

## Polypharmacy: When might it make sense?

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### Disclosure

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**P**olypharmacy is often defined as the simultaneous prescription of multiple medications (usually  $\geq 5$ ) to a single patient for a single condition or multiple conditions.<sup>1</sup> Patients with psychiatric illnesses may easily be prescribed multiple psychotropic medications regardless of how many other medications they may already take for nonpsychiatric comorbidities. According to 2011-2014 Centers for Disease Control and Prevention data, 11.9% of the US population used  $\geq 5$  medications in the past 30 days.<sup>2</sup> Risks of polypharmacy include higher rates of adverse effects as well as treatment noncompliance.<sup>3</sup>

There are, however, many patients for whom a combination of psychotropic agents can be beneficial. It is important to carefully assess your patient's regimen, and to document the rationale for prescribing multiple medications. Here I describe some factors that can help you to determine whether a multi-medication regimen might be warranted for your patient.

**Accepted medication pairings.** This describes a medication combination that has been recognized as generally safe and may provide more benefits than either single agent alone. Examples of clinically accepted medication combinations include<sup>4,5</sup>:

- a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) plus bupropion
- an SSRI or SNRI plus mirtazapine
- ziprasidone as an adjunct to valproate or lithium for treating bipolar disorder
- aripiprazole as an adjunctive treatment for major depressive disorder (MDD).

**Comorbid diagnoses.** Each of a patient's psychiatric comorbidities may require a different medication to address specific symptoms.<sup>3</sup> Psychiatric comorbidities that might be appropriate for multiple medications include attention-deficit/hyperactivity disorder and bipolar disorder, MDD and generalized anxiety disorder, and a mood disorder and a substance use disorder.

**Treatment resistance.** The patient has demonstrated poor or no response to prior trials with simpler medication regimens, and/or there is a history of decompensation or hospitalization when medications were pared down.

**Severe acute symptoms.** The patient has been experiencing acute symptoms that do not respond to one medication class. For example, a patient with bipolar disorder who has acute mania and psychosis may require significant doses of both a mood stabilizer and an antipsychotic.

**Amelioration of adverse effects.** One medication may be prescribed to address the adverse effects of other medications.

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Carefully assess your patient's medication regimen and document the rationale for prescribing multiple medications

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For example, propranolol may be added to address akathisia from aripiprazole or tremors from lithium. In these cases, it is important to determine if the medication that's causing adverse effects continues to provide benefits, in order to justify continuing it as well as adding a new agent.<sup>3</sup>

After reviewing your patient's medication regimen, if one of these scenarios does not clearly exist, consider a "deprescribing" approach—reducing or stopping medications—to address unnecessary and potentially detrimental polypharmacy. For more information on deprescribing, see

"6 Steps to deprescribing: A practical approach," (CURRENT PSYCHIATRY, June 2017, p. 36-37).

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