Simplify Care by Prioritizing Comorbidities

BY KERRI WACHTER
Senior Writer

WASHINGTON — The key to managing multiple comorbidities is to identify the highest priorities for an individual patient, according to Dr. Cynthia M. Boyd. Start by considering how the treatment of each condition may complement or hinder others. “What you need to do for one condition may end up affecting or competing with what you might do for another,” she said.

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Think of conditions in terms of clinical dominance and concordance or discordance, she advised at the annual meeting of the American College of Physicians. This framework, borrowed from diabetes care, makes sense for other conditions as well (Diabetes Care 2006;29:725-31).

Clinically dominant conditions are those that are so complex or serious that they eclipse other health problems. Examples include cancer, end-stage renal disease, and severe osteoarthritis.

When there is no clinically dominant condition, think in terms of concordant and discordant conditions. Concordant conditions are more likely to be the focus of a shared management plan. Diabetes, hypertension, and coronary artery disease are examples. Discordant conditions are not directly related in either pathogenesis or management. The coexistence of chronic obstructive pulmonary disorder and depression, or heart failure and renal failure, are examples.

“More often than not, you might end up struggling a bit in terms of coming up with a management plan to meet the goals of both conditions,” Dr. Boyd said.

Clinical practice guidelines are often developed for a single disease. When other diseases are addressed, it’s in the context of how that single disease may alter treatment of the index condition. There is limited evidence on the applicability of clinical practice guidelines to older patients with multiple comorbidities, as such patients are typically excluded from clinical trials. Clinical practice guidelines are often developed for a single disease. When other diseases are addressed, it’s in the context of how that single disease may alter treatment of the index condition. There is limited evidence on the applicability of clinical practice guidelines to older patients with multiple comorbidities, as such patients are typically excluded from clinical trials.

Symptomatic vs. asymptomatic conditions—and what’s important to patients—play an important role in quality of life. The management of an asymptomatic condition may be less important to patients than with multiple comorbidities, as such patients are typically excluded from clinical trials.

Not only do multiple comorbidities pose a management risk for physicians, patients face a treatment burden. Just taking all medications according to direction can be difficult. In addition, patients are asked to factor in dietary recommendations, nonpharmacologic therapies, self-monitoring, protective strategies and exercises, and periodic exams and referrals. Try to minimize the number of medications and simplify directions and schedules.

Last, remember that management priorities can change over time. It’s important to periodically reassess them.

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