

Geriatric Psychopharmacology

Jennifer R. Gatchel MD PhD

Assistant Psychiatrist, Geriatric Psychiatrist, Massachusetts
General Hospital/McLean Hospital

Assistant Professor of Psychiatry, Harvard Medical School

MGH Psychiatry Academy

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Considering Aging...

- Biological, natural, non-pathological process that affects all living things, characterized by:
 -
 - Decreased reproductive capability, physiological capacity and reserves, ability to maintain homeostasis
 - Effects on general health, mood, cognition, perception, and pharmacological response to medications

Examples of Age-Related Changes

- Neurological: Decrease in cortical gray matter, neuronal volume, complexity of neuronal connections, neurotransmitter synthesis
- Sleep: sleep fragmentation; phase advanced (sleeping and waking times are earlier than usual); Decreased stage 4 (NREM) sleep

Examples of Age-Related Changes:

Cognitive aging

- Begins ~ age of 50, but timing and rate of decline can vary
- Aging “neuropathology” may accumulate starting in early to mid-life
- Attention, processing speed, working memory affected; slowed learning, decreased ability for abstraction, fluid intelligence
- Vocabulary, language ability, reading comprehensive, fund of knowledge remain intact (crystallized intelligence)
- May occur on a spectrum of subjective cognitive decline, mild cognitive impairment (mild neurocognitive disorder) and dementia (major neurocognitive disorder)

Examples of Age-Related Changes

- Vision
- Auditory
- Cardiovascular
- Pulmonary
- GI/ GU
- Musculoskeletal
- Endocrine
- Sexual Function Changes

Examples of Age-Related Endocrine Changes

- Increase in basal ADH levels
 - Hyponatremia
- Decrease aldosterone
 - Dehydration, hyperkalemia
- Decrease in Vitamin D levels
 - Less efficient calcium absorption
- Increase in parathyroid hormone
 - Bone density loss
- Increase in norepinephrine
- Decrease thyroid efficiency

How might these changes impact clinical care of older adults?

- Impact on an individual's mood + perceptions
- Symptoms may go unnoticed and/or under-reported
 - Differences among racial/ethnic groups and between males/females/transgendered
- Physiological changes and multiple comorbidities can impact medication sensitivity (pharmacokinetics)
- Cognitive and psychosocial changes may present challenges to treatment adherence

How might these changes impact clinical care of older adults?...

- Sensory deficits
- Social isolation
- Cognitive decline
- Medical comorbidities
- Polypharmacy, drug-drug interactions
- Decreased hepatic inactivation and renal elimination, increased anticholinergic vulnerability
- Age-related changes in pharmacokinetics and pharmacodynamics
- Comorbid psychiatric illnesses such as dementia and delirium
- Age-related changes in cerebral structures
- Neurochemical and neuroanatomical changes associated with aging

Changes in drug distribution and metabolism

- Decreased albumin
 - Primary plasma protein that binds drugs
 - Increased proportion of free (active) drug
- Decreased body water/muscle mass
 - Smaller volume of distribution (V_d) of hydrophilic drugs
 - Higher serum levels
 - E.g.: lithium
- Increased fatty tissue
 - Increased V_d of lipophilic drugs
 - Longer half-life and elimination time/erratic release
 - E.g. most benzodiazepines, antidepressants

Key points:

- For pharmacological management: Start low and go slow...but go!
- “Comorbidity” is the rule; consider comorbid medical, neurological, psychiatric, and substance use disorders; optimize management of comorbidities and limit polypharmacy
- Collateral information and coordination with other medical treaters is critical
- For any new psychiatric conditions/change in symptoms: assume a physical cause unless proven otherwise
- Always consider 3D’s (dementia, delirium, depression) in the differential diagnosis and treatment plan
- Consider first-line or synergistic non-pharmacological approaches
- Address locus of care and need for adaptations to treatment (i.e. for cognitive changes)
- Screen for and address and care partner burden, social determinants of health

6 “Ds” of psychiatric diagnoses in older adults

- Depression
- Delirium
- Drugs (medications, substances, nutrition)
- Disease
- Dementia
- Delusional disorder; schizophrenia

