Deprescribing recommendations in major US disease-focused clinical practice guidelines

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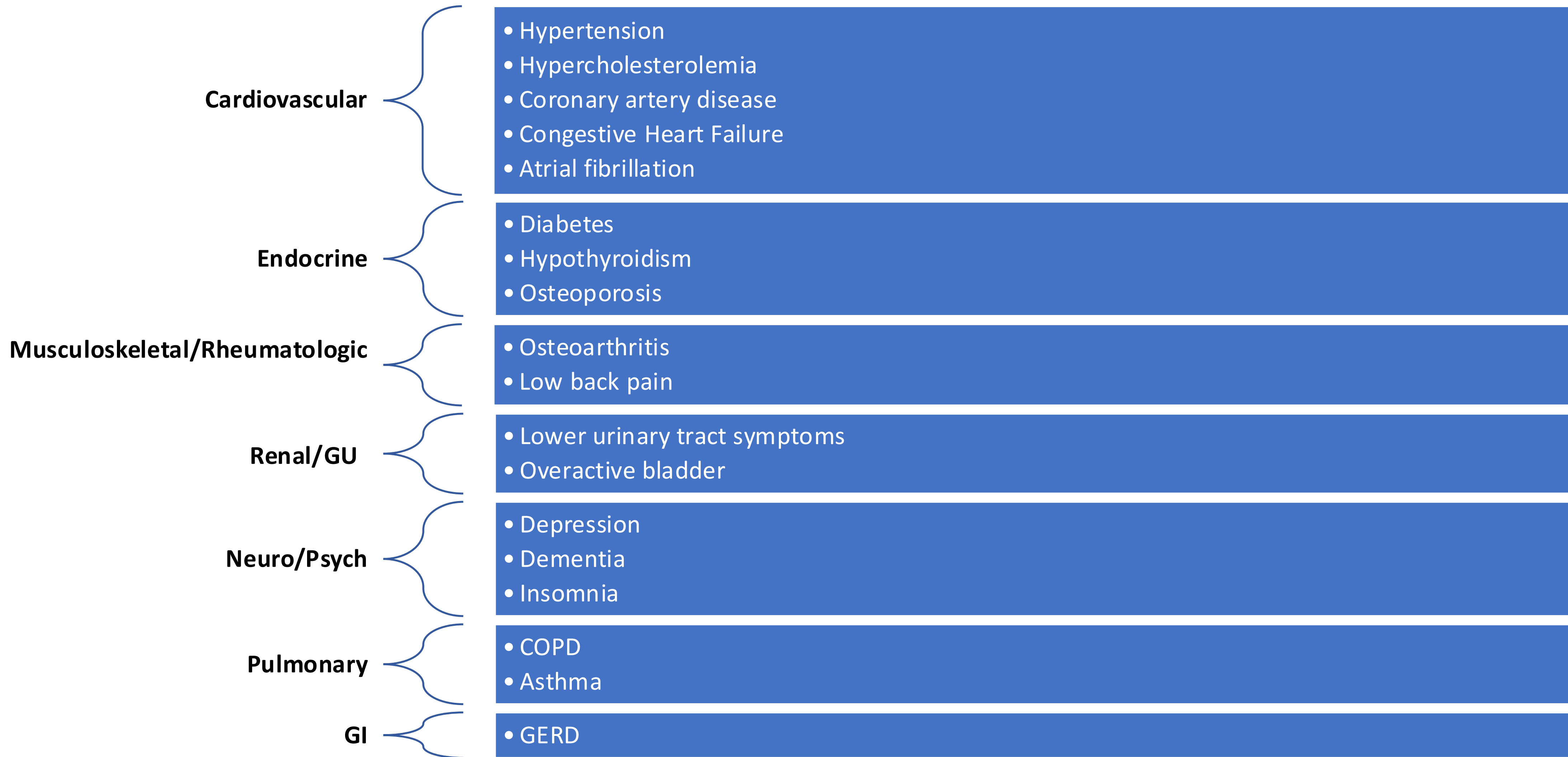
Background questions

- What is the prevalence and nature of deprescribing recommendations in disease-based clinical practice guidelines (CPGs) widely used by US clinicians?
- How do these insights inform strategies to incorporate deprescribing recommendations into disease-focused CPGs in the future?

