When Less Is More
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Story from the front lines:
A man in his 70s with history of benign prostatic hypertrophy, atrial fibrillation, hypertension and compensated systolic heart failure presented for evaluation of dizziness and recurrent falls. The week prior to our appointment, his cardiologist discontinued the patient’s warfarin over concern of future bleeding risk with near-falls.

At the time of our visit, the patient was bradycardic (51bpm), relatively hypotensive (100mmHg/66mmHg) and demonstrated positional orthostasis. The patient expressed a fear of falling and his wife was concerned about his extensive medication regimen as a possible contributor. On medication review, he reported adherence to all of his 15 daily medications including those most likely to be contributing to his current symptoms: lisinopril, metoprolol and tamsulosin. After further discussion, we learned his cardiologist had recommended simplifying his medication list however he preferred to continue ACE-inhibition and beta-blockade given their known salutary effects in the management of systolic heart failure.

As a result of his reported increase in falls, lisinopril and metoprolol were discontinued at our visit given his concerning vital signs and dizziness with positional changes. He was asked to monitor his symptoms and blood pressure at home and return for re-evaluation in one week.

Teachable moment:
With growing lists of evidence-based interventions, we need to be all the more mindful of the tension between the benefits and risks of these interventions for individual patients. While it is well established that beta blockade and ACE inhibition reduce mortality risk in patients with systolic heart failure, these well-intended treatments were causing harm to our patient – likely in excess of any benefit over the near term.

To prevent falls and injuries related to adverse effects of his medications, we elected to discontinue the likely culprit medications despite known history of hypertension and heart failure. In the coming months, we intended to reassess his symptoms and, if appropriate, reinitiate ACEI-inhibition and beta-blockade therapy at lower dosage with slow up-titration.

It is important to note that the discontinuation of his warfarin, prompted by increased complaints of falls, was probably not the preferred course of action as increased propensity for falls may not translate to higher risk for intracranial bleeds and can actually reduce quality-of-life years when compared to continuation of anti-coagulation therapy in the setting of chronic atrial fibrillation. Furthermore, stopping warfarin did not get to the root of the problem which was falls related to medication induced hypotension.

As the current health care system evolves and patients are eligible for new therapies, we must pay heed to the risk of polypharmacy and the risk of overtreatment. As physicians, we need to be comfortable
with the decision to not treat, despite evidence suggesting potential benefit in populations, when an individual patient’s immediate safety is compromised. It is estimated that approximately 20% of community dwelling elderly patients are on at least one inappropriate medication. Among patients that experience adverse drug events, approximately 28% of these events are considered preventable in certain settings. Fisher and Welch suggest that harm from treatment can be minimized by recognizing our own biases, scrutinizing the patient populations from which evidence is derived and then carefully deciding if data can be extrapolated to our individual patient cases.

In the end, each patient must be assessed individually, recognizing that every case is different in light of a person’s unique circumstances, values, and preferences. There will always be costs and benefits to consider when weighing the decision to continue or stop a particular medication. Though clinical inertia may cause us to steer away from entrenched practices, we do well to remember that less can be more.

References:

5. Fisher E, Welch H G. Avoiding the Unintended Consequences of Growth in Medical Care. JAMA, 1999;281(5) 446-53.