

July 2013

Lurasidone: classification and indications

The authors of “Atypical antipsychotics during pregnancy” (CURRENT PSYCHIATRY, July 2013, pp. 12-18; <http://bit.ly/16NrECa>) incorrectly state that all atypical antipsychotics are FDA Pregnancy Category C except for clozapine. In fact, lurasidone (Latuda) is FDA Pregnancy Category B. I was disappointed that the authors did not address this distinction; I find it puzzling why such a new medication, with such little data available, was able to obtain a FDA Pregnancy Category B label.

Laura Gilley, MD
Child and Adolescent Psychiatrist
Clinical Instructor
University of Utah
Salt Lake City, Utah

Drs. Robakis and Williams share clinically relevant information on an important issue in “Atypical antipsychotics during pregnancy.” For the most part, their information is current, but some facts need to be

updated: Notably, olanzapine is now approved for use in the treatment of bipolar I disorder in children age 13 to 17¹ and paliperidone also is approved for the treatment of schizophrenia in children age 12 to 17.²

As we move forward with development of novel drugs, we will, I hope, create safer options for pregnant patients. Until then, clinically useful discussions of available evidence and risk/benefit analyses are greatly appreciated.

Deepak Prabhakar, MD, MPH
Attending Psychiatrist
Behavioral Health Services
Henry Ford Health System
Detroit, Michigan

References

1. Christian R, Saavedra L, Gaynes BN, et al. Future research needs for first- and second-generation antipsychotics for children and young adults. http://effectivehealthcare.ahrq.gov/ehc/products/147/835/CER39_Antipsychotics-Children-Young-Adults_20120221.pdf. Accessed August 13, 2012.
2. Invega [package insert]. Titusville, NJ: Janssen Pharmaceuticals Inc.; 2013.

Consider this slow-taper program for benzodiazepines

Concerns about prescription medication abuse have led to the creation of remediation plans directed to reduce overuse, multiple prescribers, and diversion of prescribed drugs. One such plan from the United Kingdom, described below, has shown it is possible to taper a patient off of benzodiazepines.^{1,2}

Before starting a tapering plan, inform the patient about the risks of withdrawal.³ Abrupt reductions from high-dose benzodiazepines can result in seizures, psychotic reactions, and agitation.¹⁻³ Understanding the tapering regimen enhances compliance and outcomes. Stress the importance of careful adherence and provide close psychosocial monitor-

ing and fail-safe means for patient contact if someone is experiencing difficulties. Supportive psychotherapy improves the prognosis.⁴ On a clinical basis, additional, adjunctive, symptomatic, or other medications may be required for safe illness management.

Managing comorbid medical conditions and psychopathologies—including addressing other substances of abuse—is important.^{1,4} Tapering one or more substances at a time—even nicotine—is not advised. Refer patients to a self-help group or substance abuse rehabilitation program.

Slow tapering is safer and better tolerated than more abrupt techniques.¹⁻⁵ If the patient experiences overt clinical signs of withdrawal, such as tachycardia or other hyperadrenergia during dosage reduction, maintain the previous dosage until the next tapering date.

For persons who take a short-acting benzodiazepine—eg, alprazolam or lorazepam—convert the dosage into an equivalent dosage of a long-acting benzodiazepine—eg, diazepam.^{1,2} Metabolized slowly, with a long half-life, diazepam allows a consistent, slow decline in concentration while tapering the dosage. This helps avoid severe withdrawal.¹⁻⁵ For patients who have been taking alprazolam or clonazepam, 1 mg, the equivalent diazepam dosage would be 20 mg; for temazepam, 30 mg, the diazepam dosage would be 15 mg; for lorazepam, 1 mg, oxazepam, 20 mg, or chlordiazepoxide, 25 mg, the diazepam dosage would be 10 mg.^{1,2}

Prescribe the to-be-tapered benzodiazepine at five-sixths of that dose and prescribe one-sixth of the

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diazepam amount daily. Proceed with tapering every 1 to 2 weeks by a one-sixth dose reduction of the tapered medication and a one-sixth increase in diazepam. Continue until diazepam is used alone and well-tolerated.

