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# Potentially inappropriate medications in the elderly: a comprehensive protocol

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**Abstract** Elderly patients are at increased risk of drug-related morbidity and mortality. Avoiding the use of potentially inappropriate medications (PIMs) is one of the strategies that has been widely adopted to reduce the harmful consequences of drug use. There are several PIM screening tools available. In this review, we provide an overview of existing screening tools to detect PIMs in the elderly, emphasizing the advantages and disadvantages of each. Combining previously published and adopted tools (adjusted Beers list, French consensus panel, McLeod's list, and Lindblad's list of clinically important drug–disease interactions), we develop a new comprehensive tool that also includes the adjusted Hanlon's and Malone's lists of potentially serious drug–drug interactions in the elderly. In addition to listed PIMs and clinically important drug–drug interactions, alternative therapeutic solutions are suggested. The new protocol differentiates: drugs with an unfavorable benefit/risk ratio (to be avoided regardless of the underlying disease/condition), drugs with a questionable efficacy, and drugs to be avoided with certain diseases/conditions, and provides a list of potentially serious drug–drug interactions. A tool consisting of PIMs and potential drug–drug interactions within the same protocol provides more comprehensive quality assessment of drug-prescribing behavior to the elderly, which in turn may lead to better prescribing practices.

**Keywords** Potentially inappropriate medications · Elderly patients · PIM screening tools · Drug-prescribing behavior · Drug–drug interactions

## Introduction

The percentage of the total elderly population is increasing in most countries, and it is estimated that by 2050 almost 30% of the population in developed countries will be over 65 years of age [1]. Elderly patients consume approximately 30% of all healthcare resources and, therefore, the growth of this population group will have significant implications on future healthcare budgets [2]. Elderly individuals often have many chronic diseases and are consequently taking multiple medications. They also have increased risk for adverse drug reactions (ADRs) due to age-related changes in the pharmacodynamics and pharmacokinetics of drugs, co-morbidities, and polypharmacy [3]. It may thus be anticipated that this increase in the numbers of elderly people will also lead to higher drug-related morbidity and mortality [2, 4].

Suboptimal or inappropriate prescribing in elderly patients pose the risk of drug-related morbidity and mortality. Inappropriate prescribing includes the prescribing of medications with potentially serious drug–drug interactions or the underuse, overuse, and misuse of drugs. Misuse encompasses the use of potentially inappropriate medications (PIMs), inappropriate dose, or inappropriate duration of treatment. PIMs are defined as drugs with a potential risk that is higher than their potential benefit to the patient, particularly when safer alternative therapies exist for the same condition [4, 5].

Several screening tools for detecting PIMs in the elderly have been developed in the USA, Canada, and European countries [6–16]. Their role is to optimize the appropriateness of prescribing behavior and to reduce negative outcomes,

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including preventable adverse drug effects (ADEs). These screening tools encompass lists of drugs that should generally be avoided by the elderly and drugs that should be avoided with certain diagnoses or conditions. While most of the protocols are explicit (criterion-based), there is only one implicit (judgement-based) protocol, the Medication Appropriateness Index (MAI), which was developed by Hanlon and colleagues [17].

The aim of this review is to critically evaluate available protocols for detecting PIMs in the elderly and summarize these into a new comprehensive and widely applicable protocol.

### Overview of the existing screening tools for detection of PIMs in the elderly

A literature search was performed within the MEDLINE, PubMed, OVID, and Google Scholar databases using MeSH terms “aged,” “inappropriate prescribing,” “clinical protocols,” “medication errors,” and “polypharmacy.” Articles published between January 1991 and December 2010 were selected if they contained explicit criteria addressing potentially inappropriate prescribing in the elderly.

Table 1 summarizes the protocols and screening tools for detection of PIMs prescribed to the elderly, published in chronological order. For each tool in the table, data on the authors, year, country of origin, scope, main content, and main advantages/disadvantages are presented. One of the tools was developed by Barry et al. [13] to evaluate under-prescribing, i.e., for detecting omission of evidence-based medications.

We considered the potential clinical applicability of the criteria and PIMs resulting in common clinical consequences as well as the wide applicability of a protocol to different healthcare settings and different geographical regions to be advantageous. Limitations or disadvantages of a protocol were considered to be a lack of clinical assessment and evaluation or validation of the protocol, incomplete drug listings, and/or obsolete drugs listed.

According to different authors, newer criteria offer certain innovations and improvements compared to those on the original Beers list and address drug–drug interactions, underuse of drugs, drugs with questionable efficacy, among others [18–20]. However, while several new tools need to be evaluated and assessed in clinical studies, Beers criteria have been the most widely used and an association of the listed drugs with adverse outcomes has been shown by number of authors [21–34].

### The new comprehensive protocol

Taking into account the reported advantages and disadvantages of existing screening tools, it may be assumed that by

combining their clinically most useful parts together, it should be possible to develop a new comprehensive tool. In evaluating the advantages of previous tools, we focused on the potential clinical applicability of the criteria and on PIMs having common clinical consequences in the elderly [e.g., focusing on non-steroid anti-inflammatory drugs (NSAIDs), associated with multiple possible adverse outcomes].

The new protocol is developed by combining the adjusted Beers list, the French consensus panel, McLeod’s list, and Lindblad’s list of clinically important drug–disease interactions, with the addition of several new drugs [8, 10–12]. As part of the protocol, a list of clinically important drug–drug interactions in the elderly is developed by modifying Malone’s and Hanlon’s lists and adding four new drug–drug interactions [35, 36]. A clinically based approach was used to build the protocol. The new criteria have been shown by many researchers to be associated with adverse clinical and healthcare outcomes, thus confirming their relevance [27–34]. By combining parts of the North American and European tools together, we assume that new combined tool will be widely applicable in the elderly population (defined as 65 years or older).

The protocol groups PIMs into: (1) those with an unfavorable benefit/risk ratio (drugs to be avoided regardless of the underlying disease/condition); (2) drugs with a questionable efficacy, and (3) drugs to be avoided with certain diseases/conditions. Those three major subgroups are defined similarly in the French consensus panel and on Beers list. For each criterion listed, a possible alternative solution is given [8, 12, 16]. Part (4) of the protocol presents the list of potentially serious drug–drug interactions in the elderly population.

#### Drugs with unfavorable benefit/risk ratio (part 1 of new protocol)

The list of drugs with an unfavorable benefit/risk ratio is based on a combination of the adjusted Beers list and the French consensus panel, as shown in Table 2, and consists of 33 criteria or individual drugs [10, 12]. Drugs defined solely by the French panel include antipsychotic drugs with anticholinergic properties and concomitant use of  $\geq 2$  NSAIDs, clonidine, and moxonidine among the centrally acting antihypertensives and dipyridamole (according to Beers list, dipyridamole is inappropriate medication only in patients receiving anticoagulant therapy or in those with blood clotting disorders). These drugs are included in the new protocol because their use can lead to severe ADRs [37–42].

