Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Results of a US Consensus Panel of Experts

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Background: Medication toxic effects and drug-related problems can have profound medical and safety consequences for older adults and economically affect the health care system. The purpose of this initiative was to revise and update the Beers criteria for potentially inappropriate medication use in adults 65 years and older in the United States.

Methods: This study used a modified Delphi method, a set of procedures and methods for formulating a group judgment for a subject matter in which precise information is lacking. The criteria reviewed covered 2 types of statements: (1) medications or medication classes that should generally be avoided in persons 65 years or older because they are either ineffective or they pose unnecessarily high risk for older persons and a safer alternative is available and (2) medications that should not be used in older persons known to have specific medical conditions.

Results: This study identified 48 individual medications or classes of medications to avoid in older adults and their potential concerns and 20 diseases/conditions and medications to be avoided in older adults with these conditions. Of these potentially inappropriate drugs, 66 were considered by the panel to have adverse outcomes of high severity.

Conclusions: This study is an important update of previously established criteria that have been widely used and cited. The application of the Beers criteria and other tools for identifying potentially inappropriate medication use will continue to enable providers to plan interventions for decreasing both drug-related costs and overall costs and thus minimize drug-related problems.

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Toxic Effects of medications and drug-related problems can have profound medical and safety consequences for older adults and economically affect the health care system. Thirty percent of hospital admissions in elderly patients may be linked to drug-related problems or drug toxic effects. Adverse drug events (ADEs) have been linked to preventable problems in elderly patients such as depression, constipation, falls, immobility, confusion, and hip fractures. A 1997 study of ADEs found that 35% of ambulatory older adults experienced an ADE and 29% required health care services (physician, emergency department, or hospitalization) for the ADE. Some two thirds of nursing facility residents have ADEs over a 4-year period. Of these ADEs, 1 in 7 result in hospitalization.

Recent estimates of the overall human and economic consequences of medication-related problems vastly exceed the findings of the Institute of Medicine (IOM) on deaths from medical errors, estimated to cost the nation $8 billion annually. In 2000, it is estimated that medication-related problems caused 106,000 deaths annually at a cost of $85 billion. Others have calculated the cost of medication-related problems to be $76.6 billion to ambulatory care, $20 billion to hospitals, and $4 billion to nursing home facilities. If medication-related problems were ranked as a disease by cause of death, it would be the fifth leading cause of death in the United States. The prevention and recognition of drug-related problems in elderly patients and other vulnerable populations is one of the principal health care quality and safety issues for this decade.

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The aforementioned IOM report has focused increased attention on finding solutions for unsafe medication practices, polypharmacy, and drug-related problems in the care of older adults. There are many ways to define medication-related prob-
lems in elderly patients, including the use of lists containing specific drugs to avoid in the elderly and appropriateness indexes applied by pharmacists or clinicians. Systematic review of the evidence-based literature on medication use in elderly patients is another approach to defining the problem, but the number of controlled studies on medication use in elderly patients is limited.

The use of consensus criteria for safe medication use in elderly patients is one approach to developing reliable and explicit criteria when precise clinical information is lacking. The two most widely used consensus criteria for medication use in older adults are the Beers criteria and the Canadian criteria. The Beers criteria are based on expert consensus developed through an extensive literature review with a bibliography and questionnaire evaluated by nationally recognized experts in geriatric care, clinical pharmacology, and psychopharmacology using a modified Delphi technique to reach consensus. The Beers criteria have been used to survey clinical medication use, analyze computerized administrative data sets, and evaluate intervention studies to decrease medication problems in older adults. The Beers criteria were also adopted by the Centers for Medicare & Medicaid Services (CMS) in July 1999 for nursing home regulation. Previous studies have shown these criteria to be useful in decreasing problems in older adults. These criteria, though controversial at times, have been widely used over the past 10 years for studying prescribing patterns within populations, educating clinicians, and evaluating health outcomes, cost, and utilization data.

