Considerations for Medication Management in Older Adults with Multi-morbidity

Presenters:
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Julia Bareham

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Speaker Bios

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• Family physician at West Winds Primary Health Centre
• Academic teaching unit at West Winds - Care of the Elderly; focus on providing optimal care in the community setting (Long Term Care & Personal Care Homes)

Julia Bareham
• Pharmacist with RxFiles Academic Detailing
• RxFiles - primarily related to medication use in older adults
• Community pharmacy; MSc - comprehensive medication management
Presenter Disclosure

Relationships with financial sponsors:

• Rae Petrucha – contracted with West Winds Primary Health Centre (CoM)

• Julia Bareham – employee of RxFiles Academic Detailing (U of S) & Shoppers Drug Mart; Drug and Therapeutic Advisory Committee for Non-Insured Health Benefits – Indigenous Services Canada

Speakers have received no additional financial support for the preparation or delivery of the presentation

• Rae Petrucha has no conflicts of interest to declare

• Julia Bareham – conflict/bias: works for RxFiles - sells a product that will be discussed during the presentation
What is RxFiles?

Academic detailing program providing objective, comparative drug information to clinicians.

GERI-RxFiles 3rd Edition
Assessing Medications in Older Adults

Alternatives to explore, when less may be more

2019
www.RxFiles.ca

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Learning Objectives

1. Identify considerations & approaches that may be used when prescribing to older adults

2. Discuss methods to prioritize & optimize medication use in the presence of polypharmacy & multimorbidity in older adults in the primary care setting

3. Apply the principles of geriatric prescribing as it relates to sedatives, antihypertensives and anticholinergics to patient cases
Drug Therapy in Older Adults

- Definition of “Older Adult”

- Consider overall frailty & physiological age more prominently than chronological age when applying geriatric models to care

- Few RCTs include individuals >80, especially for those with multiple comorbidities

- Individualization of approach, clinical judgement & special consideration for principles of geriatric care are critical!
Prescribing Considerations for Older Adults
Special Considerations in Geriatrics –

What to consider when there is no/limited evidence when it comes to decision making

- Older adults can be challenging & time consuming to adequately assess & treat due to multimorbidity, polypharmacy, provider time constraints, etc.

- They are complex!

- Making the decision to prescribe or not prescribe takes time.
  - Navigate those discussions/decisions

- Consider more frequent visits and discuss one issue at a time
### Special Considerations in Geriatrics

- **Physiological Changes**
- **Polypharmacy & Co-morbidities**
- **Limited Life Expectancy & Time-to-Benefit**
- **Quality of Life Considerations**
- **Personal Values & Shared Decision Making**
- **Challenges related to regular medication use**
- **Cost of medications/interventions**

### Tips:
- Look/think beyond the clinical interaction at the moment or the Rx → need a wholistic approach.
- Consider the social aspect!
  - Cognitive decline with lack of social engagement
Assessing Medications: Harm vs Benefit

- STOPP Criteria (complemented by the START Criteria)

Section A: Indication of medication

1. Any drug prescribed without an evidence-based clinical indication.
2. Any drug prescribed beyond the recommended duration, where treatment duration is well defined.
3. Any duplicate drug class prescription e.g. two concurrent NSAIDs, SSRI, loop diuretics, ACE inhibitors, anticoagulants (optimisation of monotherapy within a single drug class should be observed prior to considering a new agent).

Section B: Cardiovascular System

1. Digoxin for heart failure with normal systolic ventricular function (no clear evidence of benefit).
2. Verapamil or diltiazem with NYHA Class III or IV heart failure (may worsen heart failure).
Patient Snapshot – 68 yr old Martha

- Naproxen 220mg BID
- Furosemide 20mg OD
- Amlodipine 5mg OD
- Allopurinol 200mg OD
- Metformin 500mg BID
- Atorvastatin 10mg OD
- Arthritis
- T2DM
- Dyslipidemia
- HTN
- Edema (Ankle swelling)
- Gout
Prescribing Cascades

Definition:

