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## Response to guidance on use of olanzapine and risperidone: a community-based study of primary and secondary care

### AIMS AND METHOD

The aim of the study was to assess the response to the guidance from the Committee on Safety of Medicines (CSM) on prescribing olanzapine and risperidone for older adults.

Information on 96 older patients who were prescribed olanzapine or risperidone was gathered from psychiatric case notes, general practitioners and care homes. Data were gathered 10 weeks after the CSM guidance (Time 1) and again 6 months later (Time 2).

### RESULTS

At Time 1, 71 out of 96 patients (74%) had been reviewed and 90 (94%) by Time 2. By 6 months after the guidance 34 of 52 patients with dementia (65%) and 10 of 35 patients with functional diagnoses had been withdrawn from medication; 29% (14/49) of those withdrawn from medication had significant problems associated with withdrawal. In many cases medication was continued following risk–benefit decisions taken at review and despite CSM guidance.

### CLINICAL IMPLICATIONS

Guidance has prompted review of prescribing in existing patients and some re-referrals, which has increased workload. The guidance has changed the management of existing patients, but there has been a high rate of associated clinical problems and numerous patients remain on, or return to, olanzapine or risperidone.

In March 2004 the Committee on Safety of Medicines (CSM) advised that neither olanzapine nor risperidone should be used for the treatment of behavioural and psychological symptoms in dementia. They reported that use of these atypical antipsychotics was associated with a threefold increase in stroke in people with dementia and that there was a twofold increase in all-cause mortality with olanzapine in this group of patients. Risperidone could be used for acute psychosis in dementia but only on a short-term basis and under specialist advice. Olanzapine is not licensed for this use. The CSM also advised that history of and risks for cerebrovascular disease should be considered when prescribing these drugs.

A working group, including members from the Faculty for the Psychiatry of Old Age of the Royal College of Psychiatrists, the Royal College of General Practitioners, the British Geriatrics Society and the Alzheimer's Society, produced recommendations in light of the CSM guidance (Royal College of Psychiatrists, 2004).

Since the advice, a number of studies have investigated the risk of cerebrovascular incidents with these antipsychotics. Herrmann & Lanctot (2005) reassessed the data from 11 randomised controlled trials (RCTs) and found an increase in 'cerebrovascular adverse events' but suggested that many were non-specific and not strokes. Another meta-analysis of RCTs reported a small increase in the risk of death compared with placebo (Schneider *et al*, 2005).

Two large retrospective population-based cohort studies of 32 000 and 11 000 patients respectively failed to find any increased risk of stroke (Herrmann *et al*, 2004; Gill *et al*, 2005). However, a third large population-based retrospective study found an increased risk of

cerebrovascular accidents with risperidone (but not with other atypicals) compared with traditional antipsychotics (Percudani *et al*, 2005). Other studies have found no increased risk of cerebrovascular events with atypical antipsychotics (Finkel *et al*, 2005; Liperoti *et al*, 2005; Moretti *et al*, 2005; Suh & Shah, 2005).

Mowat *et al* (2004) argued that the CSM advice could prove detrimental to patient care. They advocated discussion with relatives and carers and argued that stroke, although serious, was a rare excess risk and demanded balanced thinking against other possible benefits of medication.

It was decided to study the response of doctors to the guidelines in Gateshead. A population-based sample was chosen in order to capture the response in primary as well as secondary care. This was done as part of an ongoing audit cycle.

### Method

General practitioners (GPs) in Gateshead were contacted and asked for information on older patients who were on olanzapine or risperidone. Six practices were selected, thus sampling all the old age psychiatry sector teams. Data were initially gathered 10 weeks after the CSM guidance (Time 1). Psychiatric case notes were reviewed for those who had had contact with services. Care homes were also contacted for information. Diagnoses, reasons for prescriptions, other psychotropic medication and risk factors for cerebrovascular disease were obtained. We then ascertained whether they had been reviewed in light of the CSM guidance, by whom and the outcome of that review. A total of 98 patients were

original  
papers**Table 1. Diagnoses of 96 older patients who were prescribed olanzapine or risperidone**

Diagnosis	n
Dementia	
Alzheimer's disease	18
Vascular dementia	23
Mixed Alzheimer's disease/vascular dementia	4
Dementia with Lewy bodies	2
Frontal lobe dementia	1
'Cognitive impairment' <sup>1</sup>	3
Dementia unspecified	1
Other organic	
Organic hallucinations	3
Delirium	2
Cognitive deficit secondary to hypoxia	1
Aggression post CVA	1
Functional	
Schizophrenia	7
Paraphrenia	2
Bipolar affective disorder	5
Schizoaffective disorder	2
Delusional disorder	2
'Psychosis'	2
Psychotic depression	5
Depression	6
Anxiety	2
Panic	1
Unknown	1
Others	2

CVA, cardiovascular accident.

