

## Reducing polypharmacy: When less is more

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If the first 3 medications you prescribed were working, you wouldn't need to add a fourth

Up to one-third of psychiatric outpatients in 2006 received  $\geq 3$  medications, compared with 17% a decade earlier.<sup>1</sup> Polypharmacy is expensive, increases the risk of adverse effects, and may contribute to nonadherence. Although we recognize that at times long medication lists are justified, we offer 4 principles to help you limit unnecessary polypharmacy.

### Do not treat patients' symptoms indefinitely

William Osler stressed the importance of treating diseases, not symptoms.<sup>2</sup> Symptoms without a diagnosis are experiences. Whether physicians should treat experiences is an ethical question; however, even if your answer is "yes," such treatment should be transient. Symptoms occurring within a diagnosis should be treated conservatively, but humanely, only while waiting for syndromal relief.<sup>3</sup>

### Do not use syndrome-oriented drugs to treat symptoms

Mood disorders are not just unpleasant emotions, and anxiety disorders are more than simply nervousness. Medications that are effective for psychopathologic syndromes might not help isolated patient complaints. For example, antidepressants do not simply lift sadness, nor do they usually relieve the nonsyndromal "anxiety" many patients report. Some clinicians might disagree with this recommendation based on flaws in DSM-IV-TR taxonomy; however, these shortcomings do not translate into pharmacologic efficacy.

### Do not accumulate medications when faced with nonresponse

If the first 3 medications you prescribed were working, you wouldn't need to add a fourth. Consider discontinuing one medication for every new one you start. This principle can help you set limits with patients who demand more medications to try to eradicate nonsyndromal distress or clinically significant symptoms that psychopharmacology cannot address. Nonresponse to aggressive treatment should trigger a reassessment of the original diagnosis.

### Do not match 'soft' diagnoses with 'soft' treatments

"Soft" diagnoses come in 2 types:

- an equivocal or mild psychopathologic picture that may be called, for example, "soft bipolar illness"
- using imprecise terms as diagnostic proxies, such as "depression and anxiety."

Patients with soft diagnoses often receive combinations of lower-than-standard dosages or drugs with milder side effects but substandard efficacy. For these patients, we recommend postponing pharmacotherapy or "firming up" the diagnosis and then initiating the standard of care.

#### References

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