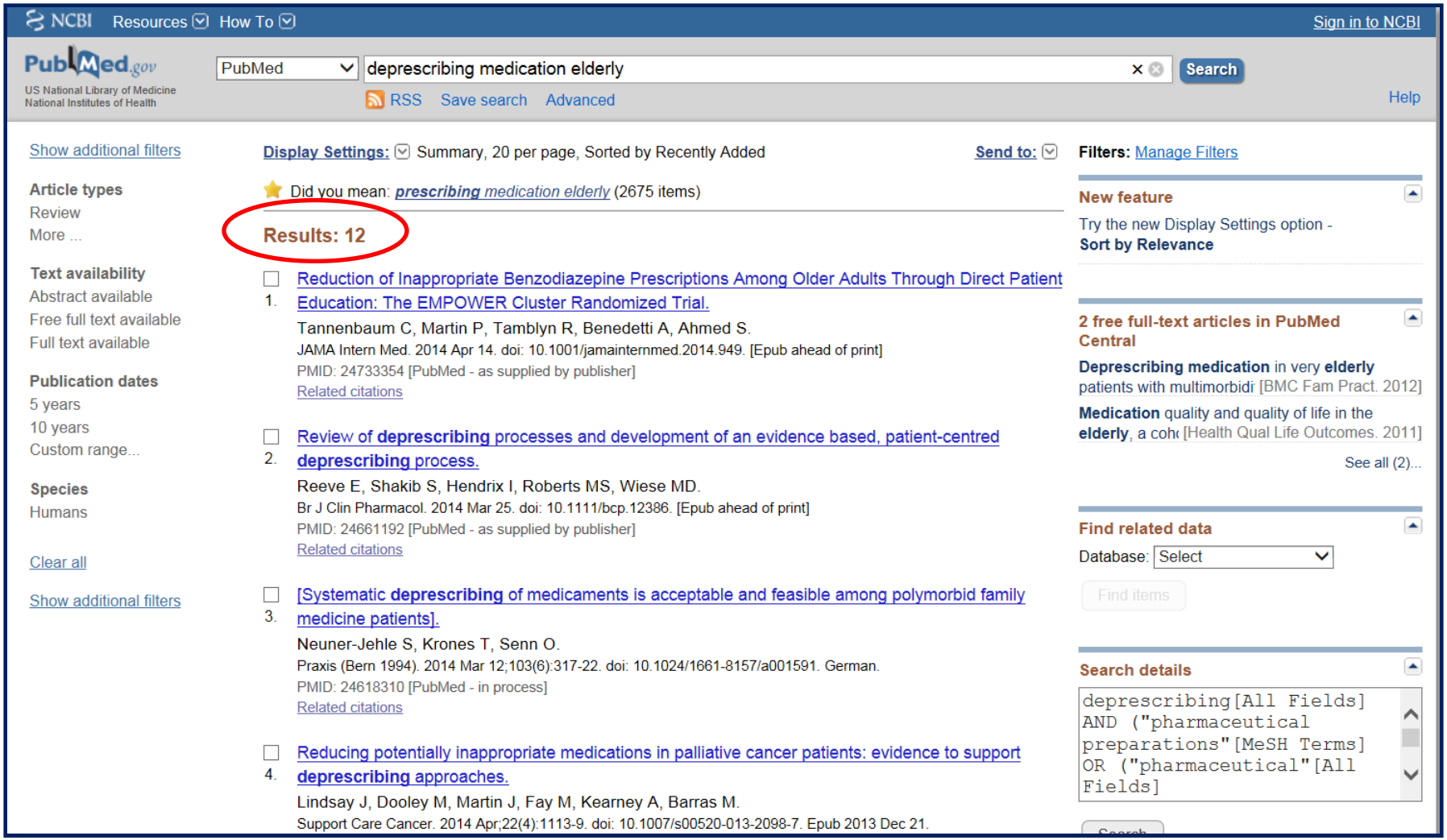
Conciliación

Proceso formal y estandarizado de obtener la lista completa de la medicación previa de un paciente, compararla con la prescripción activa, y analizar y resolver las discrepancias encontradas.

Conciliación

- En el momento del ingreso.
- En los traslados entre unidades.
- En los traslados entre hospitales.
- En el momento del alta.

- Pluripatología en el anciano
- Polifarmacia
- Desprescripción
- Desprescripción cardiovascular


