

Keep treatment regimens simple if you want to maximise adherence and minimise adverse effects

The evidence supporting interventions to help improve adherence with medicine taking is surprisingly small.¹ We know that simplifying treatments to once or twice daily dosing and reducing the total number of medicines prescribed is beneficial. It is also likely that involving patients in decisions about their treatments increases their commitment to taking medicines when they agree with the diagnosis and have had the benefits and risks fully explained.

Another important factor affecting adherence is whether the patient experiences an adverse effect. For long-term conditions such as hypertension where the patient feels no symptoms, even a minor adverse event may be sufficient to stop taking the treatment. Even the suggestion of an adverse effect (such as reading the frightening list of potential problems in the patient information leaflet) often acts as a deterrent to adherence.

Poorly tolerated, cheaper medicines will not save money in the long run

In this month's PIP Wasim Baqir reports on a retrospective audit of hypertensive use in a large general practice (p282). Among the key findings was that certain anti-hypertensives within the same class were better tolerated by patients than others. For example, lercanidipine produced less ankle oedema than amlodipine. Tolerability is an important consideration when deciding upon formulary choices. An inexpensive medicine that is poorly tolerated is a false economy because treatment failure may result in the patient abandoning any further treatment — resulting in the patient being switched to a more expensive agent in a different class, and needing further appointments for blood pressure monitoring, which takes up appointment slots and wastes patients' time.

Tolerability of calcium and vitamin D preparations is looked at in the article by Jyoti Sood (p268). Vitamin D supplements are probably of benefit in preventing falls



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and fractures in older people who are vitamin D deficient, such as care home residents. However, many patients do not like taking these products and compliance often falls off over time. Indeed poor compliance may explain why some studies have failed to demonstrate a benefit.

Offering calcium and vitamin D to older people is also a problem because older people are often taking polypharmacy through our efforts to offer them 'evidence-based medicine', and as we know, increasing the total number of prescribed medicines can be inversely proportional to adherence. For this reason it is best to only offer calcium and vitamin D to those patients that are most likely to benefit — and to offer them a product that they find palatable. Vitamin D in therapeutic doses of 800iu daily (cholecalciferol) is only commercially available with calcium. It is doubtful whether calcium is necessary and it is this that makes it unpalatable. I would like to offer a small reward — and my gratitude — to a manufacturer who would produce a once weekly (or monthly) vitamin D tablet for the UK market. This of course is probably not commercially viable, but for the Government (who run a health maintenance organisation

with 60 million members) it would make a lot of sense for them to develop and license this product themselves.

As NICE continues to churn out its recommendations it is difficult for practitioners to keep up-to-date. Two articles, this month, provide us with a summary of therapy areas reviewed by NICE. These are reducing thromboembolic risk, and tumour necrosis factor-alpha inhibitors for rheumatoid arthritis. Human papillomavirus vaccines have also been launched this autumn, but have not yet been reviewed by NICE. Although a national roll-out programme has been agreed (starting with 12–13 year-old girls with a catch-up programme to 18 year-olds) there remain a number of unanswered questions about vaccination including ethical issues about the wisdom of not vaccinating males and whether treatment should be offered to



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people outside the programme. These issues and more are discussed in the article by Anne Szarewski (p291). ❖

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References

1. Haynes RB, Yao x, Degani A *et al.* Interventions for enhancing medication adherence. *Cochrane Database of Systematic Review*, 2005.