Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/program-name/26601/

Released: 06/28/2024
Valid until: 06/28/2025
Time needed to complete: 1h 14m

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

Stratified Care: The Role of Switching or Augmentation Therapies Used When Treating Schizophrenia

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Citrome:
Hello. I'm Dr Leslie Citrome, Clinical Professor of Psychiatry and Behavioral Sciences at New York Medical College in Valhalla, New York. We're going to talk about switching or augmentation when treating patients with schizophrenia. This is a topic that we covered in episode 1 with a case patient, but let me go over some general principles here.

Do we switch, or do we augment? This is an age-old question, and we have lots of experience with this with treatment of major depressive disorder. So we know that with major depressive disorder, we can get a partial response with an SSRI or SNRI, and we want to, like, get a better response. Rather than an outright switch, we often consider augmentation with a second-generation antipsychotic. I like to call this, 'you don't want to throw out the baby with the bathwater.' If you have a partial response, you want to build upon it. So we do have experience doing that with major depressive disorder. We don't really have FDA approved treatments for augmentation of antipsychotics in schizophrenia, at least not yet. But we do do this clinically when we think about different options for our patients who have continuing symptoms of psychosis.

Novel antipsychotics with a non-dopaminergic mechanism of action are our hope here, and they may be useful for antipsychotic adjunctive treatment in people with schizophrenia who exhibit inadequate response or treatment resistance or poor tolerability to higher doses of available antipsychotics that are otherwise necessary for efficacy. We don't have these agents yet, but we may have them soon. In which case, if I have someone who has persistent positive symptoms, despite my best efforts with traditional medicines, I may want to add a non-dopaminergic mechanism of action medication. I am hopeful that 1 plus 1 equals 3, but I'll be happy with 1 plus 1 equals 2. I'm pretty sure 1 plus 1 is not just 1. It would be if I added two drugs that were kind of the same, I'm not going to get anywhere. But when I start adding drugs that have different mechanisms, I might get somewhere. And I may be even able to treat those who have expressed a certain amount to treatment resistance.

Poor tolerability is another category. I may have a patient who does quite well in terms of their symptom control with higher doses of a specific antipsychotic, but they simply don't tolerate it. Perhaps they're too sedated or have too much akathisia, and we have to back down. What can I do next? I can add something. So this happens all the time with major depressive disorder, with inadequate response to an SSRI, we add something, an antipsychotic. If we want to address treatment resistance or treatment refractory depression, we'll add a second-generation antipsychotic. And even poor tolerability, we can help address by finding the combination that suits the patients best.

Now before I jump into this, there's also some considerations that we use in major depressive disorder that we should also employ when we're treating schizophrenia. Obviously optimize the dose. Now this may mean a little lower, a little higher, and also making sure that they're actually taking their medication as prescribed. This can be difficult. I may want to consider to make sure a long-acting injectable

to be used in order to prospectively determine that I've done all I can with the agent in my mind that should work. We can change to another antipsychotic, for sure, in someone who has non response or inadequate response, but that is throwing out the baby with the bathwater. And if you have some degree of response, you don't want to do that unless, of course, the patient says, 'I don't want to take this anymore,' or 'I don't tolerate it.'

We can augment also with non-medication strategies. Even things as simple as exercise and change in diet, that can have an improvement in the person's mental state. We want to offer, if we can ,cognitive behavioral therapy, skills training, vocational rehabilitation, cognitive remediation, all these non-pharmacological therapies where, in addition to the antipsychotic, we may achieve bigger success. Even psychoeducation for patients and their families can help reduce relapse rates and rehospitalization rates. Ultimately, though, I would like to be able to augment by adding another agent with a different mechanism of action. Today, this means adding a non-antipsychotic and hoping for the best. Sometimes I actually add an antidepressant to the antipsychotic that the person is receiving with the hopes of relieving the comorbid depressive symptoms, or perhaps even negative symptoms.

So the appropriate next step for partial responders basically comes down to switch or augment. I'll switch, as I mentioned earlier, if whatever the patient is receiving is intolerable or perhaps unsafe from my point of view. If there's absolutely no response, then of course it's pointless to continue. Patient preference plays a big role here in switching as well. If a patient wants to switch, they're in the driver's seat. I can't tell them what to do. I want their buy-in in making treatment decisions. And a curious thing happens when you engage someone in motivational interviewing, when they advocate for a certain treatment themselves, they're more likely to be adherent to it. Bottom line, though, I'll add if the current regimen is tolerable, if there is a partial response, and as long as I get the patient buy-in so their preference is to go with that strategy.

By adding, we can build upon the progress that's already been achieved. We avoid delays inherent with starting over. And mechanistically, we'll combine different approaches. So that's very attractive, in my mind, in terms of making rational sense out of this; I'm not adding two things that are similar, I'm adding two things that are different, and perhaps they can act synergistically.

At the same time, I want to be able to monitor the progress that my patient is making, having them actively report how they're doing, maybe the use of a rating scale, maybe a very rudimentary rating scale, on a scale of 1 to 5 how they're doing on various types of symptoms, whether they be positive or negative, or cognitive or mood. If I get a sense I'm going in the right direction, we can proceed with that course of action.

If I am going to switch over, it's going to be a little complicated. I'm going to do a cross taper, do it gradually. Patients may have something else on their mind when switching and may be in a hurry, and that could be problematic. I like to do cross tapering to avoid any untoward withdrawal effects from going from, let's say, a sedating antipsychotic to something else.

I hope this has been helpful. I look forward to further discussions.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.