18 - Prescribing high dose antipsychotic medicatio

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Schizophrenia and related psychoses CHAPTER 1 ■ ■The use of high-dose antipsychotic medication should be an exceptional clinical practice and only ever employed when adequate trials of such medication (including clozapine) at standard dosage have failed. ■ ■If high-dose antipsychotic medication is prescribed, it should be standard practice to review and document the target symptoms, therapeutic response and adverse effects, ideally using validated rating scales, so that there is ongoing consideration of the risk–benefit balance for the patient. Close physical monitoring (including ECG) is essential. Recommendations Before using high doses, ensure that: ■ ■Sufficient time has been allowed for response (see section on ‘time to response’). ■ ■There have been adequate trials of at least two different antipsychotic medications (including, if possible, olanzapine), conducted sequentially. ■ ■Clozapine has failed or not been tolerated because of agranulocytosis or other serious adverse effects. Most other adverse effects can be managed. A small proportion of patients may also decline to take clozapine. Prescribing high-dose antipsychotic medication The decision to prescribe high doses should: ■ ■Be made by a senior psychiatrist. ■ ■Involve the multidisciplinary team. ■ ■Be done, if possible, with a patient’s informed consent. Process ■ ■Rule out contraindications (e.g. ECG abnormalities, hepatic impairment). ■ ■Consider and minimise any risks posed by concomitant medication (e.g. potential to cause QTc prolongation, electrolyte disturbance or pharmacokinetic interactions via CYP inhibition). ■ ■Document the decision to prescribe high dosage in the clinical notes, together with a description of the target symptoms. The use of an appropriate rating scale is advised. ■ ■Adequate time for response should be allowed after each dosage increment before a further increase is made. Monitoring ■ ■Physical monitoring should be carried out as outlined in the section on ‘monitoring’. ■ ■All patients on high doses should have regular ECGs (at baseline, when steady-state serum levels have been reached after each dosage increment, and then every 6–12 months). Additional biochemical/ECG monitoring is advised if drugs that are known to cause electrolyte disturbances or QTc prolongation are subsequently co-prescribed. ■ ■Target symptoms should be assessed after 6 weeks and 3 months. If insufficient improvement in these symptoms has occurred, the dose should be decreased to the normal range.

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