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October 2019

Vol. 21, No. 5

Our Mission: Helping to prepare Iowa's health practitioners to care for our growing population of elders. *E-NEWS* is one of our methods of teaching through technology.

Each month, *E-NEWS* delivers abstracts from current multidisciplinary healthcare journal articles related to a specific geriatric topic. This month's *E-NEWS* focuses on DEPRESCRIBING AND ALTERNATIVE TREATMENTS TO OPIOIDS AND ANTI-ANXIETY MEDICATIONS IN OLDER ADULTS.

DEPRESCRIBING AND ALTERNATIVE TREATMENTS TO OPIOIDS AND ANTI-ANXIETY MEDICATIONS IN OLDER ADULTS

In this issue of the *E-NEWS*, you will find abstracts for:

- A review that discusses the risks and benefits of, and alternatives to benzodiazepines.
 - An article that analyzes the risk of dementia in long-term benzodiazepine users.
 - An article that describes optimizing pain management through opioid deprescribing.
 - An article that explores non-pharmacological intervention approaches for sleep problems among older adults.
 - An article that addresses dangers, management, and alternative therapies to benzodiazepine use in older adults.
 - An article that presents the impact of interventions targeting physicians, pharmacists, and patients in deprescribing benzodiazepines in older adults.
 - An article that examines stopping or decreasing opioid therapy in patients on chronic opioid therapy.
 - A study that seeks to develop an evidence-based clinical practice guideline for deprescribing benzodiazepine receptor agonists.
 - A review that aims to evaluate interventions used to reduce benzodiazepines and Z-drugs in older adults.
 - An article that reviews chronic pain management in older adults.
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- Guina J, Merrill B. Benzodiazepines I: Upping the Care on Downers: The Evidence of Risks, Benefits and Alternatives. *J Clin Med.* 2018 Jan 30;7(2). pii: E17.

Benzodiazepines are some of the most commonly prescribed medications in the world. These sedative-hypnotics can provide rapid relief for symptoms like anxiety and insomnia, but are also linked to a variety of adverse effects (whether used long-term, short-term, or as needed). Many patients take benzodiazepines long-term without ever receiving evidence-based first-line treatments (e.g., psychotherapy, relaxation techniques, sleep hygiene education, serotonergic agents). This review discusses the risks and benefits of, and alternatives to benzodiazepines. We discuss evidence-based indications and contraindications, and the theoretical biopsychosocial bases for effectiveness, ineffectiveness and harm. Potential adverse effects and drug-drug interactions are summarized. Finally, both fast-acting/acute and delayed-action/chronic alternative treatments for anxiety and/or insomnia are discussed. Response to treatment-whether benzodiazepines, other pharmacological agents, or psychotherapy-should be determined based on functional recovery and not merely sedation.



- He Q, Chen X, Wu T, Li L, Fei X. Risk of Dementia in Long-Term Benzodiazepine Users: Evidence from a Meta-Analysis of Observational Studies. *J Clin Neurol.* 2019 Jan;15(1):9-19.

BACKGROUND AND PURPOSE: There is conflicting evidence in the literature on the association between benzodiazepines (BDZs) and the risk of dementia. This meta-analysis aimed to determine the relationship between the long-term usage of BDZs and the risk of dementia. METHODS: The PubMed and Embase databases were systematically searched for relevant publications up to September 2017. The literature search focused on observational studies that analyzed the relationship between the long-term use of BDZs and the risk of dementia. Pooled rate ratios (RRs) with 95% confidence interval (CI) were assessed using a random-effects model. The robustness of the results was checked by performing subgroup and sensitivity analyses. RESULTS: Ten studies were included: six case-control and four cohort studies. The pooled RR for developing dementia was 1.51 (95% CI=1.17-1.95, p=0.002) in patients taking BDZ. The risk of dementia was higher in patients taking BDZs with a longer half-life (RR=1.16, 95% CI=0.95-1.41, p=0.150) and for a longer time (RR=1.21, 95% CI=1.04-1.40, p=0.016). CONCLUSIONS: This meta-analysis that pooled ten studies has shown that BDZ significantly increases the risk of dementia in the elderly population. The risk is higher in patients taking BDZ with a longer half-life (>20 hours) and for a longer duration (>3 years). © 2019 Korean Neurological Association.



