169 - Clinical management of dyslipidaemia

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170 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 treated with olanzapine or risperidone gained a similar amount of weight, but with olanzapine, serum triglyceride levels increased by four times as much (105mg/dL) as for risperidone (32 mg/dL).35 Quetiapine36 seems to have more modest effects than olanzapine, although the data are conflicting.37 A case–control study conducted in the UK found that patients with schizophrenia who were treated with olanzapine were five times more likely to develop hyperlipidaemia than those with no antipsychotic exposure and three times more likely to develop hyperlipidaemia than patients receiving FGAs.38 Risperidone treatment was not associated with an increased likelihood of hyperlipidaemia compared with no antipsychotic exposure or treatment with an FGA. Clozapine Clozapine also has a relatively high propensity to induce dyslipidaemia.6,7 Mean trigly ceride levels have been shown to double and cholesterol levels to increase by at least 10% after 5 years of treatment with clozapine.39 Patients treated with clozapine have triglyceride levels that are almost double those of patients who are treated with FGA medications.40,41 Cholesterol levels are also increased.10 Particular care should be taken before prescribing clozapine or olanzapine for patients who are obese, diabetic or known to have pre-existing hyperlipidaemia.42 Screening and monitoring In patients with schizophrenia treated with antipsychotic medication, the monitoring of plasma lipids by mental health services and in primary care is generally insufficient,43–47 falling short of recommended practice.48,49 All patients should have their lipids measured at baseline, 3 months after starting treatment with a new antipsychotic medication and then annually. Those prescribed clozapine and olanzapine should ideally have their serum lipids measured every 3 months for the first year of treatment, and then annually. Clinically significant changes in cholesterol are unlikely over the short term but triglycerides can increase dramatically.50 In practice, dyslipidaemia is widespread in patients on long-term antipsychotic treatment irrespective of the medication prescribed or of diagnosis.51–53 Severe hypertriglyceridaemia (fasting level of >5mmol/L) is a risk factor for pancreatitis. Note that antipsychotic-induced dyslipidaemia can occur independent of weight gain.54 Clinical management of dyslipidaemia Patients with raised cholesterol may benefit from dietary advice, lifestyle changes and/ or treatment with statins.49,55 Statins seem to be effective in this patient group, although pharmacokinetic and pharmacodynamic interactions are possible.56,57 The outline of a systematic approach to the diagnosis and management of

hypercholesterolaemia is available,58 based on NICE guidance in the UK.59 Further, risk tables and treatment guidelines can be found in the BNF. Evidence supports the treatment of cholesterol concentrations as low as 4mmol/L in high-risk patients60 and this is the highest level

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