TRIMS • THERAPY • NOTES

Evaluating and managing patients who have tardive dyskinesia: the TRIMS program

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May 1983

Tardive dyskinesia (TD) is a side effect of long-term treatment with neuroleptic drugs. In its severe form, the disorder causes involuntary muscle spasms of limbs and face that are extremely disabling to patients. Our research group, in a survey of state hospital patients two years ago, found some evidence of tardive dyskinesia in 35 percent of the patients we examined, although only about two percent were seriously affected.

Part of the settlement of the *R.A.J.* v. *Miller* case (R.A.J. was a patient at Terrell State Hospital) called for special monitoring and therapeutic management of patients with tardive dyskinesia. Our experience with such a program may be useful to other state facilities.

The TRIMS tardive dyskinesia clinic is a diagnostic consultation service. We evaluate and recommend treatment for patients referred to us, and we select some patients to supervise their treatment with neuroleptic drugs. Our patients are primarily outpatients because the TRIMS inpatient unit is a short-term hospital in which most patients stay only two to five weeks.

Patients in the TRIMS outpatient clinics are examined for movement disorders by their own therapists. Those who exhibit possible signs of TD or other movement disorders are referred to our clinic. Here we review their psychiatric history, medication record, and manifestations of motor symptoms and other side effects. We evaluate patients with the Smith-TRIMS Tardive Dyskinesia Rating Scale, which provides quantitative ratings of total tardive dyskinesia, facial tardive dyskinesia, and pseudoparkinsonian symptoms—that is, other neuroleptic side effects which resemble but are not symptoms of Parkinson disease. Because tardive dyskinesia symptoms fluctuate, most patients are asked to come to the TD clinic several times, usually twice a month or monthly, to confirm the presence or severity of tardive dyskinesia and to identify choices of treatment.

Our diagnostic evaluations have revealed several different types of problems. Some patients have primarily tremors that represent Parkinson disease of unknown cause or pseudoparkinsonian symptoms; these patients return to their therapists with a diagnostic evaluation of their motor disorder and a recommendation for further consultation. We have discovered a few patients who suffer from a nonpsychotic psychiatric illness for which neuroleptic drugs are not appropriate; we recommend that these patients' neuroleptic drug regimen be stopped for several weeks or months while they are closely followed in our clinic. Patients with mild or questionable signs of tardive dyskinesia are examined in the TD clinic several times a year for one to two years, to see whether their TD symptoms progress or remain questionable.

Patients with distinct symptoms of tardive dyskinesia (that is, with a consistently positive total tardive dyskinesia score of 5 or more) are evaluated for possible neuroleptic dosage reduction. We ask several questions:

Is the patient currently being treated with low, moderate, or high doses of neuroleptics? Has the patient been treated for a long time with long-acting depot neuroleptics (for example, fluphenazine decanoate?) Does the patient have a history of recurrent psychosis when neuroleptics are discontinued or when the patient stops taking the medication?

What is the patient's living situation and/or family environment? If the patient suffers a temporary return of psychosis or increased aberrant behavior, will this have a serious disorganizing effect on his or her social environment, and will it result in withdrawal of family or social care support? Can the patient come regularly for evaluations of his or her psychiatric status and medication during an extended period of lower medication dosage?

Negative answers to some of these questions, especially to those concerning the patient's support system and recurrence of psychosis, encourage us to maintain some of these patients on their current neuroleptic dosages. For patients able to come to the clinic regularly and whose environment is relatively stable and adaptable, we often reduce the neuroleptic dosage and check the patient biweekly or monthly, for at least the first three or four months. Some patients whose dosages were reduced functioned well for six months to one-and-a-half years. Others required more medication

after a few months, and a few needed to be rehospitalized for further evaluation and treatment.

A few patients who come to the clinic regularly and take their medication reliably have joined our lecithin research. This is a double-blind, placebo-controlled study to evaluate the effect of daily moderate doses of lecithin (35 grams of lecithin containing 50-percent phosphotidylcholine) on symptoms of tardive dyskinesia. We evaluate these patients with electroencephalograms, computed tomography scans of the brain, neuropsychological examinations, measures of cerebral blood flow, neuroleptic and enzyme blood levels, and memory tests. Although our research and that of other groups has produced conflicting results about the efficacy of lecithin in ameliorating tardive dyskinesia, some of our patients have shown mild to moderate improvement. Moreover, lecithin has no clinically significant side effects.

Our tardive dyskinesia evaluation system has several advantages: the clinic is relatively time-efficient, requiring 1-1/2 to 3-1/2 hours per week of a psychiatrist's and research specialist's time, a small number of other back-up staff members, all of whom are specially trained in administering TD rating scales and managing patients with TD. Other hospital and clinic staff members need only a general familiarity with signs of tardive dyskinesia. The standardized scales and consultation records are useful for reviewing each patient's progress and pharmacotherapeutic management. As a whole, the record also contributes to research of tardive dyskinesia.

The Smith-TRIMS Tardive Dyskinesia Scale and our TD clinic consultation forms are available to other state facility staff members who may wish to copy or modify our system. We would be happy also to record two tardive dyskinesia training tapes for any facility which sends us blank videocassettes for that purpose. Call us for information: Dr. Smith (713) 791-6609 or STS 874-6609; Alla Shvartsburd (713) 797-1976 ext. 6297 or STS 874-6297; Mary Mauldin (713) 797-1976 ext. 6516 or STS 874-6516.

TRIMS THERAPY NOTES
May 1983 Vol. 4, No. 4

Clinical newsletter of the Texas Research Institute of Mental Sciences, the research-training-patient care facility of the Texas Department of Mental Health and Mental Retardation, an equal opportunity employer.

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