Depression in Later life

- Depression is not a normal part of aging
- Age influences presentation, risk, etiology, assessment, treatment, prognosis; maintenance treatment, outcomes
- Remember to look for LLD and to treat actively
- Depressive symptoms in later life are significant; advances in psychotherapies and somatic therapies can enhance effectiveness

Prevalence in late life:

- Clinically significant depressive symptoms: 8-15% in the community; 30-50% in long-term care facilities
- Major Depressive Disorder (MDD): 1-3% in the community; 6-25% in long-term care facilities

Unique considerations:

- Varied Etiologies
 - Recurrent early onset mood disorder
 - Medical symptoms or medication burden
 - Psychosocial and psychological factors
 - Cerebrovascular depression
 - Inflammation hypothesis
 - Neurodegenerative etiology: mild behavioral impairment
 - Combination of the above
- Locus of care
- Presentations
 - Sub-threshold; “depression without sadness;” somatic focus, cognitive symptoms, psychotic features

Depression in Dementia and Neurodegenerative disease

- Preclinical and prodromal stages of dementia syndromes; ‘mild behavioral impairment’ (MBI)
- Increased risk for all-cause dementia
- Association with neurodegenerative pathology (Gatchel et al. 2017; Munro..Gatchel 2024)
- Common in Alzheimer’s Disease, Parkinson’s Disease, DLB, FTD
- In more advanced stages of dementia, may present as/with delusions, aggression, self harm, vocalizations, apathy, weight loss
- Poor response to conventional treatments

Adverse outcomes of untreated late life depression:

- Increased utilization of non-mental health services; increased health care costs
- Reduced medical treatment adherence
- Functional decline and disability
- Increased morbidity and mortality
- Progressive cognitive impairment and dementia

Assessments:

- Center for Epidemiological Studies—Depression Scale (CES-D)
- SELFCARE-D
- Geriatric depression scale
- PHQ2, 9
- Cornell Scale for Depression in Dementia (CSDD)
- Neuropsychiatric inventory (NPI); mild behavioral impairment checklist (MBI-C)
- Young Mania Rating Scale YMRS
- CIRS-G (comorbid medical burden)
- MoCA, MMSE (Cognitive screening)

Assessment

- History: medical and neuropsychiatric history, medications; collateral report; substance use, family history, situational triggers
- Physical and Neurological exam; cognitive screening
- Clinical history; YMRS; PHQ-9/MADRS/GDS; MoCA; neuropsychological testing; Busch-Francis catatonia rating scale
- Laboratory evaluation:
 - CMP, Creatinine, GFR, CBC
 - TSH; free T3/T4 if TSH abnormal; liver function tests
 - Urinalysis and Urine drug screen
 - B12, folic acid
 - Serum blood levels of current medications
 - Infectious serologies if indicated
- Additional tests: MRI or CT (if new onset symptoms or change in baseline); consider further imaging or EEG based on differential diagnosis; electrocardiogram, Chest Xray, lumbar puncture

Treatment approach

- Identify and manage medical etiologies; optimize treatment of contributing medical factors
- Minimize polypharmacy and adverse side effects
- Address substance use and pain

Substance use in older adults

- The population of older adults misusing and abusing substances is growing; projected to continue to grow
- Unique risk factors: loss of partner, chronic illness, lack of day structure; aging is not a protective factor
- Older adults often under-diagnosed or mis-diagnosed due to decreased likelihood of providers screening them + decreased sensitivity of standard screening tools in this population

Treatment approach...