Methods: Review and synthesis of CPGs

- Focus on highly prevalent chronic conditions among older adults
- CPGs identified by specialized & generalist experts
  - *“What do you perceive to be the most well-known and widely used CPGs used in the US for the management of X condition(s*)?”
- Extraction of deprescribing-related content
  - Deprescribing-related synonyms
  - Advice re: avoiding long term use or limiting short-term use
- Quantitative and qualitative analysis

18 conditions included → 26 CPGs



High-level results

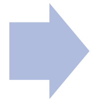
- 20 of 26 CPGs (77%) said anything at all about deprescribing
  - Applying a very generous definition
- These 20 CPGs addressed a median of 1.5 (IQR 1-3) drugs
- Concerning 45 drug classes

- **Most drugs/situations in CPGs did NOT have deprescribing guidance**
- Of >10 drug class initiation recs mentioned in *ACC/AHA et al.* Heart Failure CPG (2022), only 1 has deprescribing guidance
- Of 74 pages in the *ACC/AHA et al.* Hypertension CPG (2025), only ~4 brief mentions (few lines) of deprescribing-related material

In the clinician's mind

Clinician's Logic Model for Deprescribing:

Which drug/condition?

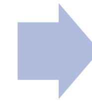


Clinical Prompt

When should I consider deprescribing?

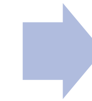
Factors to Consider

How do I weigh whether to deprescribe?



How to Discuss

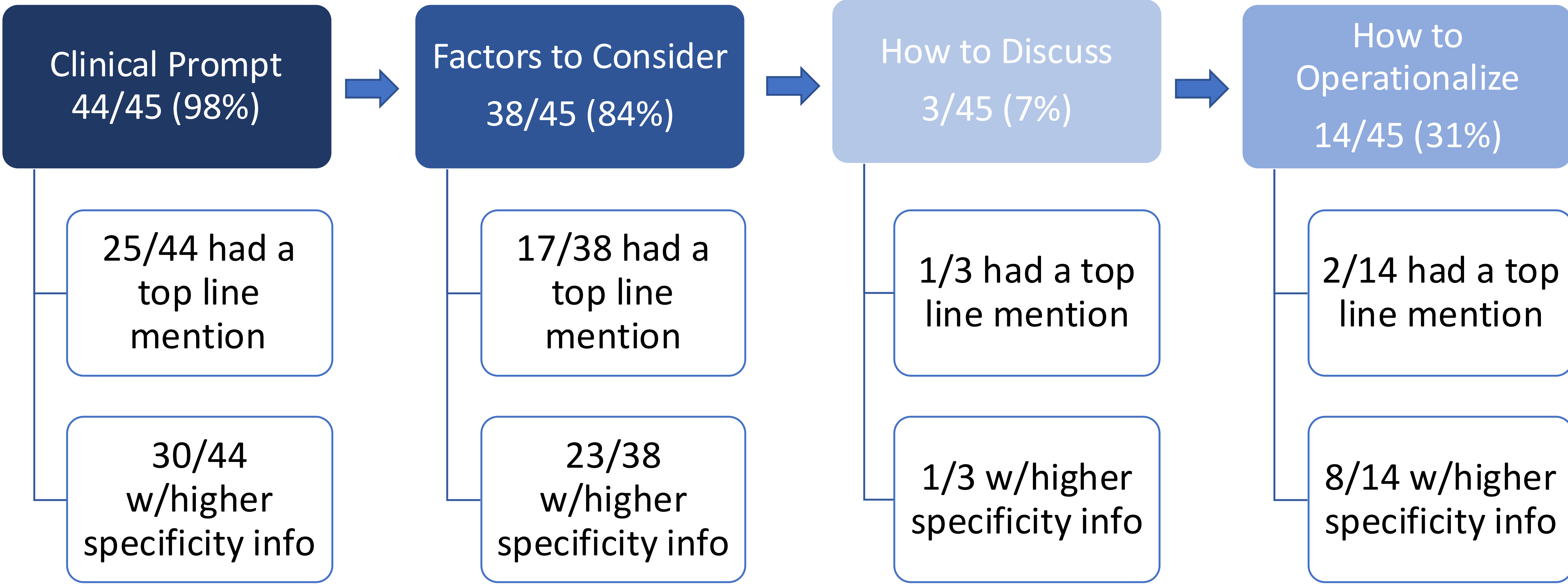
How do I talk with patient/family about this?