A recently published study of potentially inappropriate medication (PIM) use with the Beers criteria in a Medicare-managed care population found a PIM prevalence of 23% (541/2336). Those receiving a PIM had significantly higher total, provider, and facility costs and a higher mean number of inpatient, outpatient, and emergency department visits than comparisons after controlling for sex, Charlson Comorbidity Index, and total number of prescriptions. Other studies have found that specific PIMs such as nonsteroidal anti-inflammatory drugs (NSAIDs) and benzodiazepines have been associated with adverse outcomes and increased costs. In contrast, a recent study on the relationship between inappropriate drug use, functional status decline, and mortality in 3234 patients from the Duke cohort did not find an association with mortality and inappropriate drug use as determined by the Beers criteria after controlling for covariates.

In summary, these criteria have been used extensively for evaluating and intervening in medication use in older adults over the past decade. However, with the continuous arrival of new drugs on the market, increased knowledge about older drugs, and removal of older drugs from the market, these criteria must be updated on a regular basis to remain useful. Since the criteria were published in 1997, there has been an increase in the number of scientific studies addressing drug use and appropriateness in older adults, but there is still a lack of controlled studies in the older population and particularly in patients older than 75 years and patients with multiple comorbidities.

The purpose of this initiative was to revise and update the Beers criteria for ambulatory and nursing facility populations older than 65 years in the United States. There were 3 main aims: (1) to reevaluate the 1997 criteria to include new products and incorporate new information available from the scientific literature, (2) to assign or reevaluate a relative rating of severity for each of the medications, and (3) to identify any new conditions or considerations not addressed in the 1997 criteria.

There were 5 phases in the data collection for this study: (1) the review of the literature, (2) creation and mailing of the round 1 questionnaire, (3) creation of the second-round questionnaire based on round 1 and expert panel feedback, (4) convening of the expert panel and panel responses to the second-round questionnaire, and (5) completion and analysis of a third and final mailed questionnaire that measured the severity ratings of the PIMs to create the final revised list.

The criteria reviewed covered 2 types of statements: (1) medications or medication classes that should generally be avoided in persons 65 years or older because they are either ineffective or they pose unnecessarily high risk for older persons and a safer alternative is available and (2) medications that should not be used in older persons known to have specific medical conditions. The 2 statements each used a 5-point Likert scale and ask respondents to rate their agreement or disagreement with the statement from strongly agree (1) to strongly disagree (5), with the midpoint (3) expressing equivocation. The second type of question asked the respondents to evaluate the medication appropriateness given certain conditions or diagnoses (Figure). All questions included an option to not answer if the respondent did not feel qualified to answer. This methodology was similar to that used by Beers et al in the creation of the first 2 iterations of the criteria. The methodology used in the third iteration of the Beers criteria only differed in the number of panelists (13 in 1991; 6 in 1997; and 12 in 2002) and the use of a third-round survey for the severity ratings, which was done (in person) in the 1997 update of the criteria.

RESEARCH DESIGN

The modified Delphi method is a technique to arrive at a group consensus regarding an issue under investigation that was originally developed at the RAND Corporation (Santa Monica, Calif) by Olaf Helmer and Norman Dalkey. The Delphi method is a set of procedures and methods for formulating a group judgment for a subject matter in which precise information is lacking (such as medication use in older adults). The Delphi method provides a means to reach consensus within a group of experts. The method relies on soliciting individual (often anonymous) answers to written questions by survey or other type of
communication. A series of iterations provides each individual with feedback on the responses of the others in the group. The final responses are evaluated for variance and means to determine which questions the group has reached consensus about, either affirmatively or negatively.

LITERATURE REVIEW

The selection of articles for formulating the survey involved 3 steps and was phase 1 of the study. First, we identified literature published since January 1994 in English, describing or analyzing medication use in community-living (ambulatory) older adults and older adults living in nursing homes. From that, we created a table and bibliography. We used MEDLINE, searching with the following key terms adverse drug reactions, adverse drug events, medication problems, and medications and elderly for all relevant articles published between January 1994 and December 2000. Second, we hand searched and identified additional references from the bibliographies of relevant articles. Third, all the panelists were invited to add references and articles after the first survey to add to the literature review. Each study was systematically reviewed by 2 investigators using a table to outline the following information: type of study design; sample size; medications reviewed; summary of results and key points; quality, type and category of medication addressed; and severity of the drug-related problem.

