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Breaking Barriers: Effective Screening for Tardive Dyskinesia

Announcer:

You're listening to *NeuroFrontiers* on ReachMD, and this episode is sponsored by Teva Pharmaceuticals. Here's your host, Dr. Charles Turck.

Dr. Turck:

Welcome to *NeuroFrontiers* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can overcome common barriers and screen patients for tardive dyskinesia are Drs. Andrew Cutler and Michelle Scargle. Not only is Dr. Cutler a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences at the SUNY Upstate Medical University, but he's also the Chief Medical Officer of the Neuroscience Education Institute in Carlsbad, California. Dr. Cutler, thanks for being here today.

Dr. Cutler:

Thank you. It's a pleasure.

Dr. Turck:

And Dr. Scargle is the Chief Psychiatrist at Concord Health in Clearwater, Florida, where she's been voted one of the best psychiatrists in the Tampa area in 2022 and 2023. Dr. Scargle, it's a pleasure to have you with us.

Dr. Scargle:

Thank you for having me. I appreciate it.

Dr. Turck:

So jumping right in and starting with you, Dr. Scargle, how do we screen patients taking antipsychotic medications for abnormal movements and differentiate tardive dyskinesia from other syndromes?

Dr. Scargle:

The APA does recommend that if someone's taking an antipsychotic medication, we should do a formal AIMS examination once a year. If somebody is a little more high risk for tardive dyskinesia or if they're on an older antipsychotic—typical antipsychotic medication, for example—it's recommended that we do the AIMS every 6 months. But I think we should just all get in the habit of looking at our patients' physical presentation every time we see them.

Patients that have been taking antipsychotic medication for weeks to months or if the dose is changed on the antipsychotic medication may develop drug-induced Parkinsonism. And this looks basically identical to organic Parkinsonism. It's a bradykinetic presentation. They have a tremor, which is rhythmic, rapid, and usually around a fixed axis. You can have a tremor in the hand. You can also have it in the chin or the head. It's a resting tremor. Patients with drug-induced Parkinsonism may have changes in their gait, a more shuffling gait. They may not have the arm swing. They have the masked face with lack of expression. They don't blink as much. And they're also going to have some rigidity, some increased muscle tone on physical exam, and some cogwheeling.

Tardive dyskinesia is a syndrome that develops after someone's taken an antipsychotic medication for months to years. It usually takes longer for this to present if it's going to. So tardive is a hyperkinetic movement disorder. So individuals that suffer with tardive, they have involuntary, irregular movements that occur basically every moment that they're awake during the day. The symptoms do remit with sleep. And these are not rhythmic. They're kind of more kind of herky jerky and irregular. They can be choreoathetotic, kind of writhing movements. The most common place you're going to see tardive movements is going to be in the face or in the mouth, but you can have tardive movements in any voluntary muscle in your body.

Dr. Turck:

And with that in mind, let's turn to you now, Dr. Cutler. What are some common barriers that can keep us from screening patients?

Dr. Cutler:

There's many potential barriers, and unfortunately, if you're like me and you trained a while ago, you might not have been well trained in how to recognize and assess tardive dyskinesia. So one potential barrier is lack of or inadequate training or education. Another is that we kind of thought with the newer generation of antipsychotics that this wouldn't be as big of a problem, so we tend to underestimate how common it actually is. And it is quite common. As many as 10 to 20 percent of our patients may eventually develop tardive dyskinesia. There are also other barriers that include not feeling like you have enough time. You may feel like it takes too long to assess. Even though you don't have to do a full evaluation—you don't have to do the full AIMS rating scale, for instance, every time—but you do need to look for it and ask about it. There are also other potential barriers, such as noticing movements but not being sure what's causing them and not being sure what kind of movements there are. And then we've unfortunately been trained a little bit inaccurately about how to treat it. We've been trained to use anticholinergic medications when really they're not effective for this movement disorder. They can work for some.

Dr. Turck:

And along with those barriers, Dr. Scargle, can you tell us how certain aspects of tardive dyskinesia assessment, like its complexity and symptom variability, can also delay diagnosis?

Dr. Scargle:

I think most of the time tardive gets undiagnosed. We're missing up to 85 percent of our patients that have active tardive symptoms, and we're not diagnosing them because mostly, I think we're so focused on what they're saying. We work in mental health, so we're listening to their stories, right? So I think we can all just be aware that tardive is out there; even people on the newer antipsychotic medication, the atypicals, 1 in 14 of those individuals is going to develop symptoms of tardive dyskinesia. So just to be aware and to look.

We clinicians that are working in mental health, we're still allowed to touch our patients. We are still allowed to do a physical exam. So don't be timid if you're seeing a movement and you're not sure what it is to go look for cogwheel rigidity in your patient. See if they have any wrist rigidity because it could help you make the proper diagnosis.

Dr. Turck:

For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Andrew Cutler and Michelle Scargle about common barriers to diagnosing and initiating treatment in patients with tardive dyskinesia.

So coming back to you, Dr. Cutler, how can we address the barriers to screening you were talking about earlier?

