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.

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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 17 and paliperidone also is approved for the treatment of schizophrenia in children age 12 to 17.

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.

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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.

Before starting a tapering plan, inform the patient about the risks of withdrawal. Abrupt reductions from high-dose benzodiazepines can result in seizures, psychotic reactions, and agitation. Understanding the tapering regimen enhances compliance and outcomes. Stress the importance of careful adherence and provide close psychosocial monitoring and fail-safe means for patient contact if someone is experiencing difficulties. Supportive psychotherapy improves the prognosis. 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. 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. 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—e.g., alprazolam or lorazepam—convert the dosage into an equivalent dosage of a long-acting benzodiazepine—e.g., diazepam. Metabolized slowly, with a long half-life, diazepam allows a consistent, slow decline in concentration while tapering the dosage. This helps avoid severe withdrawal.

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.

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

1. Obtain baseline metabolic data and monitor him monthly
2. Switch to a newer antipsychotic, such as lurasidone
3. Lower Mr. P’s olanzapine dosage
4. Recommend diet and exercise

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?

See “Recommendations for lab monitoring of atypical antipsychotics” page 51-54

JULY POLL RESULTS

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

Data obtained via CurrentPsychiatry.com, July 2013