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Resources for the Comprehensive Geriatric Assessment based Proactive and Personalised Primary Care of the Elderly

STOPP-Frail

Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy

Purpose : List of potentially inappropriate prescribing indicators designed to assist physicians with stopping such medications in End of Life patients who meet ALL of the following criteria:

1. End-stage irreversible pathology
2. Poor one year survival prognosis
3. Severe functional impairment or severe cognitive impairment or both
4. Symptom control is the priority rather than prevention of disease progression

Admin time : Highly operator dependent - 5 mins for an expert, up to 20-30 mins

User Friendly : Moderate

Administered by : GP, Physician, Community Pharmacist

Content : STOPP-Frail comprises 27 criteria relating to medications that are potentially inappropriate in frail older patients with limited life expectancy. STOPP-Frail assists physicians in deprescribing medications in these patients.

Author : Hanora Lavan, A., Gallagher, P., Parsons, C., & O'Mahony, D. (2017)

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STOPP-Frail

Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy

STOPP-Frail is a list of potentially inappropriate prescribing indicators designed to assist physicians with stopping such medications in older patients (≥65 years) who meet ALL of the criteria listed below:

(1) End-stage irreversible pathology

(2) Poor one year survival prognosis

(3) Severe functional impairment or severe cognitive impairment or both

(4) Symptom control is the priority rather than prevention of disease progression

The decision to prescribe/not prescribe medications to the patient, should also be influenced by the following issues:

(1) Risk of the medication outweighing the benefit

(2) Administration of the medication is challenging

(3) Monitoring of the medication effect is challenging

(4) Drug adherence/compliance is difficult

Disclaimer (STOPP-Frail)

Whilst every effort has been made to ensure that the potentially inappropriate prescribing criteria listed in STOPP-Frail are accurate and evidence-based, it is emphasized that the final decision to avoid or initiate any drug referred to in these criteria rests entirely with the prescriber. It is also to be noted that the evidence base underlying certain criteria in STOPP-Frail may change after the time of publication of these criteria. Therefore, it is advisable that prescribing decisions should take account of current published evidence in support of or against the use of drugs or drug classes described in STOPP-Frail.

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Section A: General

A1: Any drug that the patient persistently fails to take or tolerate despite adequate education and consideration of all appropriate formulations.

A2. Any drug without clear clinical indication.

Section B: Cardiovascular system

B1. Lipid lowering therapies
(statins, ezetimibe, bile acid sequestrants, fibrates, nicotinic acid and acipimox)
These medications need to be prescribed for a long duration to be of benefit. For short-term use, the risk of ADEs outweighs the potential benefits [43–45]

B2. Alpha-blockers for hypertension
Stringent blood pressure control is not required in very frail older people. Alpha blockers in particular can cause marked vasodilatation, which can result in marked postural hypotension, falls and injuries [46]

Section C: Coagulation system

C1: Anti-platelets
Avoid anti-platelet agents for primary (as distinct from secondary) cardiovascular prevention (no evidence of benefit) [47]

Section D: Central Nervous System

D1. Neuroleptic antipsychotics
Aim to reduce dose and gradually discontinue these drugs in patients taking them for longer than 12 weeks if there are no current clinical features of behavioural and psychiatric symptoms of dementia (BPSD) [48–52]

D2: Memantine
Discontinue and monitor in patients with moderate to severe dementia, unless memantine has clearly improved BPSD (specifically in frail patients who meet the criteria above) [53–56]

Section E: Gastrointestinal system

E1. Proton Pump Inhibitors
Proton Pump Inhibitors at full therapeutic dose ≥8/52, unless persistent dyspeptic symptoms at lower maintenance dose [57]

E2: H2 receptor antagonist
H2 receptor antagonist at full therapeutic dose for ≥8/52, unless persistent dyspeptic symptoms at lower maintenance dose [57]

E3. Gastrointestinal antispasmodics
Regular daily prescription of gastrointestinal antispasmodics agents unless the patient has frequent relapse of colic symptoms because of high risk of anti-cholinergic side effects [57]

Section F: Respiratory system

F1. Theophylline.
This drug has a narrow therapeutic index, requires monitoring of serum levels and interacts with other commonly prescribed drugs putting patients at an increased risk of ADEs [58–60]

F2. Leukotriene antagonists
(Montelukast, Zafirlukast)
These drugs have no proven role in COPD, they are indicated only in asthma [61]

Section G: Musculoskeletal system

G1: Calcium supplementation
Unlikely to be of any benefit in the short term

G2: Anti-resorptive/bone anabolic drugs FOR OSTEOPOROSIS
(bisphosphonates, strontium, teriparatide, denosumab)
Unlikely to be of any benefit in the short term

G3. SORMs for osteoporosis
Benefits unlikely to be achieved within 1 year, increased short–intermediate term risk of associated ADEs particularly venous thromboembolism and stroke [57]

G4. Long-term oral NSAIDs
Increased risk of side effects (peptic ulcer disease, bleeding, worsening heart failure, etc.) when taken regularly for ≥2 months [62–64]

G5. Long-term oral steroids
Increased risk of side effects (peptic ulcer disease, etc.) when taken regularly for ≥2 months. Consider careful dose reduction and gradual discontinuation [65]

Section H: Urogenital system

H1. 5-Alpha reductase inhibitors
No benefit with long-term urinary bladder catheterisation [66, 67]

H2. Alpha blockers
No benefit with long-term urinary bladder catheterisation [66, 67]

H3. Muscarinic antagonists
No benefit with long-term urinary bladder catheterisation, unless clear history of painful detrusor hyperactivity [66, 67]

Section I : Endocrine system

I 1. Diabetic oral agents
Aim for monotherapy. Target of HbA1c < 8%/64 mmol/mol. Stringent glycaemic control is unnecessary [68]

I 2. ACE-inhibitors for diabetes
Stop where prescribed only for prevention and treatment of diabetic nephropathy. There is no clear benefit in older people with advanced frailty with poor survival prognosis [69]

I 3. Angiotensin receptor blockers
Stop where prescribed only for prevention and treatment of diabetic nephropathy. There is no clear benefit in older people with advanced frailty with poor survival prognosis [69]

I 4. Systemic oestrogens for menopausal symptoms
Increases risk of stroke and VTE disease. Discontinue and only consider recommencing if recurrence of symptoms [57]

Section J: Miscellaneous

J1. Multi-vitamin combination supplements
Discontinue when prescribed for prophylaxis rather than treatment

J2. Nutritional supplements (other than vitamins)
Discontinue when prescribed for prophylaxis rather than treatment [70]

J3: Prophylactic antibiotics
No firm evidence for prophylactic antibiotics to prevent recurrent cellulitis or UTIs [71–73]

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Note: There is a long list of references to support this research.
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