Concomitant medications in cancer patients: should we be more active in their management?

We thank Riechelmann and Del Giglio [1] for their recent article in *Annals of Oncology* ‘Drug interactions in oncology: how common are they?’. They make the point that dangerous drug–drug interactions (DDIs) are common in oncology patients and may have serious consequences. We believe other important aspects of concomitant medications in cancer patients should also be considered.

Many cancer patients are already taking noncancer medications at the time of starting cancer therapy, and this prevalence is increasing together with the average age of the patient receiving cancer treatment [2]. But there is wide variance among oncologists in how these co-medications are managed. A recent audit at our institution showed, in common with other studies [3], that patients starting palliative chemotherapy continued to take a wide variety of drugs prescribed before the cancer diagnosis. These medications had often been prescribed not for symptomatic illnesses but for primary or secondary prevention.

Drugs given with no immediate gain will have reduced benefits in patients whose life expectancy is now dominated by advanced cancer rather than future noncancer risks. Most landmark studies establishing common preventative medications did not include significant numbers of cancer patients, or excluded them altogether, for this reason. As well as reduced benefits, noncancer medications may carry greater risks and unwanted effects in the cancer patient. For example, cancer patients on warfarin have a greater risk of serious bleeding events [4]. Similarly, it is possible that a cancer patient on antihypertensive drugs who then develops neutropenic sepsis will be less able to mount a haemodynamic response: in an analogous situation, the recent Perioperative Ischemic Evaluation Study found a higher risk of death due to postoperative sepsis in surgical patients who had received preoperative β blockers [5].

Thus, at the time of cancer diagnosis, the cost : benefit balance of noncancer medications will shift, and although some may still be worthwhile, others will not. However, oncologists may be poorly equipped or unconfident to re-evaluate these issues for their patients, while the original non-oncology prescriber may be less engaged with the decision process after the cancer diagnosis. ‘No change’ may be the default position, but it is unlikely to be the best option for patients.

Finally, financial cost has to be another consideration, especially for preventive medications which have gained market access with borderline cost-effectiveness in noncancer patients. At a societal level, it is highly unlikely that continuing such drugs in cancer patients will result in net benefit.

For those most at risk, the elderly and those with significant comorbidities, there should be close collaboration between oncologists, hospital physicians, primary care providers and pharmacists to manage their medications proactively. The concept of ‘Comprehensive Geriatric Assessment’ offers a potential solution [6]. Withdrawal of medications requires sensitive discussion between patients and their medical team. However, in our experience, the majority of patients are keen to keep the number of medications to a minimum.

Ultimately, we require evidence to guide practice. Mathematical modelling of noncancer treatment effects in cancer populations may help to quantify potential benefits, and more careful analysis and reporting of concomitant medication data collected during cancer clinical trials may help to spot potential harm. More robust evidence could be provided by a clinical trial randomising patients between rationalisation of concomitant medications or usual care: a challenging prospect.

S. Lord1*, P. S. Hall2 & M. T. Seymour1

1Department of Medical Oncology, St James’s Institute of Oncology, 2Section of Oncology and Clinical Research, University of Leeds, Leeds, UK (*E-mail: s.r.lord@leeds.ac.uk)

references


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