*The prescribing of a new medication to treat symptoms that have arisen from an unrecognized adverse drug event related to an existing therapy.*
Naproxen 220mg BID
Furosemide 20mg OD
Amlodipine 5mg OD
Allopurinol 200mg OD
Metformin 500mg BID
Atorvastatin 10mg OD

Arthritis
T2DM
Dyslipidemia
HTN
Edema
(Ankle swelling)
Gout
Medications Commonly Involved in Prescribing Cascades

- **ANTIBIOTICS**
- **ANTIEPILEPTICS**
- **ANTIHYPERTENSIVES**
  - ACEIS
  - βBS
  - CCBS
  - DIURETICS
- **ANTIPSYCHOTICS**
- **ACETYLCHOLINESTERASE INHIBITORS**
- **DIGOXIN**
- **METOCLOPRAMIDE**
- **NITRATES**
- **NSAIDS**
- **OPIOIDS**
- **PAROXETINE**
- **SEDATIVES**

ANTICHOLINERGICS?
Preventing the Prescribing Cascade

Assume every new symptom is due to a drug until proven otherwise.

Look for opportunities to deprescribe!
Preventing the Prescribing Cascade

Start low, go slow.

Did the symptoms started after a new medication was initiated/ dose change

Pt education

Document clearly when & why a medication is stopped or started

Encourage patients/residents to keep an up-to-date list of meds

Always consider potential drug-drug or drug-disease interactions when starting new meds.
Problem-based deprescribing
Using your patients’ clinical concerns to guide medication review
Frank Molnar and Chris Frank
Canadian Family Physician April 2019, 63 (4) 206;

Choosing wisely
Avoiding too much medicine
Bartosz Hudzik, Michal Hudzik and Lech Polonski
Canadian Family Physician October 2014, 60 (10) 873-876;

Effect of comorbidities and medications on frequency of primary care visits among older patients
Tina Hu, Neil D. Dattani, Kelly Anne Cox, Bonnie Au, Leo Xu, Don Melady, Liisa Jaakkimainen, Rahul Jain and Jocelyn Charles
Canadian Family Physician January 2017, 63 (1) 45-50;
Considerations for Deprescribing

What is deprescribing?

- The process of withdrawing medications in an attempt to improve patient outcomes. Deprescribing should be considered during every regular review of a patient. It is particularly important among older people in whom multimorbidity and polypharmacy are common.
What are the risks of deprescribing?

• Withdrawal reactions
  • e.g. GI symptoms & insomnia when stopping SSRIs

• Rebound phenomena
  • e.g. tachycardia when stopping beta-blocker
  • Does it need to be tapered? See the Geri-RxFiles!

• Reappearance of symptoms
  • e.g. pain when NSAID/opioid stopped
Practical Tips/Ideas

A) A good medication review is essential!!!

B) Deprescribe.

C) One medication change at a time.

D) Explain the rationale for the medication change.

E) Plan to assess after medication changes are made whether the target symptom (or parameter) got better or worse.

F) Be watchful for unmasked drug interactions.

G) Start medications that are missing & will be of benefit.

H) Use a team approach. Communicate. Make use of each team members’ unique skill set.
Tomorrow, after watching this presentation, when you’re in clinic and you have a routine visit with a 75 year old patient who is there to see you for her prescription renewal. What would be a good ‘first step’ to ensure you’ve touched on the foundational steps for optimizing care for this patient?

A) Ensure your patient is taking the appropriate medications doses for her age, health status, etc. and renew the prescription. Have the patient rebook for follow-up the following week.

B) Take the opportunity to ask about her spouse who is not present at today’s visit, but usually attends, and is also a patient of yours. He appeared frailer at your last appointment.

C) Discuss goals of therapy and explore shared-decision making.