EXPERT PANEL SELECTION

The panel of members were invited to participate via letter by the 4 investigators and a consultant and represented a variety of experience and judgment including extensive clinical practice, extensive publications in this area, and/or senior academic rank. They were also chosen to represent acute, long-term, and community practice settings with pharmacological, geriatric medicine, and psychiatric expertise. Lastly, they were selected from geographically diverse parts of the United States. We initially invited (via regular mail) 16 potential participants with nationally and/or internationally recognized expertise in psychopharmacology, pharmacoepidemiology, clinical geriatric pharmacology, and clinical geriatric medicine to complete our survey. Our response rate for the initial invitation to participate as a panelist was 75% (12/16). Our final panel thus consisted of 12 experts who completed all rounds of the survey.

DATA COLLECTION AND ANALYSIS

We used the systematic review of the literature to construct the first round questionnaire. The first-round survey contained 4 sections. Parts 1 and 2 reviewed the latest 1997 criteria. Parts 3 and 4 were medications added for the 2002 update for medications alone (part 3) and medications considering diagnoses and conditions. Parts 3 and 4 included 29 new questions about medications or medication classes and conditions. The last question in part 4 asked panel members to add medications to the list. The panel was then surveyed via Delphi technique to determine concordance/consensus with the round 1 survey and invited to add additional medications prior to and during the second-round meeting.

We created the second and third questionnaires (severity ratings) from panel input and the results of the previous round (severity ratings) from panel input and the results of the previous round. Statements whose 95% CI included the value of 3.0 were included for further determination in the second-round face-to-face meeting.

The face-to-face meeting was convened on December 10, 2001, in Atlanta, Ga. Each panel member was given the results of the first-round survey and the added medications (from the other panel members) to review approximately 10 days before the meeting. For statements that needed further examination (neither included or excluded during round 1), each rater was given his or her previous rating and the mean rating of the group of experts in the second survey.

Any additional statements or dosing questions that had been made on the open-ended portion of the first round of the survey by any expert was included in the survey for the second round. Forty-four questions were added by expert panelists during round 1 of the survey, and 9 questions were added during the round 2 in-person survey and voted on during the in-person meeting. These questions/medications made up part 3 of the survey. Twenty-four questions from parts 3 and 4 had 95% CIs greater than 3.0 after the round 1 survey. During the second-round face-to-face meeting, the group debated these remaining statements and then rerated them using the same Likert scale. The mean rating and 95% CI were calculated. The technique used for the first round for inclusion or exclusion of the statement or dosing question in the updated criteria was used. Those statements whose 95% CI included 3.0 were excluded from the updated criteria. Lastly, in January 2002, we surveyed panelists on a 5-point scale for the severity of the potential medication problem.

RESULTS

The final criteria are listed in Table 1 and Table 2. Table 1 contains 48 individual medications or classes of medications to avoid in older adults and their potential concerns. Table 2 lists 20 diseases or conditions and medications to be avoided in older adults with these conditions. Sixty-six of these potentially inappropriate drugs were considered by the panel to have adverse outcomes of high severity. New conditions and diagnoses that were addressed this time included depression, cognitive impairment, Parkinson disease, anorexia, and malnutrition, syndrome of inappropriate antidiuretic hormone secretion, and obesity.

