Managing Non-compliant Patients

1. How do you deal with non-compliant patients?

Question submitted by: K. Govender, Regina, Saskatchewan

This is a deceptively simple, but important question. We know that 25 to 75% of persons with chronic diseases will not adhere to therapeutic advice after one year.[1] Some drop out of care altogether; they often end up in Emergency Rooms. Others miss several scheduled appointments, and still others don't adhere to lifestyle or medication advice. Evidence for improving adherence (the modern word for compliance) is limited. Providing frightening statistics doesn't seem to work. What may work includes the following:

a. Removing barriers to adherence: including scheduled appointments, simplifying regimens (once or twice daily dosing), using fixed ratio combinations, minimizing costs, and paying attention to adverse effects.

b. Increasing the frequency of appointments: perhaps letting the patient know that we take this condition seriously. A telephone follow-up by a physician or allied health professional may help.

c. Enlisting family members.

d. Developing a contract with the patients (and his/her family).

e. Providing a reward for "good" behaviour.

References
1. Garner JB: Problems of Nonadherence in Cardiology and Proposals to Improve Outcomes. Am J Cardiol; 2010;105:1495-1501.

Answered by:
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Simultaneous Use of LMWH and Warfarin in Stable Atrial Fibrilation Patient

2. If a patient presents to the clinic in a stable atrial fibrillation with the onset unknown, should they be simultaneously started on lou-molecular-weight heparin(LMWH) as well as warfarin (Coumadin)?

Question submitted by: Ronald Tremblay, Cornwall, Ontario

The use of warfarin (Coumadin) in the prevention of thromboembolic events is well established in the setting of atrial fibrillation. An individual's risk for a stroke with atrial fibrillation varies with the presence of clinical risk factors that are captured by widely used risk scores, including the CHADS2 score. The presence of these risk factors can predict an individual's stroke rate from anywhere as low as 1.9%/year (CHADS2 = 0) to 18.2%/year (CHADS2 = 6).[1]

For patients with a low annual risk of stroke, the risk of a thromboembolic event on a daily basis is very low. In such individuals, it is likely that a brief period without therapeutic anticoagulation will carry an acceptably low risk for thromboembolism, and the initiation of warfarin without bridging with low-molecular-weight heparin (LMWH) may be reasonable. An acceptable approach for such patients may involve instructing patients to take daily low-dose aspirin until they have been informed that they have reached a therapeutic INR.

For select patients who are sufficiently high-risk for a thromboembolic event, a more aggressive strategy including bridging with LMWH may be employed to ensure that the patient receives appropriate anticoagulation until their INR is therapeutic. These individuals may include those with a history of stroke or transient ischemic attack (TIA), valvular heart disease, mechanical valves, recent DVT or PE, or a CHADS2 score > 4.

Answered by:
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