Medscape EDUCATION

The Impact of Comorbidities on Schizophrenia Management

INTRODUCTION

Both psychiatric and physical comorbidities are common in schizophrenia. Psychiatric comorbidities may drive more integrated care, especially in the area of substance abuse, while metabolic disturbances substantially complicate disease management in schizophrenia.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5), CRITERIA FOR SCHIZOPHRENIA[1]

The diagnosis of schizophrenia in the DSM-5 criteria creates an artificial boundary:

- At least 2 psychotic symptoms for 1 month
- Social or occupational dysfunction
- Six-month duration
- Schizoaffective disorder: mood disorders have been excluded
- Not due to pervasive developmental disorder
- Substance abuse and medical conditions have been excluded
- Recognition of "attenuated psychosis syndrome"

PSYCHIATRIC COMORBIDITIES[2]

- Psychiatric comorbidities are common in schizophrenia
- May have a shared neuro-biological basis (genetic and nongenetic)
- Diagnostic overlap and confusion about phenomenology
- "Blurred" boundaries of schizophrenia
- Individualized and integrated services are essential, especially for substance abuse

Table 1. Comorbidities and Schizophrenia[4-6]

Condition[3]	Estimated % of Patients[3]
Depressive symptoms	50%
Anxiety disorders	30%
Post-traumatic stress disorder	15%
Obsessive compulsive disorder	8%
Substance abuse	50%

Table 2. Substance Abuse and Schizophrenia[4-6]

Complex Relationship	Neurobiology of Substance Abuse Comorbidity
• Presents with a "chicken and egg" theory; did Psychosis precede substance abuse or vice versa? • Can complicate both the initial diagnosis and the first presentation of psychosis • Not all drugs are associated with the same level of risk of schizophrenia • May increase risk for drug-seeking behavior/illicit drug use • Use occurs at all phases of illness	• Is there a common neural substrate of addiction and mental disorder? • Are patients self-medicating, and what does that tell us about the circuitry/neural targets? • Does addiction inform us about the neurobiology of mental illness? • What are the therapeutic implications?

METABOLIC COMORBIDITIES

Metabolic syndrome is defined by any 3 of the following 5 criteria:[7]

- Obesity
- High-density lipoprotein cholesterol (HDL-C)
- Triglycerides ≥ 150 mg/dL
- Blood pressure ≥ 130 mmHg systolic or ≥ 85 mmHg diastolic
- Fasting blood glucose ≥ 100 mg/dL

Table 3. Metabolic Disturbance Impact Treatment

Impact on Early Treatment Decisions[8]	Impact on Later Treatment Decisions[8]	Mitigate Metabolic Problems During Clozapine Therapy[9,10]	Other Options[11]
• Timing of early intervention • Use of other nonantipsychotic drugs/ approaches • Deciding which antipsychotic to use for first episode psychosis • How to preemptively obviate metabolic problems	• Second-choice antipsychotic • Switching medications • Antipsychotic polypharmacy • Clozapine treatment • Mitigating metabolic problems?	• Clozapine is associated with significant weight gain/ metabolic disturbances • Exercise, dietary restraint • Clozapine dose and blood level management • Discontinuation of clozapine • Trial of other agents • Aripiprazole-clozapine cotreatment	• Enforce healthy lifestyles • Add antiobesity agents • Add statins • Add omega-3 fatty acids • Go back to older antipsychotics • Selective use and staging of treatment with second generation antipsychotic

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