Treating Older Adults With Schizophrenia

Its cumulative effects challenge the interdisciplinary team.

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Decades of living with the repeated episodes of psychosis, negative symptoms, and other problems associated with schizophrenia exact a heavy toll. Moreover, negative symptoms and cognitive deficits typically appear early in the course of this illness, making patients with schizophrenia less likely to complete advanced education, pursue a career, or develop long-lasting social relationships. The family members—especially parents—who usually provide critical social support earlier in life are often unable to function as caregivers or have died by the time patients with schizophrenia become elderly. Patients with schizophrenia are also less likely to marry and have children of their own, thus increasing their chances of being alone later in life.

All of these factors make caring for older adults with schizophrenia particularly challenging. Members of the interdisciplinary team—physicians, nurses, pharmacists, and other long-term care providers—must be knowledgeable about the most appropriate treatments for schizophrenia as well as the other conditions these patients may be likely to develop.

People with schizophrenia are less likely to receive appropriate care for medical illnesses.

Increased Risk of Illness

People with schizophrenia have an unusually high risk of developing physical illnesses. The occurrence of diabetes and heart disease, for example, can partly be accounted for by these patients' tendency to be physically inactive and overweight and to smoke tobacco. Additionally, many antipsychotic medications contribute to weight gain and to increases in blood glucose and lipid levels.[1]

Substance abuse. Patients with schizophrenia have high rates of substance abuse—more than 50% in some samples.[2] Thus, the development of cardiovascular and hepatic diseases associated with the abuse of these substances, especially alcohol, is very common.

Dementing diseases. Although patients with schizophrenia are not more likely than the general population to develop dementia (including Alzheimer's disease), the cognitive deficits intrinsic to schizophrenia may become more severe as some patients grow older. Uncommonly, this culminates in chronic disability.

Missed warning signs. Some experts theorize that patients with schizophrenia are more likely to miss the warning signs of cancer and other physical illnesses. What is known is that these people are less likely to receive appropriate medical care for medical illnesses.[3] This could be because patients with schizophrenia are inattentive to or unable to act upon physical problems. However, it may also be due to health care providers incorrectly assuming that the physical complaints of such patients are "delusional." Thus, as patients with schizophrenia grow older, they are more likely than others to experience poor general medical health and have a lower-than-average life expectancy.

The most important prerequisite for treating people of all ages with schizophrenia is a complete and comprehensive diagnosis. This should also include consideration of other illnesses, both psychiatric and physical. Providing proper treat-

ment for the patient's physical conditions will often have a dramatically positive effect on his or her capacity to cooperate with and respond to psychiatric treatment.

Antipsychotic Medications

The mainstay of psychiatric treatment in patients with schizophrenia is antipsychotic medication. These drugs are generally divided into two categories: conventional and atypical (or second-generation) medications.

Conventional antipsychotic drugs first appeared in the mid-1950s. Although these medications are derived from a variety of chemical structures, they have a common pharmacologic action—dopamine-receptor antagonism. The relationship between dopamine-receptor antagonism and the therapeutic actions of conventional antipsychotics remains hypothetical; however, there is a strong correlation between the strength with which such drugs bind to the dopamine receptor (in particular, the D2 receptor) and their clinical potency.[4]

Atypical antipsychotic medications. Development of atypical antipsychotics began in the late 1980s, when it was discovered that clozapine had excellent antipsychotic efficacy with minimal neurological side effects. As researchers investigated the mechanism of action of clozapine, they found that the drug acted as an antagonist at dopamine as well as monoamine receptors—in particular, at serotonin and norepinephrine receptors. Clozapine, however, never became a first-line antipsychotic medication, because it has a propensity to cause agranulocytosis in approximately 1.3% of patients.[5] Soon afterward, other drugs that did not cause agranulocytosis were developed with similar profiles of "mixed" antagonism. Among these drugs, the combination of receptor actions is variable. Currently, the optimal combination of receptor actions (if such an ideal exists) is not known.

Schizophrenia's Signs and Symptoms

Distinguishing it from other psychiatric illnesses.

