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Summary

Schizophrenia and related psychoses CHAPTER 1 When treatment fails ■ ■If the dose of antipsychotic medication has been optimised, consider watchful waiting. ■ ■Consider increasing the antipsychotic dose according to tolerability and plasma levels (little supporting evidence for most drugs).2,50 ■ ■If this fails, consider switching to olanzapine or risperidone (if not already used). ■ ■If this fails, use clozapine (supporting evidence very strong). ■ ■If clozapine fails, use time-limited augmentation strategies (supporting evidence variable). burden and a greater risk of high-dose prescribing.43,44 Nonetheless, at a population level, antipsychotic polypharmacy does not appear to result in increased rates of hospitalisation for either physical or specifically cardiovascular illness.45 While augmentation with another antipsychotic medication as a treatment strategy should probably be avoided, under some conditions of acute exacerbation or agitation the prescriber may see this as the only practicable solution. Or quite often the prescriber may inherit the care of a patient on antipsychotic polypharmacy. Most RCT evidence suggests that such a regimen can be safely switched back to antipsychotic monotherapy without symptom exacerbation, at least in the majority of patients,46–48 although this is not a universal finding.49 Essock and co-workers48 conducted a trial involving 127 patients with schizophrenia who were stable on antipsychotic polypharmacy. Over a 12-month period, a switch to monotherapy was successful in about two-thirds of the participants in whom it was tested. And in those cases where the move to monotherapy resulted in a return of symptoms, the most common recourse was a return to the original polypharmacy. This was achieved without any significant worsening in this group. The advantages for the monotherapy group were exposure to less medication, equivalent symptom severity and some loss of weight. So when should the prescriber just continue with the current regimen? The evidence reviewed above suggests that no one strategy, such as increasing the dose, switching to another antipsychotic medication or augmentation with a second antipsychotic medication, is the clear winner in all situations. But increasing the dose if plasma drug levels are low, switching to olanzapine if this has not been tried, or augmentation if there is insufficient response to clozapine may be beneficial in some cases. Given the limited efficacy of these manoeuvres perhaps an equally important call by the treating doctor is when to just stay with the current pharmacotherapy and focus on non-pharmacological means: engagement in case management, targeted psychological treatments and vocational rehabilitation as means of enhancing patient well-being. While it may seem a passive option, staying with the current medication regimen may often do less harm than aimless switching and dosage increments. Summary

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