

# DEPRESCRIBING GUIDE FOR ANTICHOLINERGIC DRUGS FOR PARKINSONISM

(including benztropine [benztropine], trihexyphenidyl [benzhexol], biperiden)

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This guide provides deprescribing information that can be applied to written and/or verbal communication (in the form of “preferred language”) between clinicians, patients and/or carers. Adapt appropriately for individual patients.



## GO TO SECTION:

Indication

How to wean

Alternative management

Monitoring

Evidence-based advice

Summarised phrasing during admission and/or at discharge

References

## CONSIDER TWO STEPS WHEN DEPRESCRIBING:

1

Should I deprescribe?

2

How do I deprescribe?

## STEP 1: SHOULD I DEPRESCRIBE? (PATIENT ASSESSMENT)

### Deprescribing triggers:

- Inappropriate indication, no current indication, presence or risk of adverse events, drug interaction, drug-disease interaction, high drug burden index (DBI),<sup>1</sup> poor adherence, or patient preference.

### 1a) Is there a documented indication or symptoms supporting continued use?

#### Inappropriate indication for continued use:

- Unmonitored treatment of Parkinson’s symptoms in older people >65 years of age.
- Avoid use in older people and those with cognitive impairment and dementia.

#### Do not deprescribe if:

- Treatment is appropriate and under the supervision of a Parkinson’s disease specialist.
- Stopped abruptly.

### 1b) Are there adverse effects?

#### Consider potential adverse effects:

- Falls, dizziness, headaches, urinary retention, tachycardia, arrhythmia, blurred vision, dry eyes, dry mouth, hypersalivation, constipation, nausea, vomiting, dyspepsia, fever, rash, flushed skin, dry skin, hypersensitivity reactions (including anaphylaxis), confusion, hallucinations, memory impairment, drowsiness, insomnia, worsening of dyskinesia, hypersexuality, gambling.<sup>2</sup>

### 1c) Is this medication likely to cause more harm than benefit?

See [Evidence-based advice](#) for additional information on risks of harm and benefits of continued use.

### 1d) Does the patient/carer agree with the recommendation to deprescribe?

Following provision of information, discussion and shared-decision making, the patient or carer has communicated that they would like to proceed with or decline the deprescribing recommendation.

## PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

\_\_\_\_\_ is currently taking \_\_\_\_\_  
(patient name) (drug name: e.g. benztropine [benztropine] 1mg tds)

for \_\_\_\_\_, and is currently experiencing/at risk of \_\_\_\_\_  
(indication: e.g. tremor) (patient issue: e.g. adverse effects)

The \_\_\_\_\_ outweighs the \_\_\_\_\_ for continued use of \_\_\_\_\_  
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. benztropine [benztropine])

Discussed with \_\_\_\_\_ and \_\_\_\_\_ deprescribing recommendation.  
(patient /carer name) (agreed/willing to trial/considering/declined)

## STEP 2: HOW DO I DEPRESCRIBE? (RECOMMENDATION AND MANAGEMENT)

### 2a) How to wean

#### Key Points

- Establish a supportive and trusting relationship with the patient to engage in complex/sensitive discussions.
- Accompany weaning with commencement of relevant non-pharmacological therapy. See [Alternative management](#) recommendations.
- In general, wean gradually by 25% of the daily dose every 1-4 weeks.
- If reason for deprescribing is due to serious adverse effects, consider weaning faster.
- Provide advice to patient/carer on self-monitoring and what to do if symptoms re-occur.
- Organise appropriate follow up appointments with general practitioner (GP) (frequency determined by rate of weaning).

#### Initiation

Reduce dose slowly by 25-50% of the daily dose each week to month.

Do not stop abruptly as there is a risk of worsening symptoms and a small risk of neuroleptic malignant syndrome.

#### Adjustments depend on response

Adjust according to response (see [Monitoring](#) recommendations).

- Slower weaning (e.g. 12.5% reductions or alternate day dosing) can be considered when the dose of medication is low and drug formulations make it difficult to split tablet further.
- End treatment 2 weeks after administering the lowest dose.
- If no withdrawal symptoms occur, continue to wean and stop.

#### Adjustments in the case of recurrent symptoms

In the case of recurrent/withdrawal symptoms, revert to the previous lowest tolerated or effective dose. Recommence weaning after 6-12 weeks at a lower weaning rate (e.g. 5-12.5% of daily dose each month) then stop.

(Based on recommendations in [References](#)<sup>2-6</sup>)

### PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

**Recommend non-pharmacological replacement therapy to reduce reliance on anticholinergics.**

Recommend gradually reducing to \_\_\_\_\_ for \_\_\_\_\_ and  
(e.g. benztropine [benztropine] 0.5mg BD and 1mg nocte) (timeframe: e.g. 1 week)

reassess, then reduce to \_\_\_\_\_ for \_\_\_\_\_ and reassess,  
(e.g. benztropine [benztropine] 0.5mg TDS) (e.g. 1 week)

then reduce to \_\_\_\_\_ for \_\_\_\_\_ and reassess,  
(e.g. benztropine [benztropine] 0.25mg TDS) (e.g. 1 week)

then reduce to \_\_\_\_\_ for \_\_\_\_\_ and reassess,  
(e.g. benztropine [benztropine] 0.25mg BD) (e.g. 1 week)

then reduce to \_\_\_\_\_ for \_\_\_\_\_ and stop.  
(e.g. benztropine [benztropine] 0.25mg daily) (e.g. 1 week)

Follow up with GP \_\_\_\_\_ after discharge.  
(e.g. fortnightly)

## 2b) Alternative management

### Non-pharmacological support

Physical therapy, occupational therapy, speech therapy, nutritional advice, exercise, psychologist and social support. For advice, refer to [\[AMH Aged Care Companion- Parkinson's disease\]](#).

