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Simple Diagnostic Steps That Change TD Outcomes & Increase Quality of Life

Announcer:
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Dr. Fernandez:
What does your diagnostic tool kit for tardive dyskinesia look like in everyday practice?

This is CE on ReachMD, and I'm Dr. Hubert Fernandez from Cleveland Clinic.

Dr. Anderson:
And I'm Dr. Karen Anderson from Georgetown University.

Dr. Fernandez:
So, Karen, how do you approach screening your patients for tardive dyskinesia?

Dr. Anderson:
The initial screening that I do is really just looking at the patient. I know we all spend a lot of time typing on computers during visits. I know that there's a lot going on in a patient visit, but try to spend a few minutes talking with the patient, observing their movements, watching them walk down the hall to your office. These can all be some of the most helpful ways to look for tardive dyskinesia, particularly because the patient is relaxed. They don't know that you're examining them for abnormal movements, so you may see some things that you wouldn't otherwise see if they know they're being observed. As with many movement disorders, tardive dyskinesia can be suppressed at times if a patient knows he or she is being observed.

The tool that I do use is the Abnormal Involuntary Movement Scale or the AIMS. And a formal AIMS can be very helpful if you want to quantify or score the amount of tardive dyskinesia that a patient has. Sometimes it will be required for insurance reimbursement for treatment with a VMAT2 inhibitor, and it does give you a good guide at follow-up for whether you've made a difference in the tardive dyskinesia, particularly if there's a long gap between seeing a patient or you're seeing a lot of patients, and it's hard to keep track of how someone's doing.

So for the AIMS, there are several parts. The form is available online for free as a PDF. The one that we usually start with is the muscles of facial expression, so looking for eyebrow movement, movements around the mouth. I think this is what we're mostly taught to look for in TD, so I think most clinicians do think of looking at the mouth and looking at the oral buccal area. Then you move on to the lips and perioral area. You look for puckering, smacking, tongue protrusion, that type of thing that can be very helpful. Look at the jaw. So you want to see if there are grinding movements of the jaw or if there's lateral side-to-side movements of the jaw that can be part of TD. Again, focusing back on the tongue, you're really only rating the tongue movements in and out of the mouth; you're not looking for a tongue tremor or inability to sustain tongue movements.

The part of the TD exam that I think clinicians may forget to do is looking at the extremities and the trunk. So in the extremities, you want to look at the arms, wrists, hands, and fingers. It's very good to have the patient do a distraction maneuver, so something like finger tapping or pronation/supination sometimes will help you bring out some tardive dyskinesia movements. So you're looking for irregular movements, and you're looking for purposeless movements. You also want to get a good look at the legs, and particularly it's helpful to have patients take off their shoes so you can see the feet, because there are a lot of foot movements that you may not notice if a patient is wearing shoes, particularly foot tapping, squirming, or inversion/eversion of the foot. And then look at the trunk. Is the patient swaying or rocking, or do they have pelvic gyrations?

These are all clues to TD. They are things you can rate on the AIMS, and it can be very helpful for several settings.

Dr. Fernandez:
Well, thank you so much for mentioning this scale that we often use. I agree with you. The Abnormal Involuntary Movement Scale can be quite useful. And I'm glad that you mentioned that actually its primary use, not only in the recognition of it, is to facilitate kind of insurance payment for it. A lot of the payers really require a minimum degree of severity of tardive dyskinesia based on the Abnormal Involuntary Movement Scale. And so not doing this might actually delay kind of the coverage of FDA-approved medications.

So take note, though, that the Abnormal Involuntary Movement Scale really rates the severity and actually also rates treatment response, but it doesn't diagnose tardive dyskinesia, as you mentioned, so you still have to have that clinical index of suspicion for it.

Dr. Anderson:
Definitely. You do need to use the history, the onset of symptoms. You need to put that all together with the score that you get on the AIMS, absolutely.

So, Hubert, in patients taking D2 antagonists, what symptoms are you looking for? And when do you start looking for them?

Dr. Fernandez:
So as a neurologist, as a movement disorder specialist, I actually see patients when they're referred to me because of abnormal involuntary movement, so it is the 1 thing that I actually look for.

But I think for psychiatrists and primary care doctors, you have to start looking for these symptoms at each follow-up visit. I think most clinicians would see their patient in a month or 2 or 3 months, and maybe quarterly thereafter, or even more frequent, depending on how much titration they need for their behavioral condition.

During those visits, it doesn't take a long time to actually spot the presence of tardive dyskinesia. And if you do spot them, that's when you take the Abnormal Involuntary Movement Scale, especially if the patient is quite bothered by it. But if you don't spot abnormal involuntary movements, then you could go on with your behavioral assessment and your behavioral management of that patient. When you do have them and you're not sure what it is, then those are the types of patients that we see on the receiving end as movement disorder specialists.

And the symptoms I'm looking for, particularly, are the same symptoms that you described that are evaluated and scored in the Abnormal Involuntary Movement Scale, the most common being orobuccolingual movements. But pretty much every muscle group could be involved, so you could have tardive dystonia, which could usually affect the eyelids, and it could be just a flickering, a fluttering movement to a forceful closure of the eyelids, and they can be functionally blind because of this. The neck is commonly involved, and they commonly present with retrocollis or neck extension and sometimes truncal extension as well. The arms, the fingers, and the feet, as you mentioned, removing their shoes, you can see abnormal movements in their toes and their feet. In their hands, they could look like they're playing the piano because of these choreic movements in their fingers.

