Guidelines for antipsychotic drug treatment — The American Psychiatric Association Task Force report on TD

The Task Force made the following recommendations:

●Long-term use of antipsychotic drugs in neurosis, depression, anxiety, personality disorder, and chronic pain states should be discouraged.

●Even in schizophrenia or related chronic psychosis, efforts should be made to maintain patients on the lowest effective dose of antipsychotic drugs while reexamining the need for continued treatment at least every six months. After remission of a first acute psychotic episode, the dose of antipsychotic drug should at least be decreased, and probably best discontinued, within 6 to 12 months. Plans to continue treatment beyond six months require discussion with the patient and family regarding the indication for prolonged antipsychotic drug treatment and the risks of TD. (See "Pharmacotherapy for schizophrenia: Side effect management".)

●Particular care is indicated for patients age 50 and older, patients with affective disorder, patients with treatment-resistant schizophrenia and negative symptoms, and possibly women.

●Since acute antipsychotic drug-induced parkinsonism and akathisia are an indicator of the extent of D2 receptor blockade, these adverse effects should be avoided by dose reduction or by use of a less potent agent. Drug-induced parkinsonism may also mask signs of dyskinesia. It is prudent to use the smallest effective dose required to control an individual patient's symptoms.

●Except for prevention of acute dystonic reactions, chronic use of prophylactic anticholinergic drugs should be discouraged since they do not prevent TD and can aggravate the involuntary movements once they emerge.

●Early antipsychotic drug withdrawal results in a better prognosis for recovery. Thus, patients on antipsychotic drugs should be carefully monitored for signs of TD at regular intervals with use of a standard dyskinesia rating scale such as the Abnormal Involuntary Movement Scale (form 1), which is useful to heighten awareness of mild manifestations of TD [4].

●Where possible, antipsychotic drugs should be tapered and discontinued as soon as the diagnosis of TD is made, although control of the patient's psychosis may ultimately be the most critical factor in the use of the offending drug.

For patients who are developing signs of TD while receiving first generation (conventional) antipsychotic drugs, but still require treatment for psychosis, it is now considered prudent to switch to second generation (atypical) antipsychotic drugs that may be associated with a lower risk for TD. However, there is no convincing evidence that altering the medication regimen ameliorates the course of TD once symptoms have developed. (See 'Second generation antipsychotic drugs' below.)

Discontinuation of metoclopramide treatment — Metoclopramide is used primarily as an antiemetic agent and/or as a prokinetic agent for the treatment of gastroparesis. It should be stopped immediately if the diagnosis of TD is made, and alternative treatments of the gastrointestinal symptoms should be used. As a preventive measure, metoclopramide should not be used continuously for longer than 12 weeks.

PHARMACOLOGIC TREATMENT — Numerous studies have evaluated various pharmacologic treatments of TD, but few therapies have produced more than slight to moderate benefit in clinical practice [5]. Thus, prevention, early detection, and management of potentially reversible cases are the cornerstones of modern treatment.

When clinically appropriate, pharmacologic interventions may be considered for patients who are developing signs of TD. The two main strategies are:

●Discontinuation of the offending drug

●Switching from a first to a second generation antipsychotic drug

For patients with a diagnosis of TD, additional pharmacologic interventions include the following:

●Use of benzodiazepines, botulinum toxin injections, valbenazine, or tetrabenazine to control symptoms of TD

●Paradoxically, resuming treatment with antipsychotic drugs in order to suppress TD (see 'Resumption of antipsychotic drugs' below)

The need for drugs to control symptoms of TD should be carefully assessed, since symptoms are often mild and not sufficiently bothersome to require treatment. In some cases, family members are more

disturbed by the involuntary movements than the patient, who may be relatively unaware of their clinical manifestations. However, this is more common among chronic or institutionalized patients than in ambulatory patients, many of whom are in psychiatric remission when TD appears.

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