

3.2 Medication and falls risk in the Older Person

This classification has been based upon a review of the clinical evidence of medicines most commonly implicated in falls.²² The list is not meant to be fully comprehensive but intended to raise awareness. Advice is provided on how medicines should be stopped (deprescribed).

Highest risk	Guidance
Antidepressants	Avoid tricyclics with high anti-muscarinic activity, e.g. amitriptyline. SSRIs are associated with a reduced incidence of side effects. Trial of gradual antidepressant withdrawal should be attempted after 6 –12 months
Antipsychotics including atypicals	Risk of hypotension is dose related reduced by the ‘start low go slow approach.’ Atypical antipsychotics have similar falls risk to traditional ones. Attempted withdrawal MUST always be gradual. Prochlorperazine is often inappropriately prescribed for dizziness and causes drug induced Parkinson’s disease
Anti-muscarinic drugs	Oxybutynin may cause acute confusional states in the elderly especially those with pre-existing cognitive impairment
Benzodiazepines & Hypnotics	Dose reduction is beneficial if withdrawal is not possible . Avoid long acting benzodiazepines. Newer hypnotics are associated with reduced hangover effects but all licensed for short-term use only
Dopaminergics in Parkinson’s disease	Sudden excessive daytime sleepiness can occur with levodopa and other dopamine receptor agonists. Dose titration is important in initiation due risk of inducing confusion. Maintenance doses may need to be reduced with aging
Moderate risk	
Anti-arrhythmics	Dizziness and drowsiness are possible signs of digoxin toxicity. Risks of toxicity are greater in renal impairment or in the presence of hypokalaemia. Flecainide has a high risk for drug interactions and can also cause dizziness
Anti-epileptics	High risk for potential drug interactions. Important side effects include: Dizziness, drowsiness and blurred vision (dose related)
Opiate analgesics	Drowsiness is common with initiation, but tolerance to this is usually seen within 2 weeks of continuous treatment. Drowsiness is rare with codeine unless used in combination with other CNS drugs. Confusion reported with tramadol
Antihistamines	Somnolence may affect up-to 40% of patients with older antihistamines. The newer antihistamines cause less sedation and psychomotor impairment. Risk of hypotension with cinnarizine is a dose related side effect
Alpha-blockers	Doses used for treatment of BPH less likely to cause hypotension than those required to treat hypertension
ACEI/ARB	Risk of hypotension is potentiated by concomitant diuretic use. Incidence of dizziness affects twice as many patients with heart failure than hypertension
Diuretics	Postural hypotension, dizziness and nocturia are problems seen in the elderly. Diuretics should not be used in the long-term treatment of gravitational oedema
Beta-blockers	Postural hypotension and can affect up to 10% of patients. Can accumulate in renal impairment and therefore dose reduction is often necessary
Lower risk	
CCBs	Incidence of dizziness low especially for once daily dihydropyridine CCBs
Nitrates	Advise patient to sit when using GTN spray or tablets
Oral anti-diabetic drugs	Dizziness due to hypoglycaemia, but usually avoidable. Avoid long acting sulfonylureas e.g. chlorpropamide.

PPIs & H2
Antagonists

Avoid cimetidine in polypharmacy patients as high risk of drug interactions,
and causes confusion.
