

DEPRESCRIBING: LESS IS MORE

Deprescribing is the buzz word in geriatrics, and no less important in pediatrics. When someone is on multiple (often ≥ 5) medications, it is called polypharmacy. About 50% of older adults in the United States are taking five or more drugs, and at least one of them is potentially inappropriate. Data in pediatric practice is lacking; however, it is probably rampant especially in children with chronic disorders.

Deprescribing is the process of minimizing the number of drugs prescribed. It has to be done carefully, especially if patients have been on it for prolonged periods. There are now guidelines for deprescribing. The first step is to identify potentially inappropriate drugs. Next is to decide whether the dose can be reduced or stopped. Third is to carefully taper. Fourth is to monitor for problems. And fifth is to document all events.

The field of deprescribing was opened up by Mark Beers, a geriatrician who first studied the prescriptions of 850 odd inmates of various nursing homes. It struck him that many of them were on polypharmacy with significant interactions and side effects. He created a list of potentially harmful drugs for the aged, which is now called the Beers Criteria. Some of these drugs include proton pump inhibitors, asthma medications, nutritional supplements and benzodiazepines.

His oft quoted remonstrance to “think three times before picking up a pen to prescribe a drug” holds water also in pediatric practice. (*BMJ 2019;364:1570*)

NEWBORN SCREENING FOR CRITICAL CONGENITAL HEART DISEASE

By the end of 2018, all states in the USA have made it mandatory to screen/offer screening for critical congenital heart disease (CCHD). The basis was twofold. First, incidence of CCHD in the US is 2 in 1000 births. Second, data between 2007-2013 showed that deaths due to CCHD reduced significantly in infants aged below 6 months in eight states where screening had been made mandatory.

The screening algorithm includes pulse oximetry in all neonates after 24 hours of life or just before discharge if discharged before 24 hours. The oxygen saturation in the right hand and either of the two legs is taken. If saturations are above 95% and difference in upper and

lower limb saturation is less than 3%, the baby is considered to have no significant risk of CCHD. If saturations are below 90% or the difference between upper and lower limbs is more than 3%, they need further evaluation with echocardiography. Saturations between 90-95% need to be rescreened upto two more times.

Besides CCHD, a low saturation may also be due to other critical illnesses, including persistent pulmonary hypertension, sepsis, hemoglobinopathies, pulmonary disease, transient tachypnea of the newborn and hypothermia. All these will also need emergent treatment. The cardiac defects which are primarily targeted by the test include disorders that typically need surgery or catheter-based intervention in the first year of life – such as tetralogy of fallot, transposition of great arteries, coarctation of aorta, and total anomalous pulmonary venous connection. (https://www.cdc.gov/mmwr/volumes/68/wr/mm6805a3.htm?s_cid=mm6805a3_w)

THE FIGHT FOR BEDAQUILONE

Two survivors of drug resistant tuberculosis have taken on pharmaceutical giant Johnson and Johnson (J&J). Both of them, Nandita Venkatesan from Mumbai and Phumesa Tisile from South Africa, had lost their hearing during therapy for drug resistant tuberculosis. Their endeavor is to prevent J&J from extending their patent on Bedaquilone. If they lose, J&J’s patent will be extended from 2013 to 2027. This would mean another delay of four years for entry of generics. ‘Patent evergreening’ is a routine strategy by many pharmaceutical corporations by filing additional patents for unremarkable window dressing of the original molecule, to extend their monopoly on the drug beyond the standard 20 years. The cost of bedaquilone is currently out of bounds for the average Indian.

An article entitled “Such a long journey” published this January in *PLoS One* records the health seeking pathway of 47 patients with drug resistant tuberculosis in Mumbai. It is a sociological analysis of the reasons for delayed diagnosis and therapy in these patients. It gives a poignant inside view of the human experience of illness and “why people do what they do.” It requires a great wisdom to solve the complex social underpinnings of treatment of chronic disorders. (*The Hindu 9 February 2019; PLoS One 17 January 2019*).

GOURI RAO PASSI
gouripassi@gmail.com