Introduction

Using Atypical Antipsychotics in Primary Care, 2: Special Populations

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Primary care physicians write about 20% of the antipsychotic prescriptions filled in pharmacies.[1] Many patients with schizophrenia receive some care from primary care physicians, and 14% of these patients receive their care exclusively from primary care physicians.[2] Schizophrenia is only one of several disorders treated with antipsychotics in the primary care setting. In fact, almost two thirds of antipsychotic prescription refills in this setting are for off-label uses,[3] such as for dementia in the elderly and conduct disorder in youth.

Given the many ways in which a patient's psychological and somatic symptoms can be interpreted, diagnosis and treatment of psychiatric disorders can be difficult in primary care. The atypical antipsychotics are just one of the tools that can assist the primary care physician to treat these disorders effectively. However, these agents must be used with caution in special populations such as children, adolescents, and the elderly. This supplement will aid the physician in treating special populations with antipsychotics.

First, Robert L. Findling, M.D., discusses the diagnosis and treatment of aggressive behavior in children and adolescents. Many young patients with aggression are not appropriate candidates for pharmacotherapy. For the small number whose aggression is persistent, pernicious, and pervasive over the long term, though, pharmacotherapy with agents such as methylphenidate, lithium, or an antipsychotic may be a rational and helpful treatment option.

In his second article, Dr. Findling goes on to discuss the use of atypical antipsychotic medications in children and adolescents with a variety of neuropsychiatric disorders. The evidence base for this use is relatively small, but some evidence suggests that focused combination pharmacotherapy may be rational in cases of comorbidity, such as a psychostimulant for symptoms of attention-deficit/hyperactivity disorder plus an atypical antipsychotic for aggression associated with disruptive behavior disorder.

Jacobo E. Mintzer, M.D., goes to the other end of the age spectrum to review the behavioral symptoms in elderly patients with dementia associated with Alzheimer's disease. These symptoms include psychosis, agitation/aggression, anxiety, depression, apathy, and sleep disturbance. He points out that, like other aggressive patients, elderly aggressive patients with dementia have serotonin deficits, which provides a rationale for the use of serotonin antagonists such as atypical antipsychotics to aid in the management of behavioral symptoms of Alzheimer's type dementia.

Zafar A. Sharif, M.D., provides information regarding the cytochrome P450 system of primarily hepatic enzymes and their role in potential drug-drug interactions involving the atypical antipsychotics. A coadministered drug may inhibit an enzyme that metabolizes the prescribed antipsychotic, or, conversely, it may induce the action of that enzyme. In

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addition, some populations metabolize drugs faster than others (younger people faster than older people, men faster than women, and, for some antipsychotics, those who smoke cigarettes faster than those who do not). Dose adjustments may be necessary in vulnerable populations, such as the elderly.

Today's primary care physicians face an ever-growing challenge of diagnosing and treating a wide variety of conditions. Recognizing mental disorders among patients who often present with vague somatic symptoms may present an additional difficulty, but the sheer volume of antipsychotic agents and other psychotropic medications being prescribed by primary care physicians implies that not only are these doctors recognizing psychiatric disorders, they are treating these disorders as well. We hope that the articles in this supplement will help primary care clinicians to better understand and manage all patients who could benefit from antipsychotic therapy, no matter what age.

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