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Released: 12/11/2023
Valid until: 12/11/2024
Time needed to complete: 40m

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New and Emerging Treatment Paradigms for SCZ Symptom Management: One Size Fits All

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Dr. Correll:
Hello, welcome to the Roundtable Discussion: New and Emerging Treatment Paradigms for Schizophrenia Symptom Management: One Size Does Not Fit All. My name is Christoph Correll. I'm Professor of Psychiatry and Molecular Medicine at the Zucker School of Medicine at Hofstra Northwell. And I'm joined by -

Dr. Citrome:
Hi, I'm Dr. Citrome. I'm a Psychiatrist based north of New York City. And I'm Clinical Professor of Psychiatry and Behavioral Sciences at New York Medical College in Valhalla, New York.

Dr. Correll:
So, we're both very interested in treating schizophrenia, as I think our audience is, but we're also facing challenges. And one challenge is that the medications we have are not always taken by patients, they might feel, 'Oh, I'm better, or I may not be ill, or I forget.' So how are we actually dealing with this, Les? What's the best way of identifying nonadherence and dealing with it?

Dr. Citrome:
Well, the first thing I ask myself is: Why is the patient not doing as well as they could be? And I have to think about, well, maybe they're not taking the medicine as prescribed. Now, there may be two reasons for this. Two very different reasons. One is they don't want to. So that's a different topic of conversation. The other is they want to, but they simply can't get their act together to take it. So, I need to figure that out first, because if they don't want to take it, then we have some more work to do. But more often, they're quite willing to take their medicine, they just can't remember, or they don't have a place to put it that they can go back to and find it. Sometimes they're challenged in terms of understanding their illness every day. And sometimes this insight is too fleeting. Their lives may be quite chaotic. So, a lot of things go against being able to take one's medicine. And frankly, for all of us, it is difficult to take something for a chronic condition. This is like human nature. People with hypertension, diabetes, and asthma have actually the same problems with adherence as people with schizophrenia. So, I like to offer medicines that are easier for them to take. And perhaps the easiest option for them would be a long-acting injectable.

Dr. Correll:
Now, but clinicians and patients don't see it as easy. Why is that?

Dr. Citrome:
So, there are some misconceptions about long-acting injectables. Number one, they're stigmatized as a last resort for the worst of the worse, so patients who cannot be trusted to take their medicines. Well, actually, it's an easier way of receiving a medicine, and I say to the person with hypertension, 'Wouldn't you like to have your drug available for your hypertension in a long-acting injectable? Well, we

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can treat your other disorder, your schizophrenia, with a long-acting injectable, wouldn't that be easier?'

Dr. Correll:
But what about pain and undermining the relationship, I don't trust my patient by providing the suggestion of an LAI?

Dr. Citrome:
Well, I think we need to put it into perspective, as, you know, everyone misses their medicine some of the time, this is human nature, so it's not a terrible thing to receive a long-acting injectable. Actually, it's quite convenient. You don't have to remember every day to take your medicine, it's there. It's guaranteed delivery. If a younger person is living at home, I can often talk about, 'So what's it like, you know, taking your medicine at home and your parents always saying, *'Did you take your medicine? Did you take your medicine? Did you take your medicine? Did you take your medicine?'* Wouldn't it be easier if you didn't have that conflict, that conversation every single day?' So, I try to put it into the perspective of it is a easier way of getting control of your illness by getting something that you don't have to think about every day.

Dr. Correll:
That's a very good point of the control over your illness. There's also the misconception, like, 'Oh, we're taking autonomy away from the patient,' rather, we're giving them autonomy back so that they can handle the treatment better. But now, if we are convinced to maybe offer an LAI, what kind of considerations do we need to put into this conversation with patients?

Dr. Citrome:
Well, they may have some faulty knowledge of what an LAI is, they may have some idea about the size of a needle, which would be a lot bigger than the actual size of the needle, they may have misconceptions about the pain associated with injection. So, all this needs to be addressed and we can talk about the research that was done with long-acting injectables, demonstrating that pain on a scale of 0 to 100 after the first injection, the pain was rated as a 7 - 7 out of 100. Well, that puts things into perspective. I also like to show them the needle, what it looks like so there's no mystery there. Sometimes they hear that it's a shot in the butt, and they're worried about dropping their pants. So that's a legitimate concern, but we don't want patients to drop their pants, that's totally unnecessary; it's the upper outer quadrant that we inject into, and patients don't necessarily know that. So, I need to address all the misconceptions.

Dr. Correll:
Plus, aren't there other areas of the body where it can be injected?

Dr. Citrome:
Of course. There's also the deltoid for an intramuscular injection, or the back of the arm for a subcutaneous injection. So, patients need to be made aware that not only can these injections be given in the muscle, but also under the skin. And that's certainly a possibility. And that there's a variety of different formulations, some that can be given every 2 weeks, every month, every 6 weeks, every 2 months, every 3 months. Ultimately, every 6 months is also a possibility for a particular molecule. So, there's a wide variety of choices here, and we need to find what would be the best fit for that individual person.

Dr. Correll:
So, it seems that the treatment paradigm needs to shift from oral to LAI, as at least being something we offer to patients so that they can make an informed decision. Because for them, it might actually free up life and choices in order to achieve their goals.

Dr. Citrome:
So frankly, yes. You know, I always say to the patient, 'Look, try it. If you don't like it, you don't need to have your next injection, you can go back to pills. It'll be up to you.' Invariably, once a person has experienced the freedom of an injection, they don't want to go back to pills.

Dr. Correll:
Alright, well, thanks very much, Les, for this great conversation. And I hope that also our audience will learn something from that and maybe offer an LAI with the different options to patients so that they can take more charge of their lives.

Announcer:
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