Introduction

The Art and Science of Switching Antipsychotic Medications

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There are many reasons for a physician in clinical practice to recommend that a patient change his or her antipsychotic medication. The simplest reason is lack of efficacy: after an appropriate trial at a sufficient dose, the medication fails to control the patient's psychotic symptoms. Efficacy, however, exists on a continuum; a patient may experience symptom control from his or her antipsychotic, but yet not be able to function at the same level he or she did before the most recent relapse. In these cases, the potential risk of losing the attained level of symptom control must be weighed against the chance that the patient will receive even greater benefit from a different drug that may allow better daily functioning. Different physicians and patients will make different choices when in a situation such as this, but it is an important choice to consider. The ideal antipsychotic should provide patients with optimal symptom control, cause no adverse physical health effects, and permit full daily functioning.

Medication should also be switched when patients suffer intolerable adverse effects that threaten their overall health or result in nonadherence to medication. Tardive dyskinesia is an obvious example of an intolerable adverse effect, but a patient with poorly controlled diabetes and a family history of cardiovascular disease who gains significant weight on a particular antipsychotic is also a strong candidate for switching antipsychotic agents, per the American Psychiatric Association guidelines. Likewise, for selected patients, adverse effects that have other serious implications, such as pervasive and persistent sedation or galactorrhea, should also prompt the patient and physician to discuss a possible change in medication. The results of a switch motivated by adverse events are actually more assured than one motivated by efficacy, because most adverse effects are highly predictable, and research has shown that most adverse effects will subside if the patient is switched to an antipsychotic with a different mechanism of action.

The process of switching, however, is difficult. Patients may experience switch-emergent adverse events such as dopamine psychosis, cholinergic rebound, and rebound activation, which may be a particular issue when switching from a sedating antipsychotic to a less sedating agent. Many of these switch-emergent adverse events are difficult to distinguish from adverse events related to the introduction of the new agent; however, switch-emergent adverse events are almost always transient in nature.

Switch-emergent adverse events can be reduced to manageable levels in most cases, if not avoided altogether, by switching antipsychotics using a gradual cross-taper. Symptoms can be predicted to a certain extent based on the receptor-binding profiles of the old and new medications, and the appropriate adjunctive medications—e.g., transient use of benzodiazepines to manage rebound activation—can be utilized to minimize them. Good communication with the patient can also considerably lessen the impact of these switch-emergent effects, as patients are often better able to tolerate adverse effects when they understand that these effects are transient. When clinically required, switching is a collaboration between physician and patient aimed at optimizing the patient's mental and physical health and daily functioning; a properly conducted change of medication has considerable potential to do so.

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