

ALUMNI

Minimising Falls: Unveiling the Advantages of Deprescribing Fall Risk-Increasing Drugs (FRIDs)

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Falls-related injuries among older people have led to increased healthcare costs [1, 2] due to a rise in emergency department visits, ward admissions, and long-term care facility admissions [3]. Treating falls-related injuries typically incurs significant medical expenses. As the population ages, the number of falls-related injuries and associated expenditures is projected to substantially increase. In 2015, estimated medical expenses for fatal and non-fatal falls among older people in the United States exceeded 50 billion dollars [1, 4, 5].

Benzodiazepines rank as the most commonly prescribed drugs among older people in a specific country, accounting for 28.9% [6]. The concurrent use of various benzodiazepines, sudden dosage increases, and short-acting forms escalate the risk of falls [7]. Reports consistently highlight the substantial risk of falling associated with benzodiazepines and zolpidem, evident in odds ratios (OR) of 1.42 and 1.95, respectively [8].

Additionally, despite their widespread use for pain and inflammation management in older people, non-steroidal anti-inflammatory drugs (NSAIDs) pose multiple adverse effects. These include gastrointestinal bleeding, cardiovascular complications, and NSAID-induced nephrotoxicity [9]. Furthermore, CNS-related adverse effects of NSAIDs such as confusion, dizziness, drowsiness, and vision impairment, heighten the risk of falls among older people [10].

Potentially inappropriate medications (PIMs) persist in being prescribed to older people despite their unfavorable outcomes and associated adverse events. Previous studies revealed that 21.3% of community-dwelling older people in the United States received at least one of 33 PIMs, aligning with data from the 1996 Medical Expenditure Panel Survey (MEPS) [11]. Moreover, two other studies reported varying prevalence rates of inappropriate medication use among community-dwelling older people in different years. They found that 23.5% and 17.5% of older people in the United States used at least one of 20 PIMs in 1987 and 1992, respectively [12].

Deprescribing has demonstrated several potential benefits for older people [13]. It involves discontinuing inappropriate polypharmacy and PIMs, thereby mitigating the associated harm. Ceasing the use of specific medication classes, such as FRIDs, notably reduces the risk of falls among older people.

Moreover, withdrawal of benzodiazepines and NSAIDs has shown improvements in cognitive and psychomotor functions, and a positive impact on blood pressure regulation, respectively [14, 15]. Antihypertensives, also categorized as FRIDs due to side effects like dizziness and orthostatic hypotension, elevate the risk of falls in older people [16]. Discontinuing inappropriate antihypertensives has been associated with fewer cardiovascular events and lower mortality rates over a 5-year follow-up period [17].

The benefits of deprescribing extend to cost reduction through a decrease in medication usage, adverse drug reactions (ADRs), and subsequent reduced utilization of health services. Most notably, costs related to hospital and physician fees, residential and personal care, nursing facilities, care for pensioners, medical equipment, and products could potentially be reduced [4].

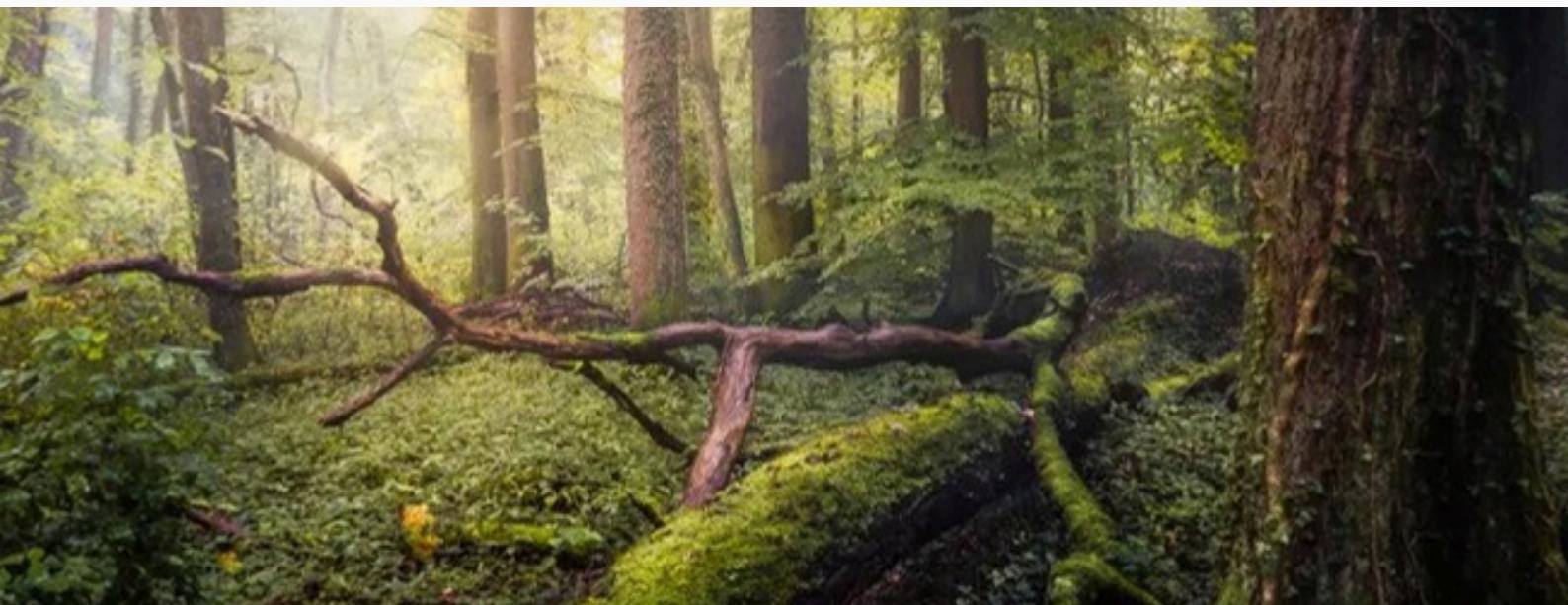
In Malaysia, deprescribing is not widely practiced, especially in community settings, primarily due to the absence of dispensing rights granted to community pharmacists [18]. The absence of a dispensing separation policy grants general practitioners (GPs) the legal right to both prescribe and dispense medications from their clinics. Consequently, many GPs do not routinely review or initiate deprescribing protocols for their older patients. Nevertheless, the implementation of deprescribing practices in Malaysia is crucial to maximise benefits for older people by addressing medication-related issues and reducing healthcare costs associated with unnecessary medications

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