NCBI Resources How To
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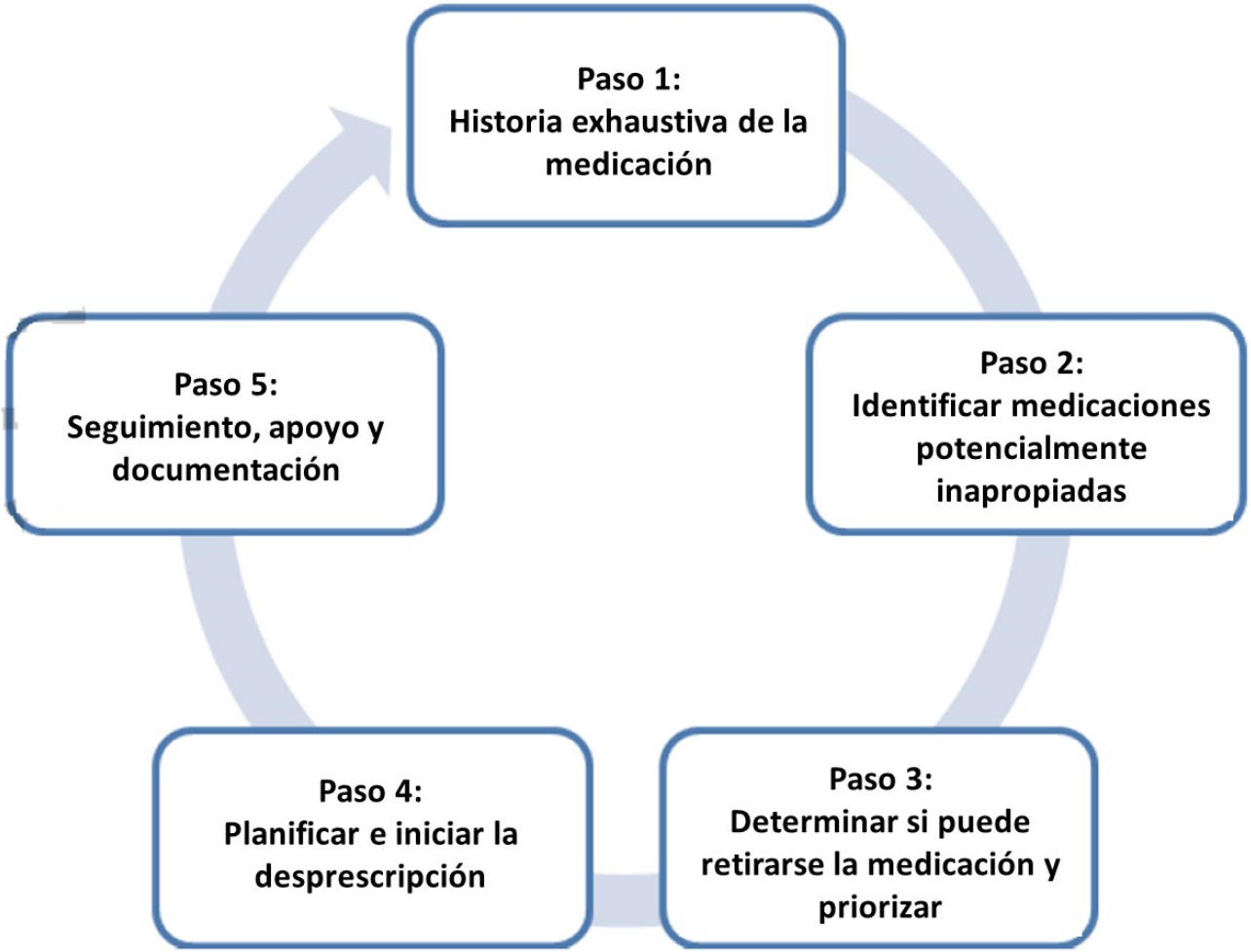
PubMed.gov
US National Library of Medicine
National Institutes of Health
PubMed
deprescribing medication elderly
Search
RSS Save search Advanced
Help
Show additional filters
Display Settings: Summary, 20 per page, Sorted by Recently Added
Send to:
Filters: Manage Filters
Did you mean: prescribing medication elderly (2675 items)
Results: 12
Article types
Review
More ...
Text availability
Abstract available
Free full text available
Full text available
Publication dates
5 years
10 years
Custom range...
Species
Humans
Clear all
Show additional filters
1. Reduction of Inappropriate Benzodiazepine Prescriptions Among Older Adults Through Direct Patient Education: The EMPOWER Cluster Randomized Trial.
Tannenbaum C, Martin P, Tamblyn R, Benedetti A, Ahmed S.
JAMA Intern Med. 2014 Apr 14. doi: 10.1001/jamainternmed.2014.949. [Epub ahead of print]
PMID: 24733354 [PubMed - as supplied by publisher]
Related citations
2. Review of deprescribing processes and development of an evidence based, patient-centred deprescribing process.
Reeve E, Shakib S, Hendrix I, Roberts MS, Wiese MD.
Br J Clin Pharmacol. 2014 Mar 25. doi: 10.1111/bcp.12386. [Epub ahead of print]
PMID: 24661192 [PubMed - as supplied by publisher]
Related citations
3. [Systematic deprescribing of medicaments is acceptable and feasible among polymorbid family medicine patients].
Neuner-Jehle S, Krones T, Senn O.
Praxis (Bern 1994). 2014 Mar 12;103(6):317-22. doi: 10.1024/1661-8157/a001591. German.
PMID: 24618310 [PubMed - in process]
Related citations
4. Reducing potentially inappropriate medications in palliative cancer patients: evidence to support deprescribing approaches.
Lindsay J, Dooley M, Martin J, Fay M, Kearney A, Barras M.
Support Care Cancer. 2014 Apr;22(4):1113-9. doi: 10.1007/s00520-013-2098-7. Epub 2013 Dec 21.
New feature
Try the new Display Settings option - Sort by Relevance
2 free full-text articles in PubMed Central
Deprescribing medication in very elderly patients with multimorbidi [BMC Fam Pract. 2012]
Medication quality and quality of life in the elderly, a coh [Health Qual Life Outcomes. 2011]
See all (2)...
Find related data
Database: Select
Find items
Search details
deprescribing[All Fields] AND ("pharmaceutical preparations"[MeSH Terms] OR ("pharmaceutical"[All Fields]

Desprescripción

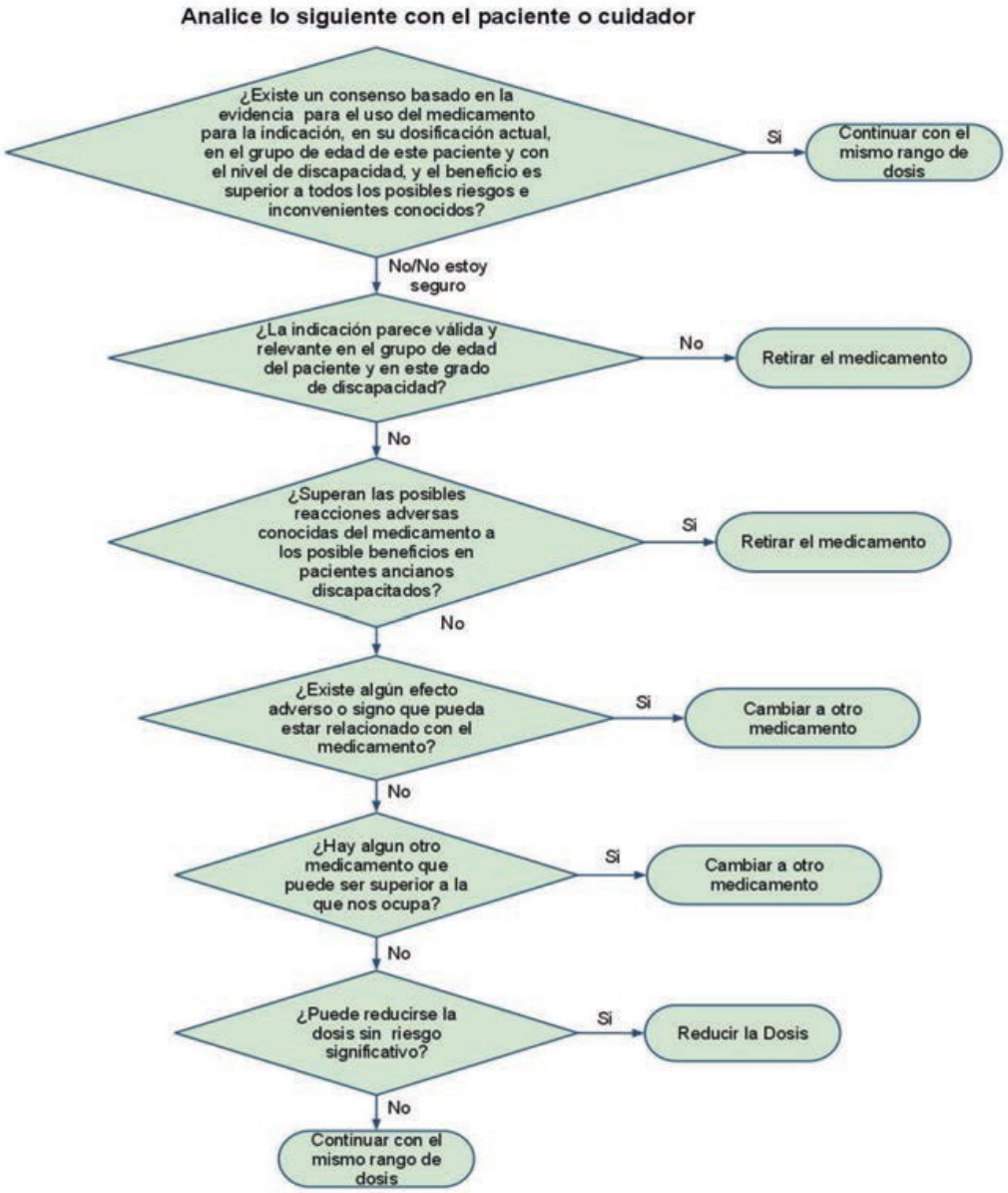
Proceso de adaptación del régimen terapéutico de un paciente mediante la reducción de dosis, sustitución o eliminación de fármacos.

