07 - General principles of prescribing

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Schizophrenia and related psychoses CHAPTER 1 General principles of prescribing ■ ■The lowest possible dose should be used. For each patient, the dose should be titrated to the lowest known to be effective (see section on minimum effective doses in this chapter). Dose increases should then take place only after 1–2 weeks of assessment, during which the patient is clearly showing poor or no response. ■ ■With regular dosing of LAIs, plasma levels rise for at least 6–12 weeks after initiation, even without a change in dose (see section on depot pharmacokinetics in this chapter). Dose increases during this time are therefore difficult to evaluate. The preferred method is to establish efficacy and tolerability of oral medication at a particular dose and then give the equivalent dose of the oral drug in LAI form. Where this is not possible, the target dose of LAI for an individual should be the dose established to be optimal in clinical trials (although such data are not always available for older LAIs). ■ ■Antipsychotic LAIs provide better relapse protection than oral treatment. LAIs should be used as first-line treatment aimed at preventing relapse. They should not be reserved only for those who have already relapsed on oral treatment. ■ ■Clozapine should be offered as soon as treatment resistance is apparent. The sooner clozapine is prescribed, the more effective it will be. ■ ■For the large majority of patients, the use of a single antipsychotic (with or without additional mood stabiliser or sedatives) is recommended. Apart from some exceptional circumstances (e.g. clozapine augmentation or adjunctive aripiprazole for prolactin elevation) antipsychotic polypharmacy should generally be avoided because of the increased adverse-effect burden and risks associated with QT prolongation and sudden cardiac death (see section on antipsychotic polypharmacy in this chapter). ■ ■Combinations of antipsychotics should only be used where response to a single anti psychotic (including clozapine) has been clearly demonstrated to be inadequate. In such cases, the effect of the combination against target symptoms and on adverse effects should be carefully evaluated and documented. Where there is no clear benefit, treatment should revert to single antipsychotic therapy. ■ ■In general, antipsychotics should not be used as ‘when necessary’ sedatives. Time- limited prescriptions of benzodiazepines or general sedatives (e.g. promethazine) are preferred (see section on rapid tranquillisation in this chapter). ■ ■Response to antipsychotic drug treatment should be assessed using recognised rating scales and outcomes documented in patients’ records. ■ ■Those receiving antipsychotics should undergo close monitoring of physical health (including blood pressure, pulse, ECG, plasma glucose and

plasma lipids; see appropriate sections in this chapter). ■ ■When withdrawing antipsychotics, reduce the dose slowly in a hyperbolic regimen, which minimises the risks of withdrawal symptoms and rebound psychosis. Note – this section is not referenced. Please see relevant individual sections in this chapter for detailed and referenced guidance.

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