A total of 15 medications/medication classes were dropped or modified from the 1997 to the 2002 update from the round 1 survey. Most of the medications dropped since 1997 were those that were associated with diagnoses or conditions. The following medications were voted to be dropped
### Table 1. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions

<table>
<thead>
<tr>
<th>Drug</th>
<th>Concern</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>May cause confusion and sedation. Should not be used as a hypnotic, and when used to treat emergency allergic reactions, it should be used in the smallest possible dose.</td>
<td>High</td>
</tr>
<tr>
<td>Ferrous sulfate &gt;325 mg/d</td>
<td>Have not been shown to be effective in the doses studied. Doses &gt;325 mg/d do not dramatically increase the amount absorbed but greatly increase the incidence of constipation.</td>
<td>Low</td>
</tr>
<tr>
<td>All barbiturates (except phenobarbital) except when used to control seizures</td>
<td>Are highly addictive and cause more adverse effects than most sedative or hypnotic drugs in elderly patients.</td>
<td>High</td>
</tr>
<tr>
<td>All nonprescription and many prescription antihistamines may have potent anticholinergic properties. Nonanticholinergic antihistamines are preferred in elderly patients when treating allergic reactions.</td>
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<td>High</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>May cause orthostatic hypotension.</td>
<td>Low</td>
</tr>
<tr>
<td>Chloropropamide (Diabecon)</td>
<td>May cause bradycardia and exacerbate depression in elderly patients.</td>
<td>High</td>
</tr>
<tr>
<td>Reserpine at doses &gt;0.25 mg</td>
<td>May induce depression, impotence, sedation, and orthostatic hypotension. It has a prolonged half-life in elderly patients and could cause prolonged hypoglycemia. Additionally, it is the only oral hypoglycemic agent that causes SIADH.</td>
<td>High</td>
</tr>
<tr>
<td>Gastrointestinal antispasmodic drugs: dicyclomine (Bentyl), hyoscyamine (Levsin and Levsine), propantheline (Pro-Banthine), belladonna alkaloids (Dronatal and others), and clidinium-chlordiazepoxide (Librax)</td>
<td>GI antispasmodic drugs are highly anticholinergic and have uncertain effectiveness. These drugs should be avoided (especially for long-term use).</td>
<td>High</td>
</tr>
<tr>
<td>Anticholinergics and antihistamines: chlorpheniramine (Chlor-Trimentol), diphenhydramine (Benadryl), hydroxyzine (Vistaril and Atarax), cyproheptadine (Periactin), promethazine (Phenergan), triphenelamine, dexchlorpheniramine (Polaramine)</td>
<td>All nonprescription and many prescription antihistamines may have potent anticholinergic properties. Nonanticholinergic antihistamines are preferred in elderly patients when treating allergic reactions.</td>
<td>High</td>
</tr>
<tr>
<td>Mefloquine (Aldomet) and mefloquine-hydrochlorothiazide (Aldomet)</td>
<td>May cause bradycardia and exacerbate depression in elderly patients.</td>
<td>High</td>
</tr>
<tr>
<td>Risperidone at doses &gt;0.25 mg</td>
<td>May induce depression, impotence, sedation, and orthostatic hypotension. It has a prolonged half-life in elderly patients and could cause prolonged hypoglycemia. Additionally, it is the only oral hypoglycemic agent that causes SIADH.</td>
<td>High</td>
</tr>
<tr>
<td>Gastrointestinal antispasmodic drugs: dicyclomine (Bentyl), hyoscyamine (Levsin and Levsine), propantheline (Pro-Banthine), belladonna alkaloids (Dronatal and others), and clidinium-chlordiazepoxide (Librax)</td>
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<td>All nonprescription and many prescription antihistamines may have potent anticholinergic properties. Nonanticholinergic antihistamines are preferred in elderly patients when treating allergic reactions.</td>
<td>High</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>May cause confusion and sedation. Should not be used as a hypnotic, and when used to treat emergency allergic reactions, it should be used in the smallest possible dose.</td>
<td>High</td>
</tr>
<tr>
<td>Ergot mesylates (Hydergine) and cyclandelate (Cyclospasmol)</td>
<td>Have not been shown to be effective in the doses studied. Doses &gt;325 mg/d do not dramatically increase the amount absorbed but greatly increase the incidence of constipation.</td>
<td>Low</td>
</tr>
<tr>
<td>Ferrous sulfate &gt;325 mg/d</td>
<td>Have not been shown to be effective in the doses studied. Doses &gt;325 mg/d do not dramatically increase the amount absorbed but greatly increase the incidence of constipation.</td>
<td>Low</td>
</tr>
<tr>
<td>All barbiturates (except phenobarbital) except when used to control seizures</td>
<td>Are highly addictive and cause more adverse effects than most sedative or hypnotic drugs in elderly patients.</td>
<td>High</td>
</tr>
</tbody>
</table>
or modified from the criteria by the panelists since the 1997 publication: phenylbutazone, oxybutynin chloride, β-blockers, corticosteroids with persons with diabetes; sedative-hypnotics in persons with chronic obstructive pulmonary disease; β-blockers in persons with asthma; β-blockers in persons with peripheral vascular disorder; β-blockers in persons with syncope and falls; narcotics in persons with bladder outflow obstruction; and theophylline sodium glycolate in persons with insomnia (Table 3). Oxybutynin was modified by not including the extended-release formula, which the panel believed had fewer adverse effects. Reserpin was changed to be avoided only at doses greater than 0.25 mg, and disopyramide phosphate avoidance now only refers to the non–extended release formulation. New information about β-blockers in elderly patients led the panel to drop this class of drugs from the list. The other criteria dropped involved use of drugs in the setting of a comorbid condition or drugs that are off the market. The expert panelists could not reach consensus about adding questions regarding setting maximum dosages for sedative-hypnotics, antipsychotics, selective serotonin reuptake inhibitors, and tricyclic antidepressants that do not have specific recommendations from the manufacturer, though there was agreement that consideration of changes in pharmacokinetics were important in older patients in preventing problems caused by excessive dosages and usage.

