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Subtle vs Syndromic: Distinguishing TD from Other DIMDs in the Neuro Clinic

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Dr. Moody:
This is CE on ReachMD, and I'm Dr. Melissa Moody. Here with me today is Dr. Tracy Hicks. We'll start our discussion with the case.

Ms. A, a 58-year-old woman, presents to the outpatient psychiatric clinic for evaluation of abnormal movements. Ms. A has a history of schizophrenia, managed with antipsychotic medication for several years. She was referred by her PCP for evaluation of tardive dyskinesia.

Over the past 6 months, she has noticed involuntary movements of her face, including grimacing, lip smacking, and repetitive tongue movements. She reported new onset of a tremor in her right hand, which she described as a rhythmic shaking that occurs at rest and sometimes interferes with activities such as holding a cup or writing.

On physical exam, Ms. A displays classic symptoms of tardive dyskinesia, including involuntary repetitive movements of the mouth and tongue. Additionally, a resting tremor is observed on her right hand with mild cogwheel rigidity. There are no signs of bradykinesia or postural instability.

Tracy, what are your thoughts on this case?

Dr. Hicks:
So I think approaching it 2-fold, okay, we have 2 things going on, right? Drug-induced parkinsonism, and especially when we think about cogwheel rigidity, that's one of the cardinal signs of drug-induced parkinsonism. We also need to think about the tardive dyskinesia, which we know is undertreated. So this is a conversation we're going to have with the patient, okay, shared decision-making.

So we know that if we approach treatment with VMAT2 inhibitors, it could exacerbate the tremors, and that is one of the things we have to consider. So we might talk to the patient about decreasing her antipsychotic a bit, but again, we have to talk about the realistic feasibility of that.

Dr. Moody:
Tracy, I think you bring up a really great point about that shared decision-making and having that conversation with your patient about the pros and cons of all different sorts of treatment.

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When we think about tardive dyskinesia, we think about using a VMAT2 inhibitor to help with that movement. And one of the great things about doing that is we don't have to reduce the medication in that circumstance. However, when you're balancing something like tardive dyskinesia with symptoms of drug-induced parkinsonism, there may need to be some adjustment to that medication.

So those are great points and things that I think we really need to take into account. Are there any red flags for other sort of drug-induced movement disorders that you've thought about in this case, that you can see, besides the ones that we talked about for drug-induced parkinsonism?

Dr. Hicks:
As mentioned earlier, we think about her having the tremor and the rigidity that suggests the possible drug-induced parkinsonism. And again, as mentioned, we know that VMAT2s may possibly worsen parkinsonism, but something like valbenazine with a smoother profile can lower the risk of exacerbating those motor fluctuations. So what we want to do is avoid over-suppressing the dopamine in someone who's already showing some EPS features.

Dr. Moody:
Right. I agree. And when we're thinking about other drug-induced movement disorders, there's always things like acute dystonia, and you want to make sure you take a good history and sort of look at when the timeline of when the movement started. And we also worry about things like akathisia. When a patient presents with some sort of new or unwanted or involuntary movement, it can sometimes be something like akathisia.

So taking that big history, finding out when the movement started and what the movement looks like can be really helpful. And then moving on to have that shared decision-making and having that conversation with your patients about making adjustments to find that balance in treating their drug-induced parkinsonism and tardive dyskinesia.

Dr. Hicks:
I love what you said about the shared decision-making and really bringing the patient in, because sometimes when they have those movements, this is a deeper conversation that we have to have. But we can do that. We can do that. Again, having those discussions with the patient is key. I always go back to that shared decision-making piece.

Dr. Moody:
Right. Well, I think we nailed it. Thank you, and we'll see you next time.

Announcer:
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