### Switching within drug class or consider alternative therapy

Switching to an alternative anticholinergic is generally not recommended; especially in older people, due to poor evidence of benefit and high potential for harm (e.g. anticholinergic side effects). If Parkinsonian symptoms become disabling, a gradual and small increase in levodopa dose may be considered.

If there is a current indication, consider dose reduction. To consider other options, refer to [\[AMH-Parkinson's Disease\]](#).

## PREFERRED LANGUAGE:

Use a **multidisciplinary** approach to treat Parkinson symptoms, including **physical therapy, occupational therapy, speech therapy, nutritional advice, exercise, psychologist** and **social support** concurrently.

## 2c) Monitoring

Monitor short term (within 1-3 days)	Monitor long term (>7 days)
<p><b>Monitor for withdrawal symptoms</b> Symptoms can occur within 1-3 days of dose reduction.</p>	<p><b>Monitor for recurrence of symptoms</b> Recurrence of previous or new symptoms (e.g. rigidity, bradykinesia, tremor, dyskinesia) may occur within 1-2 weeks of dose reduction.</p>
<ul style="list-style-type: none"> <li>• Common withdrawal symptoms (e.g. dizziness, nausea, vomiting, headache, sweating, urinary urgency, anxiety, and insomnia) are usually mild, highly variable and can last up to 6-8 weeks.</li> <li>• If severe symptoms (e.g. tachycardia, elevated body temperature, orthostatic hypotension, profuse and persistent sweating, severe anxiety, or severe insomnia) occur, restart at the previous lowest effective dose.</li> </ul>	

## PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal** symptoms which can be **mild** (e.g. *dizziness, nausea, vomiting, headache, sweating, urinary urgency, anxiety, and insomnia*) or **severe** (e.g. *tachycardia, elevated body temperature, orthostatic hypotension, profuse and persistent sweating, severe anxiety, or severe insomnia*).

Monitor for **recurrence** of symptoms within 1-2 weeks of dose reduction, including *rigidity, bradykinesia, tremor, or dyskinesia*.

Restart at the lowest effective dose with retriial weaning after 6-12 weeks.

## EVIDENCE-BASED ADVICE

### Effectiveness and safety

Cognitive and neuropsychiatric adverse events occur frequently with anticholinergics. Withdrawal of anticholinergics due to adverse events occurs more commonly than withdrawal due to lack of efficacy.<sup>7</sup>

Evidence for effect on tremor is inconclusive. Anticholinergics are not more efficacious than levodopa in tremor management.<sup>7</sup>

Over 90% of people would be willing to stop their medicines if recommended by their physician.<sup>8</sup>

### Recommended duration of use

Avoid use of anticholinergics in older adults due to significant harm (e.g. falls, fracture) including cognitive adverse effects (e.g. confusion, delirium).

# SUMMARISED PHRASING DURING HOSPITAL ADMISSION AND/OR AT DISCHARGE

When communicating deprescribing decisions to GPs at discharge, written and verbal communication should include information in the sequence of:

**“Medicine, Intention, Rationale. Clear Plan (dose change, duration, follow up). Patient agreement”**

## PREFERRED LANGUAGE

(write in GP follow up plan and medication list):

\_\_\_\_\_ : \_\_\_\_\_ due to \_\_\_\_\_ outweighing effects \_\_\_\_\_.

current medication (e.g. Benzatropine [benztropine])      stopped/reduced with aim of stopping      specific rationale (e.g. cognitive impairment)      of/on current indication (e.g. on tremor)

\_\_\_\_\_ reduced to \_\_\_\_\_ for \_\_\_\_\_, then \_\_\_\_\_. Patient/Carer agreed.

If weaning, old dose changed to new dose (e.g. Benzatropine [benztropine] 1mg TDS reduced to benztropine [benztropine] 0.5mg BD, 1mg nocte)      if weaning, time frame (e.g. 4 weeks)      follow-up action (e.g. GP to review further 0.5mg/fortnight as advised by Dr XXX, Parkinson's specialist, monitor side effects)

Refer to [www.nswtag.org.au/deprescribing-tools/](http://www.nswtag.org.au/deprescribing-tools/)

### Example:

*Benzatropine [Benztropine]: reduced with aim of stopping due to cognitive impairment outweighing effects on restlessness. Benzatropine [Benztropine] 1mg TDS reduced to benztropine [benztropine] 0.5mg BD, 1mg nocte for 2 weeks, as advised by Dr J Smith (Parkinson's specialist). Review by GP for further 0.5mg reduction/fortnight until off, monitor for recurrence of symptoms, sweating. Refer to [www.nswtag.org.au/deprescribing-tools/](http://www.nswtag.org.au/deprescribing-tools/)*



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