Drugs defined solely by the Beers list include: doxazosin, amiodarone, fluoxetine, thioridazine, ferrous sulfate  $>325$  mg/day, estrogens only (oral), methyltestosterone, long-term use

**Table 1** Characteristics of existing screening tools for potentially inappropriate medications

Authors	Year	Country	Scope	Main content	Pro's and con's
Beers et al. [6]	1991	USA	Nursing home residents $\geq 65$ years	Delphi consensus based. Thirty criteria for drugs to be avoided in the elderly	Pros: the first tool developed for PIM screening in the elderly Cons: many drugs from the list are unavailable in other countries. Developed for nursing home residents but also used in studies with other patient populations Pros: more generally applicable (for ambulatory patients)
Beers [7]	1997	USA	All patients $\geq 65$ years	Delphi consensus based; updated and expanded version. Fifteen drugs omitted from the original version. Contains 28 drugs or drug classes to be avoided in ambulatory elderly independent of diagnosis and 35 drugs or drug classes to be avoided in patients with certain disease or condition	Cons: many drugs from the list are unavailable in other countries. Drug–drug interactions and duplication of treatments are not evaluated
McLeod et al. [8]	1997	Canada	All patients $\geq 65$ years	Delphi consensus based. Thirty-eight inappropriate practices (grouped into cardiovascular, psychotropic, analgesic and miscellaneous drugs) • drug generally contraindicated (18) • drug–disease interactions (16) • drug–drugs interactions (4)	Pros: Nine inappropriate practices address prescribing of NSAIDs, including long-term prescription in patients with a history of peptic ulcer, hypertension, chronic renal, or congestive heart failure. Drug–drug interactions addressed. Alternative therapy for each criterion suggested Cons: some of the criteria obsolete (e.g., beta blockers in patients with asthma or COPD or beta blockers in patients with congestive heart failure)
Naughtler et al. [9]	2000	Canada	All patients $\geq 70$ years	Derived from McLeod's list. Fourteen inappropriate combinations of drugs and diseases	Pros: simple and easily applicable tool Cons: some of the criteria obsolete (e.g., beta blockers in patients with asthma or COPD or beta blockers in patients with congestive heart failure). Three of the criteria involve today uncommonly used tricyclic antidepressants
Fick et al. [10]	2003	USA	All patients $\geq 65$ years	Delphi consensus based updated version of Beers list. Sixty-eight criteria: 48 drugs or drug classes generally to be avoided; 20 diseases or conditions with drugs to be avoided	Pros: the most widely cited explicit criteria. Association with adverse healthcare outcomes shown Cons: many drugs from the list are unavailable in other countries. Drug–drug interactions and duplication of treatments are not evaluated. Appropriateness of some drugs from the list still subject of debate (e.g., amiodarone or amitriptyline). Only four inappropriate practices associated with the use of NSAIDs addressed
Lindblad et al. [11]	2006	USA	All patients $\geq 65$ years	Delphi consensus based. Twenty-eight clinically important drug–disease interactions, involving 14 diseases or conditions. Eleven drug–disease interactions included on Beers list and 5 included in McLeod's list	Pros: simple and easily applicable tool. Introduces new criteria not defined by Beers' or McLeod's list Cons: drugs to be avoided regardless of a disease or condition are not included
Laroche et al. [12]	2007	France	All patients $\geq 75$ years	Delphi consensus based, first European screening tool. Thirty-four criteria for inappropriateness. PIMs grouped into those with unfavorable benefit/risk ratio (25 criteria), questionable efficacy (one criterion), and both unfavorable benefit/risk ratio and questionable efficacy	Pros: Alternative drugs or therapeutic abstinence for each criterion suggested. The first tool to address drugs with questionable efficacy as potentially

**Table 1** (continued)

Authors	Year	Country	Scope	Main content	Pro's and con's
Barry et al. [13]	2007	Ireland	All patients $\geq 65$ years	(7 criteria). Twenty-nine criteria are independent of a disease or condition and five are linked to disease or condition  Delphi consensus based. START (Screening Tool to Alert Doctors to Right Treatment). Twenty-two medications included. Underprescribing or omission of clinically indicated, evidence-based medications evaluated (e.g., ACE inhibitors in chronic heart failure or beta blocker in chronic stable angina, if no contraindications). Delphi consensus based. STOPP (Screening Tool of Older Persons' Prescription). Sixty-five criteria for PIMs evaluation arranged according to relevant physiological systems.	inappropriate (cerebral vasodilators). Duplication of treatments addressed as potentially inappropriate  Cons: underuse of drugs is not addressed. Needs to be assessed and confirmed in clinical studies  Pros: first tool evaluating underuse of drugs
Gallagher et al. [14]	2008	Ireland	All patients $\geq 65$ years	Delphi consensus based. Twenty-one explicit criteria for single drugs and 15 criteria for drug–drug interactions.	Pros: innovative approach introduced (first tool to address inappropriate use of PPI for peptic ulcer and use of aspirin without history of coronary, cerebral or peripheral vascular symptoms or occlusive event). Seven criteria address prescribing of NSAIDs, including prescription in patients hypertension, chronic renal or congestive heart failure. Drug class duplication and drug–drug interactions addressed as potentially inappropriate. Sensitive for identifying patients with potential to suffer PIMs-related ADRs  Cons: drugs with questionable efficacy not addressed. Needs to be assessed and confirmed in clinical studies
Rognstad et al. [15]	2009	Norway	Patients $\geq 70$ years in general practice	Delphi consensus based. Lists a total of 83 drugs to be avoided regardless of the underlying disease/condition, contained in 18 drug classes.	Pros: Lists inappropriate single drugs (i.e., theophylline or sotalol) and drug combinations [e.g., combination of NSAIDs (or coxib) and ACE inhibitors (or ARBs) which may increase the risk of renal failure, or combination of NSAIDs and diuretics, resulting in reduced diuretic effect] not addressed by previous tools  Cons: aimed at patients in general practice. Needs to be assessed and confirmed in clinical studies
Holt et al. [16]	2010	Germany	All patients $\geq 65$ years	Delphi consensus based. Lists a total of 83 drugs to be avoided regardless of the underlying disease/condition, contained in 18 drug classes.	Pros : easily applicable tool. Names main concerns, possible therapeutic alternatives and precautions to be taken. Lists many drugs not addressed by previous tools (e.g., ketoprofen, meloxicam, prasugrel, flecainide, metildigoxin, haloperidol $> 2$ mg, zaleplon $> 5$ mg, phenobarbital). Drugs with questionable efficacy are addressed (circulation-promoting agents)  Cons: aimed primarily at German elderly population. Needs to be assessed and confirmed in clinical studies

ACE, Angiotensin converting enzyme; ADRs, adverse drug reactions; ARBs, angiotensin II receptor blockers; COPD, obstructive pulmonary disease; NSAIDs, non-steroid anti-inflammatory drugs; PIMs, potentially inappropriate medications, PPI, proton pump inhibitor