So those are the things we evaluate and to make us decide whether this is in keeping with tardive dyskinesia. And, also, it directs us to what questions we ask patients to determine how bothered they are, whether they're psychologically or functionally, or both, disabled from this condition.

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

Dr. Anderson:
Yes, I agree. I think that you do have to think big picture about this. I think for psychiatrists or others who might be starting dopamine-blocking drugs, it is helpful to do a quick AIMS before you start the medications, because some patients do have abnormal movements. Perhaps they've been exposed to a dopamine blocker previously, or perhaps they're just twitchy or have tics or a different movement disorder, and doing the AIMS can help you look at the entire patient and really focus in on abnormal movements. So I urge everybody to do a quick AIMS or a quick assessment of the patient before starting an antipsychotic medication.

Dr. Fernandez:
Absolutely. So, Karen, after diagnosing tardive dyskinesia, what are the next steps in managing the patient, including multidisciplinary care?

Dr. Anderson:
It is very important to involve the other clinicians in care. And I think this comes up quite a bit with psychiatric patients, where care at times can be a little bit fragmented, so there can be more of an effort to work with the patient's psychiatrist, to work with a movement disorder neurologist.

The first step, again, is to get the right diagnosis, make sure that it really is tardive dyskinesia, not something else. The next step is determining the amount of distress it causes the patient or the amount of functional impairment. So some patients are very distressed by the tardive dyskinesia; they notice it all the time; it has a tremendous impact. Other patients don't seem to be bothered by it, but if you talk with family, if you talk with caregivers, you may find out that the tardive dyskinesia does impair the patient in ways that he or she may not recognize because of lack of insight, which can be present in some psychiatric illness.

Once you're determined that it is tardive dyskinesia, it's distressing, you're going to treat it, then you really need to think about the first steps. I am always an advocate of reducing psychiatric medication, reducing the dopamine-blocking medications when possible. You have to do this in a very stepwise manner. This is where working closely with a general practitioner and a psychiatrist or a psychiatrist and a movement disorder neurologist comes into play to balance how much benefit you get treating the psychiatric symptoms, perhaps bipolar disorder or psychosis, versus how much distress is caused by the tardive dyskinesia, and also to balance how quickly the medicine can be withdrawn.

It's not an emergency to treat tardive dyskinesia. It's an important thing, it's a priority, but it's not an emergency. So you can go off dopamine-blocking agents very, very slowly, which is the best way to do it.

You do need to educate the patient and family that the tardive dyskinesia symptoms may actually get worse as you're withdrawing the psychiatric medications, and this does happen frequently. And this is often where we end up going to a VMAT2 inhibitor for treatment instead, because the patient either has a recurrence of severe psychiatric symptoms, particularly psychosis or mania, or the tardive symptoms actually become worse as you withdraw the dopamine-blocking drugs and you find that you need to do something else to treat the tardive dyskinesia symptoms.

Really important for the patient and family to understand that tardive dyskinesia can be treated, that they don't have to live with this condition, and that we have several options for treating it.

Dr. Fernandez:
Thank you so much, Karen, for mentioning that after diagnosing tardive dyskinesia, the next step is really to evaluate how much of the offending agent is needed. In some cases, the dopamine receptor-blocking agent actually has been used for insomnia or for other conditions, perhaps even mood disorders where there are other options, but in a lot of cases they have very refractory psychotic disorders or treatment-resistant mood disorders. And you have the dopamine receptor-blocking agent as the only one that actually was able to control their behavioral symptoms. So it can be actually quite challenging.

But the first step that we need to take is to determine how much of that dopamine receptor blocking agent is needed, and can I lower it or can I make an adjustment? And that's where the multidisciplinary care and the coordination with a behavioral clinician actually comes in.

So this has been really helpful, Karen. What's your main take-home message for the audience today?

Dr. Anderson:
If you diagnose tardive dyskinesia in a patient, your first step should be to determine does this patient need to be on a dopamine-blocking agent now and going forward? Can we reduce the dopamine-blocking agent, or is this a patient where the current dose of the drug is really needed? This person is going to be on a dopamine-blocking agent, and we need to think about a different way to treat tardive dyskinesia. Also being aware that when you decrease antipsychotic medicines and other dopamine-blocking drugs, you may make the tardive dyskinesia worse. That may be transient, but it may be a persistent problem, and again, that's when you go to one of the medications to treat TD.

Dr. Fernandez:
Well, thank you. For my take-home message, I would say the severity of tardive dyskinesia symptoms doesn’t always correlate with the disability that it produces. And the disability could be psychological or functional. And psychological doesn’t mean less disabling than functional, and so I think we shouldn’t take it for granted. We should definitely ask patients and caregivers how tardive symptoms are affecting them and then take it from there.

Well, it's time to thank our audience for listening. And thank you, Karen, for helping guide our listeners through this. It was great speaking with you today.

Dr. Anderson:
Great talking with you today, Hubert.

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