1. People with cognitive impairment have been included in the dementia group as they were either under investigation or had not been seen by psychiatric services.

identified from the six practices. Two patients had recently died, leaving 96 patients. The deaths were not related to cerebrovascular disease. Data were again gathered on these patients 6 months later (Time 2) and included data from death certificates.

## Results

### Demographics of sample

The sample consisted of 27 men and 69 women with an age of 55–95 years (mean 80 years). Fifty-three lived at home, 10 in residential care, 10 in nursing care, 6 in elderly mentally infirm (EMI) residential care, 6 in EMI nursing care, 4 in elderly severely mentally infirm (ESMI) care, 1 in continuing care, 5 in respite care and 1 in palliative care.

By Time 2, 9 people had died and 5 had left the area, leaving 82 patients available for full follow-up. None of the deaths was related to cerebrovascular incidents.

### Contact with psychiatric services

At Time 1, 43 patients were in contact with old age psychiatry services; 40 had been discharged from old age psychiatry services; 9 had not been seen by psychiatric

services; 1 was an adult psychiatry patient; 1 had been discharged from adult services and 2 had been discharged from learning disability psychiatry services. At Time 2, 33 remained in contact with old age psychiatry services.

### Diagnoses

Of those sampled, 52 people had a diagnosis of dementia, 7 had other organic diagnoses and 35 had functional diagnoses. There were 2 others, 1 with schizoid personality traits and 1 with a personality dysfunction (Table 1).

### Medication

Initially, 34 patients were on risperidone and 61 on olanzapine; 1 was on quetiapine but had been identified by the GP who was concerned about cerebrovascular risks. For olanzapine the most common total daily dose was 2.5 mg (range 2.5–20 mg); that for risperidone was 0.5 mg (range 0.5–2 mg). One patient was on a risperidone depot. The average time that people had spent on medication was 23.4 months (range 0–120 months).

There were 56 patients who were prescribed one or more other psychotropic medications. These included 30 who were receiving selective serotonin reuptake inhibitors, 7 on other antidepressants, 10 on cholinesterase inhibitors and others on mood stabilisers, benzodiazepines and hypnotics.

### Cerebrovascular disease and risk factors

Of 52 people with dementia, 31 (60%) had cerebrovascular disease compared with 3 of 7 (43%) of those with other organic diagnoses and 9 of 35 (26%) with functional diagnoses. A further 16 people with functional diagnoses had other risk factors for cerebrovascular disease.

In the sample there were 5 patients who had had a cerebrovascular event while on olanzapine or risperidone prior to the CSM advice. Four had transient ischaemic attacks and one had a stroke. Four had dementia and all had been prescribed the medication for psychotic symptoms. Four of these patients had had previous cerebrovascular events prior to being on medication.

At Time 2 there had been no reports of further cerebrovascular events in any of the patients. None of the deaths during the study was related to cerebrovascular events.

### Review of medication

At Time 1, 71 of 96 patients (74%) had been reviewed; 41 of 43 (95%) of those current to psychiatric services had been reviewed, 23 of 40 discharged patients (58%) and 5 of 9 (56%) of those not seen by psychiatric services. By Time 2, 90 of 96 patients (94%) had had their medication reviewed. This included 7 who had since died and 3 who had since left the area.

Initially 71 patients had been reviewed, 53 by old age psychiatry services. Of those, 41 were current patients;

**Table 2. Data on 96 patients prescribed olanzapine or risperidone at 10 weeks after guidance (Time 1) and 6 months later (Time 2)**

	Diagnosis			
	Dementia (n=52)	Other organic (n=7)	Functional (n=35)	Other (n=2)
Time 1				
Reviewed				
Yes	37	4	29	1
No	15	3	6	1
Medication withdrawn				
Yes	23	2	5	0
No	29	5	30	2
Time 2				
Reviewed				
Yes	47	6	35	2
No	5	1	0	0
Medication withdrawn				
Yes	34	4	10	1
No	18 <sup>1</sup>	3 <sup>2</sup>	25 <sup>3</sup>	1
Withdrawal problems				
Yes	9 <sup>4</sup>	1 <sup>5</sup>	4 <sup>6</sup>	0
No	25	3	6	2

1. Included 5 risk–benefit decisions.

2. Two risk–benefit decisions despite a history of cardiovascular accidents.

3. Only 13 patients had risk factors, 5 had risk–benefit decisions and 8 had no reason documented but raised blood pressure was their only risk factor.