**Table 2** Drugs with unfavorable benefit/risk ratio

Drug	Possible adverse effects	Possible therapeutic solutions
<b>Analgesics</b>		
Indomethacin	Severe CNS side effects	Short-term use of a weak NSAID (e.g., ibuprofen) or acetaminophen or a weak opioid (e.g., tramadol)
Concomitant use of 2 or more NSAIDs	No enhancement of efficacy, increased risk of ADRs	Short-term use of only one weak NSAID (e.g., ibuprofen)
Long-term use of full-dosage, longer half-life NSAIDs: naproxen, piroxicam	Increased risk of GI bleeding, renal failure, high blood pressure and heart failure	Short-term use of a weak NSAID (e.g., ibuprofen) or use of acetaminophen or a weak opioid (tramadol, codeine)
<b>Drugs with anticholinergic properties</b>		
Antidepressants: amitriptyline, maprotiline	Muscarinic-blocking side-effects, cardiotoxicity when overdosed	SSRIs (except fluoxetine) or SNRIs
Antipsychotic drugs: fluphenazine, levomepromazine	Muscarinic-blocking side-effects	Atypical antipsychotic drug with less anticholinergic activity (e.g., olanzapine, risperidone, quetiapine)
Antihistamines: diphenhydramine, dimenhydrinate	Muscarinic-blocking side-effects, sedation, drowsiness	Antihistamines without anticholinergic activity (e.g., cetirizine, levocetirizine, loratadine, desloratadine)
Concomitant use of drugs with anticholinergic properties	Enhanced anticholinergic ADRs	Avoid drugs with anticholinergic activity in general
<b>Sedative or hypnotic drugs</b>		
Long-acting benzodiazepines: diazepam, bromazepam, nitrazepam, flurazepam	Prolonged sedation and drowsiness, increased risk of falls	Short-acting benzodiazepines given in dose $\leq$ half the dose in younger adults
Short-acting benzodiazepines, dose $>$ half the dose in younger adults (lorazepam $>$ 3 mg, oksazepam $>$ 60 mg, alprazolam $>$ 2 mg)	Increased risk of ADRs without increased efficacy	Short-acting benzodiazepines given in dose $\leq$ half the dose in younger adults
Meprobamat	Very sedative properties, addictive with prolonged use	Short-acting benzodiazepines given in dose $\leq$ half the dose in younger adults
<b>Antihypertensives</b>		
Methyldopa	Bradycardia, exacerbation of depression	Other antihypertensive drugs, except the ones listed here [i.e., diuretics, calcium channel blockers (except short-acting ones), ACE inhibitors, AT1 blockers]
Clonidine	Orthostatic hypotension	
Moxonidine	Headache, vertigo, asthenia	
Nifedipine, short-acting	Postural hypotension, myocardial infarction, stroke	
Doxazosine	Hypotension, dry mouth, urinary incontinence	
<b>Anti-arrhythmics</b>		
Amiodarone	Prolonged QT interval, risk of "torsade de pointes", reduced efficacy in the elderly	Other antiarrhythmics, depending on the type of arrhythmia (e.g., propafenone, beta blockers, calcium channel blockers)
Disopiramide	Negative inotropic and anticholinergic properties	
Digoxin $>$ 0.125 mg	Reduced renal clearance and increased risk of ADRs	Digoxin $<$ 0.125 mg, with serum concentrations 0.5–1.2 ng/ml
<b>Antiplatelet drugs and vasodilators</b>		
Ticlopidine	Blood and liver adverse effect	Clopidogrel, aspirin
Dipyridamole	Vasodilation and postural hypotension, questionable efficacy	
<b>Drugs used to treat gastrointestinal disorders</b>		
Cimetidine	CNS adverse events, confusion, common drug interactions	Other H <sub>2</sub> -antagonists or PPIs
Scopolamine	Muscarinic-blocking agent, no proven efficacy	Mebeverine
Long-term use of stimulant laxatives: bisacodyl, sennosides	Worsening of irritable bowel syndrome	Osmotic laxatives (e.g., lactulose)

Table 2 (continued)

Drug	Possible adverse effects	Possible therapeutic solutions
Long-acting sulfonyleureas		
Chlorpropamide, glibenclamide	Protracted hypoglycemia	Short- or immediate-acting sulfonyleureas (e.g., glipizide, gliclazide)
Muscle relaxants		
Baclofen	Drowsiness, amnesia, fall	Thiocolchicoside, mephenesine
Opioid analgesics		
Pentazocin	More CNS adverse effects, including confusion and hallucinations; mixed agonist and antagonist	Other opioids, with more favorable risk/benefit profile (e.g., tramadol, oxycodone)
Meperidine	Not an effective oral analgesic in doses commonly used. May cause confusion	
Other		
Ferrous sulfate >325 mg/day	Increased incidence of constipation	Dose <325 mg/day
Nitrofurantoin	Can induce renal insufficiency, pneumopathy, peripheral neuropathy, allergic reaction	Other type of antibiotics, depending on microbiology results
Methyltestosterone	Potential for prostatic hypertrophy and cardiac problems	Avoid testosterone substitution
Estrogens only (oral)	Carcinogenic potential and lack of cardioprotective effect	If indicated, use combination of estrogens with progestones. HRT to be used for the shortest time possible.
Thioridazine	Greater potential for CNS and extrapyramidal adverse effects	Atypical antipsychotic drug with less extrapyramidal adverse effects (e.g., olanzapine, quetiapine)
Daily fluoxetine	Long half-life of drug and risk of producing excessive CNS stimulation, sleep disturbances, and increasing agitation	Other SSRIs or SNRIs

CNS, Central nervous system; GI, gastrointestinal; , SNRIs, serotonin and norepinephrine reuptake inhibitors; SSRI, selective serotonin reuptake inhibitors

of naproxen and piroxicam, and use of the opiates pentazocine and meperidine. French experts did not find those drugs relevant. However, since these drugs are commonly used and possible ADRs might have serious consequences, they are included in the new protocol [43–49]. For example, even though the European Medicines Agency in 2007 recommended restricted use of piroxicam, it seems that the extent of its restricted prescribing among the elderly is not satisfactory [50–52]. Amiodarone is a commonly prescribed antiarrhythmic drug, partly due to the lack of similar antiarrhythmic drugs on the market. However, not only is it associated with QT prolongation in the elderly, but its complex pharmacokinetic properties, very long half-life, and possible multiple drug interactions make it a drug that warrants high caution when used [45–49].

Drugs with unfavorable benefit/risk ratio listed in the new protocol that are on neither the French or Beerslist include glibenclamide, a long-acting sulphonylurea drug associated with a higher risk of inducing prolonged hypoglycemia, and promazine, an antipsychotic drug with strong anticholinergic properties [40, 53, 54].

The remaining drugs with an unfavorable benefit/risk ratio on the new list are in agreement with both the French and Beers list as being potentially inappropriate.

#### Drugs with a questionable efficacy (part 2 of new protocol)

The French list of PIMs in the elderly is the only available tool that contains drugs with questionable efficacy as potentially inappropriate [12]. Medications defined as questionably efficacious are cerebral vasodilators, such as ginkgo biloba, pentoxifylline, piracetam, and dihydroergotamine. These four commonly used vasodilator drugs are included in the new protocol, with the addition of two more drugs, betahistine and cinnarizine (except in the indication of Meniere syndrome and vestibular vertigo), which are often used as cerebral vasodilators in patients with cerebrovascular insufficiency (Table 3). Drugs used as cerebral vasodilators do not have a proven efficacy but they do have a

potential to cause ADRs in the elderly, such as postural hypotension, falls, headache, or stomach upset [55–60].

The French panel recognizes a category of drugs with both unfavorable benefit/risk ratio and questionable efficacy, such as nitrofurantoin, anticholinergic antispasmodic scopolamine, or short/intermediate half-life benzodiazepines in doses higher than half the dose given in the young patients. In the new protocol these drugs are classified among those with unfavorable benefit/risk ratio [12].

