Safer Use of Medicines a psycho geriatric/elderly perspective

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Know your audience…

- Short points machine gun style
- Short clear statistics (if there absolutely has to be any at all)
- Tell us what to do
- List of rules of thumb (ok to repeat the old ones)
- Quick fix take home messages

‘site map’

- Guidance rules
- Common areas of under treatment
- Withdrawing treatment
- Tramadol
- Tasty takeaways!

Why do we have presentations on safer use of medicines anyway?

- For every dollar spent on medicines we spend on average one dollar fixing up the problems those medicines cause further down the track

Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost of illness model. Arch Intern Med 1995;155:1949-56

Simple stats

- Most people over 70 who have been dispensed any medicine, are on at least four medicines.
- If you are on 12 medicines you are 100% likely to experience an ADR!

Some rules of thumb

- Treat the underlying disorder(s), not necessarily the symptoms
- Choose medicines that are less likely to cause adverse reactions

When is enough, enough? N Kerse, D Mangin. Best Practice, BPAC April 2010

Rule of thumb…

- Sometimes non-medicine interventions are sufficient
- Do not use chronological age as a guide for assessing potential benefit or risk of a medicine

Rule of thumb…

- Regularly review the indications for therapy

Rule of thumb…

- If it ain’t broke, don’t fix it
- What does the patient want?

Under treatment

- Bone health
- Pain
- CV

Withdrawing treatment

- Benzodiazepines/zopiclone
- Antipsychotics in dementia

Benzodiazepine dose equivalents

- Diazepam 5mg ~
  - lorazepam 0.5-1mg
  - nitrazepam 2.5-5mg
  - oxazepam 15mg
  - temazepam 10mg
  - triazolam 0.25mg
  - zopiclone 7.5mg

Overtreatment…

- Tramadol has just become fully funded on the schedule
- Think seriously before initiating this agent in the elderly
- Its not as benign as many think

Tramadol – serotonin syndrome

- Medicines to watch out for
  - Antidepressants
  - Carbamazepine, olanzapine
  - St John's Wort
  - Parkinson's medicines
  - Anti-migraine medicines (e.g. sumatriptan)
  - Dextromethorphan

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Takeaways…

- Paracetamol
- NSAIDs/PPIs
- Consider low dose morphine over codeine and don’t consider Tramadol (too soon!)
- Vitamin D & calcium
- Benzodiazepine reduction
- Antipsychotics

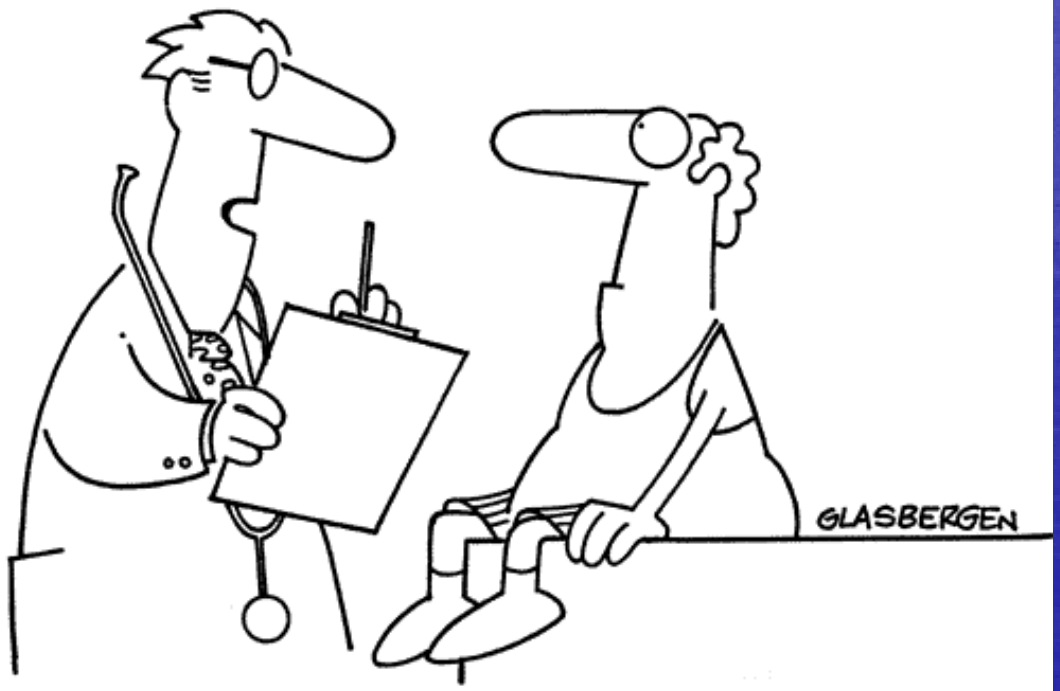
In conclusion

- "there is little to lose in trials of stopping nonessential medicines
- The aim is to prevent morbidity and maximise quality of life **and** appropriate use of medicines is essential. **This may mean stopping them, it may mean starting them.** [Prof Kerse]

Technological brinkmanship

- Recognising the point beyond which treatment has more harms than benefits is difficult, and without an effective way to approach this, treatment is continues because the ‘brink’ is not recognisable

- "The good physician treats the disease; the great physician treats the patient who has the disease: - Sir William Osler 1849 – 1919



"We can't find anything wrong with you, so we're going to treat you for Symptom Deficit Disorder."