LETTERS TO EDITOR

Clozapine: A friend estranged?

Sir,

Fact one: clozapine has proven superiority in partial or non-responsive schizophrenia and is the only evidence-based medication for treatment resistant schizophrenia.[1] Fact two: the incidence of the most feared side effect – Agranulocytosis, is as low as 0.38% and falls to 0.08% after 1 year of treatment.[2] Fact three: Clozapine has been shown to reduce suicidal behavior in comparison with Olanzapine.[3] Fact four: Only 14% of all patients who deserve clozapine are prescribed clozapine.[4]

In the face of these facts, the continuing under utilization of clozapine is difficult to explain and numerous patients undergo multiple trials of other antipsychotics and live more than a decade with disability before clozapine is considered. One, therefore, needs to look beyond drug and response characteristics to make sense of these inconsistencies. The attitude of psychiatrists toward clozapine may be of special relevance.

A recent study on the attitudes of practicing psychiatrists towards clozapine[5] brings up surprising results with 64% psychiatrists opting to combine two antipsychotics rather than opt for clozapine, in spite of several treatment guidelines clearly recommending otherwise. Clozapine’s use obviously mandates strict blood monitoring, and is accompanied by side effects quite unique to this drug, which may perhaps be seen as barriers against its more frequent use by psychiatrists. Alongside, there is perhaps an element of therapeutic nihilism that creeps in if clozapine is viewed as the last resort medication-the proverbial panic button. However, an interesting study comparing the attitudes of patients and prescribers toward clozapine[6] revealed that patients were happier and more satisfied with clozapine and were less troubled by the repeated blood tests and side effects than their prescribers believed them to be.

A recent article[2] elegantly investigated clozapine’s current status and if it can be promoted to become a second line medication for schizophrenia. The authors recommend that clozapine should be considered at
the same stage as other atypical antipsychotics, and not as a “special” drug for resistant cases. A necessary prerequisite for that to happen would be the removal of the associated misperceptions with clozapine and a gradual and thorough ‘demystification’ of the drug, so that clinicians would be much more comfortable using it. The risk of agranulocytosis though real, needs to be put in perspective. Carbamazepine, another commonly used drug in patients with psychiatric disorders, has a 1-2% risk of life-threatening hematological complications like aplastic anemia and agranulocytosis.

Thus, studies are needed to explore the role of clozapine as a second line agent vis-a-vis other antipsychotics to guide rational and effective use of all available antipsychotics. Schizophrenia is a difficult condition to manage, its natural course pockmarked with multiple relapses, incomplete recovery and limited therapeutic options. It would perhaps do us good not to estrange the occasional friend we chance upon.

Sri Mahavir Agarwal, Naren Prahlada Rao, Ganesan Venkatsubramanian
Department of Psychiatry, National Institute of Mental Health & Neurosciences,
Bangalore, Karnataka, India.
E-Mail: docnaren@gmail.com

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