| **Section** | **Rationale** |
| --- | --- |
| **Gastro-Intestinal System** |  |
| **Other than for opioid-induced constipation, stimulant laxatives (e.g. bisacodyl, senna) should not be prescribed as first-line treatment in constipation for greater than four weeks.** | *Stimulant laxatives are not suitable for continuous long-term use, other than for opioid induced constipation.* |
| **Proton pump inhibitors (PPIs) (e.g. esomeprazole, omeprazole) should not be prescribed at doses above the recommended maintenance dosage for greater than eight weeks.** | *A dose reduction or discontinuation is indicated since there is no therapeutic benefit observed with the use of higher doses of PPIs long-term (unless treatment is indicated for rare conditions e.g. Zollinger-Ellison syndrome).* |
| **Esomeprazole or omeprazole should not be used in combination with clopidogrel.** | *Esomeprazole and omeprazole may reduce the anti-platelet effect of clopidogrel and therefore should not be used in combination with clopidogrel. Other proton pump inhibitors or H* *2**-receptor antagonists are available which do not have the same potential for interaction.* |
| **Cardiovascular System** |  |
| **The use of alpha-adrenoceptor blocking drugs (e.g. doxazosin, prazosin) as monotherapy for hypertension, should be avoided.** | *Alpha-adrenoceptor blocking drugs increase the risk of orthostatic hypotension.* |
| **Aspirin doses should not exceed 150 mg/day for anti-platelet therapy.** | *Doses exceeding 150 mg/day show no evidence for increased efficacy and will increase the risk of bleeding.* |
| **Cardio-selective calcium-channel blockers (e.g. verapamil, diltiazem) should not be used in combination with beta-adrenoceptor blocking drugs.** | *Concomitant use increases the risk of atrioventricular block and myocardial depression.* |
| **The use of oral short-acting dipyridamole should not be used as monotherapy in antiplatelet treatment.** | *Oral short-acting dipyridamole may cause orthostatic hypotension; more effective alternatives available.* |
| **Respiratory System** |  |
| **First generation antihistamines (e.g. chlorphenamine, promethazine) should not be used as first-line agents for greater than seven days.** | *First generation antihistamines may cause addiction and/or exert anticholinergic properties causing unwanted side-effects e.g. constipation, drowsiness, psychomotor impairment.* |
| **Theophylline should not be used as monotherapy for asthma or chronic obstructive pulmonary disease.** | Theophylline is associated with an increased risk of arrhythmias. |
| **A concomitant bisphosphonate should be prescribed if oral corticosteroids are used long-term (greater than three months).** | *Long-term use of an oral corticosteroid increases the risk of osteoporosis and subsequent bone fracture.* |
| **Mucolytic agents (e.g. carbocisteine, mecysteine) should not be used routinely in stable chronic obstructive pulmonary disease.** | *There is little benefit from the use of mucolytic agents in stable chronic obstructive pulmonary disease.* |
| **Central Nervous System** |  |
| **Selective serotonin reuptake inhibitors (e.g. citalopram, fluoxetine) should not be used in combination with venlafaxine.** | *Concomitant use may lead to the development of serotonin syndrome.* |
| **Tricyclic antidepressants (TCAs) (e.g. amitriptyline, nortriptyline) should not be used as first-line in treatment of depression.** | *TCAs are associated with unwanted peripheral anticholinergic side-effects e.g. constipation, dry mouth and central anticholinergic side-effects e.g. drowsiness.* |
| **Benzodiazepines (e.g. nitrazepam, temazepam) should not be used long-term (greater than four weeks).** | *Long-term use of benzodiazepines increases the risk of dependency. Benzodiazepine related adverse effects include daytime sedation, cognitive impairment, agitation, irritability.* |
| **Non-benzodiazepine hypnotics (zolpidem, zaleplon, zopiclone) should not be used long-term (greater than 4 weeks).** | *Non-benzodiazepine hypnotics have adverse events similar to those of benzodiazepines with minimal improvement in sleep latency and duration.* |
| **Carbamazepine should not be used in combination with clarithromycin or erythromycin.** | *Clarithromycin and erythromycin inhibit the metabolism of carbamazepine therefore increasing the risk of adverse effects e.g. headache, drowsiness, nausea.* |
| **Strong opioids (e.g. buprenorphine, diamorphine, fentanyl, morphine, oxycodone) should not be prescribed without the co-prescribing of laxatives.** | *Strong opioids are likely to cause constipation.* |
| **Infections** |  |
| **Nitrofurantoin should not be prescribed for greater than 7 days for the management of uncomplicated lower urinary-tract infections.** | *Potential for pulmonary toxicity; safer alternatives available.* |
| **Endocrine System** |  |
| **In relation to the management of diabetes, the use of oral long-acting sulfonylureas (glibenclamide) should be avoided.** | *Oral long-acting sulfonylureas have a prolonged half-life and can cause prolonged hypoglycaemia or syndrome of inappropriate antidiuretic hormone (ADH) secretion.* |
| **Musculoskeletal System** |  |
| **Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. celecoxib, diclofenac, naproxen) should not be used long-term (greater than three months).** | *Long-term NSAID treatment should be reviewed periodically due to increased risk of thrombotic effects, and the lowest effective dose should be prescribed for the shortest period.* |
| **Unless adequate gastro-intestinal protection is provided with either a proton pump inhibitor or H** **2****-receptor antagonist, non-steroidal anti-inflammatory drugs should not be used in combination with:** | *Concomitant use increases the risk of gastro-intestinal bleeding.* |
| **a. Low-dose aspirin.** |
| **b. Selective serotonin re-uptake inhibitors.** |
| **Duplication of drug classes** |  |
| **The use of two or more drugs from the same pharmacological class should be avoided, unless used for additive effects in line with current clinical guidelines.** | *Possible unwanted duplication of effect, increasing risk of side effects and adverse events.* |
| **For example: Avoid duplication of opioid analgesics, non-steroidal anti-inflammatory drugs, benzodiazepines.** | *An example of an exception includes: duplicate beta* *2**agonists (provided one is short-acting and one is long-acting) for the management of asthma or chronic obstructive pulmonary disease.* |

**Table 4 The PROMPT criteria**

From: [The development of the PROMPT (PRescribing Optimally in Middle-aged People’s Treatments) criteria](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-014-0484-6)