This update also includes several medications that have new information or have come to market since the last study of the Beers criteria was published (1997), including selective serotonin reuptake inhibitors, amiodarone, and fluoxetine hydrochloride. The panel also voted to add methyltestosterone, amphetamines, and bupropion hydrochloride to the list of medications to be avoided in older adults. Tables 1 and 2 state why medications were added since 1997, and Table 3 summarizes all the changes to the
This study is an important update of previously established criteria that have been widely used and cited. The application of the Beers criteria and other tools for identifying PIM use will continue to enable providers to plan interventions for decreasing both drug-related costs and overall costs and thus minimize drug-related problems. Such tools are also vitally important to managed care organizations, pharmacy benefit plans, and both acute and long-term health care in-

### Table 2. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Considering Diagnoses or Conditions

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Drug</th>
<th>Concern</th>
<th>Severity Rating (High or Low)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>Disopyramide (Norpace), and high sodium content drugs (sodium and sodium salts [alginic bicarbonate, biphosphate, citrate, phosphate, salicylate, and sulfate]) (market in 2001), pseudoephedrine, diet pills, and amphetamines</td>
<td>Negative inotropic effect. Potential to promote fluid retention and exacerbation of heart failure.</td>
<td>High</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Phenytoinpropanolamine hydrochloride (removed from the market in 2001), pseudoephedrine, diet pills, and amphetamines</td>
<td>May produce elevation of blood pressure secondary to sympathomimetic activity.</td>
<td>High</td>
</tr>
<tr>
<td>Gastric or duodenal ulcers</td>
<td>NSAIDs and aspirin (&gt;325 mg) (coxibs excluded)</td>
<td>May exacerbate existing ulcers or produce new/additional ulcers.</td>
<td>High</td>
</tr>
<tr>
<td>Seizures or epilepsy</td>
<td>Clozapine (Clozaril), chlorpromazine (Thorazine), thioridazine (Mellaril), and thiothixene (Navane)</td>
<td>May lower seizure thresholds.</td>
<td>High</td>
</tr>
<tr>
<td>Blood clotting disorders or receiving anticoagulant therapy</td>
<td>Aspirin, NSAIDs, dipyridamole (Persantin), ticlopidine (Ticlid), and clopidogrel (Plavix)</td>
<td>May prolong clotting time and elevate INR values or inhibit platelet aggregation, resulting in an increased potential for bleeding.</td>
<td>High</td>
</tr>
<tr>
<td>Bladder outflow obstruction</td>
<td>Anticholinergics and antihistamines, gastrointestinal antispasmodics, muscle relaxants, oxybutynin ( Ditropan), flavoxate (Urispas), anticholinergics, antidepressants, decongestants, and tolterodine (Detrol)</td>
<td>May decrease urinary flow, leading to urinary retention.</td>
<td>High</td>
</tr>
<tr>
<td>Stress incontinence</td>
<td>α-Blockers (Doxazosin, Prazosin, and Terazosin), anticholinergics, tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride), and long-acting benzodiazepines</td>
