HEALTH: POLYPHARMACY

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Ed note: The names of the two patients and the physician mentioned in this article are pseudonyms, but all the case histories are real.

Nell Hightower, a diabetic with hypertension and arthritis, rolled into the emergency room several years ago with bilateral pneumonia. Dr. Morer, her regular physician, was not on the hospital staff and I was asked to help care for her.

My part was easy. She had a couple of drug allergies, and I tinkered with her antibiotic orders.

At a follow-up visit Mrs. Hightower came with her daughter who carried two shopping bags of medications.

“What’s all this?” I asked as I looked at enough medication bottles and boxes to stock a small pharmacy.

“I just want you to see everything my mother is taking,” replied the concerned daughter who was soon scheduled to return to her family in California.

One often overlooked ticket to poor health is too much care. If I were a health official looking at certain physician prescribing patterns or high numbers of certain elective surgeries, I would conclude that our state’s poor health statistics are fueled by an overabundance of bad care in addition to all the usual excuses such as diet and poverty.

Multiple drugs are often necessary. Obviously, a person with the New Orleans trifecta of hypertension, diabetes and elevated cholesterol needs more than one prescription medication. However, adverse drug effects increase exponentially as the number of medications increases.

In addition to adverse effects, excessive medications fuel troublesome drug interactions and scheduling difficulties to fit all the pills into one day.

Polypharmacy refers to taking excessive medications – especially when one or several are not needed. The term is not yet in mainstream dictionaries however physicians encounter the phenomenon on a daily basis.

As the number of new and effective medications increases, polypharmacy has emerged as a principal drug safety issue. On the other hand, too few medications can leave bothersome symptoms and conditions under-treated, leading to increased morbidity, hospitalizations and overall misery.

Mrs. Hightower was supposed to be swallowing 23 tablets and capsules daily, in addition to four insulin injections and eye drops. Not to mention that she had standby nitroglycerine and a couple of potent skin creams on hand for use as needed.

All the local pharmaceutical sales staff revered her physician. In their lingo, Dr. Morer was “a heavy prescriber.”

“That Dr. Morer is dynamite,” a pharmaceutical rep once told me. “You get a new drug. You drag in lunch for his office staff and one out of four patients walking out his door that day will get it. Drug reps are lined up for weeks to take lunches to his office.”

I told Mrs. Hightower that she was taking more medications than necessary. It also appeared that her medications were slanted toward newer released non-generic drugs that were being heavily promoted by drug company salesmen.

"But I need all my medicines!" was all that she uttered as I saw Mrs. Hightower turn in time to see her daughter's eyes roll. Actually, I suspect that she only took a sampling of what was really prescribed. It would be difficult to imagine how a person could function who was taking what she claimed to be.

After this failed intervention I never heard from either again but I am sure Mrs. Hightower returned to her generous support of the pharmaceutical industry. I should say "our support" as she was on a public assistance program and paid little, if any, in the way of co-pays or direct medication costs at that time.

Sometimes a person is put on a medication and simply never told to stop. This happened to Lucile Milton. She was hospitalized with a blood clot in her leg in the 1970s. She received heparin in the hospital and went home with a prescription for daily Coumadin, a common anticoagulant. The active ingredient in Coumadin is warfarin, a chemical also used to poison rodents. A mouse or rat that eats warfarin-laced bait bleeds to death internally.

Because Coumadin is a medication that requires careful adjustments to monitor its effectiveness and prevent troublesome bleeding and adverse effects Mrs. Milton reported to her physician's office for a monthly prothrombin blood test. Her original physician retired but Mrs. Milton continued with monthly monitoring, usually only interacting with the office nurse who always approved drugstore requests for her Coumadin refills.

Mrs. Milton was referred to me for recurrent cellulitis in her legs. A couple of times a year she would develop a troublesome area of cellulitis in a thigh or calf, triggering a hospitalization, intravenous antibiotics and a search for recurrent clots that were never found.

Finally, I prescribed daily antibiotics for her in an attempt to prevent what I thought were recurrent attacks of streptococcal cellulitis. The preventive antibiotic did not stop her bouts of cellulitis.

Many patients assume that all treating physicians know about all the medications each patient is taking. Often, it's a situation of too many cooks oversalting the soup, and not one physician takes the initiative to question a medication prescribed by another.
"Why, again, are you on Coumadin?" I asked one afternoon. She had brought in all her prescription bottles, which I was reviewing as she needed several refills and her primary care physician was not back in practice.

"Dr. Whitaker put me on it. He said I would be on it for the rest of my life," said Mrs. Milton. It was a statement I, and no doubt all of her other treating physicians, had heard dozens of times. Dr. Whitaker retired over 10 years ago so I called the physician who had assumed his practice.

"She's always been on it. I don't know why she's still taking it. After a clot, we usually just give it for six months. She doesn't have atrial fibrillation. I'll wean her off and see what happens," said the physician who took over Dr. Whitaker's practice.
My fingers are crossed but to date there has been no more "cellulitis". I suspect that what we had been diagnosing as a recurrent bacterial cellulitis was caused by the Coumadin. She probably spontaneously bled into her thigh or calf muscles. Blood in the wrong places can mimic infection in causing classic signs and symptoms of inflammation – localized swelling, pain, redness and an increase in temperature over the area.

Some of the more frequent drugs associated with polypharmacy are the antihistamines, the decongestants and the acid reducing medications – Claritin and Allegra combinations, Nexium, Protonix and Prilosec. Many people who take these on a long term, daily basis would do much better taking them on an as needed basis.

One way to attack polypharmacy is to ask patients to bring their actual prescription bottles of everything they are taking to each doctor's office visit. Some bring lists but I have been fooled more than once by out-of-date lists and dosage errors on lists. Additionally, looking at the actual bottle and the date of last refill gives me an idea of if the patient is taking their medication as prescribed. Also, a simple list gives no clue as to when the next written prescription is due.

"That's OK. You don't have to give me a written prescription. I'll have my drugstore call you when the refills run out," I hear

frequently.

Any advance planning that reduces phone calls and faxes from drugstores decreases the chance of error and polypharmacy. I prefer to give refills in writing when the patient and I are sitting side by side. Fielding dozens of phone calls and faxes cheats the patient and me of an important opportunity of togetherness in which we can mull over each and every medication. Often there is one that can be stopped.