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Letter to Editor

Antipsychotics, Psychotic Disorders, and Obsessive-Compulsive Disorders

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When it comes to the treatment of psychotic disorders, antipsychotic therapy can be viewed as the cornerstone of treatment and based on the severity of the symptoms of the psychotic disorder, patient preferences for antipsychotic therapy and side effect profile of the antipsychotics, an individual can either be initiated on a typical or atypical antipsychotic. For the most part, all antipsychotic therapies are considered to be equally effective, especially in their ability to reduce positive symptoms the choice of which medication to initiate can be based on a collaboration between the clinician and the patient but ultimately antipsychotic medications are viewed as mainstay therapy for most psychotic disorders (Preston & Johnson, 2011).

Individuals who have obsessive compulsive disorders (OCD) generally present to physicians other than psychiatrists (e.g., dermatologists) with chapped hands or family practitioners with

washing excessively or checking compulsion and it is only after these clinicians able to determine that these individual may in fact have a mental illness that they are ultimately referred to a psychiatrist (Hersen, Albers, Reist, 2008). While selective serotonin reuptake inhibitors are considered to be first line agents for OCD, antipsychotic medications may be helpful in augmenting SSRI therapy. Antipsychotic medications can be especially useful in treating patients with OCD when there is little response or no response to standard drug or behavioral therapy so antipsychotic medication can serve as another option for treatment (Schatzberg, Cole, DeBattista, 2010). The use of riserpidone 2-4mg as augmentation therapy is supported in the literature having the best track record as an augmenting agent for OCD and the results for olanzapine with higher dose (up to 20mg/day) has also been shown to be effective (Schatzberg, Cole, DeBattista, 2010). There are mixed results for the use of olanzapine (200mg/day) when

added to SSRI therapy but this can also be an option for OCD treatment.

Furthermore, as it currently stands both the typical and atypical antipsychotic medications have a U.S boxed warning advising against their use in elderly patients with dementia-related psychosis as a result of an increased risk of death that can be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature. The atypical antipsychotics were the first class to receive a public health advisory that was released by the Food and Drug Administration suggesting that all cause mortality was increased in patients that were treated with an atypical antipsychotic medication when compared to placebo (FDA Public Health Advisory, 2008). Eventually another meta-analysis was conducted by Wang and colleagues (2005) which compared the rates of mortality between the typical and atypical antipsychotics and it was determined that the typical antipsychotics had higher mortality rates compared to the atypical antipsychotics. There are currently no antipsychotics that are approved in the management of elderly dementia patients and it is unlikely that there will be given the reports of increased mortality but there are other reasonable alternative that can be used in individuals with dementia who demonstrate agitation, aggression, delirium, behavioral disturbances, or psychosis such as benzodiazepines or anticonvulsants therapies if the benefit of initiation outweighs the risk (Schatzberg, Cole, DeBattista, 2010). Ultimately, antipsychotics can be used as a last resort if the behaviors are severe and persistent to where it threatens the safety, functioning, and well-being of the sufferer. As a general rule, antipsychotics can be useful for controlling psychosis, agitation, and aggression and atypical antipsychotics are generally preferred due to their lower risk of EPS but other options must have been tried and proven to be unsuccessful before consideration is given to start antipsychotic therapy in a person with dementia.

Also, antipsychotic medications are used for many off-labeled indications in clinical practice and while it is generally off-label utilization that can determine whether or not a drug is effective for treating a particular condition this practice is not promoted by the FDA when it comes to prescribing. In general, antipsychotic medications are known for their use in psychiatric disorders such as schizophrenia, depression, bipolar disorder, anxiety disorders, and personality disorder but they can be used off-label for agitated organic states such as delirium, Alzheimer's dementia, mental retardation offering different degrees of benefit (Schatzberg, Cole, DeBattista, 2010). Ultimately it is the off-label use of antipsychotic medications that can lead to clinical trials being performed on its use for a specific condition and based on these trials they can receive an FDA approved indication which dictates that the use of the antipsychotic for the condition or illness is acceptable.

Lastly, the typical antipsychotic medications (first generation antipsychotics) and the newer antipsychotic medications (second generation antipsychotic medication) are similar based on the fact that they are specifically designed to target elevated levels of either dopamine and serotonin which are considered to be the cause of psychotic disorders such as schizophrenia (Stahl, 2008). While the typical antipsychotics act through dopamine antagonism, the atypical antipsychotics work through the blockade of dopamine and serotonin which leads to more EPS being observed with the typical compared to the atypical (Schatzberg, Cole, DeBattista, 2010). Both the typical and atypical antipsychotics are a heterogeneous group of agents that have advantages and disadvantages that can be associated with their use. While the typical antipsychotics are primarily known for targeting the positive symptoms, the atypical antipsychotics can target both positive and negative symptoms. Unlike the typical antipsychotics, the atypical antipsychotics are synonymous with the development of metabolic abnormalities so both the American Diabetes Association and the American Psychiatric

Association have constructed recommendation for screening for individuals that are on an atypical antipsychotics such as periodic monitoring of weight, fasting blood glucose, lipid panel, blood pressure, and family history of diabetes (Schatzberg, Cole, DeBattista, 2010). While it is recognized that the typical and atypical antipsychotics have side effect profiles and mechanism of action that distinguish one class from another for the most part they are all equally effective in treating the core symptoms of specific psychotic disorders. There are instances where antipsychotic medications cannot be used in an individual so in this case there are other psychotropic medications that can be utilized based on the person's symptom presentation and the outcome that is desired with initiating pharmacotherapy. For the management of agitation or anxiety, benzodiazepines can be utilized, if there is the presence of a mood symptom mood stabilizers can be utilized, or even non-psychotropic medications such as beta blockers, anticonvulsants, and alpha adrenergic blockers can be used to treat symptoms of psychiatric disorders (Hahn, Albers, & Reist, 2008).

The use of psychotropic medications, namely antipsychotic medications have become increasingly prevalent in the treatment of a variety of mental illnesses and prior to initiation assessments that consist of the risks versus benefits must be heavily weighed. These medications can improve people's conditions and factors such as preference, tolerability, adverse effects, and treatment outcomes should be considered with each individual.

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