35 - Alternative views

Alternative views

Schizophrenia and related psychoses CHAPTER 1 at least 3 weeks for oral antipsychotics or abrupt withdrawal of depot preparations).56 One analysis of incidence of relapse after switch to placebo found time to relapse to be very much longer for 3-monthly paliperidone than for 1-monthly and oral.57 Overall percentage relapse was also reduced. Abrupt withdrawal of oral treatment may also lead to discontinuation symptoms (e.g. headache, nausea, insomnia) in some patients.58 The following factors should be considered:55 ■ ■Is the patient symptom-free and, if so, for how long? Long-standing, non-distressing symptoms which have not previously been responsive to medication may be excluded. ■ ■What is the severity of adverse effects (EPS, TD, sedation, obesity, etc.)? ■ ■What was the previous pattern of illness? Consider the speed of onset, duration and severity of episodes and any danger posed to self and others. ■ ■Has dosage reduction been attempted before and, if so, what was the outcome? ■ ■What are the patient's current social circumstances? Is it a period of relative stability or are stressful life events anticipated? ■ ■What is the social cost of relapse (e.g. is the patient the sole breadwinner for a family)? ■ ■Is the patient/carer able to monitor symptoms and, if so, will they seek help? As with patients having their first episode, patients, carers and keyworkers should be aware of the early signs of relapse and how to access help. Be aware that targeted relapse treatment is much less effective than continuous prophylaxis.10 Those with a history of aggressive behaviour or serious suicide attempts and those with residual psychotic symptoms should be considered for life-long treatment. Alternative views While it is clear that antipsychotics effectively reduce symptom severity and rates of relapse, a minority view is that antipsychotics might also sensitise patients to psychosis. The hypothesis is that relapse on withdrawal can be seen as a type of discontinuation reaction resulting from super-sensitivity of dopamine receptors, although the evidence for this remains uncertain.59 This phenomenon might explain better outcomes seen in patients with first-episode schizophrenia who receive lower doses of antipsychotics, but it also suggests the possibility that the use of antipsychotics might ultimately worsen outcomes. It might also explain the poor outcomes seen with abrupt discontinuation of antipsychotics.56 This observation in turn leads some to question the validity of long-term studies in which active and successful treatment is abruptly stopped, since rebound phenomena and withdrawal reactions may account for at least some of the observed high relapse rates.60 The concept of 'super-sensitivity psychosis' was much discussed decades ago61,62 and has more recently seen a resurgence.59,63 It is striking that dopamine antagonists used for non- psychiatric conditions can induce withdrawal psychosis.64–66 While these theories and observations do not alter recommendations made in this section, they do emphasise the need for using the lowest possible dose of antipsychotic in all patients and the balancing of observed benefit with adverse outcomes, including those that might be less clinically obvious (e.g. the possibility of structural brain changes).67 Clinicians should remain open- minded

about the possibility that long-term antipsychotics may worsen, or at least not improve, outcomes in some people with schizophrenia.

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