The Heart Group

“De-prescription” of Cardiac Medications

Tom Pasley and Tim Sutton

Cardiology.....

– Full of guidelines when to prescribe

AMERICAN COLLEGE of CARDIOLOGY

New Zealand GUIDELINES GROUP
Te Rōpū Rarangi Tohutohu
Promoting Effective Health and Disability Services

EUROPEAN SOCIETY OF CARDIOLOGY

CSANZ
Cardiac Society of Australia and New Zealand

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

What is deprescription?

- Cessation of drug
- Reduction of dose

Why to deprescribe?

- Not indicated
- Adverse drug reactions
  - Prescribing cascades
- Polypharmacy
- Patient wishes
- Competing comorbidities
  - Frailty/Aging
  - Cognitive impairment
  - Medical comorbidities

Coe A: BMJ Open 11(9): DOI:10.1136/bmjopen-2021-052547

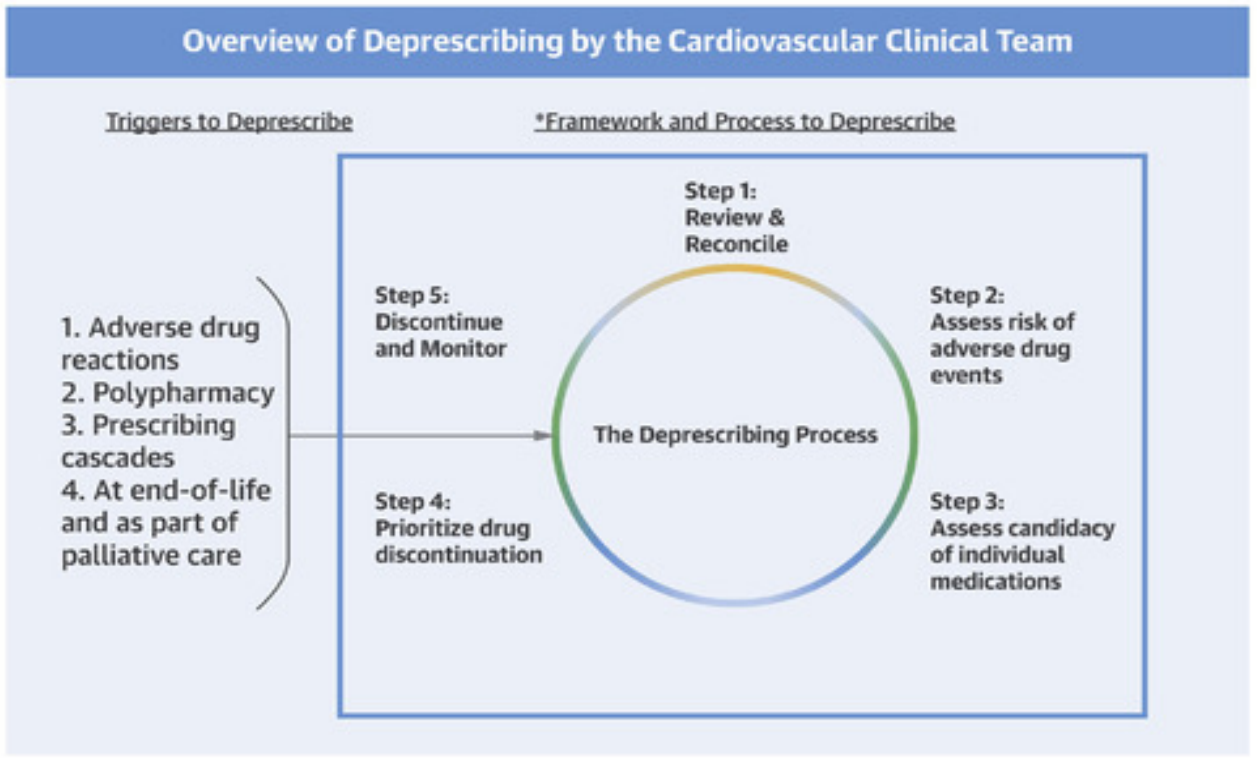
Who can deprescribe?

- Anyone involved with prescription

When to deprescribe?

