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Integration Is the Key to Success: How Will the New SCZ Therapies Fit Into Clinical Treatment Paradigms?

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Dr. Harvey:
This is CME on ReachMD, and I'm Dr. Philip Harvey. Here with me today is Dr. Martin Strassnig.

Martin, let's take a couple of minutes to look into the future. How do you envision new therapies potentially being integrated into clinical practice as we're hearing about medications that are being developed to target, for example, cognitive impairment that are not antipsychotics?

Dr. Strassnig:
That is correct, and when you look at schizophrenia as a clinical picture, it's not one clinical picture. There are various presentations of schizophrenia that can span from a purely paranoid to a purely negative symptom, or also a purely cognitive impairment picture, right? And I'm thinking of dementia praecox, for example, as to the latter. But what we are seeing is that the field starts moving into treatment of various domains rather than diagnosis, right? And what that means is you compartmentalize impairments into what you actually see, right? For example, there may be sleep impairments; there may be mood impairments; there may be auditory hallucinations. That is positive symptoms. There may be negative symptoms. There may be cognitive symptoms. And each and every patient should get a mix of medication that fits their picture rather than, you know, everybody getting on an antipsychotic or 2. Right?

And that would address several issues just beyond better treatment. It also would avoid treatment making cognition, for example, worse in that, you know, D2 receptor antagonists do worsen prefrontal cognition. Right? So Cogentin, an anticholinergic, worsens cognition. So you have to become more judicious with how you look at the individual patient and then pick and choose medications treating subdomains.

Dr. Harvey:
So it sounds almost like you're proposing psychiatry move in the direction of other medical specialties like cardiology, where in cardiology you treat high blood pressure or elevated cholesterol or rhythm disturbances with different treatments. And so you customize a treatment based on the salient problems. So if you've got someone clinically stable on a long-acting injectable antipsychotic and it's clear that they still have very significant cognitive impairments, you would treat those with a targeted treatment, or treat insomnia with another treatment. And if a treatment for negative symptoms was ever approved, to add that in as well. So the suggestion is that you promote clinical stability but then try to target other elements of the condition that need treatment without giving generic across-the-board polypharmacy to every single patient.

Dr. Strassnig:

And that is correct. It really shouldn't be a one-size-fits-all approach anymore, simply because new and emerging treatments are becoming available that allow us to target not just positive but also negative symptoms and cognitive symptoms, as well. Depression treatments are available. Sleep treatments are available already. So I think it's really coming down to an individualized treatment plan.

Dr. Harvey:
All right. Well, that's quite a bit to think about. It's a brief but great discussion, and I hope that we gave you something to consider as new treatments for schizophrenia become available and the paradigm moves to the next step.

Announcer:
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