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Polypharmacy Issues and the Elderly

POLYPHARMACY IN THE OLDER POPULATION

Remember the Jefferson Airplane song, one pill makes you larger and one pill makes you small, and the ones that mother gives you don't do anything at all, go ask Alice when she is 10 feet tall. Ever stop to think how many drugs our parents take and how many of them are appropriate. To learn more, stay with ReachMD XM, The Channel for Medical Professionals. Welcome to The Clinician's Roundtable. I am Dr. Bill Rutenberg, your host and with me today is Dr. Ken Brummel-Smith. Dr. Brummel-Smith is the Charlotte Edwards McGuire Professor and Chair, Department of Geriatrics, Florida State University College of Medicine. He is the past president and the immediate past Chairman of the Board of The American Geriatric Society.

DR. BILL RUTENBERG:

Welcome Dr. Brummel-Smith, thanks so much for joining as at The Clinician's Roundtable.

DR. KEN BRUMMEL-SMITH:

Thank you very much, its great to be here.

DR. BILL RUTENBERG:

I was visiting my mother and stepfather recently and my mother said to me, Bill come here, I gotta show you something. Can you believe that one person can take so many different medications. I counted 10 pill bottles. Is this what I have to look forward to as I get older?

DR. KEN BRUMMEL-SMITH:

Well unfortunately its pretty common, you don't necessarily have to look forward to it though.

DR. BILL RUTENBERG:

Oh great, hope they help.

DR. KEN BRUMMEL-SMITH:

I think one of the problems is that we have a strong orientation towards treating things with medications and we are not reimbursed for treating things other ways than medications, well so.

DR. BILL RUTENBERG:

I mean your cognitive thoughts aren't appreciated?

DR. KEN BRUMMEL-SMITH:

Right, yeah. For instance the evidence on treating hypertension with exercise is very strong, but you don't really get reimbursed for teaching people about exercise and there really isn't anybody selling exercise very strongly to older people for instance. So the incentives are a lot less strong for the alternatives than they are for medications.

DR. BILL RUTENBERG:

How frustrated do you get when your patients walk in and sort of dump that bag of pills on your desk?

DR. KEN BRUMMEL-SMITH:

I have to tell you, I actually don't get frustrated, but I appreciate it because one of the big problems is that you don't always know what they are taking and so if they do bring in the bag, it means something good is happening and that they recognize that it needs to be looked at. Now I realize for a primary care physician that might be a tougher situation because maybe they don't have as much time as a geriatrician would have to deal with it, but really the first step is to get that bag and that's a great first step.

DR. BILL RUTENBERG:

Are there criteria for judging the appropriateness of the medications a patient is on. How do you go about that when they come in with these medications?

DR. KEN BRUMMEL-SMITH:

Well there are some established criteria, there is 1 set called the Beers List, which was created primarily by a guy named Mark Beers, who led a group of geriatricians doing a kind of consensus based review of medication problems in older people and they were really just trying to inform other physicians about medications to be careful about, but then the Centers for Medicare and Medicaid services picked it up and applied it to nursing home care, so now every nursing home is required to look at this Beers List and I am sure many of the listeners have gotten that call from the nursing home about doctor, your patient is on a Beers drug and that's relatively a good thing. I think there are some problems, in that, you know, not every drug on the list is a really bad, bad drug, but at least it creates a sense of concern about it.

DR. BILL RUTENBERG:

The term Beers Drug was new to me. I am a pediatrician, I sort of see the other end of a spectrum. For those in our audience who are not geriatricians or perhaps not even internal medicine, family practice doctors, could you give us maybe the top 5 or 6 drugs on the Beers List that come up repeatedly as a problem?

DR. KEN BRUMMEL-SMITH:

Well at the top of the list is amitriptyline, Elavil. Its an older antidepressant that you know is an effective antidepressant, but the problem is it has very strong sedative effects and strong anticholinergic effects, so it causes a lot of side effects for older patients especially. Barbiturates are high on the list, primarily because of sedation and falls. Older drugs like chlordiazepoxide and chlorpropamide. Valium is on the list, Valium is an interesting one because it has very long duration of action in older people. The half life of Valium in an older person is up to 140 hours compared to that of 4 to 6 hours in a young person, so those are probably the top ones on the list. Mostly its older drugs and that's because generally there are newer drugs that often have fewer side effects.

DR. BILL RUTENBERG:

That's interesting because you were kind enough to share with me a lecture that you had prepared, which I had used to pick some of these questions, but you said is don't take a drug that's on the market for less than 2 years and there is sort of a contradistinction here.

DR. KEN BRUMMEL-SMITH:

Yeah well that's a good point, and the point I am making about that is that it's the really old drugs that where we probably moved on towards better drugs that are less likely to have side effects or the brand new drugs where we really don't have enough experience especially in older people since older people are very frequently not allowed to be in clinical trials because they have too many different medical problems. That I think is actually one of the most important things for the practicing physician to think about is that most drugs when they are tested and approved, have to be tested on people who don't have a lot of other you know contravening medical problems just because of safety issues, so then they get released and you know the average doctor takes care of people, who have multiple medical problems apparently like your mother because she has got 10 drugs, so that means that it may not be that the initial studies when they first come out really apply to my kind of patient. They apply to those, good to those research patients, but not to my kind. So I think you need a window in there, you don't want too old of a drug, except for some that are still great like aspirin or digoxin, but you also don't want too new where it hasn't been sufficiently tested on people to know what the side effects are going to be.

DR. BILL RUTENBERG:

I'd like to welcome those who are just joining us the Clinician's Roundtable on ReachMD XM, The Channel for Medical Professionals. I am Dr. Bill Rutenberg and I am speaking with Dr. Ken Brummel-Smith, Chair of the Department of Geriatrics at Florida State University School of Medicine and we are discussing Polypharmacy In The Older Population.