- Consider non-pharmacological approaches, alone or in combination with medications
 - Psychosocial, spirituality, psychotherapies: cognitive behavioral therapy, interpersonal therapy, problem solving therapy, ENGAGE, physical activity, tai chi
- Pharmacological approaches
 - Antidepressant efficacy: all FDA-indicated antidepressants treat depression in late life; favorable response rate and remission
- Somatic therapies/Neuromodulation
 - ECT, TMS

SSRIs are first line choice in late life depression

- Limited drug-drug interactions, generally well tolerated
- sertraline: top choice in terms of overall safety and efficacy
- citalopram: FDA dosage warning: do not use with QTc above 500 or dose >20 mg/day; less QTc prolongation with escitalopram?
- paroxetine: efficacious but problematic given anticholinergic properties

Side effects of SRIs

- Sedation
- Weight gain
- GI symptoms; risk for GI bleeding
- Hyponatremia
- Risk for bruising
- Sexual dysfunction
- Discontinuation less common with SSRI than TCA
- Risk of QTc prolongation with citalopram, escitalopram (less) amitriptyline; less in older adults with vilazodone, vortioxetine

Other treatments to consider:

- SNRIs:
 - Potential adverse effects: hypertension, anxiety, insomnia, potential for discontinuation symptoms
 - Duloxetine—analgesic effects
- bupropion: reduced sedation and sexual side effects relative; may be problematic if anxiety/psychosis
- Mirtazapine
 - weight gain, sedation, anxiolytic properties; fewer sexual side effects
 - May exacerbate REM sleep behavior in Parkinson's Disease
 - Associated with small/significant risk of neutropenia, agranulocytosis
- TCAs, MAOIs
- Newer antidepressants: vilazodone, vortioxetine, levomilnacipran, spravato (eskatamine), auvelity (bupropion/dextromethorphan), gepirone

Other treatments to consider...

- Stimulants: limited data on efficacy for stimulant monotherapy; may have some benefit for apathy
- ketamine: limited data in older adults; recent encouraging IV ketamine open-label pilot in older adults (Oughli et al. JAGP 2022).
- Esketamine (intranasal)
- ECT: greater efficacy in older adults vs. younger; underused modality suitable for: medication intolerance, prior positive response to ECT, psychosis, catatonia, mania, ?dementia
- Transcranial magnetic stimulation (rTMS): safe and well tolerated in depression in older adults (Kaster et al. 2018); no/minimal cognitive side effects; more studies needed to optimize its use

Antipsychotic adjunctive treatment

- aripiprazole: approved for adjunctive treatment of MDD and mania monotherapy; prominent AE: akathisia, insomnia
- brexipiprazole: adjunctive treatment of MDD; prominent AE: weight gain
- cariprazine: monotherapy in bipolar depression; adjunctive treatment in MDD; prominent AE: akathisia, EPS, insomnia
- lurasidone : monotherapy + adjunctive treatment in bipolar depression; prominent AE: sedation, EPS
- lumateperone: monotherapy and adjunctive treatment of bipolar depression

OPTIMUM Trial in geriatric treatment resistant depression (TRD)

- N=619 older adults, TRD
- Augment with aripiprazole (2.5-15 mg/day) or bupropion 150-450 mg/day) vs. switch to bupropion
 - augmentation was more effective than switching (28% vs. 19% remission); safer-- fewer falls
- Augment with lithium vs. switch to nortriptyline—remission similar between groups

Lenze et al. NEJM 2023; 388 (12).

Anxiety Disorders in Older Adults

- 15% prevalence in community; 30% in medical setting, ~1/3 receive treatment
- Increased morbidity and mortality in context of cognitive disorders and medical disorders (cardiovascular disease)
- More common in women; high rates in African American women, but low in AA men
- Highest rates in non-Hispanic whites and Latinos
- Etiologies and Comorbidities: MDD, Cognitive Disorders, Parkinson's Disease, Post-stroke, medical conditions (COPD, cancer, heart disease, chronic pain)

Anxiety Disorders in Older Adults

- Response rate to treatment generally lower in older relative to younger adults
- Psychotherapy more likely to be preferred treatment (CBT, MBT, ACT, Relaxation therapy, ERP)
- Pharmacotherapy: SSRIs, SNRIs are first line options; other options: mirtazapine, buspirone, gabapentin, TCAs, MAOIs, antipsychotics
- What to do about benzodiazepines?
 - Increased risk of falls and cognitive impairment; risk for misuse; slow tapering to discontinue