<td>May produce polyuria and worsening of incontinence.</td>
<td>High</td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>Tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)</td>
<td>Concern due to proarrhythmic effects and ability to produce QT interval changes.</td>
<td>High</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Decongestants, theophylline (Theaudor), methylphenidate (Ritalin), MAOIs, and amphetamines</td>
<td>Concern due to CNS stimulant effects.</td>
<td>High</td>
</tr>
<tr>
<td>Parkinson disease</td>
<td>Metoclopramide (Reglan), conventional antipsychotics, and tacrine (Cogxin)</td>
<td>Concern due to their antipsycomimetic/ cholinergic effects.</td>
<td>High</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Barbiturates, anticholinergics, antispasmodics, and muscle relaxants. CNS stimulants: dextroAmphetamine (Adderall), methylphenidate (Ritalin), methamphetamine (Desoxyn), and pemolin</td>
<td>Concern due to CNS-altering effects.</td>
<td>High</td>
</tr>
<tr>
<td>Depression</td>
<td>Long-term benzodiazepine use. Sympatholytic agents: methylpoda (Aldomet), reserpine, and guanethidine (Ismelin)</td>
<td>May produce or exacerbate depression.</td>
<td>High</td>
</tr>
<tr>
<td>Anorexia and malnutrition</td>
<td>CNS stimulants: DextroAmphetamine (Adderall), methylphenidate (Ritalin), methamphetamine (Desoxyn), pemolin, and fluoxetine (Prozac)</td>
<td>Concern due to appetite-suppressing effects.</td>
<td>High</td>
</tr>
<tr>
<td>Syncope or falls</td>
<td>Short- to intermediate-acting benzodiazepine and tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)</td>
<td>May produce ataxia, impaired psychomotor function, syncope, and additional falls.</td>
<td>High</td>
</tr>
<tr>
<td>SIADH/hyponatremia</td>
<td>SSRIs: fluoxetine (Prozac), citalopram (Celexa), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft)</td>
<td>May exacerbate or cause SIADH.</td>
<td>Low</td>
</tr>
<tr>
<td>Seizure disorder</td>
<td>Bupropion (Wellbutrin)</td>
<td>May lower seizure threshold.</td>
<td>High</td>
</tr>
<tr>
<td>Obesity</td>
<td>Olanzapine (Zyprexa)</td>
<td>May stimulate appetite and increase weight gain.</td>
<td>Low</td>
</tr>
<tr>
<td>COPD</td>
<td>Long-acting benzodiazepines: chlordiazepoxide (Librium), chlordiazepoxide-amitriptyline (Limbitrol), clidinium-chlordiazepoxide (Librax), diazepam (Valium), quazepam (Doral), halazepam (Paxipam), and chlorzepate (Tranxene), β-blockers: propranolol</td>
<td>CNS adverse effects. May induce respiratory depression. May exacerbate or cause respiratory depression.</td>
<td>High</td>
</tr>
<tr>
<td>Chronic constipation</td>
<td>Calcium channel blockers, anticholinergics, and tricyclic antidepressant (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)</td>
<td>May exacerbate constipation.</td>
<td>Low</td>
</tr>
</tbody>
</table>

Abbreviations: CNS, central nervous systems; COPD, chronic obstructive pulmonary disease; INR, international normalized ratio; MAOIs, monoamine oxidase inhibitors; NSAIDs, nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone secretion; SSRIs, selective serotonin reuptake inhibitors.
Table 3. Summary of Changes From 1997 Beers Criteria to New 2002 Criteria

