Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/frontlines-schizophrenia/optimizing-schizophrenia-care-strategies-for-managing-side-effects-and-treatment-resistance/30035/

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Optimizing Schizophrenia Care: Strategies for Managing Side Effects and Treatment Resistance

Announcer:
Welcome to *On the Frontlines of Schizophrenia* on ReachMD. On this episode, we'll hear from Dr. Joe Goldberg, who's a clinical professor of psychiatry at Icahn School of Medicine at Mount Sinai in New York. He'll be discussing how we can manage side effects and treatment resistance in schizophrenia. Let's hear from Dr. Goldberg now.

Dr. Goldberg:
So let's talk about side effects or adverse effects from antipsychotic medicines. The easiest way to manage side effects is to avoid them. Some of the newer atypical antipsychotics like lumateperone, lurasidone, or cariprazine—those are the three newest of the atypical antipsychotics—tend to have fewer of the more notorious side effects that the older, atypical antipsychotics were known for—things like weight gain, rising blood sugar, rising cholesterol, sedation, or cognitive side effects. Not that the newer drugs are devoid of side effects, but they tend to have fewer, so we often favor those over the older ones that have more sedating effects, more antihistamine effects, or more weight gain.

Some side effects can be dose related. For instance, physical restlessness is one side effect that can happen with some medicines that block dopamine. It's something called akathisia. That's usually dose related. Sometimes weight gain is dose related. It's not so clear if changes in blood sugar or cholesterol are dose related or not. Sometimes sedation is dose related. So if it's feasible, we lower the dose, but if we can't strike the proverbial balance that way, then we might sometimes think about antidote strategy.

So here's where there's been a lot of research in recent years to target what we call metabolic side effects of atypical antipsychotics. That means weight gain, rising blood sugar, or rising cholesterol. Apart from lifestyle interventions—a sedentary lifestyle with a high-calorie dense, non-nutrient diet and lack of exercise needs to get addressed for anybody, and someone who's a smoker with high risk factors for coronary artery disease needs to sort of be comprehensively addressed—there's a number of medicines that we can use above and beyond lifestyle intervention to try to manage metabolic side effects.

So it's a real vexation to think about, what do you do if many antipsychotics have failed to reach the desired response? What do you do next? One is to make sure that, if someone's taken an antipsychotic and it's failed to yield the desired response, that it was what we'd call an adequate trial. That means that someone took the medicine at an appropriate dose for a long enough period of time—that usually means at least several weeks, if not longer—with good adherence to the regimen in order to conclude, yes, indeed, this medicine didn't work. If someone says, "Well, I took one dose of this for two days, and I may be nauseous, so I stopped it," that doesn't really count. That's a failed attempt—also, if they took a subtherapeutic dose or if their adherence wasn't that good, we have to consider all of those possibilities before declaring that a trial was inadequate.

I also have to think about things that could interfere with an adequate trial. For instance, illicit substance use can sometimes offset the benefits of a psychiatric medicine. Even something like cannabis, when used heavily, can have drug interactions that'll interfere with the metabolism of an atypical antipsychotic. And depending on the strain and the potency, there's some forms of cannabis that can even cause psychosis and paranoia, so it's kind of like fighting a fire with water on one side and gasoline on the other, and cannabis is the gasoline. It's going to make the symptoms worse. So before we conclude the medicines aren't working, we want to make sure that there's nothing in the picture that's going to be interfering with the medicines doing their job. So before going to the bigger guns of treatment, sometimes a long-acting injectable is worth considering just to make sure that, yes, indeed, the medicine was being taken but didn't work.

Last but not least, ECT—electroconvulsive therapy—isn't something clinicians or even patients necessarily think of as much in schizophrenia as a treatment option as compared to people with mood disorders, where it's very often an effective strategy for hard-to-treat depression, or bipolar disorder. But there actually is pretty good literature on using ECT in very hard-to-treat forms of schizophrenia, and so lest one feel as though we've run out of options, ECT stands as one example of something that is worth considering if many other things haven't worked.

Announcer:
That was Dr. Joe Goldberg talking about how we can address side effects and treatment resistance in schizophrenia. To access this and other episodes in our series, visit *On the Frontlines of Schizophrenia* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!