26 - Summary

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24 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 Given the association between combined antipsychotic medication and a greater adverse-effect burden,15,44 it follows that it should be standard practice to document in the clinical records the rationale for prescribing combined antipsychotics in individual cases, together with a clear account of the benefits and adverse effects of an individual trial of the strategy. Medicolegally, this would seem to be prudent, although in practice it is not always done.45 The use of combined antipsychotic medications in clinical practice There are myriad possible antipsychotic medication combinations but very limited data on their relative risk–benefit profiles in relation to overall therapeutic response or target symptom clusters. The clinical disadvantages of antipsychotic polypharmacy include an increased adverse-effect burden, higher total dosage, increased risk of drug–drug interactions, poorer medication adherence related to the complexity of the treatment and difficulties in the attribution of any response to one or more of the individual anti psychotic medications prescribed, leading to difficulty in determining the implications for an optimal longer-term regimen.6 Despite the limited supportive evidence base, the use of antipsychotic polypharmacy is an established custom and practice in many countries.46–48 Further, the general consensus across treatment guidelines that the use of combined antipsychotic medication for the treatment of refractory psychotic illness should be considered only after other, evidence-based, pharmacological treatments such as clozapine have been exhausted is not consistently followed in clinical practice.6,12,13,49–51 However, a trial of clozapine augmentation with a second antipsychotic medication to enhance efficacy is a potentially supportable practice52–56 (see section on optimising clozapine treatment in this chapter). Other antipsychotic polypharmacy strategies with potentially valid rationales are the addition of aripiprazole to reduce body weight in patients receiving clozapine.57,58 Adjunctive aripiprazole can also normalise prolactin levels, although, while the study findings on resolving hyperprolactinaemia are generally positive, they are not entirely consistent.59–64 Such polypharmacy with aripiprazole may be seen as worthwhile, evidence-based practice, albeit in the absence of regulatory trials demonstrating safety. In some cases, the use of aripiprazole alone might be a more logical choice. Conclusion Prescribing more than one antipsychotic medication may improve efficacy and very probably increases medical morbidity.65,66 Nevertheless, based on evidence currently available relating to efficacy and the potential for serious adverse effects, the routine use of combined, non-clozapine, antipsychotic medications is probably best avoided. Summary ■ ■There is a dearth of robust evidence supporting the superiority of combined, non- clozapine, antipsychotic medications over antipsychotic monotherapy. ■ ■There is more substantial evidence supporting the potential for harm and so the use of combined antipsychotic medications, which is commonly a high-dose prescription, should generally be avoided.

Revision #1
Created 2026-01-04 20:13:31 UTC by Omar Ayman
Updated 2026-01-04 20:13:31 UTC by Omar Ayman