Pharmacological Management: Treatment Guidelines of Older Age Bipolar Disorder

- Limitations of current evidence base:
 - No RCT level evidence for treatments for:
 - Geriatric Bipolar depression
 - Maintenance therapy in geriatric cohorts
 - One RCT: Geriatric mania (Young et al. 2017)
- General principles: Mood stabilizer in all phases of treatment; start with atypical rather than typical antipsychotic when antipsychotic is indicated
- No treatment algorithms distinguishing early onset vs. late onset BD
- Current guidelines are similar to those for younger populations
 - **attention to side effects, drug-drug interactions, somatic comorbidities and cognitive impairment**

Treatment Recommendations: Co-morbidity Management

- BD is multi-system disease that is chronic and progressive
 - Begin co-morbidity management as early in life as possible
 - Aim for no mood relapses
- Coordinate with other medical providers to manage/reduce risk.
(HgbA1c < 7, BP and lipid control)
- Evaluate concomitant medications (i.e. drugs that alter sodium excretion with lithium)
- Incorporate non-pharmacological approaches that promote self-management

FDA Approved Agents for Bipolar Disorder

Acute Mania		Acute Depression		Maintenance	
Year	Drug	Year	Drug	Year	Drug
1970	Lithium	2003	Olanzapine + fluoxetine combination	1974	Lithium
1973	Chlorpromazine	2006	Quetiapine, XR (2008)	2003	Lamotrigine
1994	Divalproex, ER (2005)	2013	Lurasidone	2004	Olanzapine
2000	Olanzapine*	2019	Cariprazine (Vraylar)	2005	Aripiprazole
2003	Risperidone*	2021	Lumateperone (Caplyta)	2008	Quetiapine, XR (adjunct)
2004	Quetiapine, XR (2008)*			2009	Risperidone LAI*
2004	Ziprasidone			2009	Ziprasidone (adjunct)
2004	Aripiprazole*			2021	Olanzapine/samidorphan
2004	Carbamazepine ERC				
2009	Asenapine				
2015	Cariprazine				

*Adjunctive and monotherapy; LAI = Long-acting injectable Ketter TA (ed). Handbook of Diagnosis and Treatment of Bipolar Disorder, Am Psych Pub, Inc., Washington, DC, 2010, Rockville (MD): [Agency for Healthcare Research and Quality \(US\)](#); 2018 Aug. Report No.: 18-EHC012-EF

Lithium in older age bipolar disorder

- First-line treatment for maintenance monotherapy
- Reduces suicide risk; neuroprotective properties
 - Some preliminary evidence: ? may reduce risk of dementia, and possibly of cancer
- Best studied medication for OABD
 - Roles with acute mania, long term maintenance of mood, prophylaxis
 - 78% response rate in bipolar mania; RCT supports efficacy in mania/mixed states
- Narrow therapeutic window
- Reduce standard adult dose by 33-50%
- Usual dose does not exceed 900 mg per day, begin with low dose, 300 mg/day
 - Baseline screening: renal function, electrolytes, thyroid function, fasting blood glucose, EKG
 - Evaluate concomitant medications, (e.g. diuretics, NSAIDs, ACE inhibitors)

Lithium in OABD...

Target serum concentrations:

Low: 0.4-0.7 mEq/L

High: 0.8 mEq/L or higher

*Need for therapeutic drug monitoring

- Discordance between serum and cerebral Li levels¹
 - Elevated cerebral Li associated with toxicity
 - **TREAT THE PATIENT NOT THE LEVEL**
- Discontinuation
 - 50% recurrence within 6 months
 - Gradual taper may reduce relapse rate
 - Consider discontinuation with renal insufficiency, early signs of neurotoxicity (changes in alertness,

Adverse Effects of Lithium

- Weight gain, GI disturbance
- Cognitive slowing, sedation
- Ataxia, tremor
- Neurotoxic effects with minor overdose
- Polyuria, polydipsia, diabetes insipidus
- Urinary frequency, renal failure
- Peripheral edema
- Thyroid toxicity: hypothyroidism; goiter
- Cardiac toxicity: decrease in conduction => sick sinus syndrome
- Renal: chronic renal insufficiency, ARF, polyuria, polydipsia, diabetes insipidus
- Lithium toxicity: serum level 1.2: tremor, nausea, diarrhea, ataxia;
- 1.5-2.0: seizures; >2.0 acute renal failure (requires dialysis); >2.5: coma, death