- Lumish R, Goga JK, Brandt NJ. Optimizing Pain Management Through Opioid Deprescribing. *J Gerontol Nurs.* 2018 Jan 1;44(1):9-14.

The use of opioid drug therapy in older adults has increased over the past decade. Although use of opioid drugs may be clinically warranted, ongoing use needs to be monitored closely to evaluate risks and benefits, especially with the potential for adverse events and misuse. An opioid drug deprescribing protocol would provide clinicians with a method to assess an individual's need for opioid agents, as well as a systematic process to taper opioid drug therapy when deemed appropriate. Although more than 60 studies have reported methods for deprescribing, there is currently no established guideline for discontinuing opioid medications. The U.S. Department of Veterans Affairs has developed an algorithm to assist clinicians with opioid drug discontinuation decision making. As efforts to discontinue opioid drugs for chronic non-cancer pain in older adults continue to expand, nurses, as an integral part of the inter-professional team, will play a key role in monitoring and assessing patients' pain and care plans. © SLACK Incorporated.



- MacLeod S, Musich S, Kraemer S, Wicker E. Practical non-pharmacological intervention approaches for sleep problems among older adults. *Geriatr Nurs*. 2018 Sep - Oct;39(5):506-512.

Poor sleep is common among older adults, often caused by multiple underlying factors such as chronic stress. Poor sleep is subsequently associated with negative health outcomes including higher morbidity and mortality. Our primary purpose is to explore practical non-pharmacological intervention approaches integrating stress management to improve sleep quality among older adults. In doing so, we highlight approaches that appear to hold promise in real-world settings with older individuals. We conducted a tailored literature review specifically on approaches to improve sleep quality among older adults, with emphasis on those integrating stress management. Online search engines were reviewed to identify research in these areas. Various non-pharmacological intervention approaches, such as mindfulness and cognitive behavioral therapy, have shown promise in improving sleep quality and health outcomes within this population. Those integrating chronic stress management appear to be particularly successful. Thus further development of multidimensional sleep interventions integrating stress management with seniors is warranted. © The Author(s).



- Markota M, Rummans TA, Bostwick JM, Lapid MI. Benzodiazepine Use in Older Adults: Dangers, Management, and Alternative Therapies. *Mayo Clin Proc*. 2016 Nov;91(11):1632-1639.

Several major medical and psychiatric organizations, including the American Geriatrics Society, advise against using benzodiazepines or nonbenzodiazepine hypnotics in older adults. Despite these recommendations, benzodiazepines continue to be massively prescribed to a group with the highest risk of serious adverse effects from these medications. This article summarizes legitimate reasons for prescribing benzodiazepines in the elderly, serious associated risks of prescribing them, particularly when not indicated, barriers physicians encounter in changing their prescription patterns, and evidence-based strategies on how to discontinue benzodiazepines in older patients. Although more research is needed, we propose several alternatives for treating insomnia and anxiety in older adults in primary care settings. These include nonpharmacological approaches such as sleep restriction-sleep compression therapy and cognitive behavioral therapy for anxiety or insomnia, and as well as alternative pharmacological agents. © Mayo Foundation for Medical Education and Research.



- Ng BJ, Le Couteur DG, Hilmer SN. Deprescribing Benzodiazepines in Older Patients: Impact of Interventions Targeting Physicians, Pharmacists, and Patients. *Drugs Aging*. 2018 Jun;35(6):493-521.

