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Management of patients on long-term treatment with long-acting injectable antipsychotic medication

Schizophrenia and related psychoses CHAPTER 1 Management of patients on long-term treatment with long-acting injectable antipsychotic medication For people with multi-episode schizophrenia prescribed maintenance LAI antipsychotic treatment, long-term follow-up is essential. Treatment and progress should be reviewed at least once a year (ideally more frequently) by the responsible psychiatrist, including a systematic assessment of the efficacy, tolerability and safety of the medication. The assessment of adverse effects should include cardiovascular and metabolic adverse effects, and EPS (principally parkinsonism, akathisia and TD).¹⁻³ Whether LAI antipsychotic medications are more or less likely to be associated with TD than oral antipsychotic medications remains uncertain,⁴⁻⁷ but the risk of TD does not appear to be different when the LAI and oral formulations of the same antipsychotic medication are compared.^{8,9} Any reduction in dosage should be cautious and closely monitored, given the increased risk of relapse and rehospitalisation with lower than standard doses,^{2,10,11} particularly in the longer term.¹²⁻¹⁵ In a 2022 naturalistic study¹⁶ of the risk of rehospitalisation associated with maintenance treatment with a range of antipsychotic medications, both oral and LAI formulations, in a nationwide cohort (n = 61,889), the risk of severe relapse was lowest with continuing standard dose LAI, two exceptions being better outcomes for high-dose olanzapine LAI and relatively low-dose oral perphenazine. There is no simple formula for deciding when or whether to reduce the dose of continuing LAI antipsychotic treatment, so a risk-benefit analysis must be carried out for every patient. Many patients, it should be noted, prefer LAI antipsychotic preparations to oral medication.^{9,17} When considering dose reduction, the patient's individual circumstances should be considered, including the severity of the illness, the risk of relapse and its possible consequences, their response to treatment and their social situation:^{1,2} ■ ■Is the patient symptom-free and, if so, for how long? ■

■ How severe, tolerable, distressing and disabling are the current adverse effects? ■ ■ What is the previous pattern of illness? Consider the speed of onset, duration and severity of past relapses and any dangers or risks posed to self or others. ■ ■ Has dosage reduction been attempted before? If so, what was the outcome? ■ ■ What are the patient's current social circumstances? Is it a period of relative stability or should stressful life events be anticipated? ■ ■ What is the potential social cost of relapse (e.g. is the patient the sole breadwinner for a family)? ■ ■ Is the patient able to monitor their own symptoms? If so, will they seek appropriate help? If, after consideration of the above, the decision is taken to reduce the medication dose, the patient's family should be involved, and a clear explanation given of what should be done if and when symptoms return or worsen. If it has not already been done, any co-prescribed oral antipsychotic medication should be discontinued. ■ ■ Where the product labelling allows, the interval between injections should be increased to 4 weeks before starting to decrease the dose given each time. ■ ■ The dose should be reduced by no more than a third of the previous dose at any one time. ■ ■ Decrements should, if possible, be made no more frequently than every 3 months, preferably every 6 months or more.

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