

137 - Treatment first steps

Treatment – first steps

Schizophrenia and related psychoses CHAPTER 1 Treatment of tardive dyskinesia Tardive dyskinesia is a somewhat less commonly encountered problem now than in previous decades,^{1,2} probably because of the more widespread use of SGAs,^{3–6} which generally have a lower risk for the condition than FGAs. Treatment of established TD is often unsuccessful, so prevention, early detection and early remedial action are essential.^{7,8} There is evidence to suggest that TD is associated with greater cognitive impairment,^{7,9} more severe psychopathology^{10,11} and higher mortality.^{12,13} While the majority of patients seem to be unaware of the involuntary movements, the condition can still impose a substantial burden on physical, psychological and social well-being.^{14–16} While SGAs are less likely to cause TD,^{17–23} the condition still occurs with these medications. An extensive meta-analysis of relevant studies found the annualised incidence of TD across all FGA treatment groups was 6.5%, while the respective figure for SGA treatment groups was 2.6%.²⁴ However, there is a significant variation in liability between individual SGA medications.^{24–28} The risk of developing TD may be related to the extent of D2 receptor occupancy (greater occupancy, higher risk) with a medication,²⁹ although data from the meta-analysis mentioned above did not support the notion that the lower risk of TD with SGAs is a consequence of the use of relatively high equivalent doses of FGAs.²⁴ There is a hint that dopamine partial agonists (or, at least, aripiprazole) may have the lowest liability for TD.²⁴ Whether the risk of TD differs between LAI FGA and LAI SGA preparations is unclear³⁰ but there is one report suggesting that the risk of TD with LAI SGAs is lower than with the equivalent oral SGA preparations.³¹ TD can occur even with low doses of haloperidol (and in the absence of prior acute movement disorder)³² and with the use of other dopamine antagonists such as metoclopramide.³³ The characteristic abnormal involuntary movements of TD have also been observed in never-medicated patients with both first-episode^{34,35} and established³⁶ schizophrenia. This suggests that the use of antipsychotic medication adds to an inherent risk of TD that is present in people with a diagnosis of schizophrenia.

Treatment – first steps Most authorities recommend the withdrawal of any co-prescribed anticholinergic agents and a reduction in the dose of antipsychotic medication (which may initially worsen TD) as initial steps in those with early signs of TD,^{37,38} although there is a lack of robust evidence to support such a strategy.^{14,39–41} Nevertheless, it is common practice to withdraw the antipsychotic prescribed when TD is first observed and to substitute it with an antipsychotic medication that is perceived to have a lower liability for the condition. However, the evidence for a beneficial effect on TD when switching to any particular SGA is limited.⁴² Changing to clozapine^{37,43} is probably best supported,^{37,43–45} but quetiapine, another weak striatal dopamine antagonist, may also be effective.^{46–52} Olanzapine^{39–42,53,54} and aripiprazole⁵⁵ are also potential options.

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