D) Refer your patient to geriatric assessment for a full assessment.
Patient Case #1 - Sedatives

- 83 year old female - “Elsa”
- new to your practice
- oxazepam 10mg PO QHS x ~30 yrs
- too tired to manage all of the routine household chores that she is accustomed to doing independently, and that she derives great satisfaction in completing
- dosing off if she is sitting quietly doing an activity (watching TV, knitting) throughout the day
- no difficulty with initiating sleep or with waking throughout the night
What are the potential harms of benzodiazepines in older adults?
## Potential Harms & Benefits of BZDs

<table>
<thead>
<tr>
<th>Harms of sedative hypnotics (BZD &amp; non-BZD)</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk of rebound insomnia</td>
<td>Improve <strong>short-term</strong> (up to 6 weeks) sleep outcomes modestly:</td>
</tr>
<tr>
<td>• Development of tolerance, dependence &amp; withdrawal reactions</td>
<td>• ↓ sleep onset by 10 to 20 minutes</td>
</tr>
<tr>
<td>• Residual daytime sedation</td>
<td>• ↑ total sleep time by ~30 minutes</td>
</tr>
<tr>
<td>• Risk of falls, fractures &amp; cognitive impairment</td>
<td>• ↓ # of awakening by ~ 0.6</td>
</tr>
<tr>
<td>• Risk of accidents (e.g. MVAs)</td>
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</table>

*Treating 13 patients with a sedative hypnotic (BZD or Z-drug) for insomnia will improve sleep quality in 1 patient but 2 patients will likely experience with adverse effects (5 days to 9 weeks).*

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Potential Harms & Benefits of BZDs

**BZD Long-term effects on sleep:**

- 76 middle-aged & elderly chronic insomniacs using low-dose benzodiazepines (LDB), minimum of 6 months VS drug-free insomniacs to determine the effect on sleep.

- Results showed that LDB leads to a **complete loss of hypnotic activity** & **substantial suppression of delta & REM sleep**.

Deprescribing proton pump inhibitors
Evidence-based clinical practice guidelines

Babak Panahi, Korie Pells, Wade Thompson, Taline Sargsyan, Lisa Pizzo, Parul Jay Moolchand, Carlos Rojas-Perrotta, Kate Yole, Vivan Rehji and Paul Mosayebi

Deprescribing is defined as stopping or down-titrating a medication to a lower dose, or to discontinue a medication based on evidence, practice guidelines, or consensus with the patient. This article discusses the rationale, goals, and potential benefits of deprescribing proton pump inhibitors (PPIs).

Deprescribing PPIs may be beneficial for several reasons:
- Reduced risk of gastrointestinal events such as bleeding, perforation, and ulcers.
- Lower risk of osteoporosis and fractures due to reduced calcium absorption.
- Decreased risk of clostridium difficile infection (CDI).
- Reduced risk of all-cause mortality.

The guidelines recommend that PPI deprescribing be considered for:
- Patients on long-term PPI therapy for chronic conditions such as gastroesophageal reflux disease (GERD).
- Patients with a history of peptic ulcer disease or at high risk for developing ulcers.
- Patients with chronic kidney disease or liver disease.
- Patients over the age of 65 years.

Deprescribing PPIs should be approached with caution and individualized to the patient's specific circumstances. Healthcare providers should engage patients in the decision-making process to ensure informed consent and shared decision-making.

https://deprescribing.org/
You May Be at Risk
You are taking one of the following sedative-hypnotic medications:

- Alprazolam (Xanax®)
- Bromazepam (Lectapam®)
- Chlorzepate
- Chloral hydrate
- Ciclasil (Midazolam®)
- Clobazam
- Clonazepam (Rivotril®, Klonopin®)
- Divalproex sodium (Depakote®)
- Diazepam (Valium®)
- Diazepam (Valium®)
- Flurazepam
- Loprazolam
- L preview
- Lorazepam (Ativan®)
- Lorazepam (Ativan®)
- Nitrazepam
- Oxazepam (serax®)
- Quazepam
- Temazepam (Restoril®)
- Triazolam (Halcion®)
- Eszopiclone (Lunesta®)
- Zaleplon (Sonata®)
- Zolpidem (Ambien®, Intermee.D®, Edluar®, Sublimaze®, Zolpidem®)
- Zopiclone (Imovane®, Rohovane®)

Tapering-off program
Be sure to talk to your doctor, nurse or pharmacist before you try reducing your dose or stopping your medication.