Benzodiazepines (BZDs; including the related Z-drugs) are frequently targets for deprescribing; long-term use in older people is harmful and often not beneficial. BZDs can result in significant harms, including falls, fractures, cognitive impairment, car crashes and a significant financial and legal burden to society. Deprescribing BZDs is problematic due to a complex interaction of drug, patient, physician and systematic barriers, including concern about a potentially distressing but rarely fatal withdrawal syndrome. Multiple studies have trialled interventions to deprescribe BZDs in older people and are discussed in this narrative review. Reported success rates of deprescribing BZD interventions range between 27 and 80%, and this variability can be attributed to heterogeneity of methodological approaches and limited generalizability to cognitively impaired patients. Interventions targeting the patient and/or carer include raising awareness (direct-to-consumer education, minimal interventions, and 'one-off' geriatrician counselling) and resourcing the patient (gradual dose reduction [GDR] with or without cognitive behavioral therapy, teaching relaxation techniques, and sleep hygiene). These are effective if the patient is motivated to cease and is not significantly cognitively impaired. Interventions targeted to physicians include prescribing interventions by audit, algorithm or medication review, and providing supervised GDR in combination with medication substitution. Pharmacists have less frequently been the targets for studies, but have key roles in several multifaceted interventions. Interventions are evaluated according to the Behavior Change Wheel. Research supports trialing a stepwise approach in the cognitively intact older person, but having a low threshold to use less-consultative methods in patients with dementia. Several resources are available to support deprescribing of BZDs in clinical practice, including online protocols.



- Pergolizzi JV, Varrassi G, Paladini A, LeQuang J. Stopping or Decreasing Opioid Therapy in Patients on Chronic Opioid Therapy. *Pain Ther.* 2019 Aug 3. doi: 10.1007/s40122-019-00135-6. [Epub ahead of print]

With the rising concerns about long-term opioid use, particularly in patients with chronic noncancer pain, more and more patients are being considered for decreased doses or discontinuation of opioid therapy. This is a challenging clinical situation for both patient and clinician and should be presented in a shared decision-making model so that the patient understands the risks of opioid therapy and how the therapy will be discontinued. The patient should be aware of the long-range plan and its milestones. It is imperative that alternate pain control treatments be made available to the patient early, and that the patient never feels abandoned by the healthcare team. There can be many barriers in shared decision-making and multiple discussions between patient and provider may be required. Opioid use should not be decreased sharply or discontinued abruptly, but should be gradually decremented in a process known as tapering. Tapering should be systematic and planned in advance with the patient knowing the steps. Slow tapers (over months) are more comfortable for the patients but may not always be appropriate. There is guidance for planning the taper and the patient should be closely monitored throughout this process. If withdrawal symptoms occur, they can be managed, for example, with lofexidine. Patients should get full support as they explore new pain control options. For patients who have opioid use disorder, addiction counseling may be appropriate. Navigating opioid discontinuation can be slow work, but optimal results occur when the healthcare team works together and respectfully with the patient.



- Pottie K, Thompson W, Davies S, Grenier J, Sadowski CA, Welch V, Holbrook A, Boyd C, Swenson R, Ma A, Farrell B. Deprescribing benzodiazepine receptor agonists: Evidence-based clinical practice guideline. *Can Fam Physician.* 2018 May;64(5):339-351.

