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Movements With Meaning: Reading the Pattern, Not the Label

Announcer:
Welcome to CE on ReachMD. This activity, titled "Movements With Meaning: Reading the Pattern, Not the Label" is provided by Global Learning Collaborative.

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Dr. Anderson:
When abnormal movements show up, how do you know it's tardive dyskinesia and not something else? This is CE on ReachMD, and I'm Dr. Karen Anderson from Georgetown University.

Dr. Fernandez:
And I'm Dr. Hubert Fernandez from Cleveland Clinic.

Dr. Anderson:
Hubert, where do clinicians most often get tripped up when diagnosing tardive dyskinesia, or TD?

Dr. Fernandez:
Well, I think they get tripped up in 2 main ways. One is the failure to recognize tardive dyskinesia itself. The problem with tardive dyskinesia, the big challenge, is that they have a variety of presentations. And in some patients, it's a very classical presentation and it would be easy to diagnose, and in some patients, it would be a more difficult way of presenting or subtle, for example, and in some patients it's actually a combination of many little things. And so the variety of presentations trips up a clinician because they would actually fail to reach that diagnosis or appreciate the condition itself.

And the other one is mistaking it for something else, because tardive dyskinesia is not the only drug-induced movement disorder. For dopamine receptor blocking agents, you could have other extrapyramidal side effects, such as drug-induced parkinsonism. And the way patients present could be mistaken for 1 or the other or could actually be in combination.

Dr. Anderson:
Definitely, I know there are some things that can mimic tardive dyskinesia, such as Huntington's disease, occasionally Tourette, or even akathisia, right? Sometimes a patient with akathisia is very restless and could be mistaken for someone with tardive dyskinesia because they're just moving around so much.

Dr. Fernandez:
Yes, absolutely. So you have the most common presentation of tardive dyskinesia is that oral buccolingual movements. If you see that,

that's fairly classic and sometimes you don't really need any other test. It's readily seen and readily appreciated if you at least know it.

But in some tardive phenomena, they can present with dystonia, for example, which is an abnormal contraction or posturing of a body part, whether it be the eyelid muscles or the neck or the trunk, and they can present in varying degrees of severity. They can have also other tardive phenomena, tardive tics, tardive myoclonus, which is a brief twitch here and there. They're less common but nonetheless can be peppered in the overall tardive presentation. So these are signs and symptoms, and some are subtle, some are obvious, some are clear, some are less clear, and that's the big challenge that clinicians could face.

So Karen, what should clinicians know about delayed onset of tardive dyskinesia after dopamine receptor blocking agents?

Dr. Anderson:
So the really important thing to know is that tardive dyskinesia is a late-onset phenomenon. So tardive means late, dyskinesia is abnormal movement, and it happens because receptors are blocked. We don't know the exact pathophysiology. There's probably more going on than just dopamine blockade, but as a basic understanding, you have a chronic blockade of the dopamine receptors, which leads to an upregulation, which leads to a hyperkinetic movement disorder with too much movement.

And it's helpful to think about that because you contrast it with drug-induced parkinsonism, which generally has a faster onset. So tardive dyskinesia, you're thinking more months to even years of being exposed to an agent, in most cases. There are some exceptions. Whereas with drug-induced parkinsonism, it's more like weeks to months.

I mentioned exceptions. Of course, in elderly people, we sometimes see onset of tardive dyskinesia within a couple of months of a dopamine blocking agent, but in general you're looking for a history of fairly long duration of dopamine use or distant past use of dopamine blocking agents.

Dr. Fernandez:
Yes, I'm glad that you mentioned the timing, Karen, because I believe the official criterion for the timing of tardive dyskinesia is at least 3 months of exposure, and as you mentioned, sometimes it's 6 months, sometimes several years. But in the elderly, they can develop tardive dyskinesia within 1 month of the onset. Of course that's rare, but when you have an 80-year-old patient exposed to a dopamine receptor blocking agent for 2 months and develops oral buccolingual dyskinesias of the tongue region, mouth region, then that indeed could already be TD dyskinesias.

Dr. Anderson:
So Hubert, why is it so important not to lump TD in with other extrapyramidal symptoms?

Dr. Fernandez:
I think the biggest reason for not lumping them is because the treatment for each of these conditions is quite different. So for tardive dyskinesias, and this would include the orobuccolingual dyskinesia or the classical tardive dyskinesia, also called tardive stereotypy, and it would also include tardive dystonia and other features. So for those, the treatment would be VMAT2 inhibitors.

So we have now 2 FDA-approved medications to treat tardive dyskinesias, whereas for drug-induced parkinsonism, VMAT2 inhibitors would be neutral to them, and at worst, it could potentially worsen these drug-induced parkinsonism. And they're usually treated with anticholinergic agents or amantadine or some antiparkinsonian agents.