Medicines Modified Since 1997 Beers Criteria

1. Reserpine (Serpasil and Hydopres)*
2. Extended-release oxybutynin (Ditropan XL)†
3. Iron supplements >325 mg†
4. Short-acting dipryramidole (Persantine)‡

Medicines Dropped Since 1997 Beers Criteria

1. Phenybutazone (Butazolidin)
2. Recently started corticosteroid therapy with diabetes
3. β-Blockers with diabetes, COPD or asthma, peripheral vascular disease, and syncope or falls
4. Sedative hypnotics with COPD
5. Potassium supplements with gastric or duodenal ulcers
6. Metoclopramide (Reglan) with seizures or epilepsy
7. Narcotics with bladder outflow obstruction and narcotics with constipation
8. Desipramine (Norpramin) with insomnia
9. All SSRIs with insomnia
10. β-Agonists with insomnia
11. Bethanechol chloride with bladder outflow obstruction

Medicines Added Since 1997 Beers Criteria

1. Ketorolac tromethamine (Toradol)
2. Orphenadrine (Norflex)
3. Guanethidine (Ismelin)
4. Guanadrel (Hylorel)
5. Cyclandelate (Cyclospasmol)
6. Isoxsuprine (Vasodilant)
7. Nitrofurantoin (Macrodantin)
8. Doxazosin (Cardura)
9. Methyltestosterone (Andro-Test, Virilon, and Testrad)
10. Mesoridazine (Serentil)
11. Clonidine (Catapres)
12. Mineral oil
13. Cimetidine (Tagamet)
14. Ethacrynic acid (Edecrin)
15. Desicated thyroid
16. Ferrous sulfate >325 mg
17. Amphetamines (excluding methylphenidate and anorexics)
18. Thioreodiazide (Mellanil)
19. Short-acting nifedipine (Procardia and Adalat)
20. Daily fluoxetine (Prozac)
21. Stimulant laxatives may exacerbate bowel dysfunction (except in presence of chronic pain requiring opiates analgesics)
22. Amiodarone (Cordarone)
23. Non-COX-selective NSAIDs (naproxen [Naprosyn], oxaprozin, and piroxicam)
24. Reserpine doses >0.25 mg/d
25. Estrogens in older women
26. Long-acting benzodiazepines: chlordiazepoxide (Librium), chlordiazepoxide-amitriptyline (Limbitrol), clidinium-chlordiazepoxide (Librax), diazepam (Valium), quazepam (Doral), halazepam (Paxipam), and chlordiazepoxide-tranexene (COPD, stress incontinence, depression, and falls
27. Propanolol with COPD/asthma
28. Anticholinergics with stress incontinence
29. Tricyclic antidepressants (imipramine hydrochlorid, desipam hydrochloride, and amitriptyline hydrochloride) with syncope or falls and stress incontinence
30. Short to intermediate and long-acting benzodiazepines with syncope or falls
31. Clidinium-chlordiazepoxide (Librax), diazepam (Valium), chlorazepate (Tranxene) with COPD, stress incontinence, depression, and falls
32. Tolterodine (Detrol) with blood-clotting disorders receiving anticoagulant therapy
33. Decongestants with bladder outflow obstruction
34. Calcium channel blockers with constipation
35. Phenylpropanolamine with hypertension
36. Bupropion (Wellbutrin) with seizure disorder
37. Olanzapine (Zyprexa) with obesity
38. Metoclopramide (Reglan) with Parkinson disease
39. Conventional antipsychotics with Parkinson disease
40. Tacrine (Cognex) with Parkinson disease
41. Barbiruates with cognitive impairment
42. Antipsychotics with cognitive impairment
43. Antidepressants with cognitive impairment
44. CNS stimulants with attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and cognitive impairment

Abbreviations: CNS, central nervous system; COPD, chronic obstructive pulmonary disease; COX, cyclooxygenase; NSAIDs, nonsteroidal anti-inflammatory drugs; SSRIs, selective serotonin reuptake inhibitors.

