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Guidance on switching away from Piportil Depot® (pipotiazine palmitate) injection

Piportil Depot (pipotiazine palmitate) injection was globally withdrawn in March 2015 because of a shortage of the active ingredient. There are no generic versions available and pipotiazine is not available in an oral formulation. Therefore, clinicians will need to switch to another antipsychotic as existing stocks run out. In Scotland alone, about 410 patients[1] are currently prescribed Piportil Depot, which translates to roughly 5000 recipients UK-wide (if that figure is generalisable). We present our suggestions for managing the antipsychotic switch.

1 Treatment decisions should be made on an individual basis, in discussion with the patient, their carers (if the patient agrees) and the treating team.

2 An early decision is whether a long-acting injection (LAI) or depot is still required or whether a switch to oral medication should be considered. This decision should take account of the patient's views, the risk and likely consequences of a relapse and the risk of covert nonadherence with oral treatment. The main advantage of LAIs is that adherence is transparent. The patient's psychiatric history will be informative in making this decision.

3 With the exception of clozapine, there are no major differences in efficacy between individual antipsychotics, although they vary markedly in their risk of side-effects.[2] Consequently, the patient's past experience of antipsychotics, and their views on potential adverse effects, will be important considerations guiding the choice of a new antipsychotic.

4 If it is decided to switch to another LAI, then appropriate guidance, including that in the summary of product characteristics of the new LAI, should be followed regarding the details of the switch. If the patient has not previously received the new antipsychotic then a test dose is required before starting the LAI. In the case of first-generation antipsychotic LAIs, this takes the form of a low dose of the LAI, but with second-generation antipsychotic LAIs, it takes the form of a few days' treatment with the oral form of the same antipsychotic.

5 Acquisition costs vary considerably between first- and second-generation antipsychotic LAIs, but this should be only one of a range of factors considered in the selection of the new antipsychotic.

6 The long half-life of Piportil Depot makes withdrawal effects unlikely. Illness relapse is likely to be the most common clinical concern after switching. We advise clinicians to be vigilant regarding relapse for at least 12 months after the switch, and the patient's specific relapse signature should be discussed and borne in mind. Further details on the kinetics and switching of LAIs are given elsewhere.[3,4]

The long half-life means that any existing adverse effects, for example extrapyramidal symptoms or hyperprolactinaemia, are likely to persist for some months after the switch. If an anticholinergic agent has been necessary to treat extrapyramidal symptoms during Piportil Depot treatment, it may be necessary to continue it for several months after the switch, before gradually withdrawing it. Similarly, hyperprolactinaemia may continue for up to 6 months after stopping Piportil Depot, even if the new antipsychotic is not associated with raised prolactin levels. Carry-over effects need to be considered when evaluating the tolerability of any replacement antipsychotic.[4]

1 Information Services Division Scotland. *Prescribing Statistics: Medicines in Mental Health* (data tables). ISD, 2013 (http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/index.asp).

2 Leucht S, Cipriani A, Spineli L, Mavridis D, Örey D, Richter F, et al. Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. *Lancet* 2013; **382**: 951–62.

3 Taylor D, Paton C, Kapur S. *Maudsley Prescribing Guidelines in Psychiatry* (12th edn). Wiley–Blackwell, 2015.

4 Haddad P, Fleischhacker WW. Adverse effects and antipsychotic long-acting injections. In *Antipsychotic Long-Acting Injections* (eds P Haddad, T Lambert, J Lauriello). Oxford University Press, 2011.

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Undergraduate psychiatry teaching should happen in primary care

Abed & Teodorczuk[1] make a valid point in their article, but their proposed solution has been advocated for some time and, while it may be a necessary condition to improve undergraduate psychiatric teaching, it is unlikely to be sufficient.[2] Training (and psychiatry is not alone in this) is heavily dependent on service configuration for its delivery. As psychiatry has become more community based, it has also become more fragmented. The answer to this lies partly in making educational contracts more transparent, but surely we need a more radical solution. Given that the vast majority of psychiatric morbidity and care occur in primary care and given that most of our medical students will work in non-psychiatric settings, there is an urgent need for most if not all of undergraduate psychiatric education to take place in primary care.

There is an opportunity to deliver this fundamental shift through the changes recommended in the Shape of Training review.[3] The key themes of making medical training more flexible and focused on generalist training, and getting the balance between service provision and training right to ensure that patient needs drive medical training, should lead to a shift of undergraduate psychiatric teaching to primary care. An added benefit of this may be that, for once, the change in the educational tail may wag the service-provision dog, leading to more integrated services at the primary/secondary care interface.

1 Abed R, Teodorczuk A. Danger ahead: challenges in undergraduate psychiatry teaching and implications for community psychiatry. *Br J Psychiatry* 2015; **206**: 89–90.

2 Dave S, Dogra N, Leask S. Current role of service increment for teaching funding in psychiatry. *Psychiatrist* 2010; **34**: 31–5.