APPROACH TO PSYCHOSIS IN PRIMARY CARE

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Faculty/Presenter Disclosure

- **Faculty:** Jon Davine
- **Relationships with financial sponsors:**
  - **Speakers Bureau/Honoraria:**
    - Toronto East Hospital Network
    - Ontario Medical Association
    - Touchstone Institute
    - Ontario College of Family Physicians
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    - University of Alberta, Department of Psychiatry
    - Canadian Psychiatric Association
    - Pri-med, University of Toronto Family Medicine
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  - **Other:** None

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Disclosure of Commercial Support

- **This program has not received financial support**
- **Potential for conflict(s) of interest:**
  - Jon Davine has received honoraria only from not for profit organizations. He prepared the slides on his own.

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Objectives

- Describe effective questioning to evaluate psychosis.
- Describe the complete differential diagnosis of psychotic disorders.
- Identify the current psychopharmacologic treatments of psychotic disorders.

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PSYCHOSIS

- Delusion: Fixed, false idea; not consistent with one's culture
- Hallucination: Perceptual experiences without any external stimuli
- N.B. Illusions: Misinterpretation of stimulus
- Disorganized thinking, or behaviour

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ASKING ABOUT PSYCHOSIS

- Do you have unusual experiences, such as hearing voices other people cannot; or seeing things other people cannot?
- Do you have unusual thoughts; such as feeling you have special powers no one else on earth has; or do you feel there is a plot out there, by people you don't even know, who want to harm you?

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ASKING ABOUT PSYCHOSIS

- Do you ever feel the radio or TV has special messages just for you?(ideas of reference)
- Do you feel your thoughts are "broadcast" so that anyone around you can know what you're thinking. Do you feel thoughts can be inserted or taken out of your head?

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ASKING ABOUT PSYCHOSIS

- Do you feel your thoughts, actions, or feelings are controlled by some external power?
- Do you feel there is something very unusually wrong with your body(somatic delusion)?

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GENTLE QUESTIONING:

- "I think you may be misinterpreting things,"
- "I think your thoughts may be getting away from you."
  "What do you think?"

N.B. Delusion is a fixed false idea not consistent with one's cultural beliefs. Therefore, see if thought is fixed.

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DELUSIONS

- Predicting the future, reading people's minds, may not be delusional.
- May be schizotypal personality
- Religious thought often gets tricky. Compare to what was happening in the past

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STRATEGY:

- Try to ally with patient's complaints:
  - e.g. "This will help you sleep."
  - "Feel less agitated" etc.

When trying to persuade them to take antipsychotic medication.

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STRATEGY

- You can reality test for the patient:
  - "I know this is real for you, but I see things somewhat differently..."

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ENSURE SAFETY

- Command hallucinations
- Suicidal ideation
- Homicidal ideation

Note: Can make a contract with a psychotic person, but trickier

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R/O ORGANIC

1. Non-auditory, e.g., Visual Hallucinations
2. Clouded Sensorium
3. Older age at first onset

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D	Drugs
I	Infection
M	Metabolic
E	Endocrine
V	Vascular
E	Epilepsy
T	Tumour/trauma
S	Syphilis

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DIFFERENTIAL:

- Time Course

Brief Psychotic Reaction: less than 1 month
Schizophreniform Psychosis: 1 – 6 months

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DIFFERENTIAL OF PSYCHOSIS

	Hallucination	Bizarre vs Non Bizarre	Downward Drift	Affect at time of Psychosis
Schizophrenia	+/-	NB/B	+	-
Schizoaffective	+/-	NB/B	+	+
Affective Disorder	+/-	NB/B	-	+
Delusional Disorder	-	NB	-	-

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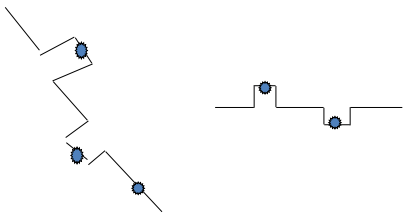
SCHIZOAFFECTIVE VS. BIPOLAR



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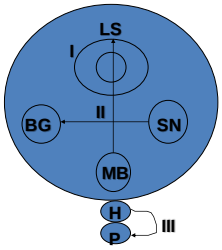
POSITIVE SYMPTOMS:



Dopaminergic Tracts

I. Mesolimbic
II. Nigro-Striatal
III. Hypothalamic-Pituitary

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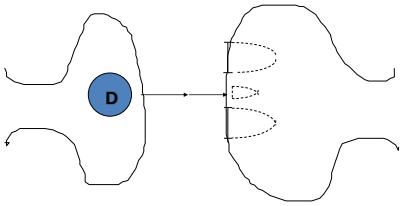
TARDIVE DYSKINESIA



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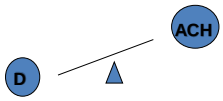
EPS



"IATROGENIC PARKINSON'S"

1. Parkinsonism
2. Akathesia
3. Dystonias

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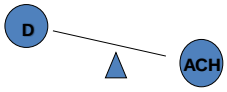
TD



"IATROGENIC HUNTINGTON'S"

- 15-20% of people on neuroleptics
- Cumulative dosage
- Older, women, on large dose, x years
- Sometimes idiosyncratic. Can be just a brief number of months.

