54 - NICE guidelines a summary

NICE guidelines – a summary

52 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 NICE guidelines for the treatment of schizophrenia1 The UK NICE guidelines1 were published in February 2014 and last reviewed in September 2024 but have remained largely unchanged. NICE guidelines – a summary First-episode psychosis For people with newly diagnosed schizophrenia, offer oral antipsychotic medication as well as psychological interventions (cognitive behavioural therapy [CBT] or family intervention). Provide information and discuss the benefits and adverse-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional together, considering: ■ ■the relative potential of individual antipsychotic drugs to cause extrapyramidal adverse effects (EPSEs; including akathisia), cardiovascular adverse effects, metabolic adverse effects (including weight gain), hormonal adverse effects (including raised prolactin levels) and other adverse effects (including unpleasant subjective experiences) ■ ■the views of the carer where the service user agrees. Before starting antipsychotic medication, undertake a thorough assessment of physical health and offer an ECG if specified in the summary of product characteristics (SPC) or clinically indicated. Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial and the following should be considered: ■ ■Recording of indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance of adverse effects. ■ ■At the start of treatment, give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the BNF or SPC. ■ ■Justify and record reasons for dosages outside the range given in the BNF or SPC. ■ ■Record the rationale for continuing, changing or stopping medication and the effects of such changes. ■ ■Carry out a trial of medication at optimum dosage for 4–6 weeks (although half of this period is probably sufficient if no effect at all is seen). ■ ■Monitor and record the following regularly and systematically throughout treatment, but especially during titration: ■ ■efficacy, including changes in symptoms and behaviour ■ ■adverse effects of treatment, taking into account overlap between certain adverse effects and clinical features of schizophrenia (e.g. the overlap between akathisia and agitation or anxiety) ■ ■adherence ■ ■weight, weekly for the first 6 weeks, then at 12 weeks, 1 year and annually ■ ■waist circumference annually

Schizophrenia and related psychoses CHAPTER 1 ■ ■pulse and blood pressure at 12 weeks, 1 year and annually ■ ■fasting blood glucose, HbA1c and blood lipids at 12 weeks, 1 year and annually ■ ■nutritional status, diet and physical activity. ■ ■Physical monitoring is to be the responsibility of

the secondary care team for 1 year or until the patient is stable. ■ ■Discuss the use of alcohol, tobacco, prescription and non-prescription medication, as well as the use of illicit drugs, with the service user and carer if appropriate. Discuss their potential interactions with the prescribed therapy and psychological treatments. ■ ■Do not use a loading dose of antipsychotic medication (note that this does not apply to loading doses of depot forms of olanzapine and paliperidone). ■ ■Do not routinely initiate regular combined antipsychotic medication, except for short periods (e.g. when changing medication). Subsequent episodes of psychosis/maintenance treatment of schizophrenia ■ ■Consider the clinical response and adverse effects of the service user's current and previous medication. ■ ■Consider offering depot/LAI antipsychotic medication to people with schizophrenia: ■ ■who would prefer such treatment after an acute episode ■ ■known to be non-adherent to oral treatment and/or those who prefer this method of administration. GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is first transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Treatment-resistant schizophrenia Offer clozapine to people with schizophrenia whose illness has not responded - adequately to treatment despite the sequential use of adequate doses of at least two different anti psychotic drugs alongside psychological therapies. The misuse of illicit substances (including alcohol) and the use of other prescribed medication or physical illness should be excluded. At least one of the drugs should be a non-clozapine SGA (see section on treatment algorithms for schizophrenia in this chapter – we recommend that one of the drugs should be olanzapine). For people with schizophrenia whose illness has not responded adequately to clozapine at an optimised dose, healthcare professionals should establish prior compliance with optimised antipsychotic treatment (including measuring drug levels) and engagement with psychological treatment before adding a second antipsychotic to augment treatment with clozapine. An adequate trial of such an augmentation may need to be up to 8–10 weeks. Choose a drug that does not compound the common adverse effects of clozapine. There are some notable differences with some more recently published guidelines. In first-episode psychosis, NICE makes no specific antipsychotic recommendation, whereas the Royal Australian and New Zealand College of Psychiatrists (RANZCP)2 guidelines recommend atypical antipsychotics. They also explicitly suggest or at least

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