# Prioritizing Comorbid Conditions Simplifies Care

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WASHINGTON — The key to managing multiple comorbidities is to identify the highest priorities for an individual patient, according to Dr. Cynthia M. Boyd.

Start by considering how the treatment of each condition may complement or hinder others. "What you need to do for one condition may end up affecting or competing with what you might do for another condition," said Dr. Boyd, of the division of geriatric medicine and gerontology at Johns Hopkins University, Baltimore.

Think of conditions in terms of clinical dominance and concordance or discordance, she said at the annual meeting of the American College of Physicians. This framework is borrowed from diabetes care, but it makes sense for other conditions as well (Diabetes Care 2006;29:725-31).

Clinically dominant conditions are those that are so complex or serious that they eclipse the management of other health problems. Examples include cancer, end-stage renal disease, and severe osteoarthritis.

When there is no clinically dominant condition, think in terms of concordant and discordant conditions. Concordant conditions represent parts of the same overall pathophysiologic risk profile and are more likely to be the focus of a shared management plan. Diabetes, hypertension, and coronary artery disease are examples of concordant conditions, she said.

Discordant conditions are not directly related in either pathogenesis or management and do not share an underlying predisposing factor. The coexistence of chronic obstructive pulmonary disorder and depression, or heart failure and renal failure, are examples of discordant conditions. "More often than not, you might end up struggling a bit in terms of coming up with a management plan to meet the goals of both conditions," Dr. Boyd said.

Keep in mind that some conditions may heighten the complexity of managing the index condition. For example, renal insufficiency often limits medication choices for other conditions.

Clinical practice guidelines don't offer much help for the management of patients with multiple comorbidities. Guidelines are often developed for a single disease. When other diseases are addressed, it's in the context of how that single disease may alter treatment of the index condition.

There is also limited evidence on the applicability of clinical practice guidelines to older patients with multiple comorbidities, as these are the patients who are typically excluded from clinical trials. In addition, guidelines rarely address quality of life or patient preferences.

Symptomatic versus asymptomatic conditions—as well as what's important to patients—play an important role in quality of life. The management of an asymptomatic condition may be less important to a patient. Talk with patients about what their priorities are. Also talk with caregivers and family members to learn their priorities, which may often focus on maintaining patient independence.

Not only do multiple comorbidities pose a management risk for physicians, but patients also face a treatment burden. Just taking all of the medications according to direction can be difficult. In addition, patients are asked to factor in dietary recommendations, nonpharmacologic therapies, protective strategies and exercises, self-monitoring, and periodic exams and referrals, so one should try to minimize the number of medications and simplify directions and schedules.

Last, remember that management priorities can change over time, Dr. Boyd said, so it's important to periodically reassess them. ■

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**References: 1.** Gross L. Metaxalone: a review of clinical experience. *J Neurol Orthop Med Surg.* 1998;18(1):76-79. **2.** Dent RW Jr, Ervin DK. A study of metaxalone (Skelaxin) vs. placebo in acute musculoskeletal disorders: a cooperative study. *Curr Ther Res Clin Exp.* 1975;18(3):433-440.