<table>
<thead>
<tr>
<th>WEEKS</th>
<th>TAPERING SCHEDULE</th>
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<tbody>
<tr>
<td></td>
<td>MO</td>
</tr>
<tr>
<td>1 and 2</td>
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<td>3 and 4</td>
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<td>5 and 6</td>
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<td>11 and 12</td>
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<td>13 and 14</td>
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<td>15 and 16</td>
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<tr>
<td>17 and 18</td>
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</tbody>
</table>

EXPLANATIONS
- Full dose
- Half dose
- Quarter of a dose
- No dose
We discussed risks of the medication (impacts on cognition, falls, increased daytime somnolence) while taking the patient’s preference into consideration.

Patient unwilling to titrate off completely, but open to reducing dose.

Gradual reduction in dose, taper is currently ongoing, but now down to oxazepam 5mg PO QHS.

Patient has a lot more energy throughout the day, is able to complete all of her housework, and is no longer falling asleep. Since she is feeling so much better she would like to see how she feels at an even lower dose.
A 96-year-old female patient of yours presents to you in clinic requesting a refill of her long-standing prescriptions of quetiapine and lorazepam that she is unwilling to discontinue. Which response to her request would you likely provide?

A) Refill her prescription. She has been taking them for years without any problems.

B) Explain the risks to her and document your discussion.

C) Discontinue the medications. They are risky in older adults.

D) Offer a non-pharmacological alternative to the medications such as CBTi since she is using the meds for sleep.
Patient Case #2 - Antihypertensives

• 93 year old female - “Anna”; new to your practice.

• Living in a personal care home for several years, and has not been to see a physician for at least a decade.

• The personal care home operator notes that she is quite fatigued most of the time and doesn’t really participate in activities within the home. No complaints of pain.

• Rockwood Frailty score of 7

• No BPs measured since living in the personal care home (~10 years)

• Review of her medication list shows that she is currently taking:
  • α-methyldopa 500mg PO BID
  • Naproxen 500mg PO BID
  • Acetaminophen 500mg PO BID PRN
Hypertension in Older Adults

- Need to look at systolic & diastolic

- May need to tolerate higher systolic in order to maintain diastolic >60mmHg to ensure adequate cardiac perfusion
  - ↑ risk with ↓ diastolic

- Multimorbidity makes it challenging to find the ideal treatment/target. Does the pt have T2DM but is also on an anticoagulant? How far do we push the target?

- Balance the harms vs the risks!
### Hypertension in Older Adults

#### BP Targets

- **What do the guidelines say??**
- **SO what do we do?**

<table>
<thead>
<tr>
<th>Population</th>
<th>Office Blood Pressure (mmHg) Threshold to treat with antihypertensive(s)</th>
<th>Blood Pressure Target (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age ≥75, High risk CVD</strong></td>
<td>SBP ≥130</td>
<td>SBP &lt;120</td>
</tr>
<tr>
<td><strong>Low risk</strong></td>
<td>SBP ≥160 or DBP ≥100</td>
<td>&lt;140/90</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>SBP ≥130, DBP ≥80</td>
<td>&lt;130/80</td>
</tr>
<tr>
<td><strong>All others</strong></td>
<td>SBP ≥140, DBP ≥90</td>
<td>&lt;140/90</td>
</tr>
<tr>
<td><strong>Older persons (≥65 years, ambulatory, non-institutionalized, community living adults)</strong></td>
<td>SBP ≥130</td>
<td>SBP &lt;130</td>
</tr>
<tr>
<td><strong>Adults with Clinical CVD or 10y ASCVD risk ≥ 10%, DM, CKD, HF, stable ischemic HD, PAD</strong></td>
<td>≥130/80</td>
<td>&lt;130/80</td>
</tr>
<tr>
<td><strong>Adults - no clinical CVD &amp; 10y ASCVD risk &lt; 10%, or 2nd stroke prevention</strong></td>
<td>≥140/90</td>
<td>&lt;130/80</td>
</tr>
<tr>
<td><strong>Very high risk of CVD, established CAD</strong></td>
<td>SBP ≥135 and/or DBP ≥85</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes, CKD, HF, LVH, Low-moderate risk without CVD, renal disease or Hypertension Mediated Organ Damage after 3 to 6 months of lifestyle intervention</strong></td>
<td>SBP ≥140 and/or DBP ≥90</td>
<td>Age ≥65: SBP 130-140, DBP 70-80</td>
</tr>
<tr>
<td><strong>All patients (including elderly age ≥80)</strong></td>
<td>SBP ≥160 and/or DBP ≥100</td>
<td>Any age: <strong>CKD</strong>: &lt;140/80 <strong>LVH</strong>: SBP 120-130</td>
</tr>
</tbody>
</table>
Back to the patient case....

