

Polypharmacy; whose responsibility is it?

Introduction

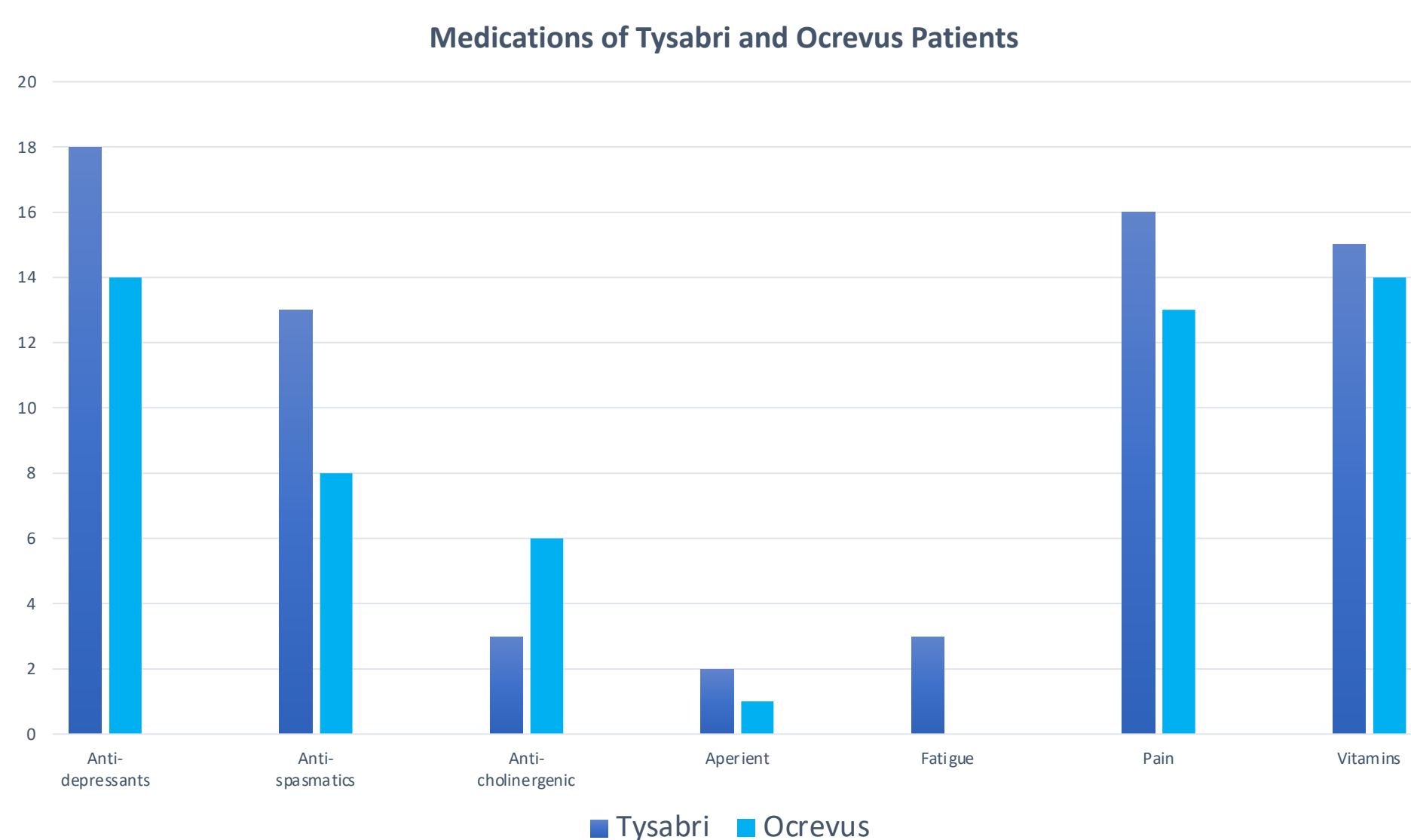
Over the past 3 months, I have monitored consultations with our MS patients. It was evident that patients may have other co-morbidities requiring polypharmacy that may or may not have a detrimental effect on their MS medication, or their health.

I surveyed 66 patients, split into two groups: 33 patients on Natalizumab, and 33 patients on Ocrelizumab, while identifying other co-morbidities and their polypharmacy.

During our consultations with MS patients, we check how they are, and if anything has changed with their MS. This includes how their bladder and bowels are functioning, if there are any concerns with their speech or swallowing, and how their memory, mood, pain, spasms are; all of which could be having an impact on their MS.

We also look at the medication they are currently taking, however we may not be looking at whether they are actually taking their medication as prescribed, including when and how they are taking it. It is estimated that only 50% of patients on long term medication are taking this as prescribed (1).