Debe tener en cuenta:
- Las evidencias científicas disponibles.
- La funcionalidad física y social.
- La calidad de vida.
- La comorbilidad.
- Las preferencias del paciente.



Reeve et al. Br J Clin Pharmacol 2014; epub ahead of print

Desprescripción

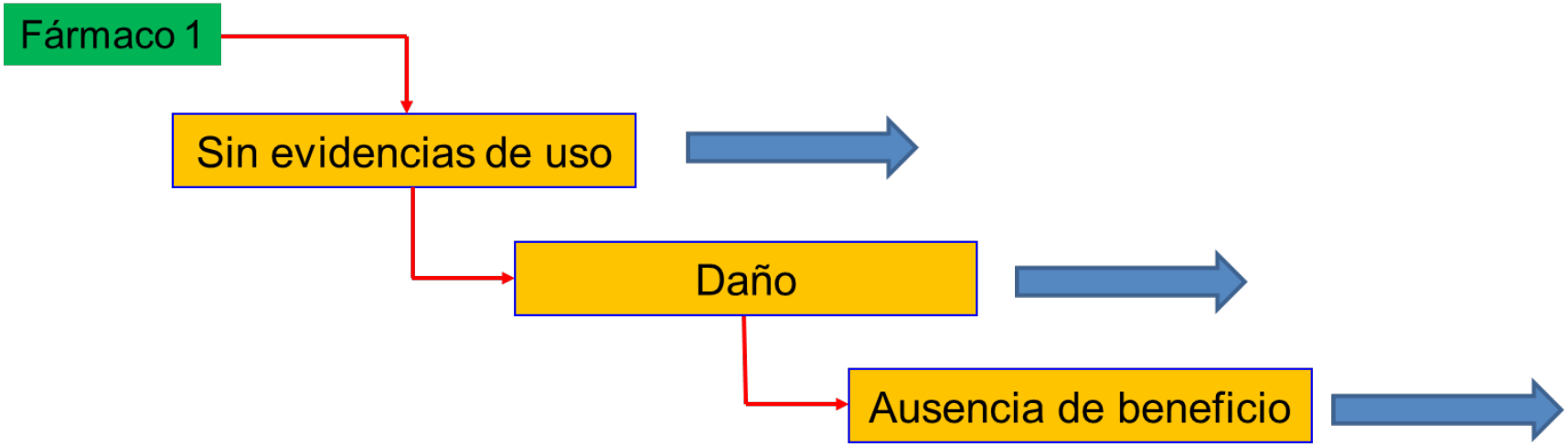


Garfinkel D, Zur-Gil S, Ben-Israel J. The war against polypharmacy: a new, cost-effective, geriatric-palliative approach for improving drug therapy in disabled elderly people. *IMAJ* 2007;9: 430-4.

Villafaina A, Gavilán E. Pacientes polimedicados frágiles, un reto para el sistema sanitario. Inf Ter Sist Nac Salud 2011: 35: 114-23.

Desprescripción

Cascada de la desprescripción



Feasibility Study of a Systematic Approach for Discontinuation of Multiple Medications in Older Adults

Doron Garfinkel, MD; Derelie Mangin, MBChB

Addressing Polypharmacy

Background: Polypharmacy and inappropriate medication use is a problem in elderly patients, who are more likely to experience adverse effects from multiple treatments and less likely to obtain the same therapeutic benefit as younger populations. The Good Palliative–Geriatric Practice algorithm for drug discontinuation has been shown to be effective in reducing polypharmacy and improving mortality and morbidity in nursing home inpatients. This study reports the feasibility of this approach in community-dwelling older patients.

Methods: The Good Palliative–Geriatric Practice algorithm was applied to a cohort of 70 community-dwelling older patients to recommend drug discontinuations. Success rates of discontinuation, morbidity, mortality, and changes in health status were recorded.

Results: The mean (SD) age of the 70 patients was 82.8 (6.9) years. Forty-three patients (61%) had 3 or more and 26% had 5 or more comorbidities. The mean follow-up was 19 months. Participants used a mean (SD) of 7.7 (3.7) medications. Protocol indicated that discontinuation was recommended for 311 medications in 64 patients (58% of drugs; mean [SD], 4.4 [2.5] drugs per patient overall, 4.9 per patient who had discontinuation). Of the discontinued drug therapies, 2% were restarted because of recurrence of the original indication. Taking nonconsent and failures together, successful discontinuation was achieved in 81%. Ten elderly patients (14%) died after a mean follow-up of 13 months, with the mean age at death of 89 years. No significant adverse events or deaths were attributable to discontinuation, and 88% of patients reported global improvement in health.

