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Polypharmacy in Nursing Homes

To the Editor: I enjoyed Ackermann and Meyer von Bremen's article on reducing polypharmacy in the nursing home.[1] They referenced an article written by Ide and myself[2] to support the statement: " . . . Prophylactic or topical antibiotics are clearly not effective . . . ," regarding the treatment of pressure ulcers.

While it is clear that antibiotics are not a primary treatment for pressure ulcers, our article did recommend the use of topicals, such as silver sulfadiazine or bacitracin, for wounds with exudate or erythema. Recent guidelines published by the Agency for Health Care Policy and Research recommend triple antibiotic or silver sulfadiazine for wounds that do not show healing after 2 to 4 weeks of standard therapy.[3]

It is certainly true that overuse of antibiotics, especially systemic agents, leads to undesirable outcomes, such as enterocolitis resulting from colonization with methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile*.

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2. Spoelhof GD, Ide K. Pressure ulcers in nursing home patients. Am Fam Physician 1993; 47:1205-15.
3. Bergstrom N, Bennett MA, Carlson CE, et al. Treatment of pressure ulcers, clinical practice guideline, no 15. Rockville, MD: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1994. AHCPR publication no. 95-0652, December 1994.

To the Editor: I enjoyed reading the article in the May-June issue of *JABFP* regarding "Reducing Polypharmacy in the Nursing Home: An Activist Approach" by Ackermann and Meyer von Bremen (JABFP 1995; 8: 195-205). In addition to their comments on various high-risk drugs mentioned in the article, I would like to make two further points.

The first point relates to the use of diuretics in general. The normal aging process is accompanied by an absolute reduction in the amount of total body water, especially in the advanced elderly population, the most common age group of the elderly in the nursing home.[1] In addition, as the authors point out, many nursing home elders have cognitive dysfunction in the form of dementia or depression with associated anorexia and reduced fluid intake. These patients often forget to eat and drink, and dehydration is a frequent problem.[1] In addition to the need to monitor potassium levels, physicians should be aware that such patients might be prone to postural hypotension and subsequent falls. Therefore, as the author indicates, ACE inhibitors and calcium channel blockers might be more appropriate drugs to prescribe.

Second, another class of drugs that should be prescribed with caution involves the anticholinergic drugs, especially the antihistamines frequently used to treat upper respiratory tract infection and allergy symptoms. The article does briefly mention the psychotropic medications as another class of troublesome medications, the discussion for which was deferred, because they deserve special attention and because they have received widespread attention since the Omnibus Budget Reconciliation Act (OBRA) of 1987. Readers might not know, however, that those psychotropic medications with high anticholinergic activity can contribute to or cause cognitive dysfunction (toxic dementia syndrome), as well as lead to functional decline.[2] These medications include the sedating major tranquilizers and tricyclic antidepressants. Leading the list of notoriously worrisome tricyclic antidepressants is amitriptyline.[3] These drugs should probably be avoided or used in the lowest possible dose in the nursing home population. Again, thank you for the very thorough discussion of this very important topic.

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2. Harrington C, Tompkins C, Curtis Grant L. Psychotropic drug use in long-term care facilities: A review of the literature. Gerontologist 1992; 32:822-33.
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The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: I agree with Dr. Spoelhof that two clinical trials support the use of topical antibiotics in selected patients with pressure ulcers.[1,2] The Agency for Health Care Policy and Research clinical practice guideline on the treatment of pressure ulcers recommends:

> Consider initiating a 2-week trial of topical antibiotics for clean pressure ulcers that are not healing or are continuing to produce exudate after 2 to 4 weeks of optimal patient care (as defined in this guideline). The antibiotic should be effective against Gram-negative, Gram-positive, and anaerobic organisms (e.g., silver sulfadiazine, triple antibiotic).[3]

Prolonged or routine use of topical antibiotics in patients with pressure sores is not indicated, and much more research in this critical area is needed.