

Deprescribing in the time of covid-19

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Since the beginning of December 2019, coronavirus disease caused by the severe acute respiratory syndrome coronavirus 2 has challenged populations across the world and resulted in social and economic turmoil. Health services have had to develop new ways of working in order to meet the needs of those with severe covid-19 and maintain ongoing care to all other patients. In the UK, regular media briefings from senior politicians and health professionals have reiterated national public health messages and provided a snapshot of the key issues of the day. While many of the headlines have focused on patient numbers and supplies of personal protective equipment, diagnostic tests and ventilators, rather less attention has been given to managing medicines during the pandemic.

Nevertheless, stories about the safety of some medicines in people with covid-19 have circulated in newspapers, medical journals and social media. Much of the concern has been on the role of ACE 2, with some people questioning whether medicines that increase expression of ACE2 may increase the risk of developing severe and fatal covid-19.¹ In response, the European Medicines Agency and other organisations have issued statements on the use of ACE inhibitors, angiotensin II receptor antagonists and other medicines (eg, NSAIDs) that can increase ACE2.^{2,3} Unsurprisingly, there is an absence of evidence on which to base advice on using such medicines in people in the community who have developed, or are at high risk of developing covid-19. This leaves the prescriber and patient with the difficult task of balancing the theoretical harm and known benefit of continuing with a medicine against the potential harm and unknown benefit of stopping or changing treatment. And what about medicines that are associated with a small increased risk of causing pneumonia and other adverse respiratory effects? Should prescribers be reviewing the use of proton pump inhibitors, opioids, benzodiazepines,

antipsychotic medicines in older people and medicines with anticholinergic activity?⁴⁻⁷

In ordinary times, deprescribing should be considered when the potential for harm outweighs the benefit of the medicine.⁸ However, we do not know which medicines are particularly problematic for people in the community who are at high risk of, or who have developed symptoms suggestive of covid-19. In addition, trying to make wholesale changes to patients' medication during the peak of a pandemic is fraught with difficulty. In the midst of the current crisis, the health service will struggle to handle the complex task of deprescribing and adjusting patients' medicines. Such changes require joint decision making with the patient and/or carer that may take time to discuss. Stopping medicines requires careful assessment, follow-up and safety netting. Patients need clear advice about how to discontinue their medicine, if and when to restart it and what to do if they have a problem. At the moment, primary care practices and community pharmacies have insufficient capacity to support large numbers of patients with complicated changes to their medicine regimens. In addition, widespread changes may prove challenging to the pharmaceutical supply chain. Also, we should not overlook the risks associated with inappropriate or unsupervised discontinuation of medicines and make sure that our messaging about medicine safety during the pandemic is not likely to lead to unintended consequences. Unless there is clear evidence to support an urgent change to patients' medicines, deprescribing should wait until the pandemic is over.

Competing interests None declared. Refer to the online supplementary files to view the ICMJE form(s).

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