Problems of multimorbidity and polypharmacy

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Today’s presentation

- Multimorbidity during consultation
- Polypharmacy during consultation
- Knowledge and knowledge gaps
Why should physicians bother about multimorbidity?
In GP practice multimorbidity is the rule rather than the exception

- Most of GP consultations concern patients with multimorbidity
- More intercurrent minor morbidity
- GP deals with ´additional´ patient visits
Figure 3  Mean number of primary care consultations, hospital outpatient visits and hospital admissions in previous twelve 12 months according to number of chronic conditions (Unadjusted).

Glynn et. al., Fam Pract, 2011
Polypharmacy, Adherence

Different physicians, hospitalizations, emergency treatments

Multimorbidity

Disease specific guidelines

Quality of life, mortality

Complexity
What happens during consultation?
Not all diseases have same impact
Not all desired outcomes may be achieved simultaneously, or only at cost of greater burden of treatment
What GPs want...

- Individualization of care
- Integrated approach
- Shared decision making
What GPs do...

Focus on specific clinical tasks ...

Sequential model
What patients want...

Manage daily life!

Workload & capacity

Psychosocial support
Management of multimorbidity

Facilitating
- Personal doctor-patient relationship

Complicating
- Mental health problems
- Complexity of diagnosis
- Treatment (polypharmacy)
Why should physicians bother about polypharmacy?
Polypharmacy:

- Chronic intake of 5 or more medications
- Consultation with multimorbidity $\approx$ consultation with polypharmacy!
Consequences

- Interactions
- Adherence
Number of prescriptions in age groups - NL

Source: Foundation for Pharmaceutical Statistics, 2009
DDD in age groups - Germany

Source: GKV, Statutory Health Insurance Fund, 2011
Patients’ treatment goals / preferences

- Patient concerns about the need to take all
- More focus on QoL than extending life
- Patient’s awareness what he wants to avoid
- Patient preferences change over time
- Embed treatment strategies
  - Minimally disruptive medicine approach
Medication decision making

Holmes et. al., Arch Intern Med. 2006;166(6)
Polypharmacy in younger patients

- Control symptoms to facilitate tasks / social roles
- Balance between ‘responsible’ (minimal) drug use and maximum use of other strategies
- Drugs can either serve as an excuse of dysfunction or can threaten identity
Policy - dilemma

- Increasingly quality indicators (based on guidelines) are economic incentives → undermines efforts to individualize care
Knowledge and knowledge gaps
Gaps

- Increase knowledge about disease patterns and medication clusters
- Increase knowledge about who’s susceptible
- Use epidemiologic and clinical knowledge → more coherent guidance for most common disease groups
Disease clusters

❖ Schäfer et al., 2011
  1) cardiovascular/metabolic;
  2) anxiety/ depression/somatoform disorders and pain;
  3) neuropsychiatric disorders

❖ Prados et al., 2012
  1) cardio-metabolic;
  2) psychiatric-substance abuse;
  3) mechanical-obesity-thyroidal;
  4) psychogeriatric;
  5) depressive
Evidence gaps in interventions, e.g.

- Non-pharmacological interventions
- Drug cessation
- Old age and multimorbidity (often excluded from trials)
- Multi/interdisciplinary approaches
- Patient involvement
Current studies on polypharmacy in primary care

- **PRIMUM (Goethe University)**
  - general practice based complex intervention to improve the medication appropriateness in older patients

- **PIL (Maastricht University)**
  - collaborative approach GP, nurse practitioner, pharmacist, specialists and patients to improve QoL in older patients through optimized chronic drug therapy
Conclusion

- Multimorbidity and polypharmacy are interwoven and joined strategies are needed.
- Interdisciplinary collaboration as well as patient participation is necessary, in care but also in research!
감사합니다

Danke

Thank You

Grazie

Dank

Merci

Obrigado

Natick

Dalu

Köszönöm

Tack

Gracias

Seeé

ありがとうございます