• Measured BPs 3x / week for a month
  • Average BP was 100/64mmHg
  • Discussed discontinuing anti-hypertensive therapy entirely due to increased risk of falls and poor cardiac perfusion with this BP, patient and family were in agreement with the plan.
  • Also discontinued naproxen due to lack of pain symptoms.

• When BPs re-checked after discontinuation of the anti-hypertensive medication average readings were 130/80mmHg
  • Care home operator noted improved energy, more participation in activities following the medication changes.
What would you do if the BP goes up to 155/104 but the patient is asymptomatic?

A) Nothing
B) Restart the methyldopa
C) Start HCTZ
D) Start ramipril if the renal function is adequate
Patient Case #3 - Anticholinergics

- 72 year old male “Olaf”; new to your practice.

- Recently admitted to LTC & care team has noted issues with daytime drowsiness & constipation.

- Hx of Alzheimer’s disease, hypertension, and diabetes.

- Pleasent to talk to, though very disorganized. His son is present & mentions that his dad had been getting increasingly confused, and that this accelerated quite rapidly, necessitating his move to LTC from a personal care home.

- His recent labs show normal renal function and an A1C of 7.8%.

- Olaf’s medication list includes:
  - Metformin 1000mg PO BID
  - Amlodipine 10mg PO QD
  - Perindopril/Indapamide 4mg/1.25mg PO QD
  - Oxybutynin 5mg PO OD
  - Risperidone 1mg PO QD
  - Senokot S 50mg/8.6mg PO QD
### ANTICHOLINERGICS: Reference List of Drugs with Anticholinergic Effects

**WHENEVER POSSIBLE, AVOID DRUGS WITH HIGH ANTICHOLINERGIC ACTIVITY IN OLDER ADULTS (>65 YEARS OF AGE)**

<table>
<thead>
<tr>
<th>Antibiotics</th>
<th>Antimuscarinics</th>
<th>Benzodiazepines</th>
<th>Muscle Relaxants</th>
</tr>
</thead>
<tbody>
<tr>
<td>ampicillin</td>
<td>ENALAPRIL</td>
<td>alprazolam</td>
<td>baclofen</td>
</tr>
<tr>
<td>cefotaxin</td>
<td>TOYVAZ</td>
<td>chloralhydrate</td>
<td>cyclobenzaprine</td>
</tr>
<tr>
<td>clindamycin</td>
<td>URSINX</td>
<td>clonazepam</td>
<td>methocarbamol</td>
</tr>
<tr>
<td>gentamicin</td>
<td>VESICARE</td>
<td>clorazepate</td>
<td>robaxin</td>
</tr>
<tr>
<td>piperacillin</td>
<td>DITROPAK</td>
<td>diazepam</td>
<td>orphenadrine</td>
</tr>
<tr>
<td>vancomycin</td>
<td>DETROL Lodge</td>
<td>flurazepam</td>
<td>tizanidine</td>
</tr>
</tbody>
</table>