- Each clinical contact
- Acute vs planned

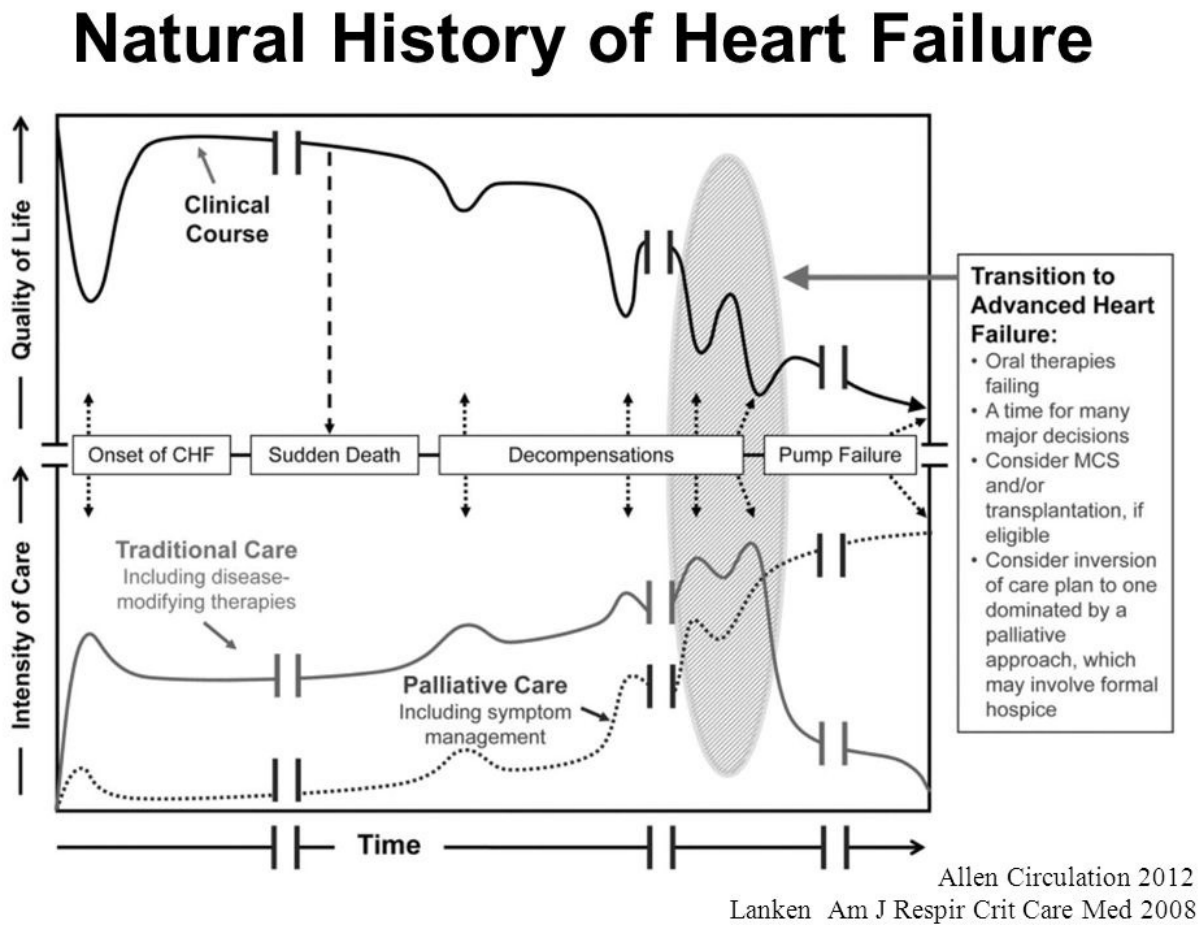
CENTRAL ILLUSTRATION: Overview of Deprescribing by the Cardiovascular Clinical Team



Krishnaswami, A. et al. J Am Coll Cardiol. 2019;73(20):2584-95.

Heart failure deprescription

- Diuretics
  - Reduce dose, keep euvolaemic
- Beta blocker*
  - HFrEF: continue, monitor HR/BP
  - HFpEF: consider withdrawing
- ACEi* / ARB* / ARNi*
  - BP/ renal function / K+
- Mineralocorticoid antagonist*
  - Renal function / K+/ gynaecomastia
- SGLT 2 inhibitor*
  - Renal function



Allen Circulation 2012
Lanken Am J Respir Crit Care Med 2008

~~* Improve survival in HFrEF~~

Post ACS

- Antiplatelet agent +/– PPI
  - PPI on DAPT, on pre ACS?
  - 2 agents for 6 months post elective PCI / 1 year post ACS
- Statin
  - As long as there is perceived benefit
- Beta blocker
  - ? LV function
- ACEi / ARB / MRA ??
- Anticoagulant
  - Generally no DAPT after 1 year post ACS (unless stated)

Case 1:

65 yr old Maori man with T2DM, PVI 12 months ago. Wants to come off his Flecainide and NOAC. Discharged from Cardiology. No other co-morbidities.

Approach?

Predicting stroke risk in Maori?

My approach:

- PVI not a definite “cure”
- Base NOAC use on CHADSVASC score
- First presentation/Sx of recurrent A.fib post may be CVA
- Same approach in in DCCV and PAF

Anti-arrhythmic:

- 3 months following PVI/DCCV (other RF’s addressed)…..”Healing LA”
- Don’t reduce mortality or CVA
- Safer to stop, especially noting long term risk of anti-arrhythmic’s

Maori:

Atrial fibrillation: Age of diagnosis?

- Maori 60 yrs, Pacifika 61yrs, all others 70
- Maori/Pacifika higher CHADSVASc scores when diagnosed
- Slightly less likely to be prescribed NOAC/Warfarin
- CHADSVASc score not evaluated specifically in Maori ? Age adjustment

Case 2:

72 yr old female, usually well but has treated HTN and hyperlipidaemia (ratio 5). Can't tolerate statin. No DM or smoking. No sig family history. On aspirin and perindopril. Calculated CVS risk score 8%/5 years. Wants to stop aspirin.....

Thoughts?

Aspirin on the way out??

- Primary prevention?

- ARRIVE: Moderate risk pts no benefit, increases bleeding
- ASPREE: > 70 years, no benefit and increases bleeding
- ASCEND: DM patients: Mild decrease in CVS events (8.5 vs 9.6%), increased bleeding (3.1 vs 4.2%)

- > 70yrs stop, < 70 in high risk
- (low risk < 5%/5 years, intermediate 5–10%, High > 10%
- ? Clopidogrel……




Questions?

TheHeart♥Group