#### Drugs to be avoided with certain diseases/conditions (part 3 of new protocol)

This part of the new protocol includes 71 individual drug–disease interactions involving 28 diseases or conditions, as shown in Table 4. Criteria from the adjusted Beers list, McLeod’s list, and Lindblad’s list of clinically important drug–disease interactions are combined and respective data updated [10–12, 61–69]. Some of the inappropriate drug–disease combinations are defined by all three tools, such as NSAIDs in peptic ulcer disease or tricyclic antidepressant in benign prostate hyperplasia. However, only McLeod’s list recognizes the long-term use of NSAIDs in patients with heart failure and hypertension or long-term use of NSAIDs to treat osteoarthritis regardless of the accompanying disease, as potentially inappropriate. NSAIDs are commonly prescribed to the elderly, and their risk/benefit ratio should regularly be checked in individual patients. As a general principle, the long-term use of NSAIDs should be avoided in patients with chronic renal or heart failure, hypertension, and peptic ulcer disease, but also in older patients regardless of their underlying disease [38]. Not only is there always the possibility that NSAIDs can worsen renal or heart failure or cause gastrointestinal toxicity, but there are emerging data on the increased risk of stroke and myocardial infarction associated with their use [39]. Also, gastrointestinal bleeding is often the most common cause of ADRs related hospital admissions in the elderly [70–72]. Therefore, it seems reasonable to include McLeod’s NSAIDs criteria in the new

**Table 3** Drugs with questionable efficacy

Drug	Possible adverse effects	Possible therapeutic solutions
Cerebral vasodilators		
Dihydroergotamine	No really proven efficacy while there is risk of postural hypotension, falls, headache, or stomach upset	Therapeutic abstention
Ginkgo biloba		
Pentoxifylline		
Piracetam		
Betahistine (except in the indication of Meniere syndrome and vestibular vertigo)		
Cinnarizine (except in the indication of Meniere syndrome and vestibular vertigo)		



**Table 4** Drugs to be avoided with certain diseases/conditions

Disease or condition/drug	Possible adverse effects	Possible therapeutic solutions
Heart failure		
Disopyramide	Negative inotropic effect	Antiarrhythmic drug without negative inotropic effect
High sodium content drugs (sodium and sodium salts [bicarbonate, biphosphate, citrate, phosphate, salicylate, and sulfate])	Potential to promote fluid retention and exacerbation of heart failure	Avoid this type of drugs
Calcium-channel blockers, except , dihydropyridines	Negative inotropic effect.	Avoid verapamil and diltiazem in these patients. Depending on the underlying diagnosis (hypertension, angina), drug without negative inotropic effect should be used
Long-term prescription of NSAIDs	Potential to promote fluid retention and exacerbation of heart failure	Acetaminophen or a weak opioid (e.g., tramadol). Monitoring of cardiovascular function.
Hypertension		
Pseudoephedrine	May produce elevation of blood pressure secondary to sympathomimetic activity	Avoid over-the-counter cold and cough medications containing this substance.
Long-term prescription of NSAIDs	May produce elevation of blood pressure secondary to salt and water retention	Acetaminophen or a weak opioid (e.g., tramadol). Monitoring blood pressure.
Chronic renal failure		
Long-term prescription of NSAIDs	May reduce renal blood flow and worsen renal failure	Acetaminophen or a weak opioid (e.g., tramadol). Monitoring renal function.
Gastric or duodenal ulcers		
NSAIDs	May exacerbate existing or produce new ulcers	Acetaminophen or a weak opioid (e.g., tramadol). If use of NSAID is deemed unavoidable, use NSAID with less gastrointestinal risk (e.g., ibuprofen) in combination with proton pump inhibitors.
Aspirin		
Seizures or epilepsy	May exacerbate existing or produce new ulcers	Use in combination with proton pump inhibitors
Clozapine, thioridazine		
Bupropion	May lower seizure threshold	Atypical antipsychotic drug without proconvulsive effect and with a favorable risk to benefit profile (e.g., olanzapine, risperidone, quetiapine)
Blood clotting disorders or receiving anticoagulant therapy		
NSAIDs	May lower seizure threshold	SSRI (except fluoxetine) or SSNI
Aspirin	Increased potential for bleeding	For analgesia use acetaminophen or a weak opioid (e.g., tramadol)
Clopidogrel	Increased potential for bleeding	If the combination is deemed unavoidable, use with extreme caution and regular monitoring of the patient
Cimetidine (those taking warfarin)	May elevate INR values and increase potential for bleeding	Other H <sub>2</sub> -antagonist or proton pump inhibitor
Bladder outflow obstruction		
Anticholinergics	May decrease urinary flow, leading to urinary retention	Use drugs without anticholinergic activity
Stress incontinence		

**Table 4** (continued)

Disease or condition/drug	Possible adverse effects	Possible therapeutic solutions
Alpha blockers (doxazosin, urapidil)	May induce or worsen incontinence	Use alternative antihypertensives (e.g., ACE inhibitors or AT1 blockers), antidepressants (SSRI or SNRI) and sedative/hypnotics (e.g., short-term use of short-acting benzodiazepines). Avoid anticholinergics.
Anticholinergics		
Tricyclic antidepressants		
Long-acting benzodiazepines		
Arrhythmias		
Tricyclic antidepressants	Concern due to proarrhythmic effects and ability to produce QT interval changes	SSRI (except fluoxetine) or SSNI
AV block		
Tricyclic antidepressants	May worsen heart block	SSRI (except fluoxetine) or SSNI
Digoxine	May worsen heart block	Avoid digoxine, non-dihydropyridine calcium channel blockers, beta blockers and antiarrhythmics
Verapamil		
Insomnia		
Decongestants	Concern due to CNS stimulant effects	Short term topical application Inhaled bronchodilators
Theophylline		Avoid this type of drug
Methylphenidate		Another type of antidepressant
MAO inhibitors		
Parkinson disease		
Metoclopramide	Concern due to their antidopaminergic/cholinergic effects	Another antiemetic drug
Conventional antipsychotics (fluphenazine, haloperidol)		Atypical antipsychotics with less D2-blocking activity (e.g., quetiapine or clozapine) Memantine for treatment of dementia
Acetylcholinesterase inhibitors (donepezil)		
Depression		
Long-term benzodiazepine use	May produce or exacerbate depression	Short-term benzodiazepine use
Methylphenidate		Avoid this type of drug
Sympatholytic agents: methyl dopa and reserpine		Another type of antihypertensive drugs (including beta blockers)
Anorexia and malnutrition		
CNS stimulants (methylphenidate)	Concern due to appetite-suppressing effects	Avoid this type of drugs
Fluoxetine		Use cautiously another type of SSRI or SNRI with shorter half-life
Syncope or falls		
Short- to intermediate-acting benzodiazepines	May produce ataxia, impaired psychomotor function, syncope, and additional falls	Avoid benzodiazepines
Long-acting benzodiazepines		Avoid benzodiazepines
Tricyclic antidepressants		SSRI (except fluoxetine) and SRNI
Conventional antipsychotics (fluphenazine, haloperidol)		Atypical antipsychotics with less alpha blocking activity (e.g., quetiapine, ziprasidone, aripiprazole)

Table 4 (continued)