4. Two patients restarted olanzapine/risperidone, 4 responded to other medication and 3 had no alternative prescribed.

5. No alternative prescribed.

6. Three patients restarted olanzapine/risperidone and 1 responded to mirtazapine.

GPs had reviewed 17 and adult psychiatry services 1. Of the patients not currently in contact with old age psychiatry services but who had been reviewed by them, 2 had been referred again; others were reviewed by community psychiatric nurses or specific advice was given to the GP. At Time 2, most of the additional reviews had been performed by GPs. Another patient had been referred back to old age psychiatry services.

## Outcomes

Outcomes for each group of patients are shown in Table 2.

## Discussion

The CSM advice has changed the management of the majority of patients with dementia. Our study found that management was changed in a smaller proportion of patients with functional illness to whom the advice applied than patients with dementia. From the outset, many clinicians were making risk–benefit decisions not to withdraw medication. In many cases these were prompted by previous trials of withdrawing medication that had failed. For the most part, these decisions were well documented and involved discussions with patients, where appropriate, and their families. This practice is in line with the subsequent guidance issued by the Faculty for the Psychiatry of Old Age in November 2004. The workload of old age psychiatry teams was increased by

the CSM advice through extra reviews and giving advice to GPs, but there were fewer re-referrals than might have been expected.

The numbers of reported cerebrovascular events on medication were low. There were five reported events prior to the advice and none over the 8 months of the study. This agrees with the findings from most of the larger population-based studies (Herrmann *et al*, 2004; Gill *et al*, 2005). It should be noted, however, that this study was not designed to specifically investigate the occurrence of cerebrovascular events.

There was a high rate of significant problems associated with withdrawal of medication. In over a third of these cases, the eventual outcome was a return to the original antipsychotic following risk–benefit discussions with patients, relatives and carers.

A limitation of this relatively small study is that it only included data on patients who were already on olanzapine or risperidone. It did not investigate the effect of the guidance on new prescribing, which one would anticipate to be more dramatic.

Strengths of the study are that it gathered information from both primary and secondary care, included patients with a range of diagnoses and in following their progress over 8 months it investigated the initial response to the guidance and subsequent problems.

In conclusion, the CSM guidance on the prescription of atypical antipsychotics for older adults has changed practice for existing patients but with a high rate of clinical problems and numerous patients remaining on, or returning to, olanzapine or risperidone.



original papers

## Declaration of interest

None.

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# Correspondence from substance misuse services – what do general practitioners really want?

### AIMS AND METHOD

To improve the quality of correspondence by identifying what general practitioners (GPs) regarded as the important attributes in patient letters from a substance misuse service. A postal questionnaire survey was carried out to determine the views of general practitioners in Brighton and Hove City.

### RESULTS

Responses were obtained from 32 out of 45 GP surgeries (71%) and indicated that correspondence should be prompt, concise and regular. An assessment summary, management plan and clear medication prescribing arrangements between primary and secondary services

were considered particularly important.

### CLINICAL IMPLICATIONS

New quality standards for correspondence to GPs have been implemented by the Brighton Substance Misuse Service. These might be of interest to other such services.

Good-quality correspondence between specialist services and general practitioners (GPs) is fundamental to patient care. However, the standard of such correspondence does not always meet with GPs' expectations (White & Marriott, 2004). Scott *et al* (2004) identified a number of highly desirable attributes of letters from specialists to GPs across a range of medical disciplines. These included diagnostic formulations, management regimes, use of clinical evaluations, prognostic statements, contingency plans and follow-up arrangements. Others (Dunn & Burton, 1999; Reynolds, 1999) have also distilled important components of correspondence from mental health services (diagnosis, presenting complaint, drug treatment, management plan, follow-up arrangements,

mental state and prognosis). However, we were unable to find any studies of written communication between substance misuse services and GPs.

The aim of this study was to identify what GPs regarded as desirable components and attributes of correspondence from our substance misuse service. It was intended that information gleaned from the survey and by other methods would help improve the quality of the service's written communication.

## Method

Brighton and Hove City is a seaside resort with a population of 260 000 served by 45 separate general