GERI-BD: a Randomized Double-Blind Controlled Trial of Lithium and Divalproex in the Treatment of Mania in Older Patients with Bipolar Disorder

- **First age-specific randomized controlled trial for late life mania**
 - 9 weeks, lithium or divalproex (no placebo group); tolerability and efficacy
- Subjects: 224 older adults (age 60 and above) with bipolar I disorder, presenting with manic, hypomanic or mixed episodes
- Starting doses: lithium: 300 mg/day (target serum concentration: 0.80-0.99 mEq/L); divalproex: 500 mg/day (target serum concentration: 80-99 micrograms/mL).
- Results: lithium and divalproex both adequately tolerated and similarly efficacious; greater reduction in manic symptoms over 9 weeks in lithium treated group
- less than 20% of all participants required adjunctive antipsychotic medication
- Authors' opinion: "treatment of older adults with bipolar I mania.. lithium and divalproex should be given consideration, perhaps emphasized, relative to antipsychotics." (but no head-to-head comparison to antipsychotics in this study).

Antipsychotic Dosages for BD Older adults

Drug	Starting dose (mg/day)	Healthy older adults (mg/day)	Frail older adults (mg/day)
clozapine[†]	6.25-25	50-400	6.25-50
risperidone	0.25-0.5	1-3	0.25-1
olanzapine[†]	2.5-5	5-20	2.5-5
quetiapine	12.5-25	100-750	25-100
ziprasidone	20-40	40-160	20-80
aripiprazole	2.5-5	10-30	5-15
asenapine	2.5-5	10-15	5-10
lurasidone	20-40	60-100	20-60

[†] Higher dose especially in chronic smokers.
mghcme.org

Use of Atypical Antipsychotics

- Somnolence, orthostatic hypotension, gait disturbance; extrapyramidal symptoms, tardive dyskinesia; ECG abnormalities (ziprasidone)
- Benzodiazepines, antipsychotics: associated with cognitive impairment
- ADA warning for risk of diabetes with all atypical antipsychotics
- In BD: associated with respiratory disease, cardiovascular disease, thyroid, musculoskeletal and renal disease
- FDA warning of increased mortality (1.6-1.7x higher) in elderly patients with dementia;
 - Causes of death varied—(heart failure, sudden death, or infections)
- Warning for elevated risk of cerebrovascular adverse events in dementia
- **Implications for older adults (non-demented) with serious mental illness are unclear**
- ^A • **GAGE-BD analysis: OABD on antipsychotics had more severe illness, more frequent hospitalizations, more often unemployed than non-users (Chen P et al. Psychopharmacol Bull 2022; 52:8 – 33).**

Treatment Recommendations

- Geriatric Bipolar **Mania or Mixed States**
 - 1st line: Monotherapy - divalproex or lithium
 - Partial responders - add atypical antipsychotic medication - olanzapine, risperidone, quetiapine (possibly aripiprazole or asenapine)
 - For “Treatment Resistant” – Consider Clozapine or ECT
 - No evidence-based guidance on duration of treatment, time to wait before augmentation, or use of other mood stabilizing anticonvulsants
- Geriatric **Bipolar Depression**
 - Monotherapy with mood stabilizer or antipsychotic
 - Consider quetiapine (monotherapy or adjunctive), aripiprazole (adjunctive) and lurasidone (monotherapy or adjunctive), combination of olanzapine with fluoxetine
 - Partial responder: cautious addition of antidepressant (SSRI, bupropion)
 - ECT: suicidal patient or patient with inadequate food/fluid intake
 - TMS/VNS
- **Maintenance**
 - 1st line: lithium; second line: lamotrigine, olanzapine, valproate, quetiapine