Figure 1: Distribution of polypharmacy among patients



Objective

- Identifying how many medications each patient is taking, and what each medication is for: MS related or other co-morbidities.
- Identify if polypharmacy is actively being monitored during MS reviews.
- Establish a structured way of reviewing patients' medication, optimising polypharmacy and the compliance of taking long-term medications.

Service development

I feel as health professionals we all have a responsibility to check how much and how often our patients are taking long term medication, especially if we are making new recommendations for our patients and highlighting to the GP if medications are not being taken as prescribed.

For this to happen, it is also important to have the infrastructure to communicate with our colleagues in primary care. We need to be clear with the patient highlighting when and how often they should be taking their medication, especially if this is a new recommendation; this should be added to our clinic letter, which the patient and GP both get a copy of; this would give the patient a clear indication of how and when to take their medication.

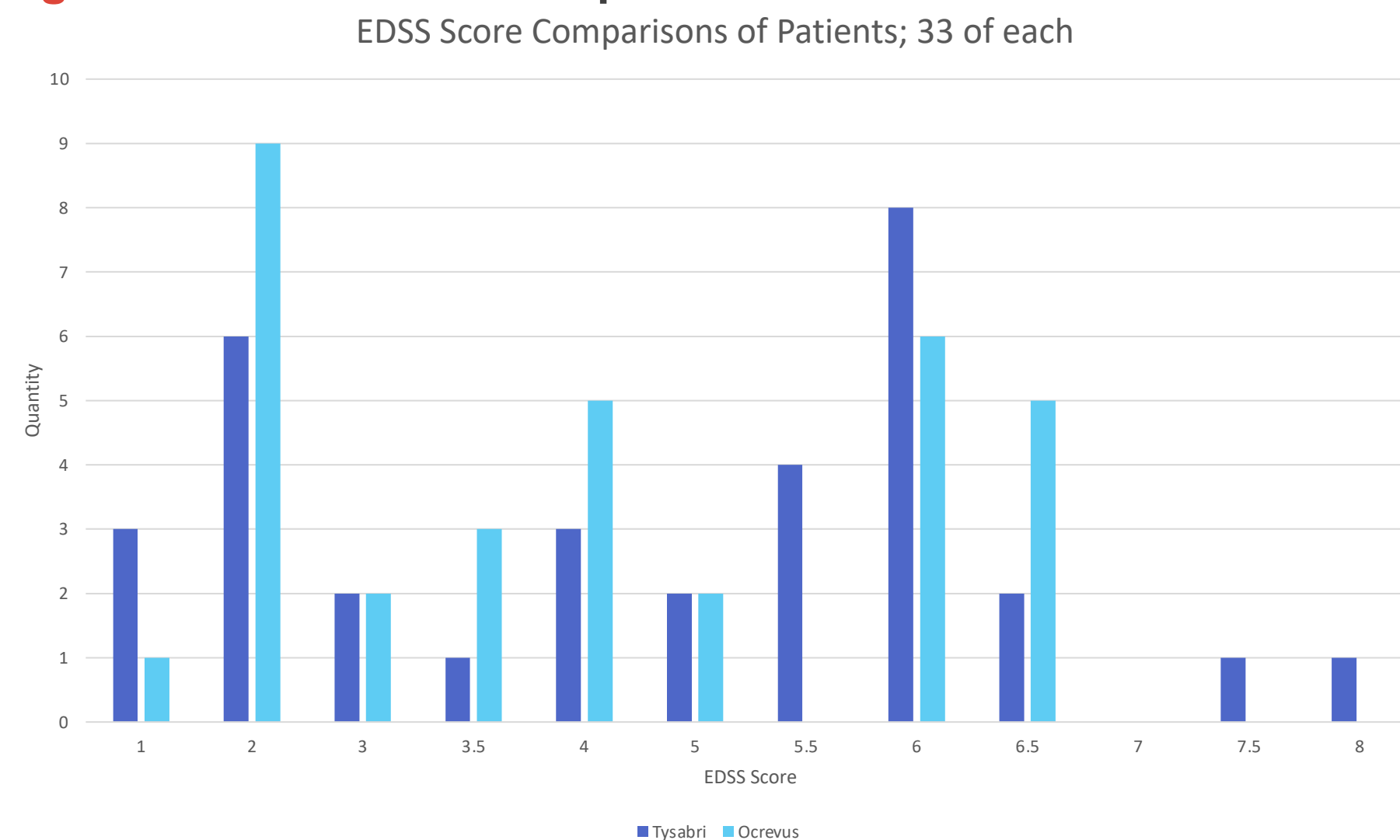
By doing this, it would give the patient a reminder of how and when to take the medication.

It is also important to highlight if a patient has stopped a medication, including why and when. This can highlight to the GP to stop this medication on their repeat prescription, which can help stop patients stockpiling.