Disease or condition/drug	Possible adverse effects	Possible therapeutic solutions
SIADH/hyponatremia SSRIs	May exacerbate or cause SIADH	Most antidepressants and antipsychotics linked to SIADH. Consider stopping the treatment or use a drug with a different pharmacological profile and monitor serum sodium levels. Consider concomitant treatment with demeclocycline
Obesity		
Olanzapine	May stimulate appetite and increase weight gain	Atypical antipsychotic drug with less effect on weight gain (e.g., ziprasidone or aripiprazole)
COPD or asthma		
Long-acting benzodiazepines	May exacerbate or cause respiratory depression	Short-term use of short-acting benzodiazepines
Beta blockers—nonselective		Cardioselective beta-blockers
Chronic constipation		
Calcium channel blockers	May cause constipation	Other types of antihypertensives, except centrally acting, or another types of antianginal drugs (e.g., beta blockers, nitrate)
Anticholinergics		Avoid anticholinergics.
Centrally acting antihypertensives		Other types of antihypertensives, except calcium channel blockers
Opioid analgesics		Concomitant use of osmotic laxatives
Gout		
Thiazide diuretics	May precipitate or worsen gout	Use different type of antihypertensive (e.g., AT1 blocker losartan or a calcium channel blocker amlodipine)
Diabetes		
Corticosteroids	May precipitate or worsen diabetes	If corticosteroid therapy is unavoidable, use smallest dose possible and monitor blood glucose
Narrow-angle glaucoma		
Anticholinergics	Acute-angle glaucoma risk increased	Use drugs without anticholinergic activity
Osteoarthritis		
Long-term prescription of NSAIDs	May cause gastropathy, bleeding and salt and water retention	Acetaminophen or a weak opioid (e.g., tramadol). NSAIDs to be used for the shortest time possible (considering gastrointestinal risk of an individual NSAIDs)
Extrapyramidal effects of antipsychotic drugs		
Anticholinergics (e.g., biperiden)	May cause agitation, delirium and impaired cognition	Atypical antipsychotic drug with less extrapyramidal adverse effects (e.g., olanzapine, quetiapine)
Dementia		
Anticholinergics		Avoid all anticholinergics
Biperiden	May worsen cognitive impairment	Avoid and use other antiparkinson drug

**Table 4** (continued)

Disease or condition/drug	Possible adverse effects	Possible therapeutic solutions
All benzodiazepines		Short-term use of low-dose benzodiazepines
Barbiturates		Avoid this type of drugs
Conventional neuroleptics		Atypical antipsychotics: risperidone, olanzapine, aripiprazole
Postural hypotension		
Thioridazine	May worsen postural hypotension	Atypical antipsychotic drug without alpha blocking properties (e.g., olanzapine, risperidone, quetiapine)
Tricyclic antidepressants		SSRI (except fluoxetine) or SSNI
Raynaud disease or peripheral vascular disease		
Long-term prescription of beta blockers	May worsen the underlying condition	Calcium channel blocker

AV, Atrioventricular; INR, international normalized ratio; MAO inhibitors, monoamine oxidase inhibitors; SIADH, syndrome of inappropriate antidiuretic hormone hypersecretion

PIMs screening tool. Preventing excessive NSAID use in the elderly is one of the most important strategies to reduce drug-related morbidity and mortality.

Lindblad’s list defines corticosteroid use in diabetic patients or opiate use in patients with constipation as inappropriate [11]. Both of these drug–disease combinations are considered clinically important and included in the new protocol.

Potentially serious drug–drug interactions (part 4 of new protocol)

In the quality assessment of drug-prescribing behavior to the elderly, an evaluation of potential drug–drug interactions leading to clinically important events is necessary. A list of 25 Delphi method-based drug–drug interactions with the greatest clinical importance in the general population was developed by Malone and colleagues in 2004 [35]. It was an important expert-based attempt to assess the clinical importance of drug interactions. These 25 interactions mostly involve drugs with a narrow therapeutic index (i.e., warfarin, cyclosporine, or digoxin) and generally are pharmacokinetic in their origin, acting through inhibition or induction of hepatic drug metabolism. Hanlon and Schmadler [36] analyzed possible drug interactions in the elderly and suggested broadening Malone’s list with seven clinically significant pharmacokinetic drug–drug interactions involving antiarrhythmics, 12 involving anti-epileptics, and 15 involving other drugs. They also suggested adding nine clinically significant pharmacodynamic drug–drug interactions, such as the combination of ACE inhibitors with potassium-sparing diuretics or potassium supplements [36].

In order to extend the evaluation of prescribing quality, we included the adjusted Malone’s and Hanlon’s lists of potentially serious drug–drug interactions in the new screening tool (Table 5) [35, 36]. As Malone’s list focuses on the general population, we excluded drugs never or rarely prescribed in the elderly (e.g. oral contraceptives, zidovudine, or dexfenfluramine). Sibutramine was also excluded as it was withdrawn from all markets in the European Union in January 2010 due to increased cardiovascular risk [73]. The original Malone’s list (25 drug–drug interactions) was reduced to 17 drug interactions overall. Among other potential clinically important drug combinations assessed by the Malone’s expert panel but not reaching the final list were four combinations of drugs commonly used by the elderly: levodopa–monoamine oxidase inhibitors; potassium–potassium-sparing diuretics; HMG Co-A reductase inhibitors–gemfibrozil; cytochrome P450 (CYP) 3A4-metabolized HMG Co-A reductase inhibitors–macrolide antibiotics [35]. In addition to these four combinations, the new protocol includes another four important potential interactions of drugs commonly prescribed to the elderly and

**Table 5** Potentially serious drug–drug interactions1. Clinically significant pharmacokinetic drug–drug interactions<sup>a</sup>

## Antiarrhythmics

- Disopyramide–Cimetidine ↑
- Disopyramide–Macrolides (except azithromycin) ↑
- Procainamide–Amiodarone ↑
- Procainamide–Cimetidine ↑
- Procainamide–Trimethoprim ↑
- Quinidine–Cimetidine ↑
- Quinidine–Fluvoxamine ↑

## Antiepileptics

- Carbamazepine–Danazol ↑
- Carbamazepine–Diltiazem ↑
- Carbamazepine–Macrolides ↑
- Carbamazepine–Verapamil ↑
- Phenytoin–Amiodarone ↑
- Phenytoin–Cimetidine ↑
- Phenytoin–Fluoxetine ↑
- Phenytoin–Isoniazid ↑
- Phenytoin–Omeprazole ↑
- Quinidine–Phenytoin ↓
- Theophylline–Phenytoin ↓
- Warfarin Phenytoin–PT-INR ↓

## Other drugs with low therapeutic index

- Digoxin–Clarithromycin ↑
- Digoxin–Amiodarone ↑
- Digoxin–Propafenone ↑
- Digoxin–Quinidine ↑
- Digoxin–Verapamil ↑
- Lithium–ACE inhibitors ↑
- Lithium–Diuretics ↑
- Lithium–NSAIDs ↑
- Procainamide–Cimetidine ↑
- Salicylates–Probenecid ↑
- Theophylline–Cimetidine ↑
- Theophylline–Erythromycin, clarithromycin ↑
- Warfarin–Amiodarone ↑
- Warfarin–Macrolides ↑
- Warfarin–Quinolones ↑
- Warfarin–Sulfamethoxazole ↑

2. Drug–drug interactions selected by Malone et al. as having greatest clinical importance (pharmacokinetic and pharmacodynamic)<sup>b</sup>

## Benzodiazepines–Azole antifungal agents

## Cyclosporine–Rifampin

## Ergot alkaloids–Macrolide antibiotics (except azithromycin)

## MAO inhibitors–Sympathomimetics (dopamine, ephedrine, phenylephrine, pseudoephedrine)

## Meperidine–MAO inhibitors

## Methotrexate–Trimethoprim

## Nitrates–Sildenafil

## SSRIs–MAO inhibitors

## Theophyllines–Fluvoxamine

## Theophyllines–Quinolones

Thiopurines–Allopurinol  
 Warfarin–Fibric acid derivatives  
 Warfarin–NSAIDs  
 Warfarin–Cimetidine  
 Warfarin–Thyroid hormones  
 Warfarin– Barbiturates

### 3. Other clinically important drug–drug interactions (pharmacokinetic and pharmacodynamic)<sup>c</sup>

Atorvastatin/simvastatin–Amiodarone  
 Potassium– Potassium-sparing diuretics  
 Clopidogrel–PPIs  
 Levodopa–MAO inhibitors  
 SSRIs–Metoclopramide  
 SSRIs–Tramadol

