

EDITORIAL



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Why Should We Prevent Polypharmacy?

At the beginning of this year, drug labelling became effectively mandatory in Hong Kong because of legislative changes. On the one hand, we, as doctors, have more information on what the patients are taking. On the other hand, the issue of polypharmacy has also begun to emerge.

In this issue of the Journal, Dr. Auyeung Tung Wai and his colleagues take a critical look at the prevalence of polypharmacy among patients attending their specialist geriatric out-patient clinics. Their prevalence is 72 per 1,000 of their clinic patients. In their study, they had defined polypharmacy as greater than 4 regular oral or injectable drugs.

Because of differences in the age of the patient population, general practitioners may not have as many patients on regular drugs as geriatricians. Therefore, we may need a different definition when we discuss polypharmacy in general practice. I personally think that even one unnecessary medication is polypharmacy.¹ However, in my experience, patients are often taking more than just one unnecessary medication. A patient on sixteen medications was reported in Australia last year.² I personally have seen an elderly patient who was put on eleven different items after a consultation with a fellow doctor in Hong Kong earlier this year. Some of these items contained multiple active agents. This patient attended my clinic because of dizziness and palpitation after taking these medications.

With the recent rapid advances in medical and pharmaceutical research, many new drugs are being marketed every year. Most research resulting in the development and marketing of these medications has been directed at proving the efficacy and safety of single drug products. Little research has been directed to determine the safety and efficacy of combining multiple medications in a single patient, whether to treat concurrent conditions or not.³ We are therefore subjecting our patients to possible unknown pharmacological interactions which may have serious and significant harmful effects. This is a particular problem in the very young and very old who are more prone to these harmful effects. When polypharmacy is associated with unnecessary injections, extra pain is suffered especially in paediatric patients.

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Polypharmacy costs money. It encourages drug dependency. It also leads to non-compliance because of the complexity of the medication regimes. It could result in essential drugs not being taken while unnecessary drugs are consumed.

The job of a doctor is to teach patients rather than just giving out pills.⁴ Improved undergraduate and postgraduate medical education in the area of therapeutics will help prevent polypharmacy. Doctors must regularly and actively review the drug regime of patients with chronic problems.⁵ The goal should be to prescribe the least complex drug regimen possible for the patient, while still taking into consideration the medical problems and symptoms and the cost of therapy.¹ Educating patients on the limitations and specific uses of medication, and sharing the decisions for making the treatment goals and plans, will help reduce the demands and expectations patients have of physicians for drug therapy.³

In conclusion, polypharmacy is costly to the health system and harmful to patients. Education for doctors and patients will help reduce the risk of polypharmacy. ■

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Lam Tai Pong
Editor

ERRATUM

Are Doctors Communicating Well Enough? 1995; 17(7): 297-298. An error occurred in this Editorial by Dr. David V.K. Chao on page 297, 2nd paragraph, line 8 "letters to a geriatric . . . (page no. 314)" was wrongly listed. It should read "page no. 323."

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