Key points

- Geriatric BD is common in clinical populations.
- Differential diagnosis: mood episode, psychotic disorder, catatonia, personality disorder vs. delirium vs. dementia (consider superimposed delirium or dementia)
- Medical co-morbidity and cognitive dysfunction are the rule.
 - Cognitive and functional screening and monitoring; early co-morbidity management
- FDA-indicated medications studied in adult aged populations without significant co-morbidities
- Mood stabilizers are mainstay of treatment; therapies with evidence in older adult populations: lithium, valproic acid, quetiapine, lamotrigine, lurasidone
- Monitor closely for drug-drug interactions and adverse effects
- Treat the patient, not the serum level
- Coordinate care with medical providers to minimize risk of adverse events
- Psychotherapy and psychosocial interventions modified for challenges to adherence and cognitive change are valuable components of treatment.

Key points..

- For pharmacological management: Start low and go slow...but go!
- “Comorbidity” is the rule; consider comorbid medical, neurological, psychiatric, and substance use disorders; optimize management of comorbidities and limit polypharmacy
- Collateral information and coordination with other medical treaters is critical
- For any new psychiatric conditions/change in symptoms: assume a physical cause unless proven otherwise
- Always consider 3D’s (dementia, delirium, depression) in the differential diagnosis and treatment plan
- Consider first-line or synergistic non-pharmacological approaches
- Address locus of care and need for adaptations to treatment (i.e. for cognitive changes)
- Screen for and address and care partner burden, social determinants of health

Inappropriate CNS-active prescribing remains common

2013–2021 TREND

Only a modest decline

Rates remained highest among older adults with dementia.

3 : 1

without a documented indication
vs with an indication

CLINICAL IMPLICATION

Documentation is part of safer prescribing.

- **Name the target symptom**

Link each CNS-active medication to a documented indication.

- **Plan reassessment**

Set a response window, adverse-effect check, and stop or taper plan.

The 2023 Beers Criteria remain the prescribing anchor

A reference standard for potentially inappropriate medications in older adults

GENERALLY AVOID

- **Benzodiazepines**
Heightened risk of cognitive impairment, delirium, falls, and fractures.
- **First-generation antihistamines**
High anticholinergic burden.
- **TCAs and barbiturates**
Anticholinergic, orthostatic, sedative, or dependence-related harms.

USE WITH CAUTION

- **SSRIs and SNRIs**
Reassess risk in patients with a history of falls or fractures.
- **Apply context**
The criteria support—not replace—clinical judgment and shared decisions.

European counterpart: STOPP/START

The 2025 companion shifts the question to “what instead?”

EARLIER FRAMING

What should I avoid?

Medication-centered
Risk identification
Deprescribing trigger



2025 COMPANION

What can I do instead?

- **Anxiety**
Condition-specific pharmacologic and nonpharmacologic alternatives.
- **Insomnia**
Safer pathways before sedative escalation.
- **Delirium**
Address causes and environmental drivers first.

Deprescribing turns medication count into a clinical question

≈3%

**higher mortality risk
associated with each
additional medication**

*Adults age 85+; observational association,
not proof of causation*

A PRACTICAL PRESCRIBING DISCIPLINE

- **Start with nonpharmacologic care**
Treat pain, sleep, environment, communication, and caregiver stressors.
- **Use the lowest effective dose**
Define the target behavior and the expected benefit.
- **Set the shortest reasonable duration**
Reassess response and harms; taper when benefit is absent or the crisis resolves.

Two FDA-approved options now target Alzheimer’s agitation

APPROVED FOR AGITATION

Brexpiprazole

Rexulti

First FDA-approved drug for agitation associated with dementia due to Alzheimer’s disease (2023)

Antipsychotic class boxed warning: increased mortality in elderly patients with dementia-related psychosis

Dextromethorphan–bupropion

Auvelity

Expanded indication for agitation associated with Alzheimer’s dementia (April 2026); first approved non-antipsychotic option

Distinct safety profile; review seizure risk, blood pressure, interactions, and antidepressant boxed warning

NOT AN ALZHEIMER’S-PSYCHOSIS APPROVAL

Pimavanserin (Nuplazid)

FDA-approved for hallucinations and delusions associated with Parkinson disease psychosis—not Alzheimer’s psychosis.