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DRUG TREATMENT

ATYPICAL NEUROLEPTICS

- Considered treatment of choice:
  - Olanzapine
  - Risperidone
  - Quetiapine
  - Clozapine
- No psychosis is considered treatment resistant until Clozapine is tried.

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ATYPICAL NEUROLEPTICS

ADVANTAGES:

- Better s/e profile
  - less EPS
  - less TD
- Possible better response with respect to negative symptoms.
- CUTLASS1 study argues against this.
  - Jones, Peter, et al. Archives of General Psychiatry, Vol.63, October, 2006, pp. 1079-1987
- Equal efficacy with respect to positive symptoms
- Liver cleared - do LFT's prior. If history of liver problems, do LFT's q 6-12 months

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RISPERIDONE (RISPERDAL)

- Blocks D_2/$5HT_2$
  also alpha adrenergic
- Peak Plasma: 1-2 hours
- Half life: 20-24 hours
- Liver metabolized

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RISPERIDONE - (RISPERDAL)

EPS increased

May increase prolactin – can cause amenorrhea, galactorrhea, sexual problems

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RISPERIDONE

Dosage:

Start 0.5 mg. BID

Range:

2-4 mg OD

Few studies, re pregnancy

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OLANZAPINE (ZYPREXA)

BLOCKS: D_2/$5HT_2$
Also D_1, D_3, D_4
Muscarinic
Alpha adrenergic
Histamine

Peak plasma 5-8 hrs after intake
1/2 life 21-54 hours
metabolized by liver - P450-2D6
Little P450 interactions

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OLANZAPINE - (ZYPREXA)

- somnolence
- orthostatic hypotension, dizziness
- ⇧hepatic transaminase (ALT, AST, GGT)
- weight gain
- no increase in prolactin
- few studies re: pregnancy/lactation

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OLANZAPINE

Dosage:

Start: 5 mg PO OD
Range:10-20 mg OD

Geriatric/hepatic impairment:
Start 2.5 mg PO OD

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QUETIAPINE (SEROQUEL)

- Blocks: $5HT_2/D_2$ Receptors
  also D_1
  H_1
  Alpha Adrenergic
- Peak plasma: 2 hours after dosage
- Half life: 6-7 hours
- Metabolized by the liver - CYP 3A4

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QUETIAPINE - (SEROQUEL)

Somnolence
Cataracts - in animals
slit lamp examination recommended

hypothyroid
weight gain less
no increased prolactin
few studies safety in pregnancy

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QUETIAPINE

Treatment range: 300-600 mg/day

Quetiapine XR 300 mg. Tabs-- Can start 300 mg. OD on day 1.
Can increase to 300 mg. BID on Day 2.

Often start at 50-100 HS

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CLOZAPINE (CLOZARIL)

- Blocks D_1 and D_4 and $5HT_2$. Less D_2
- Peak levels 2-5 hours (1-6 hours)
- 1/2 life 12 hours (6-30 hours)

- Liver metabolized - mainly P450 1A2,
  somewhat P450 2D6

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CLOZAPINE

Agranulocytosis - Follow WBC, Neutrophils

Weekly x 26 weeks, then biweekly x 26 weeks, then monthly indefinitely

Seizures - dosage linked esp >600 mg/day

Drowsiness

Hypotension, dizziness, tachycardia

Hypersalivation

Weight gain

Fever

Little tardive dyskinesia

No increase in prolactin

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CLOZAPINE

Dosage:

12.5 mg OD	Day 1
25 mg OD	Day 2
25 BID	Day 3

- then ⇧ by 25-50 mg increments daily
- target dose 300-450 mg/day by 2 weeks
- dosage range 300-600 mg/day in divided doses
- maximum 900 mg/day

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Ziprasidone

- Equal Eficacy
- Less EPS and TD
- Less Metabolic
- BUT……
- Prolonged QT. To be avoided with hx of prolonged QT, hx of cardiac arrhythmias, post MI, CHF, avoid with other drugs that prolong QT
- Dosage: 20 or 40 mg. PO BID up to 80 mg. PO BID

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Aripiprazole

- Equal Efficacy
- Less EPS and TD
- Less Metabolic Effects
- No QT Prolongation
- If this all holds true, we will all be using this a lot!!
- Dosage: 10-15 mg. Po OD. Maximum is 30 mg. PO OD

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Lurasidone

- 40, 60, 80 mg.
- Give with 350 calories
- SCZ: 40 to 80, can be 120, 160
- Adolescents: 40-80
- Bipolar depression: 40-60-80

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Metabolic Syndrome

- Increased glucose: Diabetes Type II
- Increased cholesterol
- Increased tryglycerides
- It is possible that rate of Diabetes Type II may be linked to weight gain but not clear.
- Check fasting blood sugar every four months, along with cholesterol and triglycerides.

