

UNITED KINGDOM PSYCHIATRIC PHARMACY GROUP



Combination therapies — the more the merrier

Combination therapies was just one of the themes of the 27th Annual and 9th International Psychiatric Pharmacy Group Conference, held in Reading from 11 to 13 October. Ian Maidment, pharmacy services manager for East Kent Community NHS Trust, reports

The use of combination therapies to obtain a better response to medication was discussed with particular reference to bipolar disorder, dementia, depression and psychosis. Professor PHILIP COWAN, from the university department of psychiatry, Warneford Hospital, Oxford, described the use of combination therapies in resistant depression (depression that fails to respond to at least two antidepressants given at an adequate dose for an adequate length of time). For the 17 per cent of patients who are resistant to treatment, there are three main approaches: first, to increase the dose of the antidepressant; second, to switch antidepressants; and third, to augment therapy by adding another drug.

While switching therapy is commonly employed, there are little data to support this practice. Furthermore, if antidepressants are switched, a commonsense approach would be to choose a medicine from a different class. For example, if a patient fails to respond to a selective serotonin reuptake inhibitor, a tricyclic could be tried, Professor Cowan suggested.

The weight of evidence supports the use of lithium to augment antidepressant therapy. Tri-iodothyronine has been used, but there are fewer data and most studies have been conducted with the older tricyclic antidepressants rather than SSRIs. Pindolol has also been tried, based on the possibility that the effects of SSRIs on 5HT neurotransmission can be enhanced via 5HT_{1A} autoreceptor blockade. The reported results are not encouraging but this may be because the dose of pindolol used was too small.

Atypical antipsychotics have also been used to augment therapy. In particular, one study has shown that the addition of low-dose olanzapine, 2.5mg daily, to fluoxetine produces a more rapid response, although weight gain is still a problem. There is also some evidence that clozapine is a useful treatment in refractory mood disorders.

Professor Cowan referred to another paper which showed that an increased dose of fluoxetine was significantly more effective than lithium or tricyclic augmentation.

Dr DAVID BROWN, consultant old age psychiatrist at Stobhill Hospital, Glasgow, discussed the treatment of dementia, particularly the use of memantine, a non-competitive N-methyl-D-aspartate receptor antagonist. Memantine is licensed for the treatment of moderately severe to severe Alzheimer's dis-

ease, but the current data are quite poor — most studies included patients with both Alzheimer's and vascular dementia. Because memantine has a mode of action different from that of acetylcholinesterase inhibitors, in theory, polypharmacy would be acceptable, but there are little data on combined use with acetylcholinesterase inhibitors. Memantine is related to amantadine therefore it may improve parkinsonian symptoms associated with Alzheimer's disease.

Dr Brown also discussed National Institute for Clinical Excellence guidance on the use of acetylcholinesterase inhibitors and the problems with the Mini Mental State Examination as an assessment of cognitive function. In particular, the assessment depends on education and language abilities so patients with language deficiencies may present an artificially low result. Dr Brown pointed out that NICE guidance does not cover severe dementia, yet this is important because clinical experience suggests that, occasionally, severely affected patients show a significant response to acetylcholinesterase inhibitors.

REFORM OF THE MENTAL HEALTH ACT

Dr DAVID BRANFORD, South Derbyshire Mental Health NHS Trust, talked about the draft of the Mental Health Bill, focussing on treatment aspects. The most recent major reform of mental health legislation was conducted in the 1950s by the Percy Commission. He said that in any mental health legislation, there is a tension between ensuring that people with mental health problems live as normal a life as possible and protecting the public from harm and patients from self-harm.

Recently, a dramatic increase in the number of patients being sectioned has been noticed, together with an increase in the use of locked wards. People from a black ethnic background are six times more likely to be sectioned than people from a white ethnic background. Treatments giving cause for concern include the use of electroconvulsive therapy, depot medication and polypharmacy at doses above British National Formulary limits.

The first draft of the new Mental Health Bill has been jointly opposed by the Royal College of Psychiatrists and the Law Society. The proposed definition of mental disorder is broad. The primary areas of dispute are the inclusion of personality disor-

ders within the term "mental disorder" and the use of compulsory treatment in the community. However, from a practical point of view, compulsory treatment may be difficult to implement. It is also likely that the new bill will have serious implications on the present medical manpower position within psychiatry because it calls for more patient assessments and more paperwork.

COGNITIVE DEFECTS IN SCHIZOPHRENIA

More interest is being shown in cognitive defects in schizophrenia. According to Dr DAWN VELLIGAN, associate professor, department of psychiatry, University of Texas Healthcare Science Centre, San Antonio, research has demonstrated that patients with schizophrenia perform less ably than age-matched controls in a wide range of tests of neurocognitive ability. Specific deficits in areas of memory, attention, the speed at which information is processed and executive functioning (eg, problem solving) have been identified. Deficits are often present before the onset of psychotic symptoms and may be part of the illness process. Patients often report that their "brain does not work".

Dr Velligan described a number of tests for cognitive function. The Californian Verbal Learning Test is a memory test that relies on story recall. The Wisconsin Card Sort Test is another test, often used in clinical trials to assess the effect of neuroleptics on cognitive function.

Typical antipsychotics, with their anticholinergic profiles, can adversely affect cognition. In addition, anticholinergic medicines used to treat the extrapyramidal side-effects of these compounds can further impair cognitive function. In a number of double-blind, randomised trials, patients on atypical antipsychotics have been shown to perform better in tests of cognitive function than those taking typical agents.

An improvement in cognitive function may enhance potential psychosocial interventions. This may make it easier for patients to live in the community, although it should be noted that any improvement in cognition can take many months.

