

When Less is More: Reducing the Pill Burden by Embracing Deprescribing in Primary Care

Aisha Ambreen^{1*} and Rafay Iqbal²

¹Section of Palliative Medicine, Department of Oncology, Aga Khan University Hospital, Karachi, Pakistan

²Department of Family Medicine, Aga Khan University Hospital, Karachi, Pakistan

Dear Editor,

With the dawn of a new era in this fast-paced health care environment, our approach to polypharmacy requires fundamental re-evaluation. Patients with chronic conditions and advancing age are on the rise in Pakistan [1]. Such patients often struggle to keep up with numerous medications, adding to their treatment burden and medication costs. Whilst this may be appropriate for some individuals, there is growing recognition within primary care that, many times, less is truly more, particularly in older people. Inappropriate polypharmacy, now recognized as a major public health concern, imposes a significant burden with adverse patient outcomes resulting from ill health, drug interactions, falls, cognitive or functional decline, disability, and preventable hospitalizations [2]. Although polypharmacy prevalence varies across studies and healthcare settings, estimates are consistently high. It was reported to be around 62% in the elderly population with chronic diseases in a study conducted in urban tertiary care centers in Pakistan, compared to the global prevalence of 45% in the elderly [3, 4]. Another local geriatric study from a major tertiary care hospital reported a 68% rate [5].

Deprescribing, a term first coined by Professor Michael C. Woodward in 2003, is the process of identifying and supervising the discontinuation of medications that might cause harm, to optimize patient care and improve quality of life [6]. Successful deprescribing of potentially inappropriate medications (PIM) requires a multidisciplinary approach.

Primary care physicians are uniquely positioned as frontline healthcare professionals in the community to curb polypharmacy, acting as gatekeepers to specialist and hospital-based services. The long-standing relationship they develop with their patients and families, along with the contextual insights, equip them to review and rationalize medications under proper clinical guidance. They can resist and respond effectively to prescribing pressures through effective communication and shared decision-making, allowing for a much safer,

more rational prescribing plan. Drugs like proton pump inhibitors (PPIs), non-steroidal anti-inflammatory drugs, benzodiazepines, and other psychotropic medications are frequently encountered in PIM. A planned and supervised process of reviewing such medications for dose reduction or discontinuation is safe and feasible when carried out under close monitoring [7].

To implement effective deprescribing interventions, a multifaceted approach is required in primary care. Inclusion and engagement of diverse health professionals, including physicians, nurses, and clinical pharmacists, will help optimize practices. Various barriers currently exist in our systems that must be addressed when designing any intervention. Prescribing culture of giving a pill for every ill, time constraints, and lack of awareness of PIM pose significant challenges. Use of established tools such as the Beers Criteria and the Screening Tool to Alert Doctors to Potential Medication Problems (STOPP) should be employed by primary care physicians [8, 9]. Artificial intelligence can be used to strengthen practices by using low-cost tools not only to identify PIM but also to suggest step-down plans. Targeted interventions, such as prescriber education and pharmacist integration, should be top priorities. It is imperative to implement deprescribing interventions within available resources that strengthen primary care capacity to enhance patient safety and quality of life.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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*Corresponding author: Aisha Ambreen, Section of Palliative Medicine, Department of Oncology, Aga Khan University Hospital, Karachi, Pakistan, Email: aisha_ambreen@yahoo.com

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