22 - Long term antipsychotic treatment

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22 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 Combined antipsychotics (antipsychotic polypharmacy) In psychiatric practice, prescriptions for combined antipsychotic medications are common1–3 and often long term.4 The medications combined are likely to include LAI anti psychotic preparations,5,6 quetiapine7 and FGAs,8 the last of these perhaps reflecting the frequent use of haloperidol and chlorpromazine as prn medications. Poor response to antipsychotic monotherapy A national clinical audit conducted in the UK in 20229 found that by far the most - common reason recorded for prescribing regular, combined antipsychotic medications was an insufficient response to antipsychotic monotherapy. The use of combined anti psychotic medications has been found to be associated with younger patient age, male gender, increased illness severity, complexity and chronicity, as well as poorer functioning, inpatient status and a diagnosis of schizophrenia.2,7,10–12 These associations largely reinforce the notion that antipsychotic polypharmacy is used where schizophrenia has proved to be refractory to trials of antipsychotic monotherapy.10,13–15 Importantly, there is a lack of robust evidence that the efficacy of combined antipsychotic medications is superior to treatment with a single antipsychotic.16,17 A meta- analysis of 16 RCTs in schizophrenia, comparing augmentation with a second antipsychotic with continued antipsychotic monotherapy, found that combining anti psychotic medications lacked double-blind/high-quality evidence of efficacy.18 In addition, in patients with schizophrenia, the effects of a change back from antipsychotic polypharmacy to monotherapy, even when carefully conducted, are uncertain. The findings of two randomised studies suggested that the majority of patients may be successfully switched from antipsychotic polypharmacy to monotherapy without loss of symptom control,19,20 and an open-label trial in institutionalised patients with chronic psychotic disorders found that such a switch did not increase the likelihood of relapse.21 However, an RCT in outpatients with schizophrenia reported greater increases in symptoms 6 months after a switch from two co-prescribed antipsychotic medications to one,22 although the expectation is that such exacerbations can be successfully managed.19 Long-term antipsychotic treatment A non-interventional, population-based study in Hungary sought to compare the effectiveness of antipsychotic monotherapy with the use of combined antipsychotic medications over a 1-year observation period. While the results provided evidence for the superiority of monotherapy over poly pharmacy for SGAs in terms of all-cause treatment

discontinuation in schizophrenia, polypharmacy was associated with a lower likelihood of mortality and psychiatric hospitalisations.23 Similarly, a 20-year observational study in Finland reported on the risk of rehospitalisation in a cohort of 62,250 hospital-treated patients with schizophrenia. To minimise selection bias, the investigators used within-individual analyses, with each patient used as their own control. The main finding was that antipsychotic combinations, particularly those including clozapine and LAI antipsychotic medications, were associated with a slightly lower risk of psychiatric rehospitalisation than

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