Multimorbidity Dec 2016

Prescribing...

- Multimorbidity, the presence of two or more long term conditions, can result in a significant treatment burden and reduced quality of life for individuals.
- The NICE guidance on the topic provides the guiding principles to improve the quality of life and to reduce the incidence of unplanned care.
- Drugs used to manage risk factors for future diseases and/or single disease states will not have been tested on people with multimorbidity.

Multimorbidity refers to the presence of two or more long-term health conditions, which can include

- Defined physical and mental health conditions such as diabetes or schizophrenia
- Ongoing conditions such as learning disability
- Symptom complexes such as frailty or chronic pain
- Sensory impairment such as sight or hearing loss
- Alcohol and substance misuse

All recent studies have shown that multimorbidity is common and becomes more common as people age and in people from less affluent areas. In older people multimorbidity is due to higher rates of physical health conditions, in younger people and in those from less affluent areas it is due to a combination of physical and mental health conditions, most notably depression. It is associated with reduced quality of life, higher mortality, polypharmacy and high treatment burden, higher rates of adverse drug events and much greater health services use. Treatment regimes, including non-pharmacological treatments can become very burdensome and care can become fragmented.

Multimorbidity and Polypharmacy

There is an absence of trial evidence to support the stopping of groups of drugs, so the GDG was unable to offer very specific advice. However it identified the following very useful guiding principles.

- **The management of risk factors for future disease** can be a major treatment burden for people with multimorbidity and should be carefully considered when optimising care. It is important to remember that NICE guidance on single health conditions is regularly drawn from people without multimorbidity and taking fewer drugs.
- Clinicians are recommended to "think carefully" about the risks and benefits for people with multimorbidity, of individual treatments recommended in guidance for **single health conditions**.
- Adults of any age who are prescribed **10 to 14 regular drugs**, or people on less than 10 prescribed but are at particularly high risk of side effects should have multimorbidity taken into account.

How can this be done?

The GDG advised that people with multimorbidity should be asked what their personal goals are. For some this might mean lengthening life and/or preventing events such as stroke by continuing prescribed drugs. But for others it might mean taking fewer drugs, hence reducing harm from them and reducing their treatment burden.

Two resources were identified to aid this process. The first is the Database of Treatment Effects: www.nice.org.uk/Guidance/ng56/resources, an interactive resource which shows the effectiveness of treatments, the duration of the trials and crucially the populations included in the trials. It shows the numbers needed to treat and the annualised absolute effect.

The STOPP-START tool which was developed by a specialist multi-disclipinary unit in Cumbria http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/StopstartToolkit2011.pdf offers more specific guidance on stopping medication that may be harmful. It also reminds clinicians of areas where there may be under-treatment and evidence of benefit e.g. depression and pain.

The GDG advises that people who are on treatments to **relieve symptoms** should be asked whether or not they are beneficial or causing harm. If a person is unsure of benefit or is experiencing harm, then reducing or stopping treatment should be considered. A plan should be made to review any changes made and to decide whether any further changes to treatments are needed.

The GDG also advises that there is a possibility of a lower likelehood of overall benefit of continuing treatments that offer **prognostic benefit**, particularly in people with limited life expectancy or frailty. Trials undertaken ten to twenty years ago would not have included people with multimorbidty.

They further advise that a discussion should be had with people with multimorbidity and limited life expectancy as to whether they wish to continue with treatments recommended in guidance on **single health conditions,** which may offer them limited overall benefit.

The GDG acknowledged that local priorities will have been identified. In the Bailiwick across primary and secondary care, many priorities have been identified for deprescribing including fish oils, glucosamine, ezetimibe, long-term PPIs, long-term hypnotics, stepping down ICS in stable asthma, low dose atypical antipsychotics in dementia, clopidogrel and antibiotics for self-limiting illnesses.

In summary

The NICE guidance on multimorbidity provides guiding principles on reviewing treatments. If an individual wishes to reduce their treatment burden, drugs used to relieve symptoms should be reviewed. If they are causing any harm they should be stopped. Drugs that provide a prognostic benefit or those recommended for single diseases may provide less benefit than expected in multimorbidity.

Written by : Geraldine O'Riordan, Prescribing Advisor, Social Security, Wheadon House, Le Truchot, St Peter Port GY1 3WH.