OBJECTIVE: To develop an evidence-based guideline to help clinicians make decisions about when and how to safely taper and stop benzodiazepine receptor agonists (BZRAs); to focus on the highest level of evidence available and seek input from primary care professionals in the guideline development, review, and endorsement processes. **METHODS:** The overall team comprised 8 clinicians (1 family physician, 2 psychiatrists, 1 clinical psychologist, 1 clinical pharmacologist, 2 clinical pharmacists, and 1 geriatrician) and a methodologist; members disclosed conflicts of interest. For guideline development, a systematic process was used, including the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach. Evidence was generated by conducting a systematic review of BZRA deprescribing trials for insomnia, as well as performing a review of reviews of the harms of continued BZRA use and narrative syntheses of patient preferences and resource implications. This evidence and GRADE quality of evidence ratings were used to generate recommendations. The team refined guideline content and recommendations through consensus and synthesized clinical considerations to address front-line clinician questions. The draft guideline was reviewed by clinicians and stakeholders. **RECOMMENDATIONS:** We recommend that deprescribing (tapering slowly) of BZRAs be offered to elderly adults (≥ 65 years) who take BZRAs, regardless of duration of use, and suggest that deprescribing (tapering slowly) be offered to adults aged 18 to 64 who have used BZRAs for more than 4 weeks. These recommendations apply to patients who use BZRAs to treat insomnia on its own (primary insomnia) or comorbid insomnia where potential underlying comorbidities are effectively managed. This guideline does not apply to those with other sleep disorders or untreated anxiety, depression, or other physical or mental health conditions that might be causing or aggravating insomnia. **CONCLUSION:** Benzodiazepine receptor agonists are associated with harms, and therapeutic effects might be short term. Tapering BZRAs improves cessation rates compared with usual care without serious harms. Patients might be more amenable to deprescribing conversations if they understand the rationale (potential for harm), are involved in developing the tapering plan, and are offered behavioral advice. This guideline provides recommendations for making decisions about when and how to reduce and stop BZRAs. Recommendations are meant to assist with, not dictate, decision making in conjunction with patients. © the College of Family Physicians of Canada.



- Reeve E, Ong M, Wu A, Jansen J, Petrovic M, Gnjdic D. A systematic review of interventions to deprescribe benzodiazepines and other hypnotics among older people. *Eur J Clin Pharmacol*. 2017 Aug;73(8):927-935.

PURPOSE: Benzodiazepines are effective medicines for insomnia and anxiety but are commonly used beyond recommended treatment time frames, which may lead to adverse drug events. The aim of this systematic review was to critically evaluate the success of interventions used to reduce benzodiazepines and 'Z-drug' use, and the impact of these interventions on clinical outcomes in older adults. METHODS: A search was conducted in PubMed, Embase, Informit, International Pharmaceutical Abstracts, Scopus, PsychINFO, Cochrane Central Register of Controlled Trials (CENTRAL) and CINAHL. Studies conducted in older adults (≥65 years) and published between January 1995 and July 2015 were included. Two authors independently reviewed all articles for eligibility and extracted the data. RESULTS: Seven studies of benzodiazepines and Z-drug withdrawal were identified. Benzodiazepine discontinuation rates were 64.3% in one study that employed pharmacological substitution with melatonin and 65.0% in a study that employed general practitioner-targeted intervention. Mixed interventions including patient education and tapering (n = 2), pharmacological substitution with psychological support (n = 1) and tapering with psychological support (n = 1) yielded discontinuation rates between 27.0 and 80.0%. Five studies measured clinical outcomes following benzodiazepine discontinuation. Most (n = 4) observed no difference in prevalence of withdrawal symptoms or sleep quality, while one study reported decline in quality of life in those who continued taking benzodiazepine vs. those who discontinued over 8 months. CONCLUSIONS: Current evidence shows that benzodiazepine withdrawal is feasible in the older population, but withdrawal rates vary according to the type of intervention. As the benefits and sustainability of these interventions are unclear, further studies should be conducted to assess this.



- Schwan J, Sclafani J, Tawfik VL. Chronic Pain Management in the Elderly. *Anesthesiol Clin*. 2019 Sep;37(3):547-560.

Chronic pain is extremely prevalent in older adults and is associated with significant morbidity, including limited mobility, social isolation, and depressed mood. Pain is defined by a biopsychosocial model highlighting the importance of a multidisciplinary approach to treatment, including multimodal medications, selected interventions, physical therapy and rehabilitation, and psychological treatments. In this narrative review, the authors highlight the use of these approaches in older adults with specific attention paid to considerations unique to aging, including alterations in drug metabolism, avoidance of polypharmacy, and physiologic changes predisposing to painful conditions. © Elsevier Inc.



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Reducing Risk of Negative Health Outcomes;
Immunizations and Beers Criteria Update

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