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Weight Gain

Olanzapine and Clozapine more than Risperidone and Seroquel

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TRADITIONAL NEUROLEPTICS

		Alpha Blocking	Antihistamine	Anticholinergic	EPS inducing
CPZ	100	H	H	H	L
Mellaril	100				
Perphenazine	8	M	M	M	M
Stelazine	5				
Loxapine	10-15				
Haldol	2	L	L	L	H

Usual daily antipsychotic dosage: CPZ 300-500 mg

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Use of Neuroleptics I

- Anti-psychotic
  - Organic
  - Psychiatric
- Anti-manic (After Mood Stabilizer, Benzos)
- For Prophylaxis in schizophrenia and schizoaffective
- Quetiapine approved for Bipolar prophylaxis monotherapy

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Use of Neuroleptics II

- For treatment resistant OCD patients
- For agitation in demented patients (low dose Risperidone 0.25mg.)
- Remember black box warning of increased death
- In bipolar depression (Quetiapine)
- For augmentation in unipolar depression (Aripiprazole, Quetiapine, Risperidone)

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Use of Neuroleptics III

- Do not use in general for nighttime sedation—QUETIAPINE
- APA and Choosing Wisely have come out against
- Benzos/hypnotics preferred, because no risk of metabolic issues

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Three Pronged Effect of Neuroleptics

1. Motor Agitation - minutes to hours
2. Perceptual - three to seven days
3. Disordered Thoughts - three to six weeks

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NMS

- can happen in 1-2% of people on neuroleptics
- has 15% mortality

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NMS - Neuroleptic Malignant Syndrome

⇧ Temperature

Sympathetic lability (BP, Pulse)
Confusion
Rigidity

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NMS

- Usually associated with:
  - Starting Neuroleptic
  - Increasing Neuroleptic
  - Changing Neuroleptic

But can be anytime
No neuroleptic better than another

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NMS

- Increased CPK
- Myoglobinuria

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NMS

Treatment:

D/C Neuroleptic

Use Benzos for agitation, sedation

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NMS

As per P. Rosebush Studies

- After two weeks symptom free, can rechallenge with another neuroleptic. Switch to a different class.
- If you don't wait two weeks, NMS may reappear

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NMS

- NB:

If FUO and on neuroleptic:
d/c Neuroleptic
use Benzos for agitation

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I.M. NEUROLEPTIC

• e.g.		Given
Modecate	(Fluphenazine Decanoate)	q 2-4 wks
Moditen	(Fluphenazine Enanthate)	
Haldol LA	(Haloperidol Decanoate)	
Risperidal Consta	(Risperidone)	25 mg q 2 wks

Close if compliance an issue e.g. paranoid states
But - stuck if problems with side effects.

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- For EPS, use Anticholinergics

Benzotropine (Cogentin) 2-6 mg OD
Procyclidine (Kemadrin) 2.5 mg -5 mg BID - TID

NB: I.M. Benztropine 2 mg for acute dystonic reaction e.g. oculogyric crisis

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Please fill out your session evaluation now!

Complete a session evaluation one of two ways:

- **FMF app** **Session #: F79**
- **Fmf.cfpc.ca** **Session Name: Approach to Psychosis in P.C.**

YOUR FEEDBACK IS IMPORTANT TO US!

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TOM

Tom is a 30-year old male who presents with a three month history of depressed mood and problems with sleep, appetite, energy, enjoyment and concentration. He is not suicidal. He also describes hearing voices for the last few months and has unusual thoughts that articles in the newspaper have specific messages for him alone that are telling him to harm himself. He denies the use of street drugs and alcohol. He is medically healthy and is on no medication.

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TOM

Five years ago, Tom tells you he had an episode where his mood was unusually good and he had increased energy and decreased need for sleep. This lasted about six or seven days and then passed. He remembers having unusual thoughts at this time that he was on a special mission from God, though this also passed after six or seven days. He did not receive treatment at this time.

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TOM

Tom has been married for eight years and has a six year old son. His family life goes well. He gets on well with his wife and his son. He has friends and maintains social contacts.

Tom has worked at Stelco for seven years and has a good work record. He enjoys his work and gets along well with his colleagues at work.

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TOM

- 1. Using the grid, what is the preferred diagnosis? How could you rule out other diagnoses?
- 2. What is the pharmacologic treatment you would use at this time?

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DIFFERENTIAL OF PSYCHOSIS

	Hallucination	Bizarre vs Non Bizarre	Downward Drift	Affect at time of Psychosis
Schizophrenia	+/-	NB/B	+	-
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Affective Disorder	+/-	NB/B	-	+
Delusional Disorder	-	NB	-	-

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