HMG Co-A reductase inhibitors–gemfibrozil  
 Atorvastatin/simvastatin–Macrolide antibiotics

### 4. Clinically significant pharmacodynamic drug–drug interactions<sup>d</sup>

Object drug/drug class	Interacting drug/drug class	Outcome
ACE inhibitors	Potassium-sparing diuretics	↑ Potassium level
ACE inhibitors	Potassium supplements	↑ Potassium level
Anticholinergic	Anticholinergic	↑ Anticholinergic effect
Antihypertensive	NSAIDs	↓ Antihypertensive effect
CNS agents (e.g., diazepam)	CNS agents (e.g., codeine)	↑ CNS effect
Diuretics	NSAIDs	↓ Diuretic effect
NSAIDs, Aspirin	Corticosteroids	↑ Peptic ulcer risk
Verapamil	Beta blockers	↓ Heart rate
Warfarin	Antiplatelet agents	↑ Risk of bleeding
Antiplatelet agent	Antiplatelet agent	↑ Risk of bleeding

Arrow indicates the influence of the second (interacting) drug on the concentration of the first, object drug

<sup>a</sup> Clinically significant pharmacokinetic drug–drug interactions selected by Hanlon and Schmader [36]

<sup>b</sup> Clinically significant drug–drug interactions selected by Malone et al. [35]

<sup>c</sup> Other clinically important drug–drug interactions, not selected by Malone’s panel, including an additional four drug–drug interactions we added [35]

<sup>d</sup> Clinically significant pharmacokinetic drug–drug interactions selected by Hanlon and Schmader, including additional two drug–drug interactions we added [36]

possibly leading to serious adverse events: combination of amiodarone with CYP3A4-metabolized HMG Co-A reductase inhibitors, i.e. either simvastatin or atorvastatin (acting by inhibiting CYP3A4, amiodarone increases the concentration of the two statins and leads to increased risk of rhabdomyolysis); combination of selective serotonin reuptake inhibitors with either tramadol or metoclopramide (both combinations could result in high serotonin levels and life-threatening serotonin syndrome); combination of clopidogrel with proton pump inhibitors (PPIs) (acting through CYP2C19 inhibition, PPIs decrease the formation of the clopidogrel-active metabolite and reduce its antiplatelet activity) (Table 5) [74–78].

Hanlon’s adjunct to Malone’s list contains overall 34 pharmacokinetic and nine pharmacodynamic drug–drug interactions in the elderly population. Among the pharmacodynamic interactions, a potential interaction between corticosteroids and NSAIDs (increased risk of peptic ulcer disease) was

defined by Hanlon and Schmader [36]. The new protocol extends the list to potential interactions between aspirin and corticosteroids, also leading to the increased risk of peptic ulcer, and to potential interactions between two antiplatelet agents, resulting in increased risk of bleeding [74].

In total, 70 potentially clinically important drug–drug interactions were included in the new protocol.

## Discussion and conclusion

There are numerous strategies aimed at improving drug-prescribing behavior to the elderly, which is the population most sensitive to adverse effects of drugs. These strategies include reducing the underuse, overuse, and misuse of drugs, as well as reducing potentially important drug–drug interactions. The overuse of drugs and polypharmacy, leading to increased risk of ADRs and drug–drug interactions,

can be avoided if only drugs with a clear indication, proven efficacy, and favorable risk-to-benefit profile are used [5, 18]. The overall number of drugs should be the smallest possible and the duration of treatment the shortest possible.

Potentially inappropriate medications represent one form of drug misuse. Numerous authors have concluded that avoiding PIMs reduces drug-related morbidity and mortality in elderly patients [2]. The use of explicit screening tools, as the most simple and easiest method of detecting PIMs, is expected to improve the quality of prescribing [4]. There are several tools currently available, each with a different degree of comprehensiveness and complexity and some with more advantages than others. As there are marked differences between the availability of drugs in different countries, we recommend that each country adapt the most acceptable screening tool. For European countries, adaptation of the French or German screening tools together with Beers criteria may be advisable.

However, no one screening tool can substitute for the prescriber's thorough consideration of each individual elderly patient. Appropriate prescribing in the elderly also includes all measures aimed at improving the patient's adherence to the therapy, including good communication between the prescriber and the patient, but also among all physicians involved in providing healthcare to that patient [3–5, 18, 79]. Reducing the use of PIMs is just one of the strategies that can be adopted for better and safer prescribing in the elderly, but all useful strategies should be implemented together.

The new protocol reported here, which combines the French, Beers, McLeod, and Lindblad criteria, represents a well-balanced and comprehensive tool that may be widely applied in the analysis of drug prescribing in the elderly (defined as 65 years or older). It could be argued that the present protocol contains drugs that have not been found to be potentially inappropriate by some other experts (i.e., amiodarone), but it follows both the Beers' criteria and the French panel. Although the McLeod criteria were developed back in 1997, the definition of inappropriate long-term NSAIDs use along with hypertension, chronic renal, or heart failure in these criteria is still relevant and should be part of screening tools for PIMs.

Table 5, which lists potentially clinically important drug–drug interactions, may seem complex and difficult to follow, but there are many potentially important drug–drug interactions and while reducing their number would make the tool easier to follow, it would result in very important adverse drug combinations being ignored.

In conclusion, the new protocol is able to detect potentially clinically important drug–drug interactions and PIMs in the elderly and suggests alternative therapeutic solutions. As PIMs and drug interactions are often overlapping, analyzing them within the same protocol will provide more

comprehensive quality assessment of drug prescribing in the elderly and facilitate the detection of adverse outcomes caused by either PIMs or drug interactions. Both outcomes may in turn result in better prescribing practices. We expect the new tool to be used internationally by prescribers and pharmacists in ambulatory and clinical settings as well as in nursing homes. Combining North American and European tools together makes the tool applicable worldwide in the elderly population.

The sensitivity of our tool in detecting PIMs and in assessing PIM- or drug interaction-related morbidity and hospital admissions should be tested against other criteria in the real life environment.

## References

1. United Nations Population Division. World Population Ageing: 1950–2050. Available at: <http://www.un.org/esa/population/publications/worldageing19502050/>. Accessed 1 Oct 2011
2. Gallagher P, Barry P, O'Mahony D (2007) Inappropriate prescribing in the elderly. *J Clin Pharm Ther* 32(2):113–121
3. Routledge PA, O'Mahony MS, Woodhouse KW (2004) Adverse drug reactions in elderly patients. *Br J Clin Pharmacol* 57(2):121–126
4. Hamilton HJ, Gallagher PF, O'Mahony D (2009) Inappropriate prescribing and adverse drug events in older people. *BMC Geriatr* 9:5
5. Laroche ML, Charnes JP, Bouthier F, Merle L (2009) Inappropriate medications in the elderly. *Clin Pharmacol Ther* 85(1):94–97
6. Beers MH, Ouslander JG, Rollinger I, Reuben DB, Brooks J, Beck JC (1991) Explicit criteria for determining inappropriate medication use in nursing home residents. *Arch Intern Med* 151:1825–1832
7. Beers MH (1997) Explicit criteria for determining potentially inappropriate medication use by the elderly: an update. *Arch Intern Med* 157(14):1531–1536
8. McLeod PJ, Huang AR, Tamblyn RM, Gayton DC (1997) Defining inappropriate practice in prescribing for elderly people: a national consensus panel. *Can Med Assoc J* 156(3):385–391
9. Naugler CT, Brymer C, Stolee P, Arcese ZA (2000) Development and validation of an improved prescribing in the elderly tool. *Can J Clin Pharmacol* 7:103–107
10. Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH (2003) Updating the Beers criteria. *Arch Intern Med* 163(22):2716–2724
11. Lindblad CI, Hanlon JT, Gross CR, Sloane RJ, Pieper CF, Hajjar ER et al (2006) Clinically important drug–disease interactions and their prevalence in older adults. Consensus statement. *Clin Ther* 28(8):1133–1143
12. Laroche ML, Charnes JP, Merie L (2007) Potentially inappropriate medications in the elderly. A French consensus panel list. *Eur J Clin Pharmacol* 63(8):725–731
13. Barry PJ, Gallagher P, Ryan C, O'Mahony D (2007) START (screening tool to alert doctors to the right treatment)—an evidence-based screening tool to detect prescribing omissions in elderly patients. *Age Ageing* 36(6):632–638
14. Gallagher P, Ryan C, Byrne S, Kennedy J, O'Mahony D (2008) STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment). Consensus validation. *Int J Clin Pharm Ther* 46(2):72–83

