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Can New Treatment Approaches Impact Function and Quality of Life in People With Schizophrenia?

Announcer:
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Dr. Citrome:
Hello, I'm Dr. Leslie Citrome, Clinical Professor of Psychiatry and Behavioral Sciences at New York Medical College in Valhalla, New York. Can new treatment approaches help us impact function and quality of life and people with schizophrenia? I sure hope so. The current treatments we have available only do a partial job.

Now, I wish we had an intervention for the prodrome. So let's talk about the prodrome. When people begin to develop schizophrenia, there is an emergence of nonspecific symptoms that don't quite reach the level of psychosis. And these include some degree of suspiciousness and unusual thought content. It may also involve poor attention and emotional blunting. I wish we had something to offer. Not everyone who has the prodrome becomes psychotic though, so we've been reluctant to give an antipsychotic to people in the prodrome. Perhaps the risk of giving an anti-psychotic to the people with the prodrome is not worthwhile. And we worry about using traditional antipsychotics because of the risk of tardive dyskinesia, metabolic disturbances, and so on. So it's considered a toxic intervention for someone who may not eventually develop schizophrenia. So perhaps these new agents to address schizophrenia would be kinder and gentler. And perhaps we can do studies in people with the prodrome and see if we can intervene at that juncture.

We can certainly intervene earlier in patients with schizophrenia. Sometimes patients with schizophrenia have a period of untreated psychosis that is rather extended. If we are more inclined to identify psychosis earlier and treat it earlier, maybe we can have an impact on their ultimate course of their disorder.

Here's a study looking at the duration of untreated psychosis, across a variety of studies, and looking at the effect sizes of these relationships between the duration of untreated psychosis and outcomes such as negative symptoms, positive symptoms, global psychopathology, social functioning, and so on. And we can say overall, the longer the duration of untreated psychosis, the worse off our patients are in terms of their outcomes. So we want to keep the period of untreated psychosis to a minimum. We want to improve our opportunities for remission. We want to eliminate as much as we can relapse. So we can do that by identifying psychosis earlier and intervene earlier. And perhaps with better tolerated and effective treatments for schizophrenia, we can do that.

Now, there is something called secondary prevention, which is just another term of we have a person in their acute symptoms of schizophrenia stage of illness, and we need to treat it, it may be their first episode. And wouldn't we want to use a new novel intervention that is less toxic for those patients? Perhaps that would lead to actually better addressing their symptoms, and they'd be better inclined to adhere to their treatment. Now, of course, we would offer this to those in the prodrome too, if it turns out that this would be a lower risk intervention.

Ultimately, though, we're treating patients in the maintenance phase of their illness. We want to avoid recurrence or relapse. We need to

increase the adherence to medicines amongst our patients with chronic diseases like schizophrenia. And if we had better tolerated novel agents, perhaps that would be a good avenue to use. Perhaps we'd be able to avoid the need for clozapine if we can effectively treat from the get-go. So that's the potential role of new non-D2 to agents.

We do have this multidisciplinary and individualization of the treatment of schizophrenia that is important to consider. And it's important to remember that the clinical features of schizophrenia are multidimensional. We do know that positive symptoms are not the only kind of symptoms that our patients experience. They may also have negative symptoms and cognitive deficits that we need to address and perhaps we would be better able to address them with more novel agents that are effective, and perhaps that will impact social and occupational functioning better. We can avoid motor symptoms, perhaps if our drugs don't block postsynaptic D2 receptors in the motor striatum. So it wouldn't be great if our treatments for schizophrenia didn't do that. We'll also need to consider not only medicines, of course, and I don't want to minimize the importance of cognitive remediation and vocational rehabilitation that may be necessary, as well as supportive and supported employment and housing, as well as intensive case management.

I do want to emphasize the importance of the concept of recovery. So this is having a life. A life worth having means having relationships, living independently, having a job, things we take for granted. That's part of the definition of recovery. And you'll notice I didn't say anything about symptoms, I'm talking about outcomes that are related to functioning.

If we take a look at how well our medicines do in terms of social functioning, it's not bad. Here is a meta-analysis of social functioning across a variety of scales and time points. And drug is superior to placebo in many instances. But, ultimately, quality of life, we have not moved the needle. In this meta-analysis, we see no difference between drug and placebo, in terms of a measurement of quality of life. So I think we can do better.

We can also do better in terms of helping our patients with employment. That will require actually intervening early and aggressively, getting patients to be able to be employed. Currently, we're not able to do that.

So I'm hopeful that new medicines will offer new avenues for the treatment of schizophrenia that we can employ early and perhaps lead to better outcomes. That's my hope.

Thank you so much for your attention.

Announcer:
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