Chapter 16

Medication Inventory

BACKGROUND

Many older adults use both prescription and non-prescription pharmaceutical products. The use of these products is of interest for several reasons. Their use is an important indicator of overall health, and the nature of the drugs taken can be a strong indicator of clinically manifested disease. Some drugs are specific for a single condition, while others have many uses. Thus, analysis of drug data requires clinical knowledge of the indications for the medications analyzed.

A repeated assessment of medication use at Visit 3 will follow the same protocol as at the baseline and V2 examinations. Because a number of years have passed and the drugs reported are likely to have changed, we will do a new inventory and not simply update the old one. The information will be used to determine **changes** in health status.

- A new onset of a condition since baseline can be defined by a new medication, if that medication is specific for a condition. For example: Parkinson's drugs tend to be specific for Parkinson's disease, while some blood pressure and cardiovascular drugs are non-specific, thus incident disease must include a related self-reported condition to define incident hypertension or cardiovascular disease. Thus these variables will have to be created for specific conditions of interest.
- A worsening of a condition can be defined if a higher dose of medication, a second drug or another medication is reported. For example, worsening hypertension can be defined by a report of a higher dose or a second drug for blood pressure being added, even if the measured blood pressure itself is not higher compared to the baseline.

The medication inventory will also be completed for the grandchildren generation and any newly enrolled offspring generation or spousal control.

METHODS

The appropriate box will be marked under the header to indicate whether this form was administered in-person, via the telephone or by a designated family reporter/Proxy.

Using Panel 6, all participants are asked to have all prescription and non-prescription medications on hand and in their original containers with medication label for their study visit. If the participant does not have his/her medications available, ask to see his/her medication list. If a list is not available, ask the participant to recall all the prescription and nonprescription medications that s/he has taken during the past two weeks. Medications include: pills, tablets, drops, salves, injections, creams/ointments, inhalers, suppositories and dermal patches. Non-prescription medications include: vitamins, aspirin, laxatives, dietary supplements, nicotine replacement (gum, e-cigarettes, etc.), and herbal preparations.

Using the supplied script, ask the participant whether s/he has taken any prescription or non-prescription medications in the **past 2 weeks**. If the participant replies that no medications are taken and you are certain that the participant has understood the question, check NO and move on to the next assessment form. If the answer is "don't know" or "refused" proceed to the next assessment form.

Otherwise, transcribe the complete name, strength and unit(s) of each product onto the Medication Inventory Form, exactly as they appear on the medication label. For tablets and capsules, which are the most common formulations, units are usually provided in mg (milligrams). Use the formulation codes provided on the form to indicate whether the medication is taken orally, topically or via some other route. Under 'Container Seen', check either the Yes or No box to indicate whether the medication container was seen for each entry. An additional line has been provided to document any notes regarding each medication.

Write the name of each medication on a separate line. Do not record medications that have not been taken during the past two weeks. Record the names of all medications.

After the prescription medications have been transcribed, continue on the next line to list the non-prescription (i.e. over-the-counter) medications and supplements that were taken in the **past 2 weeks**. Record the manufacturer's name of all vitamins and herbal preparations. The strength of herbal preparations and multi-vitamins should be coded as not applicable (N). Attach additional pages as needed.

During data entry into REDCap the research assistant should look up all medication in the drug database (http://druginfo.nlm.nih.gov/drugportal/drugportal.jsp) to ensure correct spelling.

- Foods (e.g., broccoli) and candy (e.g., M&Ms) should not be entered as medications even if prescribed by a physician.
- Nonspecific terms (e.g., purple pill, pipe cleaner, drain cleaner) should be probed for the proper name of the medication.
- "Don't Know", "Refused", "Didn't want to answer", "Daughter has meds" should be entered as Don't Know or Refused to the question "Did the participant take any prescription or non-prescription medications in the past 2 weeks?" field and should not be entered in the Medication Name field.
- Do not include form of drug in Medication Name field (e.g. Tablets, caplets, liquigels, liquid, etc.)
- Do not put both the brand name and generic name in the medication field (e.g. Lipitor/Atorvastatin) - use one or the other as listed on the bottle.
- Do not use quotation marks or other unneeded characters in the medication field (e.g. "Walgreens" calcium).
- Any medication with 3 or more components should be coded as "N" for strength and units (example - Cal/Mag/Vit D should have "N" for strength and "N" for units rather than 1200/600/1000 mg/mg/iu).

Study Documents Referred to in this Chapter:

- Panel 6: Medication Inventory