Pediatrics has a similar problem, in that up until several years ago when there was a law passed by the Federal Government that medications given to children didn't have to be tested in children. Is The American Society for Geriatrics trying to work the other end of the spectrum and get regulations requiring that drugs also be tested in the elderly population.

DR. KEN BRUMMEL-SMITH:

Yeah that's a very good point. I mean the 3 populations probably that are the most at risk are pediatrics, pregnant women, and older patients and AGS has been pushing to include more elderly in all clinical trials, not just drug trials so that we can be more honest with our patients about the recommendations we make.

DR. BILL RUTENBERG:

I want to ask you again on the issue of old versus new drugs. One of course, how do people especially with all the accusations made against us for listening to the detail people, how do people get on these really old medications and how are they staying on them and not being, you know, moved to something that may be older, but not outdated.

DR. KEN BRUMMEL-SMITH:

Well I mean, especially for an older patient they may have been put on it really a long time ago and as long as it's not necessarily causing a problem, then physicians tend to leave people on medications. That's something that I think is another way to look at. So the Beers List is one way, another way to look at how to reduce polypharmacy is what level of suspicion are you going to hold with that list of 10 drugs like your mom had. So for instance, a kind of average way of looking at is to say I don't say a problem, so I guess I will just keep it going. Whereas a higher test is to say, am I really certain it's helping the patient and if I am not certain, why don't I try stopping it. So you see its just a little higher index of suspicion that I think is justified either in an older person who has a lot of other medical problems where the side effect could be hidden under the guise of a disease or in someone where you are worried about their compliance or adherence to the medications. Those are the ones you really want to be careful about trying to reduce the number of drugs they take.

DR. BILL RUTENBERG:

Do you have any rules of thumb in terms of steps to approach in evaluating new drugs and current drugs the patient is on?

DR. KEN BRUMMEL-SMITH:

Well I would say the first thing would be, look hard at any drug that could have a functional impact on the patient. So if for instance a drug is being given to prevent something in the future. Lets say it's a statin drug for preventing a stroke or heart attack, that's an important goal to have, but on the other hand if its causing muscle pain and decreased activities of daily living today, then we are giving them a disease in trying to prevent something that hasn't even happened yet. So especially for older people, their ability to function independently is very high value to them. Its very directly linked to total healthcare costs and we don't want to cause functional disability in people due to trying to prevent something that hasn't even occurred. So that will be the first place I would start. The second place I would start would be what is going to be the most difficult one for them to be adherent to if they have a drug that is difficult to take because of frequency, you know its got to be taken 4 times a day or it has very special ways, it has to be taken like no lying down for 30 minutes afterwards or on an empty stomach, then those are often the ones that are taken wrongly or not taken anyway. So those would be ones I would have a high worry about and then the last one is where there is you know kind of opposite values being served. So for instance a really important common problem in older people is, lets say they have Alzheimer's and they are given an anticholinesterase inhibitor for their memory, but they also have incontinence. So they are given a bladder relaxant for their bladder. While the reality is those both counteract each other. So they are basically 2 expensive drugs and neither of them work.

DR. BILL RUTENBERG:

How much does the patients overall health, the remaining life expectancy, goals of care, how do these figure into your choice of medications and whether to either continue or to stop a medicine?

DR. KEN BRUMMEL-SMITH:

I think it should enter a lot and especially a lot as the person gets older, so for instance when we are treating a 20-year-old or 30-year-old, they have got a 50, 60-year life expectancy and so the importance of preventing a heart attack in that person is huge, so we want to be aggressive at trying to help prevent, you know treat their hypertension or treat their diabetes. On the other hand if you have someone near to the end of their life. An 85-year-old, who is frail for instance. Only has a 2 or 3-year life expectancy, then you know it really doesn't make sense to be giving someone a statin that would serve to prevent a heart attack 5 to 7 years from now when its past their life expectancy, but it would be extremely important to treat their pain, which interferes with them on a daily basis. So if the goal of care is to prevent something that's long away and that long away time is even past their life expectancy, it really doesn't make sense to treat it, but if the goal of care is to give high quality of life today, then we should be very aggressive at making sure the patient gets the right treatment.

DR. BILL RUTENBERG:

Have you ever personally had one of those eureka moments when you realized that, that this patient is on some medications and maybe that's really what is causing their confusion or their delirium. How you ever been there when you sort of saved a life by stopping a medicine?

DR. KEN BRUMMEL-SMITH:

Unfortunately, it has actually happened lots of times in my career. It just happened a few weeks ago where I was asked to consult on a patient, who was told by her primary care physician that she needed hospice care because she was dying. After reviewing her case, it seemed like she was going down way too fast for her underlying Alzheimer's disease to be the cause and she just seemed stuporous during the interview and so I suggested to the doctor, you know if you really think she is going to die, why don't we just stop everything that is being used to treat these chronic diseases, only manage her with symptomatic treatment like for pain and let us just see how she does over the next couple of weeks and she completely woke up and started recognizing her family and so, you know its definitely something that happens frequently and that would probably be my main encouragement to physicians is to not be so fearful about going ahead and trying to reduce drugs in older people. The number of people, who have an adverse drug withdrawal event is far below the number of people, who have adverse drug events from the wrong medication.

DR. BILL RUTENBERG:

Our time has just flown by Dr. Brummel-Smith. I would like to thank you for being my guest and we have been discussing polypharmacy in the elderly.

I am Dr. Bill Rutenberg, you have been listening to The Clinician's Roundtable on ReachMD XM, The Channel for Medical Professionals. We welcome your comments and questions. Please visit us at ReachMD.com and explore our on-demand and podcasts

features, which gives you access to our entire program library. Until next time, I wish you good day and good health.