15. Rognstad S, Brekke M, Fetveit A, Spigset O, Wyller TB, Straand J (2009) The Norwegian General Practice (NORGE) criteria for assessing potentially inappropriate prescriptions to elderly patients. A modified Delphi study. *Scand J Prim Health Care* 27(3):153–159
16. Holt S, Schmiedl S, Thürmann PA (2010) Potentially inappropriate medications in the elderly: the PRISCUS list. *Dtsch Arzteblatt Int* 107(31–32):543–551
17. Hanlon JT, Schmadler KE, Samsa GP, Weinberger M, Uttech KM, Lewis IK et al (1992) A method for assessing drug therapy appropriateness. *J Clin Epidemiol* 45(10):1045–1051
18. Page RL 2nd, Linnebur SA, Bryant LL, Ruscin JM (2010) Inappropriate prescribing in the hospitalized elderly patient: defining the problem, evaluation tools, and possible solutions. *Clin Interv Aging* 5:75–87
19. Levy HB, Marcus EL, Christen C (2010) Beyond the beers criteria: a comparative overview of explicit criteria. *Ann Pharmacother* 44(12):1968–1975
20. Gallagher P, O'Mahony D (2008) STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria. *Age Ageing* 37(6):673–679
21. Pitkala KH, Strandberg TE, Tilvis RS (2002) Inappropriate drug prescribing in home-dwelling, elderly patients: a population-based survey. *Arch Intern Med* 162(15):1707–1712
22. Onder G, Landi F, Cesari M, Gambassi G, Carbonin P, Bernabei R, Investigators of the GIFA Study (2003) Inappropriate medication use among hospitalized older adults in Italy: results from the Italian Group of Pharmacoepidemiology in the Elderly. *Eur J Clin Pharmacol* 59(2):157–162
23. van der Hooft CS, Jong GW, Dieleman JP, Verhamme KM, van der Cammen TJ, Stricker BH et al (2005) Inappropriate drug prescribing in older adults: the updated 2002 Beers criteria—a population-based cohort study. *Br J Clin Pharmacol* 60(2):137–144
24. Fialová D, Topinková E, Gambassi G, Finne-Soveri H, Jónsson PV, Carpenter I, AdHOC Project Research Group et al (2005) Potentially inappropriate medication use among elderly home care patients in Europe. *JAMA* 293(11):1348–1358
25. Bonk ME, Krown H, Matuszewski K, Oinonen M (2006) Potentially inappropriate medications in hospitalized senior patients. *Am J Health Syst Pharm* 63(12):1161–1165
26. Barry PJ, O'Keefe N, O'Connor KA, O'Mahony D (2006) Inappropriate prescribing in the elderly: a comparison of the Beers criteria and the improved prescribing in the elderly tool (IPET) in acutely ill elderly hospitalized patients. *J Clin Pharm Ther* 31(6):617–626
27. Fick DM, Waller JL, Maclean JR et al (2001) Potentially inappropriate medication use in a Medicare managed care population: association with higher costs and utilization. *J Manag Care Pharm* 7(5):407–413
28. Fu AZ, Liu GG, Christensen DB (2004) Inappropriate medication use and health outcomes in the elderly. *J Am Geriatr Soc* 52(11):1934–1939
29. Lau DT, Kasper JD, Potter DE, Lyles A, Bennett RG (2005) Hospitalization and death associated with potentially inappropriate medication prescriptions among elderly nursing home residents. *Arch Intern Med* 165(1):68–74
30. Fu AZ, Jiang JZ, Reeves JH, Fincham JE, Liu GG, Perri M 3rd (2007) Potentially inappropriate medication use and healthcare expenditures in the US community-dwelling elderly. *Med Care* 45(5):472–476
31. Jano E, Aparasu RR (2007) Healthcare outcomes associated with beers' criteria: a systematic review. *Ann Pharmacother* 41(3):438–447
32. Fick DM, Mion LC, Beers MH, Waller JL (2008) Health outcomes associated with potentially inappropriate medication use in older adults. *Res Nurs Health* 31(1):42–51
33. Bongue B, Laroche ML, Gutton S, Colvez A, Guéguen R, Moulin JJ et al (2011) Potentially inappropriate drug prescription in the elderly in France: a population-based study from the French National Insurance Healthcare system. *Eur J Clin Pharmacol* 67(12):1291–1299
34. Lindblad CI, Artz MB, Pieper CF, Sloane RJ, Hajjar ER, Ruby CM et al (2005) Potential drug-disease interactions in frail, hospitalized elderly veterans. *Ann Pharmacother* 39(3):412–417
35. Malone DC, Abarca J, Hansten PD, Grizzle AJ, Armstrong EP, Van Bergen RC et al (2004) Identification of serious drug-drug interactions: results of partnership to prevent drug-drug interactions. *J Am Pharm Assoc* 44(2):142–151
36. Hanlon JT, Schmadler ES (2005) Editorial. Drug-drug interactions in older adults—which ones matter? *Am J Geriatr Pharmacother* 3(2):61–63
37. Becker LC (1978) Conditions for vasodilator-induced coronary steal in experimental myocardial ischemia. *Circulation* 57(6):1103–1110
38. Vonkeman HE, van de Laar MA (2010) Nonsteroidal anti-inflammatory drugs: adverse effects and their prevention. *Semin Arthritis Rheum* 39(4):294–312
39. Trelle S, Reichenbach S, Wandel S, Hildebrand P, Tschannen B, Villiger PM et al (2010) Cardiovascular safety of non-steroidal anti-inflammatory drugs: network meta-analysis. *Br Med J* 342: c7086. doi:10.1136/bmj.c7086
40. Mintzer J, Burns A (2000) Anticholinergic side-effects of drugs in elderly people. *J R Soc Med* 93(9):457–462
41. Kostis JB, Rosen RC, Holzer BC, Randolph C, Taska LS, Miller MH (1990) CNS side effects of centrally-active antihypertensive agents: a prospective, placebo-controlled study of sleep, mood state, and cognitive and sexual function in hypertensive males. *Psychopharmacology (Berl)* 102(2):163–170
42. Prichard BN, Graham BR (2000) II imidazoline agonists. General clinical pharmacology of imidazoline receptors: implications for the treatment of the elderly. *Drugs Aging* 17(2):133–159
43. Einhorn PT, Davis BR, Massie BM, Cushman WC, Piller LB, Simpson LM, ALLHAT Collaborative Research Group et al (2007) The Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) Heart Failure Validation Study: diagnosis and prognosis. *Am Heart J* 153(1):42–53
44. Cipriani A, Barbui C, Brambilla P, Furukawa TA, Hotopf M, Geddes JR (2006) Are all antidepressants really the same? The case of fluoxetine: a systematic review. *J Clin Psychiatry* 67(6):850–864
45. Bardy GH, Lee KL, Mark DB et al (2005) Amiodarone or an implantable cardioverter-defibrillator for congestive heart failure. *N Engl J Med* 352:225–237
46. Coceani M, Mariotti R (2006) Is amiodarone safe in heart failure? *Br Med J* 332:317–318
47. Zimetbaum P (2007) Amiodarone for atrial fibrillation. *N Engl J Med* 356(9):935–941
48. Foley P, Kalra P, Andrews N (2008) Amiodarone—avoid the danger of torsade de pointes. *Resuscitation* 76(1):137–141
49. Wyse DG (2009) Pharmacotherapy for rhythm management in elderly patients with atrial fibrillation. *J Interv Card Electrophysiol* 25(1):25–29
50. European Medicines Agency (2007) European Medicines Agency recommends restricted use for piroxicam. Available at: [http://www.ema.europa.eu/docs/en\\_GB/document\\_library/Press\\_release/2009/11/WC500012655.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/Press_release/2009/11/WC500012655.pdf). Accessed 1 Oct 2011
51. Gulmez SE, Droz-Perroteau C, Lassalle R, Blin P, Bégaud B, Rossignol M et al (2011) Are traditional NSAIDs prescribed appropriately among French elderly with osteoarthritis? Results from the CADEUS cohort. *Eur J Clin Pharmacol* 67(8):833–838
52. Agency for Medicinal Products and Medical devices of Croatia. (2010) Annual report on drug consumption for 2009. Available at [http://www.almp.hr/?ln=hr&w=publikacije&d=promet\\_lijekova\\_2009](http://www.almp.hr/?ln=hr&w=publikacije&d=promet_lijekova_2009). Accessed 1 Oct 2011



