Let’s put a stop to the prescribing cascade

I am delighted by the commonsense approach Drs. Weiss and Lee have taken in advising us to be wary of prescribing—or continuing—too many medications for our older patients (“Is your patient taking too many pills?” page 652). Frankly, this advice applies to all patients, regardless of their age, and to virtually all family physicians. We all have stories about medication overuse. I’d like to tell you 2 of mine.

When Mrs. S, a 68-year-old patient, came to see me for the first time, I scanned her medication list. It included a nasal steroid for allergic rhinitis, a PPI for reflux, and 2 asthma inhalers—albuterol and an inhaled corticosteroid.

I asked her if she had hay fever. She didn’t think so. Heartburn? She said No. A history of asthma? No. So why was she taking these medications? To treat a chronic cough, the patient said. Was the cough better? No.

In the past 12 months, Mrs. S had seen an allergist, a gastroenterologist, and an otolaryngologist. The result? All 3 specialists added their favorite medication. I scanned the patient’s medication list again and noticed that she was taking amitriptyline 25 mg as a sleep aid. Because of the drug’s anticholinergic adverse effects, I had a hunch, and asked her to go one week without the amitriptyline. She agreed.

You can guess the happy ending. Mrs. S’s cough vanished, along with 4 medications she never needed in the first place. She was a victim of the prescribing cascade.

The other story is even more dramatic.

A friend who’s both an FP and a geriatrician believed that Mrs. T, a 73-year-old resident when he took over was 9.6. Systematically, he went about reevaluating what residents really required. In the first year, the average number of medications per resident when he took over was 9.6. Systematically, he went about reevaluating what residents really required. In the past 12 months, Mrs. S had seen an allergist, a gastroenterologist, and an otolaryngologist. The result? All 3 specialists added their favorite medication. I scanned the patient’s medication list again and noticed that she was taking amitriptyline 25 mg as a sleep aid. Because of the drug’s anticholinergic adverse effects, I had a hunch, and asked her to go one week without the amitriptyline. She agreed.

A week later, Mrs. S’s cough vanished, along with all the meds she never needed in the first place.

After a year and a half, the average had fallen to 5.4. The residents were no more depressed or agitated, and were generally more alert.

But here’s the catch: I checked back at the nursing home a couple of years after my friend left, and the average number of meds was back up to 10. It takes constant attention to not overprescribe. In fact, I now spend about as much time stopping meds as starting them.

Our health care system is the land of excess. It is up to family physicians—indeed, to all primary care clinicians—to ensure that we only prescribe or continue prescriptions when it’s the right patient, the right medication, at the right time.

Now it’s your turn. Send me your favorite, or most dramatic, medication overtreatment stories for our Letters column. We’ll continue the dialogue there.