Match the drug to the symptom—and the evidence

Behavioral and psychological symptoms of dementia (BPSD)

AGITATION: STRONGEST SIGNALS

0.48 **Non-opioid analgesics**

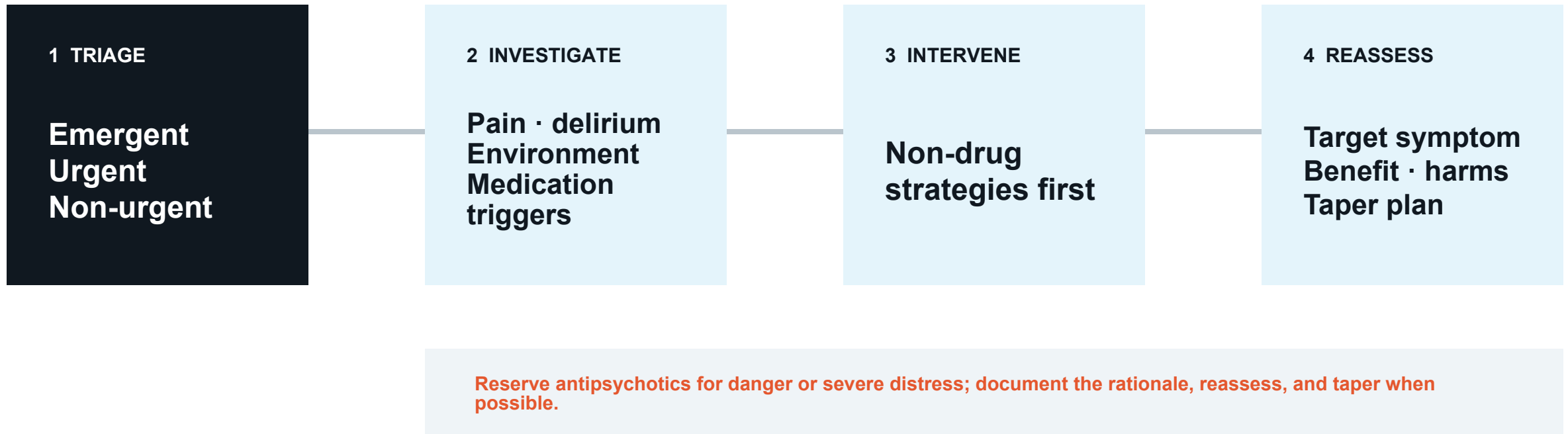
0.30 **Citalopram**

Effect sizes from the cited evidence synthesis

SIGNALS TO AVOID OVERREADING

- **Mirtazapine**
Ineffective for agitation in available evidence.
- **Quetiapine**
Commonly prescribed despite comparatively weak support.
- **Sleep symptoms**
Trazodone and orexin-receptor antagonists have the best evidence signals.

Urgency determines the next step—not the diagnosis alone



Benzodiazepines: high costs, weak late-life anxiety evidence

≈2×

fall and fracture risk

Plus delirium, cognitive impairment, and motor-vehicle crash risk

Observational evidence; risk varies by patient, agent, dose, and duration.

LATE-LIFE ANXIETY EVIDENCE

- **Benzodiazepines**
Evidence supporting routine use is scarce; harms often dominate.
- **Quetiapine**
Low-certainty evidence and important tolerability concerns.
- **Pregabalin**
Very-low-certainty evidence; monitor sedation, dizziness, and falls.

Safer prescribing is a cycle, not a one-time choice

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|-----------|-------------------------|---|
| 01 | Anchor decisions | Use the 2023 Beers Criteria plus the 2025 alternatives companion. |
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| 02 | Choose by target symptom | For Alzheimer's agitation, weigh newer FDA-approved options against patient-specific risk. |
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| 03 | Deprescribe deliberately | Prioritize nonpharmacologic care, the lowest effective dose, and the shortest duration. |
|-----------|---------------------------------|---|
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| 04 | Document and reassess | Name the indication, measure benefit and harms, and preserve a taper plan. |
|-----------|------------------------------|--|
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The goal: symptom relief with the least medication burden and the clearest follow-up plan.