Once the patient is taking only diazepam, decrease the dosage by 2 mg every 2 weeks until the patient is doing well on a relatively small dosage of diazepam.^{1,2} Subsequent diazepam reductions are at 1 mg less every 1 to 2 weeks, until the patient is able to completely discontinue the medication.

Continue monitoring until clinical stability is achieved or otherwise indicated. Be aware that some people might switch to other substances of abuse.

Thripura Thirtala, MD
Observer physician

Kanwaldeep Kaur, MD
Observer physician

Surya Kumar Karlapati, MD
Observer physician

Steven Lippmann, MD
Professor

Department of Psychiatry and Behavioral Sciences
University of Louisville School of Medicine
Louisville, Kentucky

References

1. Ashton H. Benzodiazepine withdrawal: an unfinished story. *Br Med J (Clin Res Ed)*. 1984;288(6424):1135-1140.
2. Benzodiazepines: how they work and how to withdraw (aka The Ashton Manual). <http://www.benzo.org.uk/manual>. Accessed March 27, 2013.
3. Lader M. Benzodiazepine harm: how can it be reduced? [published online August 10, 2012] *Br J Clin Pharmacol*. doi: 10.1111/j.1365-2125.2012.04418.x.
4. Morin CM, Bastien C, Guay B, et al. Randomized clinical trial of supervised tapering and cognitive behavior therapy to facilitate benzodiazepine discontinuation in older adults with chronic insomnia. *Am J Psychiatry*. 2004;161(2):332-342.
5. Lopez-Peig C, Mundet X, Casabella B, et al. Analysis of benzodiazepine withdrawal program managed by primary care nurses in Spain. *BMC Res Notes*. 2012;5:684. doi: 10.1186/1756-0500-5-684.

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This month's instantpoll%

Mr. P, age 25, has a 2-year history of schizophrenia. His psychotic symptoms respond well to olanzapine, titrated to 10 mg/d, but he gains 30 pounds in the first 2 months of treatment and his blood glucose level hovers in the pre-diabetic range during that period. **How would you treat Mr. P's metabolic challenges?**

- Obtain baseline metabolic data and monitor him monthly
- Switch to a newer antipsychotic, such as lurasidone
- Lower Mr. P's olanzapine dosage
- Recommend diet and exercise

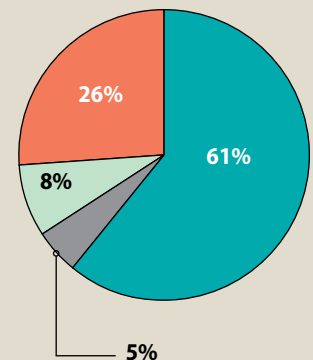
See **"Recommendations for lab monitoring of atypical antipsychotics"** page 51-54

Visit **CurrentPsychiatry.com** to answer the **Instant Poll** and see how your colleagues responded. Click on **"Have more to say?"** to comment.

JULY POLL RESULTS

Ms. Z, age 31, has a history of bipolar I disorder, which has been well controlled with risperidone, 2 mg/d, for 5 years. She recently learned that she is 6 weeks pregnant with her first child. She is concerned about risperidone's effect on her baby. **How would you treat her?**

- 61%** Maintain Ms. Z's risperidone dose and educate her about the risks of untreated illness
- 5%** Switch Ms. Z to quetiapine, 400 mg/d
- 8%** Switch Ms. Z to lurasidone, 40 mg/d
- 26%** Discontinue risperidone and schedule frequent follow-up appointments



SUGGESTED READING:
Robakis T, Williams KE. *CURRENT PSYCHIATRY*. 2013;12(7):12-18.

Data obtained via CurrentPsychiatry.com, July 2013