DEPRESCRIBING GUIDE FOR SEDATING ANTIHISTAMINES

(including promethazine, pheniramine, dexchlorpheniramine, diphenhydramine, cyclizine, cyproheptadine, alimemazine [trimeprazine])

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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.

CONSIDER TWO STEPS WHEN DEPRESCRIBING:

1 Should I deprescribe?

2 How do I deprescribe?

STEP 1

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),[1] poor adherence, or patient preference.

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

Inappropriate indication for continued use:

- Long-term therapy >6 months.
- Allergic conditions without prior trial of non-sedating antihistamines.[6]
- Non-histamine mediated condition (e.g. neuropathic itch).
- Chronic itch in older people. This can be caused by skin dryness, medical conditions, polypharmacy, and neuropathy which do not respond to antihistamines.[7]
- Hypnotic or sedative.

Do not deprescribe if:

- Allergic condition requiring ongoing treatment with failed response to all other options.

1b) Are there adverse effects?

Consider potential adverse effects:

- Falls, dizziness, confusion, drowsiness, headache, constipation, dry eyes, blurred vision, dry mouth, urinary retention.[2]

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. promethazine 10mg daily)

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

The _____ outweighs the _____ for continued use of _____.
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. promethazine)

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 25-50% of the daily dose every 1-4 weeks.
- If reason for deprescribing is serious adverse effects, wean faster or cease immediately.
- 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.

Adjustments depend on response

Adjust according to response (see Monitoring recommendations).

- Consider slower weaning (e.g. 12.5%) when reducing to the final lowest dose. End treatment 2 weeks after administering the lowest dose.
- Consider alternate day dosing to aid with weaning if dosage forms are limited.
- If no withdrawal symptoms occur, continue to wean then stop.

Adjustments in the case of recurrent symptoms

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

(Based on recommendations in References[2-5])

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

Recommend non-pharmacological replacement therapy to reduce reliance on sedating antihistamines.

Recommend gradually reducing to _____ **for** _____ **and stop.**
(drug: e.g. promethazine 5mg daily) (timeframe: e.g. 1 week)

Follow up with GP _____ **after discharge.**
(e.g. fortnightly)

2b) Alternative management

Non-pharmacological support

Depends on indication. Refer to [AMH-Antihistamine].

For chronic itch, consider minimising or eliminating contact with irritating materials or allergens from the environment, apply cool moist cloth wraps, keep room temperature cool, and keep skin moisturised.

Switching within drug class or consider alternative therapy

Dependent on indication. Consider non-sedating antihistamine (e.g. loratadine). Refer to [AMH-Antihistamine].

In some instances (e.g. chronic urticaria), non-sedating antihistamine can be titrated up to four fold higher than the standard dose without compromising safety.[6]

Topical treatments include moisturisers, anti-inflammatories and local anaesthetics.

PREFERRED LANGUAGE:

Use **moisturisers** to keep skin barrier healthy, **minimise or eliminate contact** with chemicals or environmental allergens, or **treat underlying disease** concurrently.

2c) Monitoring

Monitor short term (within 1-3 days)	Monitor long term (>7 days)
Monitor for withdrawal symptoms Anticholinergic discontinuation symptoms can occur within 1-3 days of dose reduction.	**Monitor for recurrence of symptoms** Recurrence of previous or new symptoms (e.g. itching, rash, sneezing, watery eyes) may occur within 1-2 weeks of dose reduction.

- Withdrawal symptoms are usually mild (e.g. nausea, vomiting, headache, sweating, anxiety, dizziness), highly variable and can last up to 6-8 weeks.
- In the unlikely event of severe withdrawal symptoms (e.g. urinary urgency, tachycardia, orthostatic hypotension, severe anxiety, or severe insomnia), restart at the previous lowest effective dose.

PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal** symptoms which are usually **mild** (e.g. *dizziness, nausea, vomiting, headache, anxiety*) and are very rarely **severe** (e.g. *urinary urgency, tachycardia, orthostatic hypotension, severe anxiety, or severe insomnia*).

Monitor for **recurrence** of symptoms, including *itching, rash, sneezing, watery eyes*.

Restart at the lowest effective dose with retrial deprescribing at *6-12 weeks*.

EVIDENCE-BASED ADVICE

Effectiveness and safety

Antihistamines are effective in relieving itch that is due to histamine release (e.g. urticaria), but there is limited evidence for their efficacy in itch due to other causes.[2]

First generation sedating antihistamines have higher risk of adverse effects (e.g. falls, cognitive impairment). There is no evidence that suggests sedating antihistamines are more efficacious than second generation non-sedating antihistamines.[8,9]

Over 90% of people would be willing to stop their medicines if recommended by their physician.[10]

Recommended duration of use

Limit drug treatment to short-term use. Long-term use is not recommended, especially in older adults who are at higher risk of adverse drug events (e.g. falls, fractures).

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. Promethazine)
_____ — stopped/ reduced with aim of stopping
_____ — specific rationale (e.g. sedation)
_____ — of/on current indication (e.g. on itch)

_____ reduced to _____ for _____, then _____. Patient/Carer agreed.

_____ — If weaning, old dose changed to new dose (e.g. promethazine 10mg nocte reduced to promethazine 5mg)
_____ — if weaning, time frame (e.g. 2 weeks)
_____ — follow-up action (e.g. GP to stop or taper depending on patient tolerance)

Refer to www.nswtag.org.au/deprescribing-tools/

Example:

Promethazine: reduced with aim of stopping due to sedation outweighing effects on itch. Promethazine 10mg nocte reduced to promethazine 5mg nocte for 2 weeks then GP to stop or taper depending on patient tolerance. Patient agreed. Refer to www.nswtag.org.au/deprescribing-tools/

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1. Hilmer SN, Mager DE, Simonsick EM, et al. A drug burden index to define the functional burden of medications in older people. Arch Intern Med. 2007; 167(8):781-787. Available at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/412262 **2**. Australian Medicines Handbook (AMH): Sedating antihistamines. 2018. **3.** AMH Aged Care Companion: Appendix A: Drugs with anticholinergic effects. 2018. **4.** Medstopper. Available at http://medstopper.com **5.** Kouladjian O'Donnell L, Gnjidic D, Nahas R, et al. Anticholinergic burden: considerations for older adults. J Pharm Pract Res. 2017; 47(1): 67-77 **6.** Katelaris CH, Smith W, Choi J, etal. Chronic spontaneous urticarial (CSU) Guidelines. Australasian society of clinical immunology and allergy. 2015. Available at https://www.allergy.org.au/images/stories/pospapers/ASCIA_Guidelines_Chronic_Urticaria_2015.pdf **7.** Valdes-Rodriguez R, Stull C, Yosipovitch G. Chronic pruritus in the elderly: pathophysiology, diagnosis and management. Drugs & Aging. 2015; 32(3):201-15. **8.** Monroe EW, Bernstein DI, Fox RW et al. Relative efficacy and safety of loratadine, hydroxyzine and placebo in chronic idiopathic urticaria. Arzneimittelforschung 1992; 42:9 1119-21. **9.** Monroe EW. Relative efficacy and safety of loratadine, hydroxyzine, and placebo in chronic idiopathic urticaria and atopic dermatitis. Clin Ther. 1992; 14:1:17-21. **10.** Reeve E, Wiese MD, Hendrix I, et al. People's attitudes, beliefs, and experiences regarding polypharmacy and willingness to deprescribe. J Am Geriatr Soc. 2013; 61(9): 1508-1514.

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