A SERVICE USER'S PERSPECTIVE

TIM NEWAY gave a service users' perspective. In addition to being a service user,

Cannabis from plant to patient

There is growing interest worldwide in the use of cannabis as a medicine. Professor TONY MOFFAT, chief scientist at the Royal Pharmaceutical Society, told delegates about the present state of play relating to the research into cannabis as a medicinal product. Cannabis has been used for thousands of years as a medicine — indeed, Queen Victoria is known to have taken it in the 19th century to treat menstrual cramps. Today, however, the use of cannabis as a medicine is banned, although many patients attest to its efficacy, particularly in multiple sclerosis. Other possible indications include pain relief, glaucoma, epilepsy, bronchial asthma and nausea and vomiting.

There are two licensed products related to cannabis. Nabilone is licensed in the United Kingdom for the treatment of nausea and vomiting following chemotherapy. Dronabinol is licensed in America as an anti-emetic and also as an appetite stimulant in patients with HIV.

Two trials are currently under way. One involves 660 patients with multiple sclerosis and another involves 400 patients with acute pain following surgery.

Professor Moffat also discussed problems with the oral administration of cannabis, especially its variable bioavailability. Alternatives include a suppository formulation, a sublingual spray and a patch, but it is likely that an inhaler will be the preferred option. The use of cannabis for medicinal purposes will not affect its legal position as a recreational drug, he said.

Mr Newey lectures extensively on his experiences and has contributed to the NICE guidance on atypical antipsychotics. Mr Newey described becoming ill with schizophrenia and the precipitating factors and went on to outline his treatment in a number of different treatment units.

He described his experience with both typical and atypical medication. With atypical medication, he was able to function at a much more competent level than typical medication allowed. He was optimistic for the future and foresaw advances in the treatment of schizophrenia that would allow

more positive outcomes. Cost should not be a factor in deciding the best form of treatment for individual patients, he said.

IMPROVING COMPLIANCE, IMPROVING HEALTH

Dr RICHARD GRAY, MRC fellow in health services research, Institute of Psychiatry, talked about compliance therapy for people with schizophrenia. With 50 per cent of patients stopping their medication within one year and 75 per cent within two years, compliance therapy is as important as any new medication, he said.

Compliance therapy was developed as an intervention, based on interviewing and cognitive behavioural therapy, to enhance adherence to treatment. Some results suggest the main outcome may be to increase patients' knowledge but not necessarily to improve compliance. Dr Gray also mentioned the term "concordance", which is designed to reflect teamwork between patients and health care professionals, and the joint processes used to decide upon the most appropriate treatment. The aims of compliance therapy include the engagement of service users and the improvement of detection and management of adverse events.

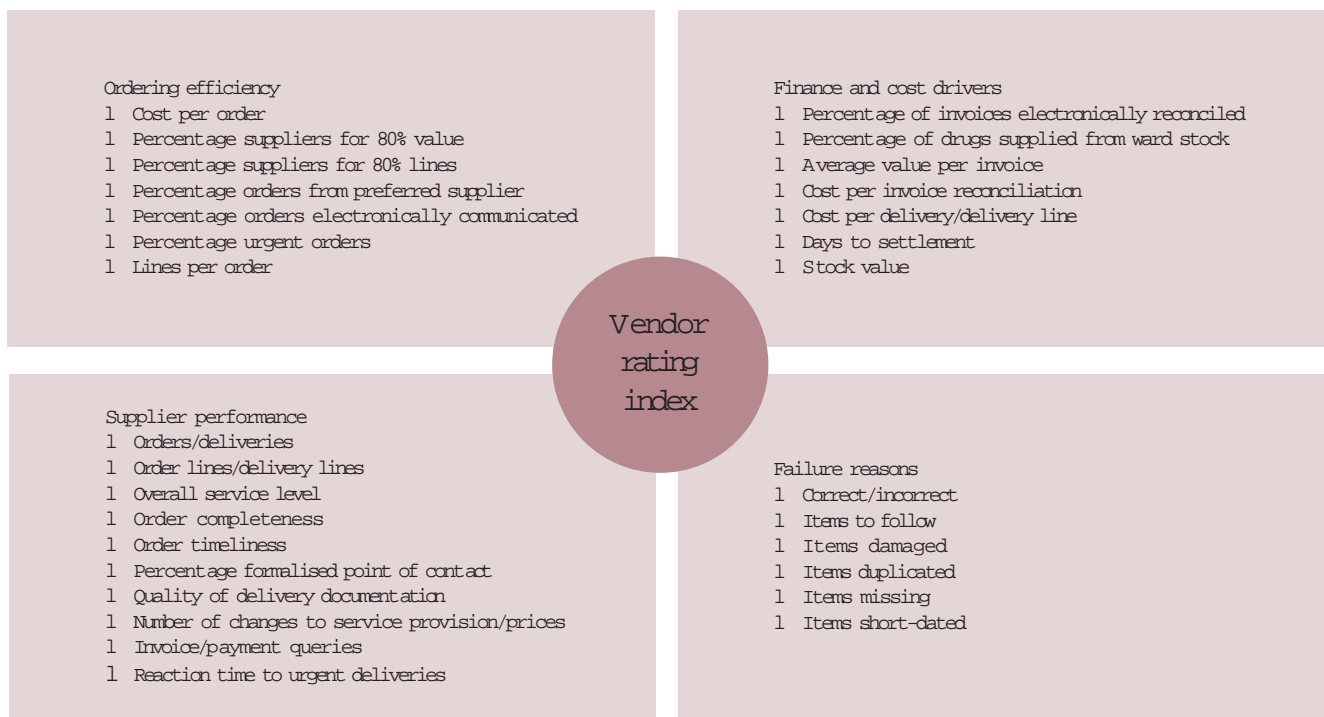


Figure 1: Core key performance indicators