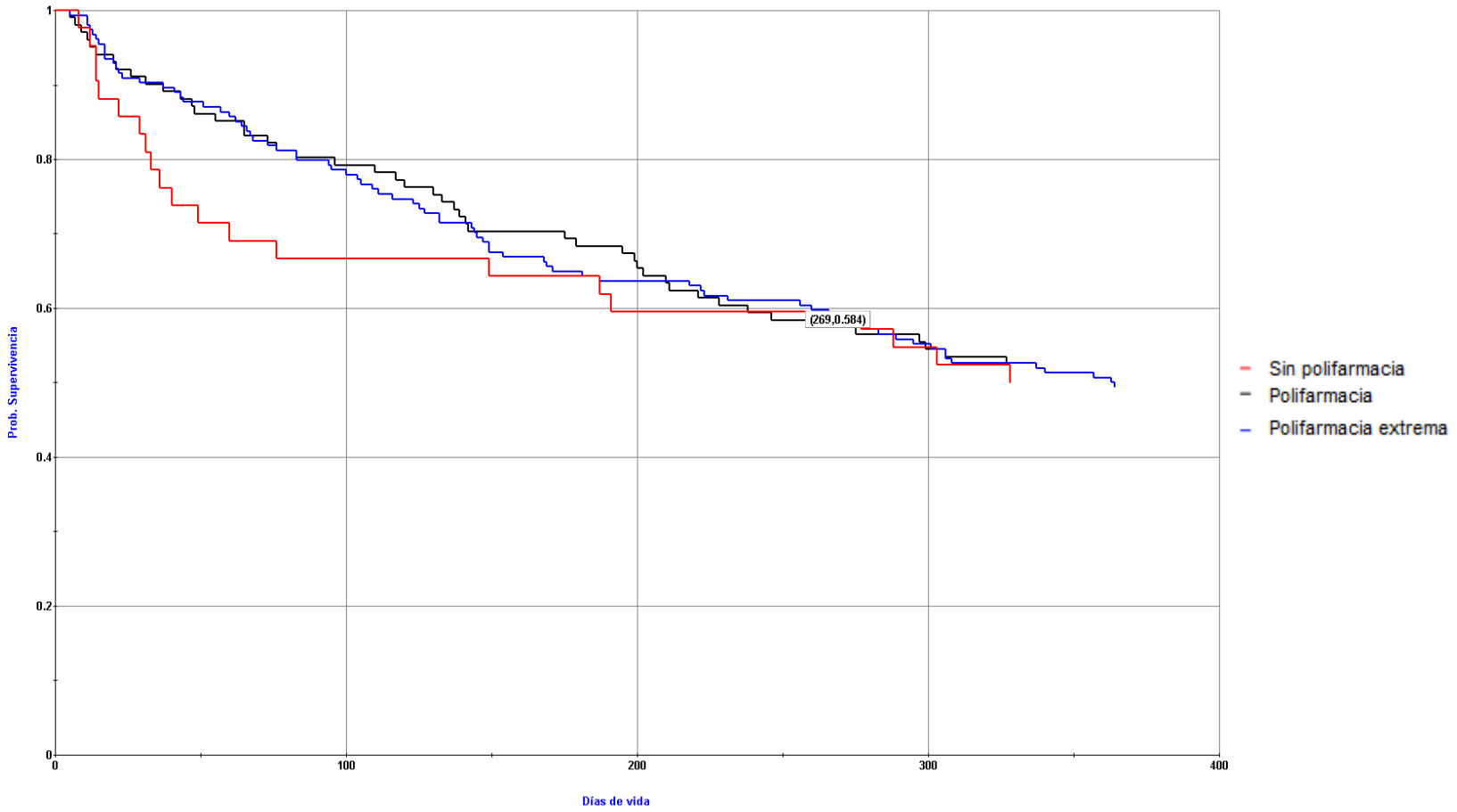
Conclusions: It is feasible to decrease medication burden in community-dwelling elderly patients. This tool would be suitable for larger randomized controlled trials in different clinical settings.

