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Treatment of First-Episode Schizophrenia in a Young Woman

Robert A. McCutcheon, MRCPsych; Tiago Reis Marques, PhD; Oliver D. Howes, MD, PhD

A 20-year-old woman was referred by her family physician to a community mental health team in London, United Kingdom. Her mental state had deteriorated progressively over the previous 12 months, following the death of her father. After a period living alone, she had returned to the family home 4 months prior to her presentation and had been noted to be socially withdrawn, preoccupied, and distractible. Her family physician, suspecting a depressive episode, had prescribed citalopram up to a dosage of 40 mg once daily, to no effect. Her family subsequently sought advice from the family physician when the patient was noted to be speaking to herself, expressing concerns about people meaning her harm, and professing the belief that she could hear other peoples' thoughts.

The patient had been born in Sierra Leone after a complicated delivery and had traveled to the United Kingdom as a child with her family, who were fleeing from a civil war. On arrival in the United Kingdom, her family claimed asylum and moved into a small apartment in a high-rise building in central London. Although there was no reported developmental delay, she had struggled academically at school and was bullied for having overweight. She left school without qualifications at age 16 years and worked as a shop assistant. She left this job about a year prior to her referral to psychiatry after a period of sick leave following the death of her father. She was a nonsmoker, did not drink alcohol, and denied illicit drug use. A paternal relative was reported to have a diagnosis of schizophrenia. There was no comorbid physical illness.

On review, the patient was kempt and had overweight. Eye contact was fleeting, and she presented as anxious, with a degree of psychomotor agitation. Her speech was normal in rate, volume, and tone, although tangential. There was no other evidence of thought disorder. She denied feeling low in mood or suicidal and was objectively euthymic. There was some sleep disturbance, with the patient reporting being fearful to go to sleep owing to persecutory beliefs regarding her neighbors. She reflected that over the preceding few months, she had experienced a sensation of detachment from her immediate environment, as though it was not real, making her world similar to that of a video game. She reported that in the apartment where she had previously been living, she had realized that something was amiss and had become convinced that the door number of her neighbor's flat, number 6, signified that they meant her harm. She explained this was because 6 was associated with the number of the devil. She reported hearing her neighbors commenting negatively about her appearance. These distressing experiences prompted her to return to her family home, but she continued to hear her neighbors' voices making derogatory comments about her appearance and began to hear them commenting on her actions and thoughts in the third person as well. On returning home, her paranoia regarding her previous neighbors worsened, resulting in her rarely leaving the house. The volume and frequency of derogatory auditory hallucinations also worsened, and she reported hearing the thoughts of others as well. There was a degree of insight, and although the patient was convinced of the reality of her experiences, she also saw the stress of losing her father as associated with her experiences and was accepting of input from mental health services.

WHAT WOULD YOU DO NEXT?

A. Commence treatment with oral amisulpride

B. Commence treatment with oral olanzapine

C. Commence treatment with oral clozapine

D. Commence cognitive behavioral therapy for psychosis

Diagnosis

Schizophrenia

What to Do Next

A. Commence treatment with oral amisulpride

Discussion

There are no clear differences in efficacy between licensed antipsychotic medications in head-to-head trials, although network meta-analyses[1,2] suggest that clozapine, olanzapine, and amisulpride are among the most efficacious. In addition to the short-term efficacy of antipsychotic medication, there is also evidence that maintenance treatment with antipsychotic drugs lowers the risk of relapse.[3]

In addition to efficacy, the risk of adverse effects should be carefully considered when discussing treatment options. The patient in this clinical challenge is of African origin and had overweight, both of which increase the likelihood of adverse metabolic effects developing during antipsychotic treatment.[4] Furthermore, psychosis itself is associated with an increased risk of metabolic dysfunction.[5] Consequently, if efficacy and other risks of adverse effects are equal, treatments with a high risk of adverse metabolic

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effects, such as olanzapine (choice B), should be avoided if possible. Alternatives to amisulpride with relatively low levels of adverse metabolic effects include haloperidol and aripiprazole.

Although clozapine (choice C) has demonstrated superiority compared with other antipsychotic medications, this has not been established for patients experiencing first episodes of psychosis, and it has a high burden of adverse effects and requires regular monitoring of full blood cell counts because of the risk of agranulocytosis. As a result, it is typically not recommended as a first-line treatment. It is, however, the only drug licensed for treatment resistance, and evidence indicates that early use in patients with treatment resistance leads to better outcomes.[6]

Long-acting injectable antipsychotic medicationss are an underused treatment option and should be considered early in the illness course.[7] However, even if a long-acting injectable drug is to be used from the first episode, it is generally preferable to first start with oral medication to allow an estimation of dosage and accommodate the time a drug takes to reach effective plasma levels.[8]

The patient's mental health team specialized in the management of first-episode psychosis, and dedicated early-intervention services are associated with considerable benefits for the individual patient and also their family.[9] These teams provide social and psychological support in addition to pharmacological treatments. Cognitive behavioral therapy (choice D) does not have clear evidence of efficacy when given as a stand-alone treatment, but it shows benefit when given in combination with an antipsychotic drug.[10]

Patient Outcome

Oral amisulpride in a dosage of 200 mg, twice daily, was prescribed initially. At a review 2 weeks later, although auditory hallucinations had reduced in intensity, the patient's paranoid delusions persisted. She reported good medication concordance, and this was corroborated by the family. The dosage was therefore increased to 400 mg, twice daily, and cognitive behavioral therapy was also commenced. The patient complained of some stiffness, which improved when the morning dosage was reduced back to 200 mg, twice daily. The psychotic symptoms gradually resolved over the next 4 weeks, although she remained socially withdrawn. Her mother was supportive but became increasingly frustrated about her lack of activity and failure to get a new job, and she frequently criticized her for this. Six months after commencing amisulpride, the patient's positive symptoms returned, and after concerns regarding weight loss secondary to reduced food and fluid intake, she was admitted to a psychiatric hospital. Antipsychotic plasma levels at the time of admission suggested poor compliance with antipsychotic treatment. After discussing this with the patient, she reported finding it difficult to remember to take the treatment regularly, although her family also stated that she had reported to them that she did not feel the need to continue taking her medication. After considering the options, she elected to try treatment with a long-acting injectable formulation of risperidone to avoid the need to remember to take pills. This was started after trying the oral form for a week to check that it suited her.

ARTICLE INFORMATION

Author Affiliations: Department of Psychosis Studies, Institute of Psychiatry, Psychology, and Neuroscience, Kings College London, London, United Kingdom (McCutcheon, Reis Marques, Howes); Psychiatric Imaging Group, Medical Research Council, London Institute of Medical Sciences, Hammersmith Hospital, London, United Kingdom (McCutcheon, Reis Marques, Howes); Institute of Clinical Sciences, Faculty of Medicine, Imperial College London, London, United Kingdom (McCutcheon, Reis Marques, Howes).

Corresponding Author: Oliver D. Howes, MD, PhD, Department of Psychosis Studies, Institute of Psychiatry, Psychology, and Neuroscience, Kings College London, De Crespigny Park, PO Box 67, London SE5 8AF, United Kingdom (oliver.howes@kcl.ac.uk).

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