

proper MeSH term to use for this particular subject. I doubt I am the first one to point out why your MEDLINE search did not produce the desired results.

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## References

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2. Rogers JD, Zhao J, Liu L, Amin RD, Gagliano KD, Porras AG, et al. Grapefruit juice has minimal effects on plasma concentrations of lovastatin-derived 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors. *Clin Pharmacol Ther* 1999;66(4):358-66.

## Overdrugged patients: enough is enough

I am surprised that Dr Frank<sup>1</sup> implies that up-to-date physicians almost automatically put eligible seniors with heart disease on ramipril, based on the HOPE trial. Yes, I have heard of this study, and yes, I am aware that many physicians are stampeding to use angiotensin-converting enzyme (ACE) inhibitors in its aftermath, but I have to demur, because most of my elderly patients are already overdrugged by me and other consultants they see.

The ACE-inhibitor cough is far more common and dangerous than it seems from drug monographs, and unwary practitioners can lead patients through many unnecessary tests and treatments for this cough. This is but one of the hazards our patients face through polypharmacy. In fact, I have been around long enough to see some of the most common diseases turn from benign to lethal or disabling through the introduction of modern drugs.

For example, arthritis always hurt, but it seldom killed until nonsteroidal anti-inflammatory drugs (NSAIDs) entered the scene and caused upper gastrointestinal hemorrhage. Cyclooxygenase-2 inhibitors, supposedly gastrointestinal-safe, are not. Numerous patients complain of pain, nausea, or diarrhea. Fenfluramine, or

“Fen-Fen” (not available in Canada), a weight reduction drug, had to be discontinued after heart-valve damage was discovered.

If abused, asthma inhalers can lead to an unexpected increase in asthma deaths. Earlier antiarrhythmic drugs caused fatal arrhythmias and were banned, while amiodarone (Cordarone), though safer, can create a catalog of important illnesses, such as pulmonary fibrosis and thyroid disorders. Simple allergies became lethal on occasion when terfenadine (Seldane) was used; hiatus hernia treatment with cisapride (Prepulsid) led to heart ailments and was banned. Elevated lipids, if treated with cerivastatin (Baycol), led at times to rhabdomyolysis, while others of the now ubiquitous statins become hazardous with grapefruit juice, and recent research from Denmark describes statin-induced neuropathy.

Consider what female patients must think when told that long-term use of replacement hormones for menopause was recently discovered to cause an increase in all three dreaded female cancers: ovarian, breast, and, as was previously known, uterine. These same hormones also cause an increase in heart disease and stroke, as well as blood clots. This covers most of the causes of death and debility in women, and I do not blame women for being disappointed with their physicians at this point.

Men also are now being told that testosterone drugs might help them for some of the same vague reasons estrogens are given to women, for example, sense of well-being, improved mood, and better cholesterol ratios with a debatable lower risk of heart disease. Will men also have an increase in cancer and vascular disease that we will have to explain later?

We physicians know that adverse drug reactions occur commonly in the gastrointestinal tract but sometimes forget that the central nervous system is equally vulnerable: anxiolytic drugs, such as benzodiazepines, cause

depression because they are central nervous system depressants, but virtually any sort of drug can be mood-altering and might convert compliant patients into polypharmacy zombies. We often hear our patients complain of fatigue, asthenia, irritability, insomnia, anxiety, headache, and dizziness—all disabling and often due to prescribed drugs. Patients do not know about this relationship, but we do.

We physicians now have the ability to alter personalities and mimic many disease states through careless prescribing. Will we remember that the simple act of discontinuing a drug might make these puzzling disease states disappear? Or do we launch a prescription cascade to treat the adverse drug reactions and cause more adverse drug reactions?

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## Reference

1. Frank C. Conscientious family physicians and polypharmacy [editorial]. *Can Fam Physician* 2002;48:1418-20 (Eng), 1430-3 (Fr).

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