Arch Intern Med. 2010;170(18):1648-1654

ESTUDIO PLUPAR

Paciente Pluripatológico hospitalizado en medicina interna en Aragón

Mortalidad en estadios 3-4 PROFUND

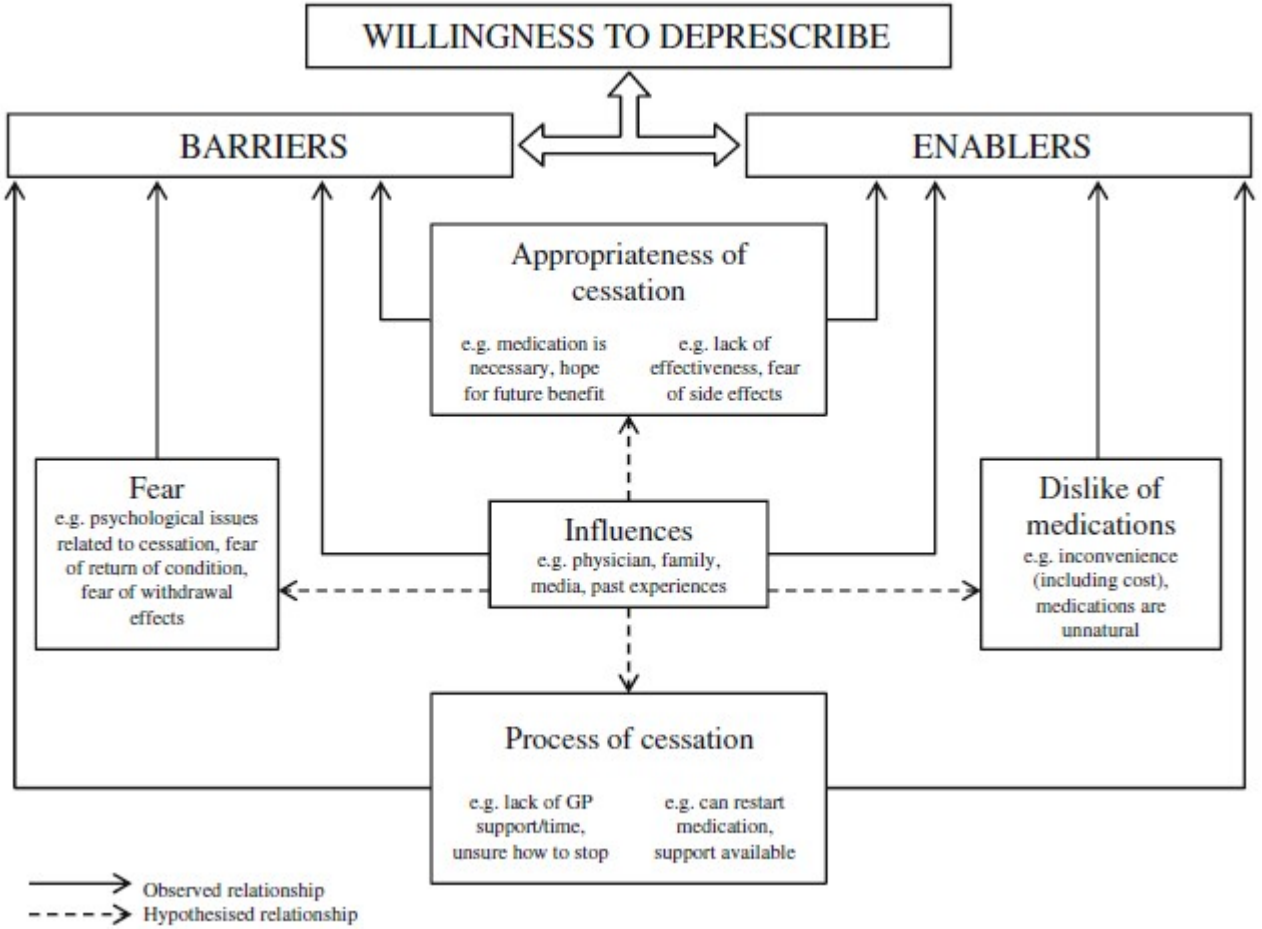


Drugs Aging (2013) 30:793–807
DOI 10.1007/s40266-013-0106-8

SYSTEMATIC REVIEW

Patient Barriers to and Enablers of Deprescribing: a Systematic Review

Emily Reeve · Josephine To · Ivanka Hendrix · Sepehr Shakib · Michael S. Roberts · Michael D. Wiese



Deprescribing medication in very elderly patients with multimorbidity: the view of Dutch GPs. A qualitative study

Jan Schuling*, Henkjan Gebben, Leonardus Johannes Gerardus Veehof and Flora Marcia Haaijer-Ruskamp

Background: Elderly patients with multimorbidity who are treated according to guidelines use a large number of drugs. This number of drugs increases the risk of adverse drug events (ADEs). Stopping medication may relieve these effects, and thereby improve the patient's wellbeing. To facilitate management of polypharmacy expert-driven instruments have been developed, sofar with little effect on the patient's quality of life. Recently, much attention has been paid to shared decision-making in general practice, mainly focusing on patient preferences. This study explores how experienced GPs feel about deprescribing medication in older patients with multimorbidity and to what extent they involve patients in these decisions.

Methods: Focusgroups of GPs were used to develop a conceptual framework for understanding and categorizing the GP's view on the subject. Audiotapes were transcribed verbatim and studied by the first and second author. They selected independently relevant textfragments. In a next step they labeled these fragments and sorted them. From these labelled and sorted fragments central themes were extracted.

Results: GPs discern symptomatic medication and preventive medication; deprescribing the latter category is seen as more difficult by the GPs due to lack of benefit/risk information for these patients.
Factors influencing GPs'deprescribing were beliefs concerning patients (patients have no problem with polypharmacy; patients may interpret a proposal to stop preventive medication as a sign of having been given up on; and confronting the patient with a discussion of life expectancy vs quality of life is 'not done'), guidelines for treatment (GPs feel compelled to prescribe by the present guidelines) and organization of healthcare (collaboration with prescribing medical specialists and dispensing pharmacists.

Conclusions: The GPs' beliefs concerning elderly patients are a barrier to explore patient preferences when reviewing preventive medication. GPs would welcome decision support when dealing with several guidelines for one patient. Explicit rules for collaborating with medical specialists in this field are required. Training in shared decision making could help GPs to elicit patient preferences.

Schuling et al. BMC Fam Pract 2012; 13:56.

Table 2. Results from Questions One to Ten of the Patients' Attitudes Towards Deprescribing Questionnaire

Question	Strongly Agree %	Agree %	Unsure %	Disagree %	Strongly Disagree %
1. I feel that I am taking a large number of medications.	21	44	7	25	3
2. I am comfortable with the number of medications that I am taking.	16	53	8	22	1
3. I believe that all my medications are necessary.	29	49	17	4	1
4. If my doctor said it was possible, I would be willing to stop one or more of my regular medications.	38	54	5	3	0
5. I would like to reduce the number of medications that I am taking.	32	36	14	14	4
6. I feel that I may be taking one or more medications that I no longer need.	4	12	21	50	13
7. I would accept taking more medications for my health conditions.	12	59	4	23	2
8. I have a good understanding of the reasons I was prescribed each of my medications.	25	65	8	2	0
9. Having to pay for fewer medications would play a role in my willingness to stop one or more of my medications.	2	30	10	48	10
10. I believe one or more of my medications is giving me side effects.	5	26	15	45	9

54% de los pacientes han intentado dejar la medicación

Reeve et al. JAGS 2013; 61:1508.

Table 5 Medication appropriateness and quality of life

Group	*EQ-5D index at study start*			*EQ-5D index at 6 months*			*EQ-5D index at 12 months*		
	Mean	Median	n=	Mean	Median	n=	Mean	Median	n=
A (lowest MAI score)	0.58	0.73	47	0.59	0.69	34	0.57	0.73	33
B (medium MAI score)	0.51	0.66	44	0.50	0.60	32	0.43	0.62	32
C (highest MAI score)	0.33	0.39	46	0.32	0.41	32	0.37	0.37	34
	p = 0.001			p = 0.001			p = 0.013		

Statistical analyses were done using Jonckheere-Terpstra trend test.
A higher MAI score equals worse medication quality.
A higher EQ-5D index represents better quality of life (range 0 - 1, though negative values are possible and represents status "worse than death").

Table 6 Medication appropriateness and quality of life

Group	*EQ VAS at study start*			*EQ VAS at 6 months*			*EQ VAS at 12 months*		
	Mean	Median	n=	Mean	Median	n=	Mean	Median	n=
A (lowest MAI score)	55.8	50.0	47	61.0	60.0	33	63.2	60.0	32
B (medium MAI score)	51.2	50.0	43	51.7	50.0	32	51.0	50.0	32
C (highest MAI score)	46.2	50.0	46	45.2	50.0	29	51.7	50.0	34
	p = 0.026			p = 0.003			p = 0.007		

Statistical analyses were done using Jonckheere-Terpstra trend test.
A higher MAI score equals worse medication quality.
A higher EQ VAS represents better self-rated quality of life (range 0 - 100).

Olsson et al. Health Qual Life Outcomes 2011; 9:95.

