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Editorial

Healthcare providers in South Asia must pay attention to DEPRESCRIBING

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The simultaneous use of five or more prescription and non-prescription drugs by one patient is called as polypharmacy [1-2]. Because of the association of polypharmacy with increased adverse drug reactions (ADR), drug interactions and decreased drug concordance particularly in the elderly and at-risk populations, there is rising concern especially in the developed world about poly pharmacy [2-3]. There is drug interaction between drugs but it could also be between drugs and diseases or between drugs and food items [4]. Generally, the clinician in healthcare system globally are trained in starting drugs rather than reducing drugs, so, polypharmacy is a challenge to everyone [5].

Polypharmacy is common world-wide; the overall estimated prevalence was 37% as per systemic review done by Delara et al in 2021and published in 2022 [6]. Prevalence of polypharmacy is reported to be high in mostly populated countries of South Asia. In India in elderly adults, over all prevalence of polypharmacy (simultaneous use of 5–9 drugs), 49% and hyper-polypharmacy (simultaneous use of ≥10 drugs) 31% documented by Bhagavathula AS et al in their systemic review published in 2021 [7]. The occurrence of polypharmacy in patients >65 years age was 68% reported from one the major tertiary care hospitals of Pakistan documented by Ahmed B et al. They found incidence of adverse drug reactions more than 10% among these patients [8]. In Bangladesh, polypharmacy (prescription contains more than 5 drugs) was seen in 49.47% of prescription of public hospital and

71.01% of private hospital of Dhaka reported by Samad et al. [9]. Prevalence of polypharmacy in elderly in two tertiary care hospitals of Nepal was found to be 34.5% reported by Shrestha et al in a study published in 2021 [10]. To tackle the problems of polypharmacy, lately the strategy called deprescribing drugs in other words, deprescription have been used in the practice of medicine especially in developed countries like USA, Canada, UK [3, 6, 11]. It is critical for healthcare providers to know and understand deprescribing, how it works, and for whom, and how to sustain its implementation in clinical practice [7,12].

Deprescribing is the process of withdrawal of drug/s or reduction of the dose of drug/s thought to be inappropriate for an individual patient under the supervision of a healthcare provider [1, 13]. The drugs are considered to be inappropriate either they are harmful to the patient or are no longer required (no longer indicated or effective) or not medically necessary [2, 4, 7, 12]

It is rational to withdraw one medicine at a time so as to find the possible harms and benefits of withdrawal [4]. There are benefits of deprescribing such as the resolution of ADRs, comparably better quality of life, improved concordance to drugs and a reduction in medication costs [8, 13].

Literature has revealed that polypharmacy increases with age [2]. Deprescribing has been shown to be feasible in the elderly [1]. Age must not be the sole criterion for initiating deprescribing, but it should also be considered when treatment is inappropriate and must be offered to patients who are at high risk of polypharmacy irrespective of their age [2]. Hence, consistent evaluation of the patient is essential with regard to the intake of drugs and their effects for taking a proactive approach to deprescribing [2, 6,11].

Potentially Inappropriate Medication (PIM) prescribed to the patient put the patients at an increased risk of adverse drug reactions (ADRs) from minor to life threatening such as myocardial infarction. PIM prescribing practice is comparatively highly observed in elderly patients [14].

Specific procedures or frameworks or guidelines for effective deprescribing have been designed to concentrate on a specific objective [3-4,6, 11]. Barbara Farrell and Dee Mangin have mentioned five steps to individualize deprescribing practices for each patient. These are 1) to identify possible inappropriate drugs; 2) to decide can drug dosage be reduced or the drug be stopped; 3) to plan tapering; 4) to monitor for discontinuation symptoms or the need to restart and support the patient; and 5) to document outcomes [5].

Deprescribing must be planned for elderly patients when: 1) they present with a new symptom or syndrome indicative of ADR; 2) they have advanced or end-stage disease, terminal illness, severe dementia, extreme frailty, full dependence on others for daily living activities; 3) they receive high-risk medicines or their combinations; 4) they take preventive medicines with no obvious short to mid-term benefit [4].

There is a lack of evidence on the prevalence of deprescribing in developing countries. It is presumed that the concept is yet new to them [7,12]. In countries of South Asia, the practice of polypharmacy is evident as allopathic

drugs and traditional medicine are simultaneously prescribed by the healthcare providers and used by the patients and self-medication is widely practiced because of varied reasons [9,15]. But deprescribing is not being practiced. It is high time for the countries of South Asia to reduce the practice of polypharmacy and integrate deprescribing into healthcare practices as the percentage of elderly people has been increasing in South Asia and all other risk factors for promoting polypharmacy exist. Authorities must find out the potential barriers and enablers in implementing deprescribing by conducting pilot quantitative study involving clinician, pharmacist and nurses; utilize protocols, procedures etc. developed by other countries; adopt these keeping local context in mind; make patients and healthcare providers aware of the benefits of deprescribing; and identify the opportunities locally to initiate the process of deprescribing by engaging patients and healthcare providers.

It is high time to create posts of clinical pharmacist in secondary and tertiary care hospitals both in public and private sectors according to patients' workload and ensure the placement of well-trained clinical pharmacist in healthcare facilities of South Asian countries. Clinical Pharmacist plays critical leadership role in minimizing polypharmacy and implement deprescribing with cooperation of clinicians and collaboration of all stakeholders facilitating in reducing morbidity and mortality associated with polypharmacy and hyper-polypharmacy.

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