SCHIZOPHRENIA MANAGEMENT: Facilitating Evidence-Based Individualized Treatment for Optimal Patient Management

CLINICAL PEARLS

• Effective treatment in the early stages of schizophrenia has the greatest potential to limit the progression of illness.
  – Relapse prevention is critical
• Multiple oral and injectable antipsychotic treatment options are available for the treatment of patients with schizophrenia. Differences among these agents in tolerability and efficacy are important considerations in treatment selection.
• Long-acting injectable antipsychotics are an option as part of the individualized treatment selection for any patient (including early in disease course) for whom long-term treatment is indicated.
  – Long-acting injectable antipsychotics offer clear advantages for patients who have difficulty with adherence with oral medication.
  – Transition from an oral to long-acting antipsychotic requires careful planning to ensure that therapeutic efficacy is maintained during initiation of the injectable medication. Clinicians are encouraged to consult the package insert for recommendations specific to each long-acting injectable antipsychotic.
• A switch in antipsychotic treatment may be prompted by lack of efficacy, tolerability issues, or at the request of a patient or caregiver.
  – Following a careful strategy for switching antipsychotics will help to optimize outcomes and minimize risk for relapse or symptom exacerbation.
  – Patients should be educated about the reason for a change in medication and counseled about expectations regarding a switch in medication (including more frequent visits or contact during the transition period).
• Polypharmacy is common in patients with schizophrenia, but evidence is lacking to support this approach for most patients.
  – Antipsychotic monotherapy is preferred, conducting adequate trials (dose and duration) to achieve optimal response.
• If patients are not improving following an antipsychotic trial of adequate dose and duration, consider rapid medication metabolism or poor medication absorption (pharmacogenetic testing can provide information about liver CYP enzyme profile).
• Standardized rating scales are important tools for monitoring symptoms and response to therapy.

References
CONSIDER AT EACH STAGE
A. Major suicide risk
B. Metabolic issues (especially with olanzapine) and treatment-included side effects
C. Severe agitation or violence
D. Noncompliance
E. Depression or mood symptoms
F. Substance abuse
G. Prodromal or first episode
H. Catatonia or neuroleptic malignant syndrome

An Example of a Schizophrenia Treatment Algorithm

1. Diagnosis of schizophrenia or schizoaffective disorder

2. Consider critical initial or emergent issues affecting management and choice of drugs (here and at each subsequent treatment mode)

MONOTHERAPY
3. 4- to 6-week trial of an atypical antipsychotic (amisulpride, aripiprazole, asenapine, brexiprazole, cariprazine, iloperidone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone) or, if not available, a trial of haloperidol, chlorpromazine, or other typical antipsychotic.

4. Trial of adequate dose, duration, no intolerability?

5. Psychosis persists after adjusting dose?

MONOTHERAPY
6. Second 4- to 6-week trial of second atypical antipsychotic, if available, or second typical antipsychotic, if not

7. Adequate trial? (see 4)

8. Psychosis or moderate-to-severe tardive dyskinesia or tardive dystonia after adjusting dose?

9. 6-month trial of clozapine up to 900 mg/d

10. Persistant symptoms?

11. Optimize clozapine and/or augment with electroconvulsive therapy or adjuvant medication, alternate strategies

12. Enter maintenance phase

Adapted from www.ipap.org/schiz.