

04 - Choosing an antipsychotic

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2 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 very low or zero liability for extrapyramidal symptoms (EPS). Others show dose-related effects, although, unlike with typical drugs, therapeutic activity can usually be achieved without EPSEs. This is possibly the real distinction between typical and atypical drugs: the ease with which a dose can be chosen within the licensed dosage range that is effective but does not cause EPSEs (for example, compare haloperidol with olanzapine). The typical/atypical dichotomy does not lend itself well to classification of antipsychotics in the middle ground of EPSE liability. Thioridazine was widely described as atypical in the 1980s but is a 'conventional' phenothiazine. Sulpiride was marketed as an atypical but is often classified as typical. Risperidone, at its maximum dose of 16mg/day, is just about as 'typical' as a drug can be. Alongside these difficulties is the fact that there is nothing either pharmacologically or chemically which clearly binds these so-called atypicals together as a group, save perhaps a general but not universal finding of preference for D2 receptors outside the striatum. Nor are atypicals characterised by improved efficacy over older drugs (clozapine and one or two others excepted) or the absence of hyperprolactinaemia (which is usually worse with risperidone, paliperidone and amisulpride than with typical drugs). Lastly, some more recently introduced agents (e.g. pimavanserin, xanomeline) have antipsychotic activity and do not cause EPS but have almost nothing in common with other atypicals in respect to chemistry, pharmacology or adverse-effect profile. In an attempt to get round some of these problems, typicals and atypicals were reclassified as first- or second-generation antipsychotics (FGA/SGA). All drugs introduced since 1990 are classified as SGAs (i.e. all atypicals) but the new nomenclature dispenses with any connotations regarding atypicality, whatever that may mean. However, the FGA/SGA classification remains problematic because neither group is defined by anything other than time of introduction – hardly the most sophisticated pharmacological classification system. Perhaps more importantly, date of introduction is often wildly distant from date of first synthesis. Clozapine is one of the oldest antipsychotics (synthesised in 1959) while olanzapine is hardly in its first flush of youth, having first been patented in 1971. These two drugs are of course SGAs, apparently the most modern of antipsychotics. In this edition of the Maudsley Prescribing Guidelines, we conserve the FGA/SGA distinction more because of convention than some scientific basis. Also, we feel that most people know which drugs belong to each group – it thus serves as a useful shorthand. However, it is clearly more sensible to consider the properties of individual antipsychotics when choosing drugs to prescribe or in discussions with patients and carers. With this in mind, the use of Neuroscience-based Nomenclature (NbN)¹ – a naming system that reflects

pharmacological activity – is strongly recommended. Choosing an antipsychotic In the UK, the National Institute for Health and Care Excellence (NICE) guideline for medicines adherence² recommends that patients should be as involved as possible in decisions about the choice of medicines that are prescribed for them, and that clinicians should be aware that illness beliefs and beliefs about medicines influence adherence. Consistent with this general advice that covers all healthcare, the NICE guideline for schizophrenia emphasises the importance of patient choice rather than specifically recommending a class or individual antipsychotic as first-line treatment.³

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