*Reserpine in doses >0.25 mg was added to the list.
†Ditropan was modified to refer to the immediate-release formulation only and not Ditropan XL and iron supplements was modified to include only ferrous sulfate.
‡Do not consider the long-acting dipyridamole, which has better properties than the short-acting dipyridamole in older adults (except with patients with artificial heart valves).

Institutions. However, to remain useful, criteria must be regularly updated and must take into account the ever-increasing, evidence-based literature in the area of medication use in older adults.

The argument in favor of using explicit criteria in prescribing practice is overwhelming: improvements in therapeutic practices and reduction in medication-related ADEs will increase the quality of care and enhance patient outcome at the same time as optimizing resource utilization and promoting fiscal prudence. These criteria, though widely used, have been controversial because of their adoption by nursing home regulators and have been criticized by nursing home regulators and have been criticized as too simplistic and limiting the freedom of physicians to prescribe. However, we believe that thoughtful application of the updated 2002 Beers criteria and other tools for identifying PIM use can enable providers and insurers to plan interventions aimed at decreasing drug-related costs and overall health care costs, while reducing ADE-related admissions in elderly patients and improving care. The updated Beers criteria will enable everyone from individual physicians to health care systems to integrate the new criteria-based prescribing recommendations into their organic, mechanical, and electronic information systems.
The proponents of explicit criteria and evidence-based prescribing are among the biggest players in the health care industry: the IOM, the CMS, the Agency for Healthcare Research and Quality (AHRQ), and the American Association of Health Plans (AAHP), to name but four.\(^\text{36,37}\) Indeed, finding a voice of dissent is challenging. In “Crossing the Quality Chasm” the IOM\(^\text{38}\) presents a template for the future, when the traditional values of physician integrity, altruism, knowledge, skill, and dedication to lifelong patient care are seamlessly integrated into an information era of point-of-care, computerized decision support that facilitates appropriate care using the available resources. The updated Beers criteria are one component of that movement, enabling all parties, from providers to insurers, to integrate our recommendations into their clinical information systems.

Given the aforementioned, there appears to be a potential niche for the Beers criteria in fulfilling the missions of the IOM, CMS, AHRQ, and AAHP. However, translating research into measurable quality improvement may be more challenging. In the first instance, despite the much-lauded public statements about quality by many (including the above organizations), there is widespread recognition that perhaps cost containment is the principal driver of change in the health care world.\(^\text{39}\) Individual health care providers and organizations will demand objective evidence that implementation of the updated Beers criteria (or, indeed, other inappropriate medication guides) will result in objective, quantifiable improvements in the clinical effectiveness and cost-effectiveness of health care services. To date, despite extensive literature demonstrating association—based on retrospective studies on administrative data—there is an absence of rigorous, prospective research in this field. We (D.M.F., J.L.W., and J.R.M.) are completing a randomized controlled study among a Medicare managed care population at this time, using the 1997 medication criteria for older adults. Well-controlled studies are needed that show prospectively that using these criteria make a difference in patient outcomes.\(^\text{40}\)

These criteria have some limitations, however, and must be regularly updated to remain useful to both clinicians, health care administrators, and researchers. These criteria are meant to apply to the general population of patients 65 years and older, thus some that are not appropriate for significantly older or more frail persons do not appear in this list. These criteria are not meant to regulate practice in a manner to which they supersede the clinical judgment and assessment of the physician or practitioner. In addition, defining inappropriate medications by specific lists of medications rather than other mechanisms may miss some problems such as the underuse and interactions of drugs in older people.\(^\text{26,40}\) A true meta-analysis was not conducted for this study. Lastly, this study has the same limitations previously documented regarding the use of the Delphi technique.\(^\text{35,41}\)

A further challenge to adoption of the Beers criteria will come from the information systems and information technology sector. Despite phenomenal advances in hardware and software, decision support systems continue to have significant limitations, and presenting the right information to the right person at the point of clinical need remains a challenge for the information systems and information technology engineer, the behavior change specialist, and the medical profession.\(^\text{42}\)

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