Without an annual review, patients may not be taking their medication as prescribed which could lead to possible hospital admissions, which are estimated to cost the NHS £400m a year. Furthermore, patients who have stopped taking medication that is still on their repeat prescription, can lead to stockpiling of medication, which can cost the NHS around £300m a year in England alone (2,3).

For a full, structured, medication review, it is estimated at least 15-30 minutes are needed (4). This could reduce the likelihood of patients stockpiling medications and possible hospital admissions as a result of not taking their medication as prescribed.

Figure 4: EDSS Score Comparison

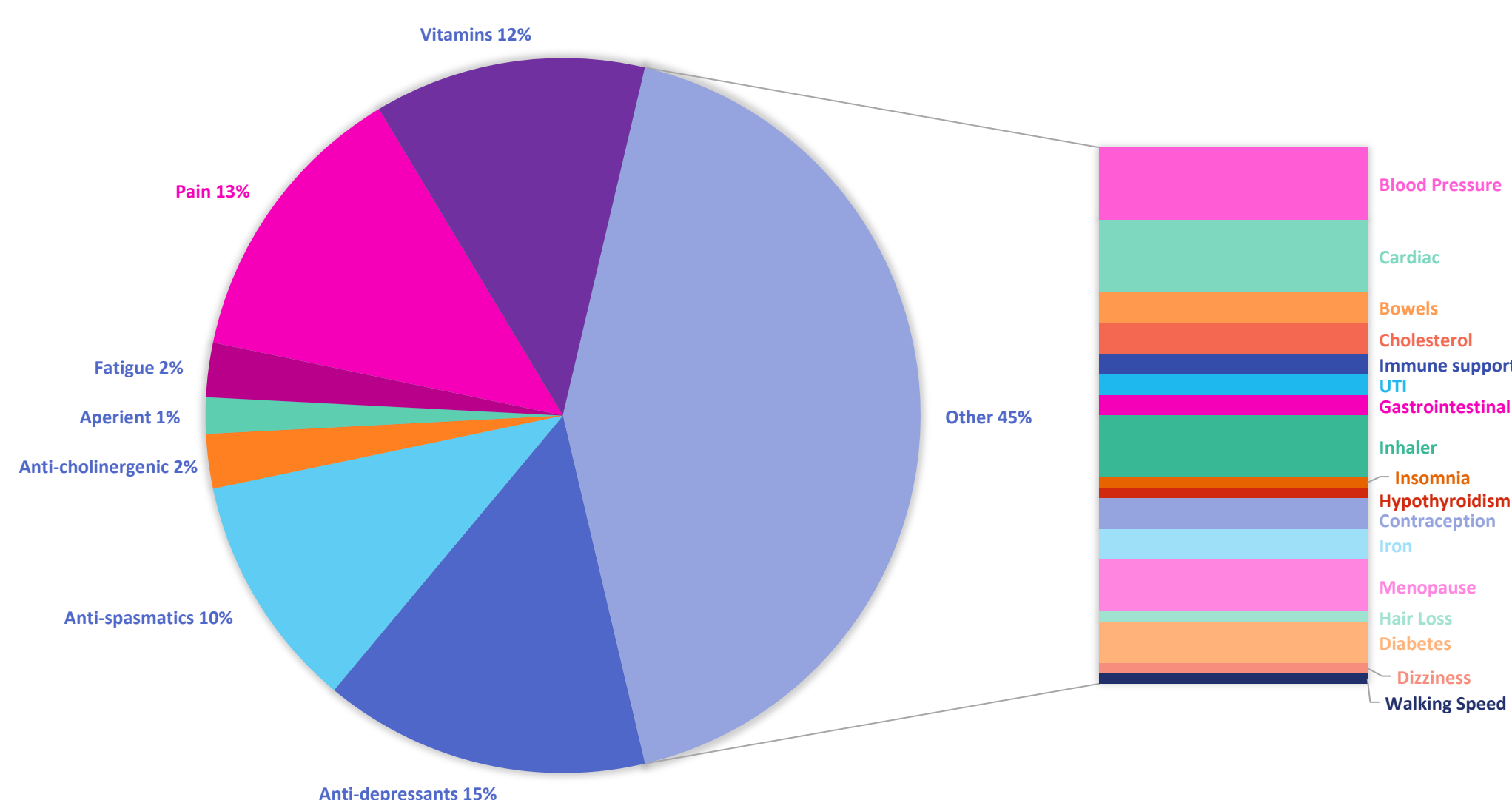


Average EDSS Score Tysabri = 4.4
Average EDSS Score Ocrevus = 4.1

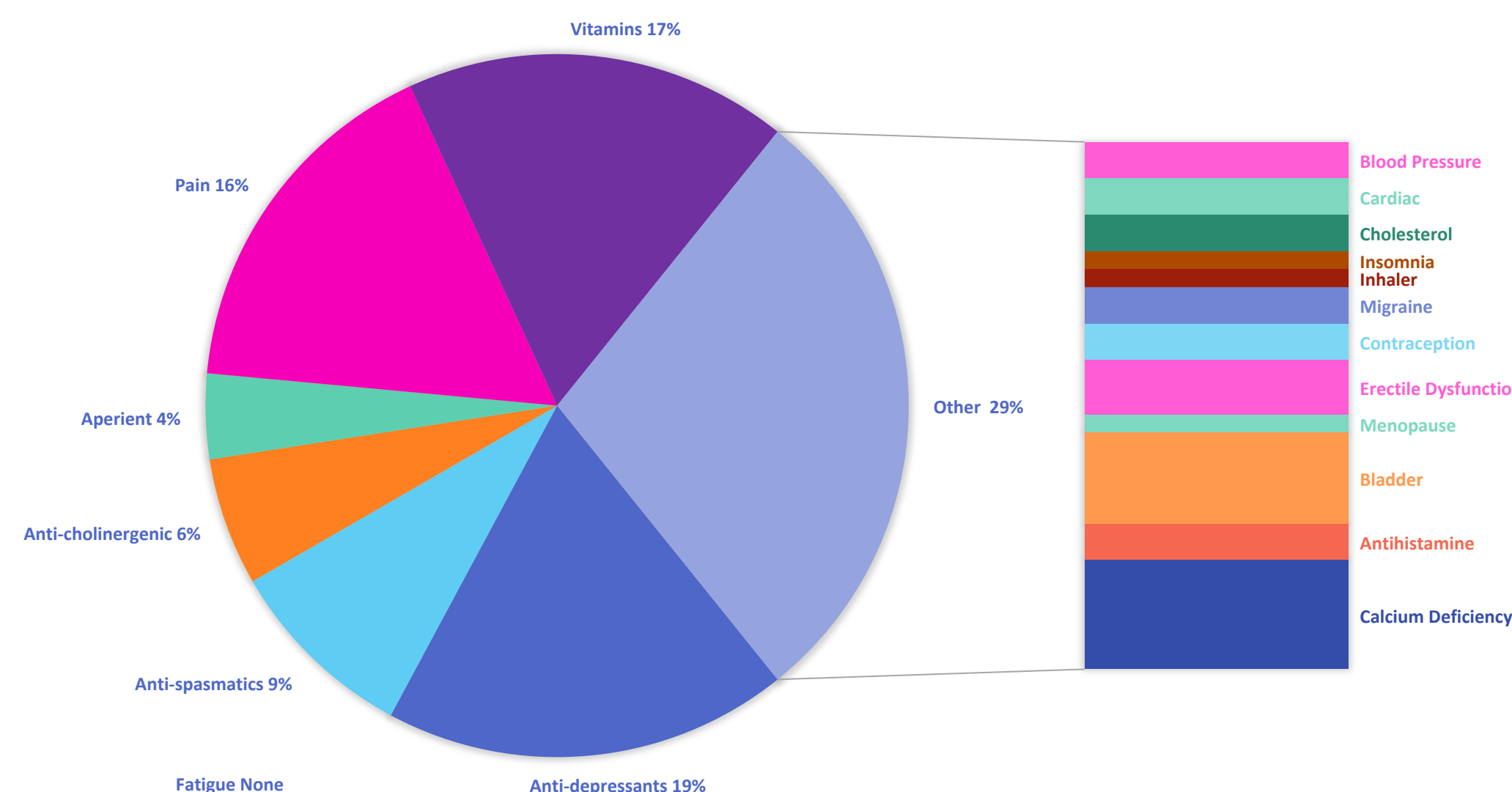
Median = 5
Median = 4

Figures 2 and 3: Medication category

DISTRIBUTION OF MEDICATIONS AMONGST 33 TYSABRI PATIENTS



DISTRIBUTION OF MEDICATIONS AMONGST 33 OCREVUS PATIENTS



Results

- Total Medications of Tysabri patients: 122
- 122/33 patients = 3.7 medications per patient
- However, 1 patient accounts for 24 of the total, another accounts for 13.
- Eliminate the anomalies: 85/31 = 2.7 medications per patient.

- Total Medications of Ocrevus patients: 102
- 102/33 patients = 3.1 medications per patient

Only 12% of the 66 patients in this study have had an active medication review with their GP in the past year.

Conclusions

Ideally, if we had interoperability between systems, we could add updates in real time, reducing medication errors and improving compliance as patients/families/careers would have access to shared care records, and patient medication passports.

However, this is not currently possible at this moment due the lack of infrastructure, and an integrated system where staff from across primary and secondary care can cooperate and communicate with regards to patient documentation.

References

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