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From “EPS” to Personalized TD Treatment: Matching VMAT2 MOA to the Patient

Announcer:
Welcome to CE on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

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Dr. Moody:
This is CE on ReachMD, and I'm Dr. Melissa Moody. Here with me today is Dr. Tracy Hicks.

We'll start our discussion with the case. Ms. A is a 57-year-old woman with schizophrenia who has been treated with risperidone for over 10 years. She presents to clinic with complaints of new involuntary facial grimacing and repetitive tongue movements, which her family first noticed 3 months ago. She reports no awareness of these movements but has been feeling self-conscious in social situations.

On exam, she exhibits mild to moderate orofacial dyskinesias and intermittent choreiform movements of her fingers. Her Abnormal Involuntary Movement Scale, or AIMS score, is 7. Ms. A has a history of nonalcoholic fatty liver disease, and recent workup reveals moderate hepatic impairment, or Child-Pugh B. Her liver function tests show persistently elevated transaminases.

What considerations factor in when managing her tardive dyskinesia? What do you think, Tracy, what kind of things do you think we need to consider in this specific case and in Ms. A’s circumstances?

Dr. Hicks:
I actually see cases like this in practice all the time, because we know that people living with mental health issues often have issues with hepatic impairment.

So the best choice in this case, for me, would be valbenazine with dose adjustment. So deutetrabenazine, in this case, is not recommended in hepatic impairment. When we talk about valbenazine, so we can use valbenazine with dose reduction; it's more predictable for the metabolism despite hepatic compromise.

So what is the key prescribing point here? So you want to start lower doses, 40 mg daily basedon moderate hepatic impairment. You want to monitor those liver function tests and the clinical response. And then you want to think hepatic disease, choose valbenazine, because, again, it's been well studied in those areas.

Dr. Moody:
Those are great points, Tracy. I think when we're meeting patients for the first time and we see tardive dyskinesia, there's so many things to take into consideration. Things like once-daily dosing versus twice-daily dosing and availability for that patient, other medications they're on.

I think sometimes as psychiatrists, we forget that we have to look at the physical side of things too. We have to evaluate their labs and get a good, thorough history of any sort of lab abnormality or medical history that might come into play. Patients don't always know that they have liver disease. That's really common in some of our patient population. They don't recognize or realize that they have these elevated transaminases or have disease processes like nonalcoholic fatty liver disease that can maybe pose an issue for prescribing medications. So as prescribers, we need to make sure that we're up to date on their most recent labs, and we're looking at those things and fully aware of what's really happening with their physical health so that we can fully help their tardive dyskinesia and their mental health.

So great points, Tracy.

Dr. Hicks:
Absolutely. I think this has been a great discussion, lots of good information, because again, like you said, patients don't know they have these elevated transaminases, so it's important for us to do our clinical monitoring and have those conversations with our patients.

And again, it goes back to building rapport, because if you don't ask those open-ended questions, you don't find out what's really going on. And we have to do that psychoeducation piece to really understand and do a comprehensive care model for our patients.

Dr. Moody:
So, well, this has been a great bite-sized discussion. Our time is up. Thanks for listening.

Dr. Hicks: Thank you.

Announcer:
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