- Pluripatología en el anciano
- Polifarmacia
- Desprescripción
- Desprescripción cardiovascular

Table 1. Estimates of benefits and risks of commonly used medication classes in older people

Medication	Benefit	Study population*	RR, OR, HR (95% CI)	NNT	NNH
Statins	Secondary prevention of all cause mortality	≥60 years[24–26]	RR=0.85 (0.78–0.93)	28 to prevent death over 5 years	10–20 to experience myalgia
Antihypertensives	Secondary prevention of all cause mortality	≥60 years[28]	RR=0.90 (0.84–0.97)	84 to prevent death over a mean time of 4.5 years	Two to experience any overall adverse events over a mean time of 4.5 years
	Secondary prevention of all-cause mortality	≥80 years[28]	RR=1.01 (0.90–1.13)		
Aspirin	Primary prevention of all cause mortality	Mean age of 57 years[20]	OR=0.94 (0.88–1.00)	120 to prevent one cardiovascular event over 6 years	73 to experience a non-trivial bleed over 6 years

Hilmer S et al. Aust Fam Phys 2012; 41:924-8.

REVIEW ARTICLE

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1170-229X/08/0012-1021/$48.00/0

Medication Withdrawal Trials in People Aged 65 Years and Older

A Systematic Review

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Withdrawal of diuretics was maintained in 51–100% of subjects and was unsuccessful primarily when heart failure was present. Adverse effects from medication withdrawal were infrequently encountered. After withdrawal of antihypertensive therapy, many subjects (20–85%) remained normotensive or did not require reinstatement of therapy for between 6 months and 5 years, and there was no increase in mortality. Withdrawal of psychotropic medications was associated with a reduction in falls and improved cognition. In conclusion, there is some clinical trial evidence for the short-term effectiveness and/or lack of significant harm when medication withdrawal is undertaken for antihypertensive, benzodiazepine and psychotropic agents in older people.

Table 2. Success Rate of Drug Discontinuation (DD) According to Types of Drugs

Drug Group	Patients Using Drug, No.	DD Suggested, No. (%[a])	DD Actually Performed, No. (%)	Specific Compliance, %[b]	Eventual DD Success Rate, %[c]
Antihypertensives	95[d]	58 (61)	50 (53)	86	84
β-Blockers	26	15 (58)	11 (42)	73	67
Calcium channel blockers	22	13 (59)	11 (50)	85	85
Disothiazide	11	11 (100)	10 (91)	91	91
ACE inhibitors	32	9 (28)	8 (25)	89	89
α-Blockers	8	6 (75)	2 (25)	33	33
Nitrates	5	5 (100)	5 (100)	100	100
Furosemide	18	14 (78)	13 (72)	92	79
Aspirin	24	2 (8)	2 (8)	100	100
Statins	26	18 (69)	14 (54)	78	72
Sulfonylurea	6	5 (83)	5 (83)	100	100
Metformin	11	5 (45)	3 (27)	60	60
H_2 blockers	8	8 (100)	6 (75)	75	75
Omeprazole	18	10 (56)	9 (50)	90	90
Benzodiazepines	36[e]	36 (100)	35 (97)[e]	97	97
SSRIs	33	13 (39)	11 (33)	85	77
Other antidepressants	12	10 (83)	9 (75)	90	90
Antipsychotics	8	3 (37)	3 (37)	100	100
Levodopa-carbidopa	10	7 (70)	5 (50)	71	71

Garfinkel et al. Arch Intern Med 2010; 170:1648.

Table I. Randomized, double-blind, placebo-controlled studies of thiazide withdrawal

Study (y)	Setting	No. of subjects	Duration (wk)	% Withdrawn[a] (placebo)	% Withdrawn[a] (controls)
Burr et al.[26] (1977)	Inpatient	106	12	85	95
Myers et al.[27] (1982)	Nursing home	77	52	100	100
de Jonge et al.[28] (1994)	General practice	63	6	76	100
Walma et al.[29] (1997)	General practice	202	26	51	87

a Subjects who remained off the medication at the completion of the study.

Table II. Open-label, prospective observational studies of antihypertensive withdrawal (includes non-randomized studies of thiazides in hypertension)

Study (y)	Setting	No. of subjects	Duration (wk)	% withdrawn[a]
Hansen et al.[36] (1983)	Inpatient and outpatient	105	52	85
Lernfelt et al.[37] (1990)	Community	25	104	56
Walma et al.[38] (1993)	General practice	15	26	40
Straand et al.[35] (1993)	General practice	33	26	55
Ekbom et al.[32] (1994)	Health centre	333	260	20
Nadal et al.[39] (1994)	Outpatient	86	156	27
van Kraaij et al.[33] (1997)	Inpatient and outpatient	218	52	69
van Kraaij et al.[34] (1998)	Nursing home	82	52	47
Nelson et al.[30] (2002)	General practice	6291	4	20
Nelson et al.[31] (2003)	General practice	503	52	36

a Subjects who remained off the medication at the completion of the study.

Table 2 Characteristics that are independent predictors of "maintain normotension" status 12 months after withdrawal of all antihypertensive drugs versus "return to hypertension." The results for "return to hypertension early" were very similar

	Univariate analysis		Multivariate analysis	
Characteristic	**Relative risk (95% CI)**	**P value**	**Relative risk (95% CI)**	**P value**
On-treatment systolic blood pressure (10 mm Hg increase)	0.82 (0.75 to 0.89)	<0.001	0.85 (0.81 to 0.89)	<0.001
Age (years):				
65-74	1.61 (1.16 to 2.24)	0.005	1.57 (1.13 to 2.17)	0.007
75-84	1.00		1.00	
Waist:hip ratio (0.1 unit increase)	1.12 (0.98 to 1.28)	0.11	1.22 (1.12 to 1.32)	0.02
Single drug treatment	2.44 (1.54 to 3.85)	<0.001	2.38 (1.50 to 3.76)	<0.001
Two or more drugs	1.00		1.00	

Nelson et al. BMJ 2002; 325:815.

