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Hypertension

Schizophrenia and related psychoses CHAPTER 1 Antipsychotics with a high affinity for postsynaptic α1-adrenergic receptors are most frequently implicated in postural hypotension. Among the SGAs, the reported incidence is highest with clozapine (24%), quetiapine (27%) and iloperidone (19.5%) and lowest with lurasidone (<2%) and asenapine (<2%).2 There are limited quantitative data for FGAs,6 but low-potency phenothiazines (e.g. chlorpromazine) are considered most likely to cause orthostatic hypotension.7 All reported frequencies are somewhat dependent on titration schedules used. Please see the section on relative adverse effects – a rough guide in this chapter for a summary of the relative incidence and severity of hypotension with antipsychotics. Hypertension There are two ways in which antipsychotic drugs may be associated with the development or worsening of hypertension: ■ ■Slow steady rise in blood pressure over time. This may be linked to weight gain. Being overweight increases the risk of developing hypertension. The magnitude of the effect has been modelled using the Framingham data: for every 30 people who gain 4kg, one will develop hypertension over the next 10 years.8 Note that this is a very modest weight gain. The majority of patients treated with some antipsychotics gain more than this, increasing further the risk of developing hypertension (see section on antipsychotic-induced weight gain in this chapter). ■ ■Unpredictable rapid sharp increase in blood pressure on starting a new drug or increasing the dose. Increases in blood pressure occur shortly after starting, ranging from within hours of the first dose to a month. The mechanism for the rapid increase in blood pressure (i.e. that independent of obesity) is uncertain, so the risk of hypertension cannot be predicted from antipsychotic pharmacology. One review of the literature suggested a possible mechanism related to Pharmacological therapies for patients with a compelling indication for treatment where alternatives are not suitable (e.g. clozapine) and management strategies have failed ■ ■Sodium chloride supplementation may help antidepressant-induced orthostatic hypotension ■ ■Fludrocortisone has been used to treat clozapine-induced orthostatic hypotension where other measures have failed (electrolyte and blood pressure monitoring essential). Long-term use is not recommended.4 ■ ■Midodrine, an α1 receptor agonist, has been used in one small case series (including one patient on clozapine) to reduce symptom severity.4 Of note, midodrine has been linked to acute dystonia when used alongside antipsychotics.5 A review suggests that midodrine should be considered second line in clozapine-induced orthostatic hypotension or where fludrocortisone is contraindicated or poorly tolerated.4 ■ ■Other sympathomimetic drugs have also been used to treat orthostatic hypotension, although for most there is an absence of evidence in the treatment of psychotropic-related cases. Etilefrine has shown benefit in psychotropic-induced hypotension but cannot be recommended owing to unfavourable risk–benefit profile.4 Table 1.41 (Continued)

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