Dr. Cutler:

Well, Dr. Turck, I first have to say that programs like this are critically important. I think that there is an educational gap, and the more education we can do around this about, as I mentioned, how common these are—up to 10 to 20 percent of patients—and the fact that our guidelines say every patient on an antipsychotic, a D2, dopamine-2, receptor-blocking agent should be screened for TD at every visit, not just baseline and every now and then, which is a newer way of thinking about this. Now that doesn't mean you have to do that full AIMS rating scale or some other standardized scale; that you should do at least a couple times a year, but at every encounter, you should at least look for it and ask about it. And it doesn't have to be a lot more complicated than that. Ask the patient, not only have they noticed something, but has anyone else noticed? Has anyone else commented? Is there anything that you feel like you're not able to do or you're embarrassed to do? Or have you noticed any movements that have impacted your ability to function?

It's so important to try to get people to understand this, but also to understand that these movements are not just limited to the face, which is how I was trained. They can affect any part of the body. They can be quite variable. And they are one of a number of potential drug-induced movement disorders. Tardive dyskinesia is more considered tardive or later onset. There are three common acute drug-induced movement disorders, and they're all distinct, and the treatment is different. And that's probably the most important thing: to recognize that you have to get the right diagnosis in order to institute the correct and effective treatment.

Dr. Turck:

Now, Dr. Cutler, you've alluded to the treatments for tardive dyskinesia being different from those for other movement disorders. What sort of treatments have shown to be effective for tardive dyskinesia?

Dr. Cutler:

Well, that's a great question because before 2017, it was so frustrating; we did not have any effective treatments. But in 2017, two drugs in a class called VMAT-2 inhibitors, or vesicular monoamine transporter type 2 inhibitors, were actually FDA approved. So we now

have evidence-based and FDA-approved treatments, and they're also recommended by all of our guidelines. And those are not the right treatments for other kinds of drug-induced movement disorders. And I want to reiterate: anticholinergic medications, despite some people being trained that way, are not effective and not recommended for tardive dyskinesia.

Dr. Turck:

And, Dr. Scargle, would you share some counseling strategies for talking to patients about screening?

Dr. Scargle:

Yes, don't be afraid to talk to your patients about tardive, honestly. So with anybody in the clinic that I see that is either taking an antipsychotic medication or we're considering starting an antipsychotic medication, I have this very kind of laid-back discussion, and I tell them, "Okay, look, so I think that this medication we're talking about, this antipsychotic, it may help you for these reasons. I think it may help you to regulate the dopamine in your nervous system, which could potentially help you with your depression or your psychosis or your bipolar symptoms. It could help you. Dopamine in our bodies does a lot of other things. In addition to control emotional health or other mental health symptoms, it also plays a role in physical movement. And so if you could potentially develop a side effect where you might have some dopamine crosstalk and you might have some involuntary movements potentially as a side effect. If you see any of this, any involuntary movements, just let me know. Call me. If you're having movements and you're not sure what it is, call me up, and I can see you sooner, and we can screen the movements and see what's going on. If you are having movements, we can treat those." I've had two people in my clinic who've actually taken me up on that offer and have called me and said, "I'm having movements. I want to see what this is." And both of them had essential tremor. We were able to assess it and put their mind at ease.

So I think just educating the patient or the caregiver or the family that medications have potential side effects. There's no med without possibility of side effects. So this one could have some dopamine crosstalk and involuntary movement. So if you see any of those things, then just let me know. And patients don't seem to be nervous to take the medications we're recommending. They seem to just appreciate that you're telling them about something that could potentially happen.

Dr. Turck:

Now just to bring this all together before we close, Dr. Cutler, why is routine screening for tardive dyskinesia so important? And what kind of impact can timely diagnosis and treatment have on our patients?

Dr. Cutler:

Well, it's so important because, as I mentioned, it's not something that has gone away with our newer generation, it can still be in up to 10 to 20 percent of our patients. Now we don't know if recognizing and instituting treatment early can head off some of the complications or alter the course of the disease, but we do know that what it can do is make a significant impact on somebody's life. Because tardive dyskinesia, I like to say, is not just a cosmetic problem and it's not just funny-looking movements; tardive dyskinesia can affect somebody psychologically, socially, and functionally in their occupation or academics. Also, there are some physical complications people can have, such as problems with their teeth or muscle spasms or blisters. So it's really important to try to recognize and diagnose this as early as possible, so you can institute effective treatment and ideally prevent these things from becoming bigger problems down the road. And the problem is a lot of times the patient doesn't know or the clinician doesn't recognize that this is related to the treatment. Another issue is it doesn't have to take that long. I know people are concerned about the time it might take to evaluate these movements. It doesn't have to take that long. You can do it in your regular visit, just look for abnormal movements and ask about them.

Dr. Turck:

Well, given the considerable health burden it can represent, I want to thank our guests, Drs. Andrew Cutler and Michelle Scargle, for joining me to share their expert insights on how we can overcome barriers and optimize our approach to assessments in tardive dyskinesia. Dr. Cutler, Dr. Scargle, it was a pleasure speaking with you both today.

Dr. Cutler:

Thank you.

Dr. Scargle:

Well, thank you very much for having me. I appreciate it.

Announcer:

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