So 1 treatment for tardive dyskinesia would be to suppress abnormal movement, and the treatment for drug-induced parkinsonism would be to alleviate the stiffness and the slowness and even the tremor that goes along with the drug-induced parkinsonism. So the recognition is critical because the treatment is really different for 1 or the other.

Dr Anderson:
For those just tuning in, you're listening to CE on ReachMD. I'm Dr. Karen Anderson, and with me here today is Dr. Hubert Fernandez. We're discussing the diagnosis of tardive dyskinesia.

Dr. Fernandez:
So Karen, in the past month, tell me about a memorable patient with tardive dyskinesia that you treated and how this patient presented

and what you did.

Dr. Anderson:
I had a very memorable patient who worked as a musician and he was performing in public quite a bit, obviously, and found that he had unusual movements on his face which distracted the audience a lot. People were making comments about how he looked like he was on street drugs, he looked like he was distracted, and the other band members eventually didn't want to play with him. So he was really losing performance gigs because of the abnormal movements. He also seemed to be moving his pelvis when he was on stage, so he had these strange thrusting movements in addition to the mouth movements that were very distracting. So it was impacting his professional career and his development.

He's somebody who had taken aripiprazole a couple of years ago for several months for depression, was fully treated and then stopped that medication and developed this tardive dyskinesia, as I diagnosed it, after being off medication for over a year.

We decided that it was worth trying to treat it because it was impacting his livelihood, it was impacting his social life, and it was impacting his happiness. His depression was fully treated, so I was not concerned about a side effect of depression, which can happen with VMAT2 inhibitors, and we were able to improve his tardive dyskinesia so that it was not nearly so noticeable, and it didn't cause distraction when he was performing at gigs.

Dr. Fernandez:
Thank you for sharing that, Karen. You bring up a great point. I think in my practice, a lot of the patients I see, the psychiatrist treating patients with their mood disorder fail to recognize the tardive dyskinesia presentation, mainly because they're so focused in treating the behavioral condition, which is their specialty, that is their comfort level, and so they tend to ignore the tardive dyskinesia presentations that patients come with.

On the other hand, neurologists aren't immune from this. As a movement disorder specialist, for example, I see the worst of the worst, and so when I see someone with subtle orobuccolingual dyskinesias, up until we had FDA-approved medications for it, I kind of, not dismissed it, but I didn't think highly of it, because I would think that there are bigger fish to fry. Little did I know that these movements, as subtle as they may be in my eyes, they're really quite disabling to patients. And so that's also a lesson for me.

Dr. Anderson:
Absolutely. I mean, we see this all the time, where it's a quote unquote cosmetic effect of tardive dyskinesia, but it actually can impair social interactions. I think sometimes clinicians think tardive dyskinesia is only seen in chronic psychiatric patients who may not be working, they may be in a more sheltered setting, so what's the problem? But people who work can have tardive dyskinesia. It can occur in people who've been treated for depression. I think as the antipsychotics get used off label for more and more things in psychiatry, we unfortunately see much more of this.

Dr. Fernandez:
Absolutely. I think this is the amazing contradiction in the sense that our newly developed antipsychotic agents, these dopamine receptor blocking agents, on paper, and perhaps in reality, are less likely to cause tardive dyskinesia and extrapyramidal side effects. However, their use, their indication has broadened. So although they're less likely to cause these extrapyramidal side effects, their greater utilization really creates still a significant prevalence of these conditions.

Dr. Anderson:
Well, so interesting, because when I was a resident, there was this concept of sparing antipsychotics, and it was a very big deal to start an antipsychotic on someone. And I think now a lot of them have also been labeled as mood stabilizers.

Well, this has certainly been a fascinating conversation, but before we wrap up, Hubert, can you share with our audience your 1 take-home message?

Dr. Fernandez:
Well, the 1 take-home message that I would like to bring our audience today is that you can't treat a condition that you don't recognize. So I think it first comes to recognition of a disorder, of a rather common drug-induced movement disorder such as tardive dyskinesia. The challenge is that the presentation may not always be so obvious, so have a high index of suspicion.

Dr. Anderson:
I think when a patient comes to you with an abnormal movement, the first thing is to take a really good history and establish has there been an exposure to a dopamine-blocking drug, and then what's the time frame for that? That will help you sort out whether it's a drug-induced parkinsonism versus tardive dyskinesia and again will help you select the right treatment for your patient.

That's all the time we have today. I want to thank our audience for listening in, and thank you, Hubert, for joining me and sharing all of your valuable insights. It was great speaking with you today.

Dr. Fernandez:
And thank you, Karen, for having me. The pleasure is all mine. Goodbye.

Dr. Anderson:
Goodbye.

Announcer:
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