WeMeReC
Welsh Medicines Resource Centre
Canolfan Adnoddau Moddion Cymru

Supplement

Medication Review for the 10 minute consultation

Case study 1

A 78-year-old gentleman, Mr G, attends because three out of five of his repeat medicines need re-authorising and he is increasingly troubled by peripheral oedema. He has hypertension, visual impairment, and he had a hip replacement six months ago. He describes his medicines as "paracetamol for knees, blood pressure tablets, and sometimes a stomach tablet." His blood pressure (BP) was 165/70 mmHg three months ago.

Repeat medication:

nifedipine	10 mg bd	56
Zoton®	30 mg od	28
gauze	10 cm x 10 cm	1x10
paracetamol	500 mg prn	60
tramadol	50 mg q6h	60

What aspects of his treatment do you want to check before re-authorising his medicines?

Need and indication

His spontaneous comments suggest that he is no longer taking tramadol. Was the dressing also used postoperatively and, if so, can it be removed from the repeat list?
Why is he taking a proton pump inhibitor (PPI) and why is he on a "treatment" vs "maintenance" dose?

Open questions

What does Mr G know about his "stomach tablet"?

Tests and monitoring

Disease monitoring

Does he have adequate pain control?
Does he still get indigestion or abdominal pain? Should the PPI dose be reduced?
Does he still have high systolic BP?

Blood monitoring

You do not know his blood cholesterol concentration. Should this be checked?

Evidence and guidelines

The PPI dose should be reduced to a maintenance dose after an initial treatment period. Is *H. pylori* eradication appropriate?

The antihypertensive regimen is not ideal as it is not providing adequate BP control and it could be exacerbating peripheral oedema. Thiazide diuretics can be helpful for isolated systolic hypertension and it may be worth considering using one here.

Adverse effects

Mr G complains of uncomfortable ankle swelling in the evenings. Is his peripheral oedema caused by his medication?

Risk reduction and prevention

It transpires that Mr G has trouble differentiating between his tablets because of visual difficulties. Other agencies may need to be involved.

Simplification and switches

If nifedipine is to be continued, the regimen may be simplified by changing from 10 mg twice daily to 20 mg once daily. This is likely to be cost-effective and may improve compliance.
Note that nifedipine MR is a medicine considered as an "inappropriate generic", i.e. it should be prescribed by brand name (National Prescribing Indicators for Wales).
Zoton® can be prescribed as generic lansoprazole.

Case study 2

Ms B is 54 years old and has been seeing the neurologist for troublesome trigeminal neuralgia. She has been on and off antidepressants for years. She cares for her elderly mother who is becoming increasingly dependent. Today she attends for a medication review and describes dizziness and headaches. She also says that she is not getting enough co-codamol. An asthma check with the nurse three months ago was good.

Her medication record shows:

salbutamol inh	1	4/6*
salmeterol inh	1	6/6
beclometasone 200 mcg inh	1	6/6
Prozac® 20 mg od	28	2/6
carbamazepine 200 mg tds (trigeminal neuralgia)	84	6/6
co-codamol 30/500 mg	200	6/6

* This prescription item has been repeated four times and is authorised for six repeats. All medicines were re-authorised six months ago and the system reset at 0/6.

What issues could you address during a 10-minute consultation?

This lady has complex problems. Given that there are no outstanding issues following her recent attendance at an asthma clinic, this aspect of her treatment need not be re-assessed.

Need and indication

Do hospital letters advise continuing use of carbamazepine at this dose?
Does Ms B feel she still needs all the medicines?
Has she stopped any medications? Is this confirmed by recent consultations?
Is the indication clearly recorded on the prescription?

Open questions

What does she think about her medications?
What does she take on a regular basis? The number of repeats issued suggests she does not take the *Prozac*® (fluoxetine) regularly.
Is she using the co-codamol appropriately? Would other medication be better?
Is she taking any over-the-counter medicines or herbal remedies?

Tests and monitoring

Disease monitoring

Brief mood assessment: are non-drug interventions needed? What duration of use is appropriate before review?
Is the trigeminal neuralgia adequately controlled?

Blood monitoring

Consider an electrolyte test as she is at risk of hyponatraemia [carbamazepine and fluoxetine].
An annual full blood count is recommended [carbamazepine]. Check carbamazepine levels if toxicity is suspected.

Evidence and guidelines

NICE guidance states that patients with a moderate or severe depressive episode should continue antidepressants for at least six months after remission. This needs to be discussed with the patient and a management plan agreed.

Adverse effects

Is she getting analgesic headaches? Could her dizziness and headaches be due to an increased concentration of carbamazepine caused by concomitant use of fluoxetine?
Does she also have nausea or visual disturbance (particularly double vision associated with peak plasma concentrations of carbamazepine)?

Risk reduction and prevention

If many of the issues discussed above were addressed and documented at a previous medication review, time may allow for preventative considerations. Smoking status, BP, and other issues covered in the GMS contract can be addressed.
Ensure that she is not on the epilepsy register because of her use of carbamazepine.
Lack of support in caring for her elderly mother may be a major problem for her. Respite care or support services may be appropriate.

Simplification and switches

Switch *Prozac*® to generic fluoxetine?
Note that generic carbamazepine is appropriate when prescribed for trigeminal neuralgia; it should be prescribed by brand name for epilepsy to avoid variations in bioavailability.