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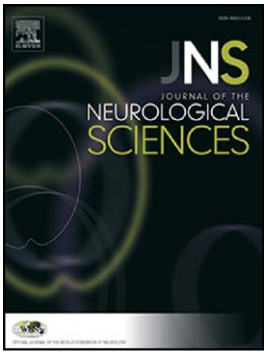

Reprint of: Clinical management of tardive dyskinesia: Five steps to success

Leslie Citrome

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Review Article

Reprint of: Clinical management of tardive dyskinesia: Five steps to success☆,☆☆

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ABSTRACT

Tardive dyskinesia (TD) has long been thought to be a generally irreversible consequence of the use of dopamine receptor blocking agents. There is now an opportunity to successfully manage this condition with agents approved by the US Food and Drug Administration. This is important because TD has not been eliminated with the use of second-generation antipsychotics, and the expansion of antipsychotics to treat conditions other than schizophrenia has resulted in millions of additional individuals at risk for developing TD. Recognition of TD requires careful observation; a structured approach using the Abnormal Involuntary Movement Scale is encouraged. Harm reduction can be achieved by using antipsychotics judiciously when possible and by paying attention to other modifiable risk factors such as drug-induced parkinsonian symptoms and the use of anticholinergic medication. Once TD has emerged and is associated with dysfunction or distress, treatment with a VMAT2 inhibitor such as deutetrabenazine or valbenazine is well supported by several controlled clinical trials.

Contents

1. Introduction

Tardive dyskinesia (TD) has long been thought to be a generally irreversible consequence of the use of dopamine receptor blocking agents. Dopamine receptor blocking agents not only include antipsychotic medications used for the treatment of psychiatric disorders, but also antitussive agents such as promethazine and antiemetic medications such as metoclopramide used for symptomatic gastroesophageal reflux in patients who fail to respond to conventional therapy and for diabetic gastroparesis. Warnings regarding TD are included in US product labeling for all antipsychotics [1]. Within the product label for metoclopramide, the warning for TD is boxed and bolded and reads "…Metoclopramide therapy should be discontinued in patients who develop signs or symptoms of tardive dyskinesia. Treatment with metoclopramide for longer than 12 weeks should be avoided in all but rare cases where therapeutic benefit is thought to outweigh the risk of developing tardive dyskinesia" [2]. In the treatment of psychotic disorders such as schizophrenia, treatment with antipsychotics is often

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