# Polypharmacy Review in Adults Living with Moderate to Severe Frailty

NHS Greater Glasgow and Clyde

## WHAT IS FRAILTY?

- Frailty can be defined as state of increased vulnerability to a decline in function and adverse health outcomes in the context of an acute stressor (which may appear to be minor)
- There are several tools to help identify frailty, a commonly used tool in NHS GG&C is the **Rockwood Clinical Frailty Scale** (see below and click here www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html)

### Rockwood Clinical Frailty Scale

**1 Very Fit –** People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2 Well –** People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

**3 Managing Well –** People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

**4 Vulnerable –** While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

**5 Mildly Frail –** These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6 Moderately Frail –** People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7 Severely Frail – Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8 Very Severely Frail –** Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9. Terminally Ill –** Approach ing the end of life. This category applies to people with **a life expectancy <6 months,** who are **not otherwise evidently frail.**

### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

## MEDICINES AND FALLS RISK

- Any medicine which can cause sedation, hypotension or hypoglycaemia can increase falls risk
- Review any medicines which can increase the risk of falls
- Resources to aid decision making regarding falls can be found **here STOPPFalls**

## GASTROINTESTINAL DISORDERS

### Antispasmodics

- Can cause anticholinergic side effects
- Avoid long term use particularly of hyoscine and dicycloverine

### PPIs

- Consider discontinuing if no proven peptic ulcer, GI bleeding or dyspepsia for 1 year
- Continue if Barrett's Oesophagitis, severe oesophagitis grade C or D, history of bleeding GI ulcers
- Continue if on for gastro protection (whilst taking medicines which increase risk of GI bleeding)

## CARDIOVASCULAR DISEASE

### Drugs for atrial fibrillation

- Anticoagulants to reduce stroke risk are effective even in frail patients
- Reduce HR lowering medicines if pulse consistently <60
- Review DOAC dose to account for weight, age, CrCl

### Antiplatelets

- Aspirin not recommended for primary prevention
- For secondary prevention of IHD or stroke should usually continue unless problematic
- **In severe frailty** consider risk v benefit, especially if approaching end of life

### Anti-angina drugs

- Consider reducing if mobility/exertion has decreased, asymptomatic for >6 months and low risk of residual coronary heart disease

### Drugs for hypertension

- Review if BP <130 systolic and/or <65 diastolic or if on more than one antihypertensive
- May need continued if prescribed for another condition e.g heart failure

### Drugs for Heart failure

- Usual treatment unless problematic

### Lipid regulating drugs

- Review statin if limited life expectancy or if falling due to weakness

## RESPIRATORY – COPD

- **Inhaled therapy -** Ensure able to use device
- **Theophylline –** Monotherapy not appropriate, consider stopping in COPD without co-existing asthma
- **Antihistamines –** Stop where possible
- **Mucolytics –** Continue only if symptomatic improvement

## CENTRAL NERVOUS SYSTEM

### Hypnotics and anxiolytics (NHSGGC Psychotropics)

- Confirm if patient is receiving ongoing input from specialist mental health team
- If initiation of anxiolytic necessary only use short term, lorazepam is first line in frailty
- Benzodiazepines increase risk of dementia and falls in elderly, ensure regular review but do not stop suddenly (see above for deprescribing)
- Antipsychotics for stress and distress should be a last resort and reviewed regularly (**NHSGGC Antipsychotics in Dementia**)

### Antidepressants GGC Guideline

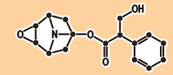
- If appropriate slowly reduce long-term
- SSRIs are preferred in frailty, consider gastroprotection, especially if on other drugs which increase bleeding risk
- Sertraline - first line and safest cardiac profile, Citalopram - Max dose is 20mg in >65yrs
- Mirtazapine - second line agent for depression, 15mg dose is more sedating

### Analgesics

- Use minimum effective dose for shortest duration, Abbey Pain Scale useful in those unable to communicate
- **Paracetamol -** reduce dose if patient <50kg
- **NSAIDS -** avoid if possible, especially if CrCl <30; if essential use ibuprofen or naproxen short term and consider PPI
- **Opioids -** consider trial dose reduction to avoid side effects/toxicity, use **pain data**
- **Neuropathic pain** (tricyclic antidepressants/ gabapentinoids) – Use **LANSS** to assess efficacy. Consider gradual dose reduction then stop. Reduce gabapentinoid dose in renal impairment (toxicity more likely)

## ANTICHOLINERGICS

- The benefits of anticholinergics are often outweighed by side effects – these include postural hypotension, constipation, dry mouth and confusion
- Combinations of medicines with anticholinergic effects increase the risk of side effects, calculate score using **ACB Calculator***
  *www.acbcalc.com
- If used for urinary incontinence/urge but are ineffective (ongoing continence issues) consider a trial off medication




## ENDOCRINE SYSTEM

### Diabetes

- **Target HbA1c 65-75,** aim of treatment is symptom control
- Avoid HbA1c < 65 especially if on gliclazide or insulin
- **Metformin -** First line with maximum daily dose of 1000mg if eGFR is 30- 44 ml/min. Contraindicated if eGFR <30ml/min
- **Sulphonylureas -** Avoid if possible – risk of prolonged hypoglycaemia
- **SGLT2s -** Use with caution in those with renal impairment or those at risk of dehydration or hypotension

### Bone metabolism

- All patients over 80 years who have been on oral bisphosphonate for 10 years should have treatment stopped
- Consider stopping bisphosphonate if eGFR < 35ml/min (discuss with specialist if high fracture risk)
- Patients with osteoporosis who have been on bisphosphonates for 5 years should be referred to Direct Access DXA Service (DADS) for review
- **In Severe frailty** with limited life expectancy, consider whether continuing bisphosphonate is of significant clinical benefit

**For full guideline see: Polypharmacy review in adults living with moderate to severe frailty (QR code above)**

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