Deprescribing, When Less is Better

A recent study from Canada examined polypharmacy and inappropriate medication use in the elderly. The investigators’ vision was to develop deprescribing guidelines (tapering, reducing, or stopping medications not deemed necessary or safe). The process involved three rounds of surveys of up to 64 Canadian clinical experts in medicine and pharmacy who had expertise in geriatric pharmacotherapy. The survey process developed five main criteria for determining priorities for drug deprescribing guidelines:

- Risks associated with continuation
- Questions about ongoing indications
- Prevalence of overuse
- Challenges in stopping
- The availability of other treatment options

A final list of medication classes to be prioritized for deprescribing included benzodiazepines, atypical antipsychotics, statins, tricyclic antidepressants, and proton pump inhibitors.

The current culture of healthcare facilitates diagnosing and prescribing but pays relatively little attention to deprescribing or reducing chronic medications. They recommend the development of evidence-based deprescribing guidelines for these medication classes. Is it time to take a different view of medications in the elderly, not simply inquiring whether all are being taken but asking whether they need or want them all?

The senior population (those aged 65 years and older) comprises 13.7% of the US population but uses 40% of all prescription drugs. A study in Canada recently showed that in a group of elderly patients (mean age, 81 years), the average number of medications taken was 15 with 8.9 drug-related problems occurring per patient. When these problems were analyzed, 2.5 of those 8.9 problems were found to be caused by drugs that were not needed. In the United States, 28% of hospitalizations in seniors are caused by medication-related problems.

The key must be appropriate prescribing as well as considering deprescribing medications as patients get older. For example, most studies on statins for HLD were conducted on people 70 years or younger. It is not known whether the benefits extend beyond that age or what the harms might be.

When stopping or deprescribing medications, it is important to stop them one at a time to monitor the individual effects of the medication, whether positive or negative. Some drugs (beta-blockers or SSRIs) may need to be tapered before stopping. The result may be a patient taking fewer medications, feeling better, more able to afford the medication, and better able to take them as scheduled.

Reconciling medication lists has become a common practice during office visits, but the review of medications must include consideration of the need for each medication and an opportunity to discuss deprescribing where appropriate. Prescribing must focus on doing no harm and improving the quality of life for the elderly patient. Less may be better.
Use of OTC Medications continued...

(76%) and polyethylene glycol (PEG 3350; 90%) were equally effective. Despite this, a minority “always” or “very often” directed their patients to purchase a store brand PPI (35%) or laxative (40%). In addition, gastroenterologists tended to underestimate the cost savings associated with store brand medicines and had limited knowledge regarding the regulation of store brands.

CONCLUSIONS: Among U.S. gastroenterologists, OTC medications now dominate primary therapy of GERD and CC. Despite feeling that name brand and store brand PPIs and laxatives are equally effective, the majority of gastroenterologists recommend brand name medicines and underestimate the cost savings associated with store brands. In this age of accountable care, greater efforts to help physicians and patients to better utilize their health-care dollars is warranted.

Hopefully this will provide Primary Care Providers with some assurance that OTC medications for GERD and CC are used and recommended by subspecialists and remind us all of the impact of helping provide cost saving yet effective means of therapy to our patients. Source: The American Journal of Gastroenterology, June 9, 2015

Did You Know

90% in U.S. Get Too Much Sodium; 5 Foods Blamed. CDC: Average American Gets 2x Recommended Sodium Intake

The average American eats 3400 mg sodium daily—far more than the recommended 1500-2300 mg daily (1500 mg is recommended for nearly 70% of the population who are middle aged, elderly or African American). High sodium intake is related to hypertension, increased heart disease, stroke, stomach cancer and kidney disease.

5 high-sodium foods—not all of them salty tasting—are a big reason why 9 in 10 Americans get far too much sodium, but only 10% of it comes from our shakers. An estimated 77% comes from sodium in processed or restaurant foods. Grains and meat—the foods we eat most—contribute the most sodium.

The CDC report identifies five foods that give Americans most of their sodium: chicken and mixed chicken dinners, yeast breads, pizza, pasta dishes, cold cuts.

Grains contribute 37% of our daily sodium. These foods include grain-based frozen meals and soups, breads, and pizza (which is mostly salty bread). Meats, including poultry and fish, contribute 28% of our daily sodium. Vegetables contribute more than 12% of our daily sodium, and canned vegetables, vegetable soups, and vegetable sauces tend to be loaded with sodium.

The CDC calculates that if everyone followed sodium-intake guidelines there would be as many as 120,000 fewer cases of heart disease and up to 66,000 fewer strokes each year. What can we do?

- Eat less processed food
- Eat more fresh and frozen vegetables
- Check food labels
- When using canned vegetables or beans, rinse the food well with water
- Pick low sodium menu choices when dining out
- Avoid high sodium foods—lunch meat, vegetable juice, tomato sauce, frozen meat, and some dairy products

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