Atypical Antipsychotics

Presenting Problem:

A participating PCP emailed a consultation request to WI CPCP regarding a 14-year-old male patient with a history of ADHD, anxiety, and severe major depression with psychosis. Due to physical abuse by a parent, this patient has had two distant inpatient hospitalizations for suicide attempts. The patient has been in foster care for over a year and is thriving. His mood has been great, his ADHD symptoms are well controlled, and no significant behavioral outbursts have occurred in over 10 months. He had been seeing a child psychiatrist until that clinician retired. The PCP will continue current psychotropic medications while the patient awaits transfer to a new psychiatrist. The PCP requests guidance regarding multiple unfamiliar psychotropic medications, a concern for polypharmacy, and a 30-pound weight gain noted over the past year. Below is a list of current medications and why they were prescribed:

- ADHD
    - methylphenidate CR 54mg daily - started 4 years previously
    - methylphenidate 20mg at 1pm - started 3 years previously
    - guanfacine ER 4mg daily - started 2 years previously
- Anxiety and psychotic depression
    - fluvoxamine 50mg at HS - started 3 years previously
- Behavioral outburst
    - divalproex 500mg at HS - started 2.5 years previously
    - guanfacine ER 4mg daily - started 2 years previously
    - gabapentin 300mg at HS - started 2 years previously
    - quetiapine 50mg at HS - started 1.5 years previously

Consultant's Response:

- Now that the patient has been in a stable, non-abusive living setting over the past year, he may be taking medications that are no longer necessary. It would be appropriate to slowly taper some medications one at a time, perhaps peel off one medication per month.
    - Start by tapering **quetiapine** (50mg at HS) due to the 30-pound weight gain. **Quetiapine,** an atypical anti-psychotic medication, is often started along with an anti-depressant. Due to the side effect burden, try tapering once the depression is resolving.
        - Can be used for 'off-label' treatment of aggressive outbursts. Once symptoms are under control for at least 3-months, it is prudent to taper off to gauge ongoing need.
    - Second: taper **divalproex** (500mg at HS) due to lack of clear indication and risk of side effects.
        - Can be used for 'off-label' treatment of mania in bipolar disorder and aggressive outbursts. Once symptoms are under control for at least three months, it is prudent to taper off to gauge ongoing need.
            - Lab monitoring for hepatic dysfunction and bone marrow suppression highly recommended.
    - Third: taper **gabapentin** (300mg at HS) due to lack of clear indication.

        - Can be used 'off-label' in adults for a variety of conditions, such as anxiety and depression, without much evidence base. There is no evidence base for using to treat pediatric mental health problems. Once symptoms are under control for at least 3 months or so, it is prudent to taper off to gauge ongoing need.
- The low dose of quetiapine, divalproex, and gabapentin were likely added to target psychotic symptoms and/or aggressive outbursts.
    - When targeting a single set of symptoms, it is recommended to **maximize** the first medication before considering the need for a second one, let alone a third one.
    - It is possible past aggressive outbursts and past psychosis were *reactive to his past living setting* and may not return in *a stable setting* even if these medications were tapered off.
- **Monitoring Guidelines for Anti-Psychotic medications:**
    - Obtain baseline and periodic monitoring of BMI, waist circumference, HbA1c, fasting plasma glucose, and fasting lipids.
        - Metabolic Monitoring for Patients on Antipsychotic Medications
    - Obtain a baseline and periodic monitoring of AIMS Abnormal Involuntary Movement Scale throughout the medication trial.
- The **methylphenidate CR** (54mg daily) and **methylphenidate IR** (20mg at 1pm) *might* be needed long-term.
- **Guanfacine** (4mg daily) is generally used for ADHD, but possibly was added in an effort to control irritability/aggression. One *might* consider slowly tapering off to gauge ongoing need during the summer break.
    - When considering tapering **guanfacine,** it is recommended to decrease by one-fourth or one-fifth, as it may still be needed for ADHD symptom control.
- If **fluvoxamine** (50mg at HS) was originally prescribed for major depression, it is recommended to taper and attempt to discontinue after symptoms have resolved for at least 6 months (or 12 months for severe depression with psychotic features).
    - When considering tapering **fluvoxamine,** it is recommended to decrease by one-fourth or one-fifth, as symptoms of depression have not been noted for many months.

Teaching Points

- When facing **polypharmacy** in patients who appear psychiatrically stable for months, tapering medication to gauge ongoing need is prudent. There are no hard or fast rules about the rate at which to taper. It is recommended to start slowly tapering a single medication while monitoring for resurgence of symptoms. Once that one is discontinued, start slowly tapering a second med.
    - For *dangerous* medication side effects, it is recommended to discontinue that one first.
        - If there are no FDA approvals for a current medication, and it is not clear that FDA-approved options were tried first, consider tapering.
- **More information on thoughtful deprescribing can be found here:** Deprescribing Unnecessary Medications: A Four-Part Process