53. Veitch PC, Clifton-Bligh RJ (2004) Long-acting sulfonylureas—long-acting hypoglycaemia. *Med J Aust* 180(2):84–85
54. Greco D, Angileri G (2004) Drug-induced severe hypoglycaemia in Type 2 diabetic patients aged 80 years or older. *Diabetes Nutr Metab* 17(1):23–26
55. Spagnoli A, Tognoni G (1983) ‘Cerebroactive’ drugs. Clinical pharmacology and therapeutic role in cerebrovascular disorders. *Drugs* 26(1):44–69
56. Frampton JE, Brogden RN (1995) Pentoxifylline (oxpentifylline). A review of its therapeutic efficacy in the management of peripheral vascular and cerebrovascular disorders. *Drugs Aging* 7(6):480–503
57. Hoyer S (1995) Possibilities and limits of therapy of cognition disorders in the elderly. *Z Gerontol Geriatr* 28(6):457–462
58. Teive HA, Troiano AR, Germiniani FM, Werneck LC (2004) Flunarizine and cinnarizine-induced parkinsonism: a historical and clinical analysis. *Parkinsonism Relat Disord* 10(4):243–245
59. No authors listed (2010) Haemorrhage due to Ginkgo biloba? *Prescrire Int* 17(93):19
60. Electronic Medicines Compendium. Available at: <http://www.medicines.org.uk/EMC/medicine/2571/SPC/Serc-8mg/> Accessed 1 Oct 2011
61. Andrus MR, Holloway KP (2004) Clark DB (2004) Use of beta-blockers in patients with COPD. *Ann Pharmacother* 38(1):142–145
62. Verdoux H, Lagnaoui R, Begaud B (2005) Is benzodiazepine use a risk factor for cognitive decline and dementia? A literature review of epidemiological studies. *Psychol Med* 35(3):307–315
63. Kotlyar M, Dysken M, Adson DE (2005) Update on drug-induced depression in the elderly. *Am J Geriatr Pharmacother* 3(4):288–300
64. Raivio MM, Laurila JV, Strandberg TE, Tilvis RS, Pitkälä KH (2007) Neither atypical nor conventional antipsychotics increase mortality or hospital admissions among elderly patients with dementia: a two-year prospective study. *Am J Geriatr Psychiatry* 15(5):416–424
65. Weiden PJ (2007) EPS profiles: the atypical antipsychotics are not all the same. *J Psychiatr Pract* 13(1):13–24
66. Kamble P, Chen H, Sherer J, Aparasu RR (2008) Antipsychotic drug use among elderly nursing home residents in the United States. *Am J Geriatr Pharmacother* 6(4):187–197
67. Maher AR, Maglione M, Bagley S, Suttrop M, Hu JH, Ewing B et al (2011) Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults: a systematic review and meta-analysis. *JAMA* 306(12):1359–1369
68. Larsson V, Engedal K, Aarsland D, Wattmo C, Minthon L, Londo E (2011) Quality of life and the effect of memantine in dementia with lewy bodies and Parkinson’s disease dementia. *Dement Geriatr Cogn Disord* 32(4):227–234
69. Wu CS, Ting TT, Wang SC, Chang IS, Lin KM (2011) Effect of benzodiazepine discontinuation on dementia risk. *Am J Geriatr Psychiatry* 19(2):151–159
70. Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ et al (2004) Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *Br Med J* 329(7456):15–19
71. Huic M, Macolic V, Vrhovac B, Francetic I, Bakran I, Giljanovic S (1994) Adverse drug reactions resulting in hospital admission. *Int J Clin Pharmacol Ther* 32(12):675–682
72. Franceschi M, Scarcelli C, Niro V, Seripa D, Paziienza AM, Pepe G et al (2008) Prevalence, clinical features and avoidability of adverse drug reactions as cause of admission to a geriatric unit: a prospective study of 1756 patients. *Drug Saf* 31(6):545–556
73. European Medicines Agency (2010) European Medicines Agency recommends suspension of marketing authorisations for sibutamine. Available at: [http://www.ema.europa.eu/docs/en\\_GB/document\\_library/Press\\_release/2010/01/WC500069995.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/Press_release/2010/01/WC500069995.pdf). Accessed 1 Oct 2011
74. Baxter K (ed) (2005) Stockley’s drug interactions, 7th edn. Pharmaceutical Press, London
75. Dvir Y, Smallwood P (2008) Serotonin syndrome: a complex but easily avoidable condition. *Gen Hosp Psychiatry* 30(3):284–287
76. Marot A, Morelle J, Chouinard VA, Jadoul M, Lambert M, Demoulin N (2011) Concomitant use of simvastatin and amiodarone resulting in severe rhabdomyolysis: a case report and review of the literature. *Acta Clin Belg* 66(2):134–136
77. Laine L, Hennekens C (2010) Proton pump inhibitor and clopidogrel interaction: fact or fiction? *Am J Gastroenterol* 105(1):34–41
78. Siller-Matula JM, Jilma B, Schrör K, Christ G, Huber K (2010) Effect of proton pump inhibitors on clinical outcome in patients treated with clopidogrel: a systematic review and meta-analysis. *J Thromb Haemost* 8(12):2624–2641
79. Spinewine A, Schmader KE, Barber N, Hughes C, Lapane KL, Swine C et al (2007) Appropriate prescribing in elderly people: how well can it be measured and optimised? *Lancet* 370(9582):173–184