Riesgos de la desprescripción

Table 2 Medications commonly associated with discontinuation syndromes which require slow weaning

Medication	Type of discontinuation syndrome	Clinical manifestations
α-Blockers	W, R	Agitation, headache, hypertension and palpitations
ACE-inhibitors	D	Heart failure and hypertension
Antianginal agents	D	Angina
Anticonvulsants	W, D	Anxiety, depression and seizures
Antidepressants	W, D	Akathisia, anxiety, chills, coryza, gastrointestinal distress, headache, insomnia, irritability, malaise, myalgia and depression
Antiparkinsonian agents	W, D, R	Hypotension, psychosis, pulmonary embolism, rigidity and tremor
Antipsychotic	W	Dyskinesias, insomnia, nausea and restlessness
Anticholinergics	W	Anxiety, nausea, vomiting, headache and dizziness
Baclofen	W, R	Agitation, anxiety, confusion, depression, hallucinations, hypertonia, insomnia, mania, nightmares, paranoia and seizures
Benzodiazepines	W	Agitation, anxiety, confusion, delirium, insomnia and seizures
β-Blockers	W, D	Angina, anxiety, hypertension, acute coronary syndrome and tachycardia
Corticosteroid	W, R, D	Anorexia, hypotension, nausea, weakness, hypothalamic–pituitary–adrenal axis suppression and inflammatory states
Digoxin	D	Heart failure and palpitations
Diuretic	D	Heart failure and hypertension
Narcotic analgesia	W	Abdominal cramping, anger, anxiety, chills, diaphoresis, diarrhoea, insomnia and restlessness
NSAIDs	D	Recurrence of gout and arthritis

D, disease recrudescence; NSAID, non-steroidal anti-inflammatory drug; R, rebound; W, withdrawal.

Scott et al. Evid Based Med 2013;18:121.

Table 3. New Events Requiring Hospitalization During Follow-up After Drug Discontinuation (DD)

Event	Time After DD, Months	Age, y	DD, No. of Drugs	Functional[a] and Cognitive Status	Improvement Score[b] Following DD Before Event	Possible Relation to DD
Stroke	10	87	1	Disabled	Significant	No
Hip fracture	6	81	3	Disabled	Significant	No
Pneumonia, sepsis	12	85	9	Disability and dementia	Significant	No
Pressure sore, below-knee amputation	8	90	5	Disabled	Mild	No
Pneumonia, sepsis	5	102	2	Disability and dementia	Mild	No
Placement in LTC facility[c]	6	79	0	Disability and dementia	None	No
DVT	3	87	2	Frail and dementia	None	Yes[d]
Paroxysmal AF placement in LTC facility	15	86	4	Frail and dementia	Outstanding	No
Congestive heart failure	12	79	6	Frail	Outstanding	No
Ileus	11	80	5	Frail	Significant	No

Garfinkel et al. Arch Intern Med 2010; 170:1648.

Tab. 1: Bewertung von Akzeptanz und Praktikabilität durch die Prüfärzte (n=13)

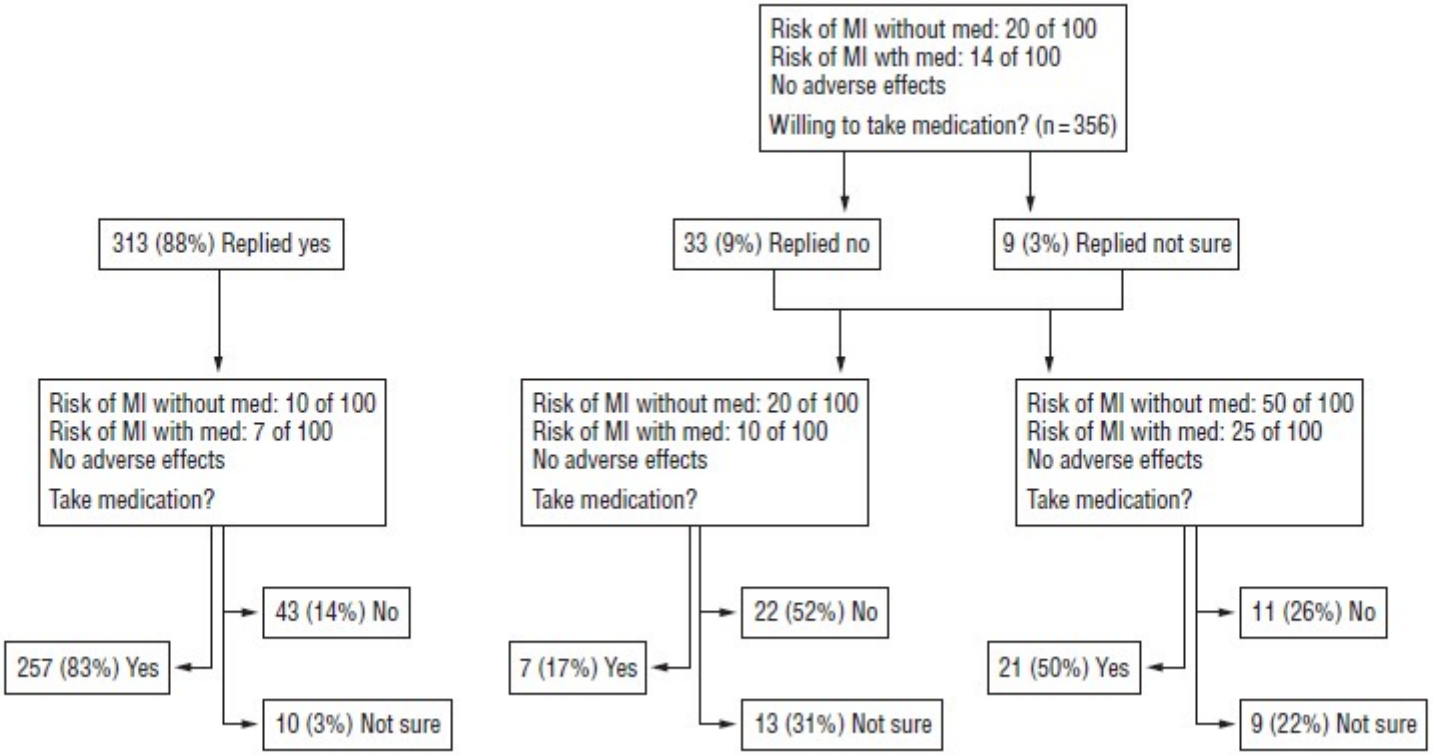
Item im Fragebogen	Mittel-wert	SD	Likert-Skala Kat. 1	Likert-Skala Kat. 2	Likert-Skala Kat.3	Likert-Skala Kat. 4	Likert-Skala Kat. 5
Der Algorithmus war gut einsetzbar in der Sprechstunde.	4,2	0,83	0	0	23%	31%	46%
Der Algorithmus war nützlich für das Absetzen von Medikamenten.	4,0	0,91	0	8%	15%	46%	31%
Der Algorithmus war nützlich für die Dosisänderung von Medikamenten.	3,5	1,05	0	23%	15%	46%	16%
Der Algorithmus war nützlich für das Wechseln auf ein alternatives Medikament.	3,2	1,3	8%	31%	8%	38%	15%
Ich werde den Algorithmus auch weiterhin in der Sprechstunde einsetzen.	3,7	1,03	0	15%	23%	39%	23%
Ich würde den Algorithmus auch einem Kollegen empfehlen.	4,0	1,04	0	8%	25%	25%	42%
Die Reaktionen meiner Patientinnen/Patienten auf den Vorschlag, die Medikation zu überdenken, waren positiv.	4,6	0,9	0	8%	0	17%	75%

Items und Bewertungen mittels fünfteiliger Likert-Skala: Kategorie 1: Trifft nicht zu. Kategorie 2: Trifft wenig zu. Kategorie 3: Trifft teilweise zu. Kategorie 4: Trifft eher zu. Kategorie 5: Trifft in hohem Mass zu.

