

## Polypharmacy in primary care: managing a clinical conundrum

Polypharmacy can be appropriate and beneficial for patients. However, polypharmacy also increases the risk of problematic prescribing and is associated with adverse health outcomes. The number of people prescribed multiple treatments is continuing to climb as the age of the population, the number of preventative treatments, and the number of long-term conditions that are diagnosed also increase.

### What are the general principles?

The problem that must be resolved on a case-by-case basis is deciding what constitutes “too many medicines” for an individual patient. The key aims should be preservation of function, maintaining or improving quality of life and to a lesser degree, extending life. However, always consider the context for each patient: what are the goals of the patient at this time? When managing medicines it is also vital that concerns over possible problematic prescribing do not lead to under-treatment in patients. The goal is to avoid or stop problematic prescribing, while continuing treatment where there is a clear benefit to the patient.

### How can you make changes?

1. Adopt a systematic approach to new prescribing and always consider:
  - Are the patient’s symptoms due to an adverse drug reaction?
  - What are the goals of treatment?
  - Is the patient likely to live long enough to receive a benefit from treatment?
  - Is the patient likely to receive a net benefit from treatment, and if so, what is the magnitude of this benefit?
  - Are there non-pharmacological treatments that can be considered instead of a medicine?
  - If the decision is to not treat, are you clear what it is that is not being treated?
  - What does the patient want?
2. Be aware of medicines and conditions that are often associated with adverse drug reactions – is the patients dyspepsia due to a NSAID, or their gout due to a thiazide? Also be aware of clinical situations where it is often difficult to avoid the accumulation of multiple medicines, such as Parkinson’s disease
3. Consider if a trial of treatment is appropriate and de-prescribe medicines if they are not as effective as expected. Avoid using the phrase “withdrawing active

treatment” because your care will still be very active, but the focus of that care may be different, e.g. increasing support for the patient and their family

4. Do not assume that you know all of the medicines that a patient is taking - remember to ask about over-the-counter products, traditional medicines and home remedies
5. Always document the reasons for a treatment so they are clear for other health professionals and also document discussions about treatment or any plan for stopping medicines as the process may often take more than one consultation
6. Perform periodic medicine reviews for patients at risk of problematic prescribing, especially patients taking ten or more medicines simultaneously, and in patients following hospital discharge
7. Always check prescriptions for errors before signing. Each prescription should:
  - Include the condition that the medicine is intended to treat
  - Provide specific instructions rather than “as required” or “take as directed”
  - Specify once or twice daily prescribing wherever possible
8. Consider seeking the assistance of a pharmacist for medicine reviews, helping to address patient adherence issues and creating medicine management plans

### Peer group discussion points:

1. What do you consider to be the main drivers of polypharmacy in primary care? Are any of these factors modifiable?
2. How do you reduce inappropriate prescribing in your own practice?
3. Do you ever discuss time-limited trials of treatment with patients? If not, is this something you might consider?
4. Do you perform medicine reviews in your practice? What are the major barriers that you find to doing so? How might these barriers be addressed?
5. Have you ever requested pharmacist involvement in performing a medicine review? If so, was this useful? If not, is this something you would consider?
6. How do you approach the subject of withdrawing treatments with patients?



## Looking back

In this ongoing series, we look back at the key messages and practice points from selected articles in BPJ 64 (October, 2014).

We have added some suggested discussion questions for peer groups, or for personal review.

As this is a new feature of Best Practice Journal, we would be very interested in getting feedback from our readers as to whether this is useful. Please email your comments to: [editor@bpac.org.nz](mailto:editor@bpac.org.nz)