Schizophrenia is characterized by a unique pattern of symptom groupings, including psychosis, disorganization of thinking, negative symptoms, and deficits in cognition. Patients with this condition generally suffer from a mixture of these symptom groups; the symptoms may wax and wane or be constantly present (see chart, below).

Schizophrenia must be distinguished from other psychiatric illnesses that have similar symptoms. Among these illnesses, manic-depressive psychosis (ie, bipolar disorder) is most commonly confused with schizophrenia. It is characterized by extremes of mood accompanied by psychosis. Delusional disorder, which tends to have an onset of illness later in life, is characterized by isolated delusions that are usually resistant to both medication and psychosocial intervention.

Symptom Grouping	Manifestation
Psychosis	Hallucinations; delusions
Negative symptoms	Impaired affect; avolition
Disorganization of thinking	Loose associations
Deficits of cognition	Impaired concentration; impaired working memory

Source: Expert Consensus Guidelines (Expert Consensus Guideline Series: Treatment of Schizophrenia 1999). *J Clin Psychiatry* 1999;60(suppl 11):1-80.

A Closer Look at Atypical Antipsychotics

Drug Name	Starting Dose
Risperidone	0.5 mg BID
Olanzapine	5 mg QD
Quetiapine	25 mg BID
Ziprasidone	20 mg BID

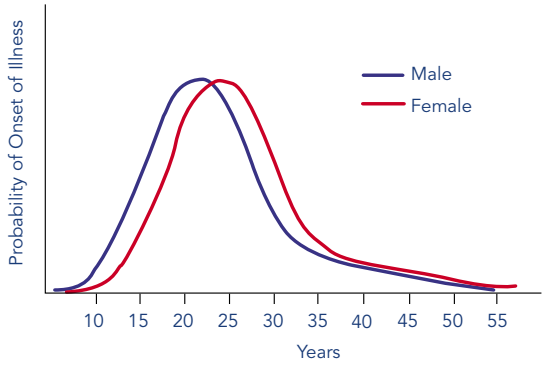
Please refer to manufacturers' prescribing information for additional dosing recommendations.[8-11]

Effective Treatment in the Elderly

Atypical antipsychotic medications are especially useful for the treatment of schizophrenia in older adults compared to conventional antipsychotics; these drugs tend to have a low incidence of neurological side effects, such as pseudoparkinsonism and tardive dyskinesia, to which the elderly are espe-

Age of Onset

Schizophrenia usually surfaces in early adulthood, although it can also begin later in life. Men tend to have an earlier age of onset and a greater severity of symptoms than do women. In all patients, a later age of onset usually predicts a milder course of illness.



Source: Hafner H, et al. Is schizophrenia a disorder of all ages? A comparison of first episodes and early course across the life-cycle. *Psychol Med* 1998;28(2):351-65.

cially prone.[6] With all antipsychotics, prescribing should be consistent with the need to minimize the risk of tardive dyskinsia. If signs and symptoms appear, discontinuation of therapy should be considered. In addition, many atypical antipsychotics have a low incidence of antagonism at the acetylcholine receptor, which can contribute to cognitive deficits in some elderly patients.[4]

Increased effectiveness. In comparison to conventional antipsychotic medications, the atypicals are generally considered to be more effective at treating the negative symptoms and cognitive deficits associated with schizophrenia.[7] These symptoms may be especially prominent in elderly patients with schizophrenia, making atypical antipsychotic medications especially useful in this population.

Medication Administration

When administering antipsychotic drugs to elderly patients with schizophrenia, lower-than-ordinary starting doses may be needed (see Table on page 6, "A Closer Look at Atypical Antipsychotics"). This is particularly important because the elderly are more likely than other patients to be taking several medications concurrently.

In short-term trials, the most commonly observed adverse events in adult patients with Risperdal occuring at an incidence of ≥ 5% and at least 2 times placebo were: anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia. Percentage of patients experiencing weight gain (≥ 7% of baseline body weight) in short-term trials was 9% placebo versus 18% risperidone ($p < 0.05$). In a study in an elderly population, the risk of EPS was comparable to placebo at doses ≤ 1mg/day and differ significantly from placebo at doses ≥ 2mg/day.

Please see enclosed full Prescribing Information.

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