Neuner-Jehle et al. Praxis 2014; 103:317.

Effects of Benefits and Harms on Older Persons' Willingness to Take Medication for Primary Cardiovascular Prevention

Terri R. Fried, MD; Mary E. Tinetti, MD; Virginia Towle, MPhil; John R. O'Leary, MA; Lynne Iannone, MA



Fried et al. Arch Intern Med 2011; 171:923-8.

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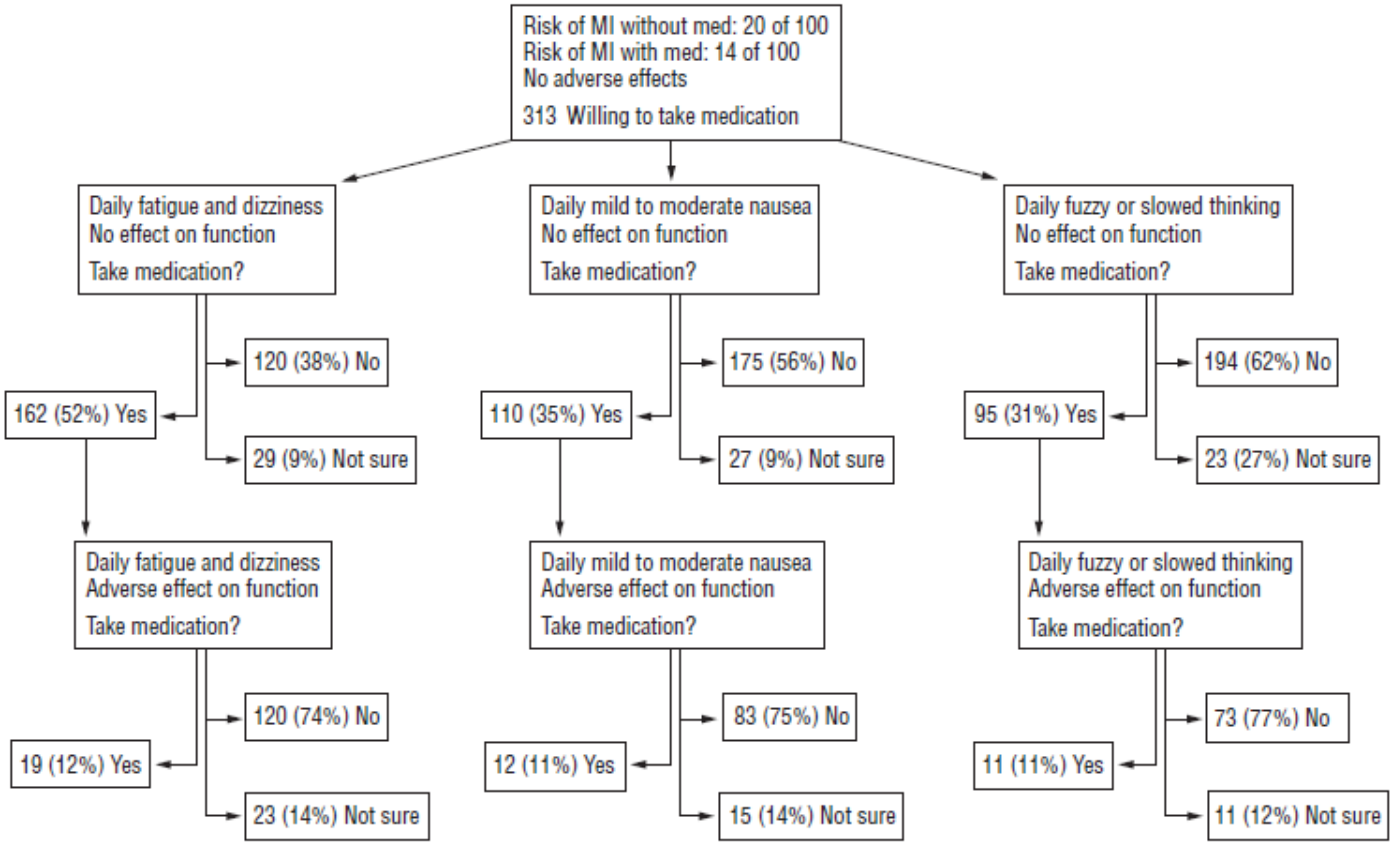

Fried et al. Arch Intern Med 2011; 171:923-8.

Escenarios

- Paciente de 88 años, encamado, con demencia avanzada y dependencia grave para las actividades básicas de la vida diaria (índice de Barthel = 20) con fibrilación auricular no valvular en tratamiento con ACO.

- Paciente de 85 años con diabetes mellitus tipo 2 de 10 años de evolución e insuficiencia renal leve en tratamiento con insulina y linagliptina.

- Paciente de 91 años con hipertensión arterial sin lesión de órgano diana con cifras de 142/91 mm Hg en tratamiento con candesartan, hidroclorotiazida, manidipino y doxazosina.

- Paciente de 82 años sin antecedentes de enfermedad cardiovascular con colesterol de 280 mg/dL en tratamiento con ácido acetilsalicílico y pravastatina.

Diseño y validación de una herramienta para la desprescripción de medicamentos en pacientes pluripatológicos

Rodríguez Pérez A, Alfaro Lara ER, Santos Ramos B, Ruiz Cantero A, Díez Manglano J, Fernández Villalba EM, en representación del grupo SEMI y grupo CRONOS

VI Congreso Nacional de Atención Sanitaria al Paciente Crónico

Mesa Redonda de Proyectos de Investigación

Viernes 28 de Marzo de 2014

FASES

VI Congreso Nacional de Atención Sanitaria al Paciente Crónico
27, 28 y 29 de marzo 2014
Hotel Barceló Renacimiento. Sevilla

Identificación de escenarios — FASE 1

Evaluación por expertos — FASE 2

Diseño de la herramienta — FASE 3

Validación — FASE 4

Muchas gracias