Polypharmacy: prevention and management

We have followed the *CMAJ* series of case-based practice articles on polypharmacy with great interest and we commend the authors[1,2] for drawing attention to this issue. As the population of older Canadians with multiple chronic conditions grows, the challenge of managing medications in these patients becomes more pressing.

Farrell and colleagues[1,2] have presented two instructive cases of senior patients with multiple chronic conditions, complex medication regimens and multiple prescribers. We wish to emphasize the essential role of the interprofessional team in making sense of the complexities inherent to such cases. In both the cases[1,2] the patients benefited greatly from referral to a local geriatric day hospital. Unfortunately, current demand for such specialized services far outstrips supply. Consequently, much of the management of complex medication regimens is performed in primary care. This is a time-consuming process, as Frank[3] has indicated, and is not well suited to the usual 10- to 15-minute family-physician visit.

Necessity being the mother of invention, we developed a new primary care model designed specifically for older patients with complex health and medication needs. The IMPACT clinic[4] features an extended 90-minute visit, during which an interprofessional team conducts a comprehensive 360-degree assessment and co-creates, with the patient and family, a plan of care that is mutually agreed upon. Review of medication appropriateness and reconciliation is a vitally important component of the clinic, and all IMPACT patients and their families are provided with an up-to-date, user-friendly medication list.

Given the high frequency of change in complex regimens, which are often driven by visits to multiple prescribers, we believe that primary care is the appropriate setting for ongoing medication management in complex patients. The series by Farrell and colleagues[1,2] also underscores the importance of applied research to develop, implement and evaluate management tools for complex medication regimens.

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The authors respond

We thank Tracy and colleagues for their supportive letter[1] in response to our series of case-based practice articles on polypharmacy.[2,3] Their letter accentuates the challenges of complex, ever-changing medication regimens, numerous comorbidities, multiple prescribers and time constraints in the effort to effect positive medication change. We applaud Tracy and colleagues for their initiative.

We agree that more tools are needed to support primary care physicians in their work with seniors. Not all physicians have access to a specialized interdisciplinary team, nor are they able to afford a significant block of time to address all the issues at hand. We hope that our case series (a total of eight case reports and two commentaries in *Canadian Family Physician* and the *Canadian Pharmacists Journal*)[4–11] will help physicians to prioritize medication changes and to realize that these changes do not need to happen all at once. In emphasizing the supporting roles of the various health professionals on our team, we hope to assist primary care physicians to determine whether some functions could be carried out by existing team members. Physicians should also be aware of local community supports, such as physiotherapy clinics with fall-prevention programs, when access to a specialized geriatric team is not available. We recognize that this is a work in progress.

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Dental profession fails to meet needs of disabled Canadians

Kelsall and O'Keefe[1] emphasize the poor health implications for seniors caused by their inability to pay for necessary dental treatment, but disabled Canadians are also seriously affected by inequitable access to dental care.

Provincial-government dental plans for the disabled have stagnated for years even as dental fees have increased annually. Some government plans now pay only 50%–60% of typi-

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cal dental fees. Because only a few dentists will accept such low fees, and because disabled Canadians are more likely than most Canadians to be poor and unable to pay the remainder of a typical fee, disabled adults often have difficulty finding a dentist. As a result, many people with disabilities have lost teeth that could have been saved with easier and earlier access to treatment.

The Canadian Institute for Health Information reported in 2013 that Canada performed "poorly" relative to the 34 countries that make up the Organisation for Economic Co-operation and Development in ensuring equitable access to dental care.[2]

Provincial dental colleges often pass regulations that benefit dentists rather than society, despite laws that require them to regulate in the public interest. These colleges allowed dentists to administer cosmetic botulinum toxin treatments, but they've done nothing to ensure equitable access to dentistry.

Dental education also suffers from bad regulation. The Canadian Dental Association, which represents dentists' interests, also administers faculty accreditation requirements and does not require these faculties to teach students to treat adults with special needs. Similarly, Canadian dental regulators don't recognize a special-needs specialization, unlike Australia, New Zealand and various European countries.

We don't have to add dental treatment to medicare to make dentistry more accessible. The provinces can regulate dental fees and access. Germany is an example of a country that successfully combines private dental insurance with government regulation over fees and access.

According to an article from *The Canadian Press*, medicare is the number one accomplishment that makes us "most proud to be a Canadian."[3] Our governments must work to put equitable dental care at the top of the next such survey.

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Competing interests: Joan Rush's report, *Help! Teeth Hurt: Government's Obligation to Provide Timely Access for Dental Treatment to B.C. Adults Who Have Developmental Disabilities: A Legal Analysis*, was funded by a grant from the Law Foundation of BC.

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Oral health and prevention and screening for HPV

Oral health is critical to overall good health and it also serves as a surrogate marker in critical disease. We commend Kelsall and O'Keefe[1] for highlighting the need to eliminate barriers to dental care for some of our most vulnerable patients.

Oropharyngeal cancers are among the most commonly occurring malignancies in Canada. Human papillomavirus (HPV) is the causative factor in 80% oropharyngeal cancers, and it is estimated that, in the United States, these cancers will overtake uterine HPV cancers in the next 15 years;[2] noncervical cancers are dramatically on the rise in Canada as well.[3]

The development of HPV vaccine has changed the face of gynecologic oncology, but an important emerging area is the role of immunization in HPV-related oral malignancies, and research is underway.

It is a common misconception that HPV vaccine is only effective in those who have not yet been exposed to the disease, however there is evidence that patients treated for HPV malignancy benefit from recurrence from other HPV strains with immunization.[4]

Understanding of HPV malignancies is growing. In one study, patients with oropharyngeal squamous-cell carcinoma had a 25-fold increased risk of cervical cancer.[5] Referral and screening across the spectrum is critical.

Patients with HPV disease and malignancy provide an opportunity for interdisciplinary collaboration for those working in primary and secondary prevention, including immunization, oncology, oral health and gynecology.

Research is required to explore the role of immunization against HPV-related diseases, particularly in the senior population. We must collaborate with our dental health colleagues to promote awareness and prevention.

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Young's postulate

Young's postulate,[1] which says that that the last doctor to see a patient is also the smartest doctor, rings true.

I know of a situation where a hospital doc found metatarsal fractures in a patient three months after an injury. The fractures were missed because of overlying cellulitis, a sufficient cause for pain, erythema and swelling in a patient with uncontrolled diabetes.

Now, in keeping with Young's postulate, that hospital doc is the smartest doc and has reportedly said to the patient that the rural doctor, the hospital that treated her as an inpatient, and her own family doc (who followed the resolving cellulitis when she returned home), all missed the fractures and shouldn't have. Maybe. Or maybe this is an example of Young's postulate at work. But I have to ask myself — have I spoken this way about other physicians? Do we all do it?

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