

IMPACT OF DEPRESCRIBING ON HOSPITALIZED OLDER ADULTS

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Introduction. The high prevalence of polypharmacotherapy in the elderly is a major public health concern, associated with increased risks of adverse drug reactions, hospitalizations, and mortality. Potentially inappropriate medications (PIMs) are frequent and often preventable through structured medication review and deprescribing. The inclusion of a clinical pharmacist in a multidisciplinary team may enhance prescribing appropriateness and patient safety.

Objectives. To assess the effectiveness of a structured educational intervention on deprescribing in reducing PIMs at discharge in patients aged ≥ 75 years on polypharmacotherapy. Secondary objectives included evaluating polypharmacy prevalence, inappropriate prescriptions, and the role of the hospital pharmacist.

Materials and Methods. This prospective multicenter observational study was conducted in Geriatrics, Neurology, and Orthopedics units of Alto Vicentino Hospital. Patients aged

≥ 75 years taking ≥ 5 medications were enrolled. The intervention included a training phase and a monitoring phase. During training, 36 patients underwent multidisciplinary medication review using STOPP/START and Beers criteria, with a 30-day telephone follow-up.

Results. The intervention significantly reduced the mean number of medications (up to -1.86), across sexes and age groups, with greater effects in patients >85 years. PIMs decreased significantly ($p < 0.001$). Polypharmacy prevalence declined ($p = 0.025$), with 5 patients no longer classified as polypharmacy at discharge. Moreover, 27 patients with ≥ 1 PIM at admission had none at discharge ($p < 0.001$). No significant association between polypharmacy and PIMs was found.

Conclusions. A structured educational intervention involving pharmacists and clinicians effectively reduces medication burden and PIMs in elderly patients, supporting a multidisciplinary approach with sustained post-discharge benefits.