How to Operationalize

How do I deprescribe and monitor?

Drug class level results (of n=45 drug classes where there was a recommendation)



Examples: Prompt

Lower Specificity	**Higher Specificity**
"In patients with chronic coronary disease and rheumatoid arthritis, high-dose glucocorticoids should not be used long term if alternative therapies are available because of increased cardiovascular risk." *AHA/ACC et al. Chronic Coronary Disease Guideline, 2023*	"Clinicians should discontinue oral medications in patients with OAB who have an appropriate response to a minimally invasive procedure but should restart pharmacotherapy if efficacy is not maintained." *AUA/SUFU Overactive Bladder Guideline, 2024*

Examples: Factors to consider

Lower Specificity	Higher Specificity
"When initiating a new glucose-lowering medication, reassess the need for and/or dose of medications with higher hypoglycemia risk (i.e., sulfonylureas, meglitinides, and insulin) to minimize the risk of hypoglycemia and treatment burden." *ADA Diabetes Guideline, 2025*	Regarding bisphosphonates: "The decision of a temporary treatment discontinuation (holidays) should be individualized and based on baseline risk for fractures, type of medication and its half-life in bone, duration of discontinuation, benefits and harms of discontinuation, and higher risk for fracture due to drug discontinuation." *ACP Osteoporosis Guideline, 2023*

Examples: Discussion

Lower Specificity	Higher Specificity
Regarding statin discontinuation: “A shared decision-making process between clinicians and patients that targets individualized decisions is warranted.” *AHA/ACC, et al. Cholesterol Management Guideline, 2018*	Regarding deprescribing generally: “Shared decision-making helps healthcare providers, people with CKD, and family members to reach agreement on the treatment direction that is appropriate with the person’s values and preferences and family goals. This process should be performed in a culturally appropriate way with consideration of appropriate health literacy.” *KDIGO CKD Guideline, 2024*

Examples: Operationalizing

Lower Specificity	Higher Specificity
“When second generation antidepressant treatment is discontinued, the dose should be gradually decreased (tapered) to minimize withdrawal symptoms.” *ACP Depression Guideline, 2023*	Regarding antipsychotic tapering: “Weekly or monthly visits are likely to be required for patients with complex, distressing, or potentially dangerous symptoms or during the administration of specific therapies. For example, outpatients with acute exacerbations of depressive, psychotic, or behavioral symptoms may need to be seen as frequently as once or twice a week, sometimes in collaboration with other treating clinicians, or be referred to intensive outpatient treatment or a partial hospitalization program." *APA Dementia Guideline, 2007 (upd. 2014)*

Closing thoughts

- New guidelines are coming and may increasingly incorporate deprescribing-related recommendations
- Deprescribing has a foothold in disease-based CPGs used in US
  - Of 26 widely used CPGs, 20 (77%) had <u>something</u>
  - But <u>most</u> drugs unaddressed
- Paucity of information re: how to discuss & operationalize deprescribing
- Recommendations and supporting text <u>are often vague</u>

Thank you!

- Mike Steinman, MD
- Tim Anderson, MD, MAS
- Ariel Green, MD, PhD
- Cynthia Boyd, MD, MPH

Extra material

Deprescribing-related research priorities mentioned in 1 CPG (KDIGO)

“Determine whether persons who have a >30% decline in eGFR while using RASi, SGLT2i, and MRAs have better outcomes if they continue versus discontinue these medications.”

“Develop and refine CKD-specific risk assessment tools for CVD and major bleeding, so as to provide more individualized decision-making for the use of all agents (including deprescribing).”

“Evaluate the impact of deprescribing of nonessential/nonevidence-based medications on patient adherence and outcomes.”

CPG-level results (of n=20 with *any* deprescribing content)