**Antidpressants**

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Antiparkinsonian</th>
<th>Antipsychotics</th>
<th>Antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMITRIPTYLINE</td>
<td>AMANTADINE</td>
<td>ARIPIPRAZOLE</td>
<td>ATENOLOLOXIDE</td>
</tr>
<tr>
<td>CLIOMPRAMINE</td>
<td>BENZTRYPINE</td>
<td>ASENAPINE</td>
<td>BACLOFEN</td>
</tr>
<tr>
<td>DESIPRAMINE</td>
<td>BROMOPIPRINOL</td>
<td>CHLOROMAZINE</td>
<td>COLCHICINE</td>
</tr>
<tr>
<td>DOXEPIN</td>
<td>CARBIDOPA/LEVODOPA</td>
<td>Clozapine</td>
<td>DIPYRIDAMOLE</td>
</tr>
<tr>
<td>IMIPRAME</td>
<td>ENTACAPONE</td>
<td>DLPIPERIDONE</td>
<td>DIPYRONE</td>
</tr>
<tr>
<td>NORPINE</td>
<td>ETHOPTROPINE</td>
<td>HAPZINE</td>
<td>METOPROLOL</td>
</tr>
<tr>
<td>NORTRIPTYLINE</td>
<td>PRAMIPEXOLE</td>
<td>HALOPERIDOL</td>
<td>NIFEDIPINE</td>
</tr>
<tr>
<td>TIOFANIL</td>
<td>PROCYCLINE</td>
<td>LORAZEPAM</td>
<td>QUINIDINE</td>
</tr>
<tr>
<td>TRIMIPRAME</td>
<td>SELENDINE</td>
<td>METOPROLOL</td>
<td>TIAMETRINE</td>
</tr>
<tr>
<td>SURMONTI</td>
<td>TOLIPROLOL</td>
<td>MITOXANTRONE</td>
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</table>
## Spectrum of Anticholinergic Side-Effects

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Drowsiness</td>
<td>• Excitement</td>
<td>• Profound restlessness &amp; disorientation, agitation</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Restlessness</td>
<td>• Hallucinations, delirium</td>
</tr>
<tr>
<td>• Mild amnesia</td>
<td>• Confusion</td>
<td>• Ataxia, muscle twitching, hyperreflexia, seizures</td>
</tr>
<tr>
<td>• Inability to concentrate</td>
<td>• Memory impairment</td>
<td>• Exacerbation of cognitive impairment (in patients with dementia)</td>
</tr>
</tbody>
</table>
Thorough medication review with geriatric pharmacist & conversation with his son did not find any indication for the oxybutynin, which was discontinued.

Subsequent to this medication change care staff noted that Olaf’s bowel movements were quite loose, and that he was stooling up to 4 times per day. His Senokot-S was discontinued, with resumption of his regular stooling pattern.

Care staff had ongoing concerns about Olaf’s level of daytime sedation, and his risperidone was gradually tapered and discontinued. There were no issues with responsive behaviours or aggression with the discontinuation of the risperidone.

After all three medications were discontinued Olaf’s son and care staff noticed that he was much more alert and engaged more readily in daily activities. His mobility improved and he was again able to mobilize with his walker without assistance from staff.
A final question....

82-year-old with history of anxiety & dementia, otherwise well. She lives at home with her family providing care. She has been taking amitriptyline because she reported trouble sleeping, as well as paroxetine for anxiety for many years. Currently, she is sleeping well but is displaying increased behaviours that are affecting the family’s ability to care for her in her home (patient’s wish). The family has come to you today asking if there is anything they can do to keep her in her own home longer. What might you suggest be done?
A) Discontinue both amitriptyline and paroxetine as they are likely causing the problem

B) Discontinue amitriptyline, then cross taper paroxetine to sertraline

C) Discontinue the paroxetine, continue the amitriptyline

D) Start discussing the need for an increased level of care (Personal Care Home/LTC).
Links to valuable resources

Clinical Frailty Score – Dalhousie University
https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html

Deprescribing Guidelines and Algorithms
https://deprescribing.org/resources/deprescribing-guidelines-algorithms/

Deprescribing Information Pamphlets for Patients – EMPOWER Brochures
https://deprescribing.org/resources/deprescribing-information-pamphlets/
Links to RxFiles Resources

Q&A - STATIN INTOLERANCE - MANAGEMENT CONSIDERATIONS

Q&A - ASA: When to Prescribe?

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