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EDITORIAL

Polypharmacy in Psychiatric Practice: Weighing the Benefits and the Risks

Polypharmacy has been a major cause of concern for physicians and patients alike. Broadly defined, the term may simply refer to unnecessary and excessive use of medications to treat a medical condition. It often conveys a meaning that "more is being used when less would have sufficed". One oft-quoted definition of polypharmacy in psychiatry is: The use of two or more medications to treat the same condition, use of two or more drugs of the same chemical class, or use of two or more drugs with the same or similar pharmacologic actions to treat different conditions.[1] Polypharmacy is known across various medical specialties, especially in those dealing with chronic conditions. Psychiatry has come into focus as a specialty with high degree of polypharmacy. Polypharmacy poses several risks to the patient — higher incidence of adverse effects and drug interactions, greater chances of non-adherence and medication errors. However, not all instances of polypharmacy are irrational or unjustified. Often, a rational combination of two drugs leads to a better outcome of illness than can be achieved by either drug alone. Lithium has been known to augment the antidepressant action of selective serotonin reuptake inhibitors (SSRIs) or low-dose antipsychotics have been known to augment the antiobsessive action of SSRIs. These are examples of "rational polypharmacy" which are also evidence-based and more commonly, have a place in the existing treatment guidelines. However, we all are concerned with increasing use and "silent acceptance" among our own fraternity of the practice of irrational polypharmacy—multiple benzodiazepines in the same patient, two or more antipsychotics in sub-optimal doses in the same patient and similar other examples.

What could be the possible causes of irrational polypharmacy? Commonly, the clinician achieves some degree of response in his patient after using a drug in a particular dose. However, when the response is not adequate, the psychiatrist is often hesitant or apprehensive about discontinuing the initial drug before starting the second. As a result, the second drug is added. If there is inadequate response here too, the third may follow. This tendency to add may lead to irrational polypharmacy of various degrees. Some practitioners develop their own unique heuristics where a combination of certain doses of two or more drugs having similar action is "thought to produce most effective response". As a result, they tend to follow this blindly, expecting good clinical response without bothering about the long-term consequences. Another common cause of irrational polypharmacy is the clinician being unsure of the diagnosis. In such cases, he may tend to add two or more drugs having efficacy for two or more conditions in an empirical approach. Another common trap is when the patient is settled on multiple medicines and the psychiatrist fears that altering medicines will lead to an unpleasant "flare up". In today's world, expectations of patients and their guardians are often excessive and unrealistic. When they pressurize the clinician for a better outcome than simple remission, the latter often resorts to polypharmacy in expectation of a better response. Sometimes, anecdotes of early response by use of combinations tempt clinicians to try them. Finally, when response does occur, the clinician is unsure regarding which drug caused the response. Fearing relapse, he does not "meddle" with the combination and it goes on.

In order to avoid irrational polypharmacy, it is better to try treating with single agents to begin with. It is better to take some time out to clarify the diagnosis rather than using multiple agents to "tackle" diagnostic confusion. It is always better to follow standard evidence-based guidelines and treatment protocols. Polypharmacy, if used, should be rational and evidence-based, not erratic and arbitrary. The clinician should always reevaluate his prescriptions from time to time and try to use the minimum number of drugs possible. The clinicians should repeatedly remind themselves of the age-old dictum of bioethics and an integral part of the Hippocratic oath: Primum non nocere or first, do no harm!

Gautam Saha
Director, Clinic Brain, Neuropsychiatric Institute and
Research Center Barasat, West Bengal, India
e-mail: drgautamsaha@gmail.com

Reference

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