139 - Treatment other possible options

Treatment – other possible options

136 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 Treatment – other possible options The large number of proposed treatments for TD undoubtedly reflects the somewhat limited effectiveness of standard remedies, at least before the introduction of valbenazine and deutetrabenazine.14 Table 1.30 lists some of these putative treatments, most of which have a low level of evidence.8,62 Treatment – additional agents Given that there is insufficient evidence to recommend dose reduction as a treatment for TD, and that switching or withdrawing antipsychotic medication is not always effective or advisable, add-on agents are often considered. Evidence--based, pharmacological treatment algorithms for TD have been published.41,56 A 2020 meta-analysis57 concluded that vesicular monoamine transporter 2 (VMAT-2) inhibitors (such as deutetrabenazine and valbenazine), vitamin E, amantadine and vitamin B6 (pyridoxine) are probably effective treatments. VMAT-2 inhibitors are considered agents of first choice, given the body of evidence supporting their use58–60 and their additional antipsychotic action.61 Table 1.29 describes the most frequently prescribed add-on medications for TD. Table 1.29 First-choice agents prescribed for tardive dyskinesia (alphabetical order; no preference implied). Drug Comments Amantadine56,57,62–64 Rarely used and evidence for efficacy is limited. Dose is 100–300mg/day. Benzodiazepines37,38 Widely used for TD, but a Cochrane review considered that the limited evidence for efficacy was inconclusive.65 Intermittent use may be necessary to avoid tolerance to effects. Most commonly used are clonazepam 1–4mg/day and diazepam 6–25mg/ day, with better supporting evidence for clonazepam.42,66 Deutetrabenazine8,56,58,60,67,68 Deutetrabenazine (a VMAT-2 inhibitor) is effective as a treatment for TD. Licensed for TD in the USA.69 Better supporting evidence than for tetrabenazine. Longer half-life than tetrabenazine but still needs to be taken twice a day (a once daily slow-release tablet is in development).70 Low incidence of psychiatric and neurological effects. Dose is 12–48mg/day. Ginkgo biloba56,71,72 Well tolerated. A Cochrane review concluded that while Ginkgo biloba could reduce TD symptoms, the available evidence did not justify its routine use as a treatment.73 A meta-analysis of three Chinese RCTs showed a good effect with 240mg/day.74 Pyridoxine75 Supported by a Cochrane review76 and a 2020 meta-analysis.57 Dose is up to 400mg/day. Tetrabenazine77,78 The only licensed treatment for moderate to severe TD in UK. Depression, drowsiness, parkinsonism and akathisia may occur.66,79 Dose is 25–200mg/day. Reserpine (similar mode of action) also effective but rarely, if

ever, used. Valbenazine8,59,67,73,80 Evidence supports a favourable benefit–risk ratio for valbenazine (VMAT-2 inhibitor) as a treatment for TD. Licensed for TD in the USA.81 A dose of 80mg once daily is effective. It has a benign cardiovascular profile and a low incidence of depression and akathisia. Vitamin E57,82 Numerous studies but efficacy remains to be conclusively established. A Cochrane review suggested that there is evidence only for slowing the deterioration of TD,8,83 but a 2022 meta-analysis also suggested a treatment effect.84 Dose is in the range 400–1600 IU/day.

Revision #1
Created 2026-01-04 20:12:46 UTC by Omar Ayman
Updated 2026-01-04 20:12:46 UTC by Omar Ayman