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/understanding-schizophrenia-early-intervention-and-prevention-strategies/30032/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Understanding Schizophrenia: Early Intervention and Prevention Strategies

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 early detection and treatment of schizophrenia. Let's hear from Dr. Goldberg now.

Dr. Goldberg:
So let's consider what the most important factors are for identifying schizophrenia early and think about early detection for people who are at risk. Schizophrenia is a disorder that primarily involves perceptions, psychosis, false ideas, delusions, false perceptions, and hallucinations. It's a disorder that primarily strikes people in youth, so late adolescence or young adulthood. It has a familiality to it. And when we see a younger adult patient or late adolescent patient who's manifesting signs of disorganized thinking, perceptual abnormalities, or problems with functioning, schizophrenia has to come into the differential diagnostic assessment. But we have to have a differential diagnostic assessment because, especially in younger patients, even a presentation of psychosis could be schizophrenia, could be a mood disorder with psychotic features, could be a substance use disorder, could be a trauma-related disorder, or could be a developmental disorder. So the clinician has to really go through a careful differential diagnosis, and some of the clues would include family history. So if someone has a first-degree relative with known schizophrenia, that gives them about an eight-fold higher chance that they themselves may have that disorder. If there are two first-degree relatives, that gives them about an 11 times higher risk. So it's not all genetics, but if genetics are present, it helps guide things.

Schizophrenia can have a gradual onset, or sometimes a more abrupt onset. But there's usually a prodromal period somewhere in middle teenage years where we might hear a history that speaks to impaired functioning, maybe some social isolation, and some unusual ideas or beliefs. And there's a slow progression of that prodromal or pre-illness phase until we actually see a first episode of psychosis, and if that occurs, we don't want to miss it. We want to treat it adequately using medications that are known to treat psychosis.

So once we've made the diagnosis of schizophrenia, the cornerstone of pharmacology treatment is medication that treats psychosis. So we call these antipsychotic medicines, and really, since the 1950s, the backbone of pharmacology for schizophrenia has involved medicines that modulate, block, or otherwise affect dopamine receptors in areas of the brain that we think are responsible for abnormal thought patterns, misperceptions, and hallucinations. That's an area called the associative striatum, and we think that there's just too much release of dopamine in neurons that run on that signaling circuit. So medicines that we call antipsychotics work by blocking receptors for dopamine.

There are some people with schizophrenia who have very treatment-resistant symptoms though. That's often defined as not getting a meaningful improvement after even just one or two adequate trials of an antipsychotic medicine, and the FDA says we have one and only one medicine that's considered indicated for treatment-resistant schizophrenia. That's a medicine called clozapine, and it's been around since 1989. It has a lot of side effects though, so it requires very careful monitoring. It can affect blood counts; it can cause weight gain; it can dysregulate blood sugar levels; it's not an easy drug to take, but it can work when nothing else does. It's also the only medicine in all of psychiatry that has a label that says it can reduce the chances of suicide in people with schizophrenia, so clozapine has a unique role.

And then last but not least, when we talk about medicines for schizophrenia we should talk about the class we call long-acting injectable, or LAI, antipsychotics. So these are the same atypical antipsychotics that we use in oral formulations, and just a handful of them have

been developed as long-acting injections that patients can take every two weeks or every four weeks. We have newer formulations that are coming along that are every two months, every three months, and potentially even every six months. So the nice thing about the long-acting injectables is they guarantee the medicine is being administered, and one of the biggest reasons for relapse in schizophrenia is not taking medicine, stopping medicines, and nonadherence for one reason or another. So a long-acting injectable becomes a very compelling option with poor adherence or even things like lack of awareness or lack of insight—the patient thinks they're okay, and they don't really even think they need a medicine. So the LAIs represent another important class of treatment for schizophrenia.

Announcer:
That was Dr. Joe Goldberg talking about early detection and treatment of 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!