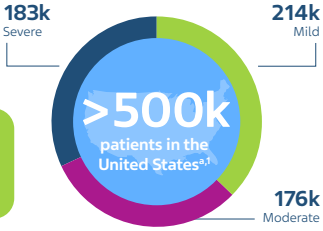
Exploring the functional, social, professional, and psychological impact of tardive dyskinesia (TD) movements on patients' lives

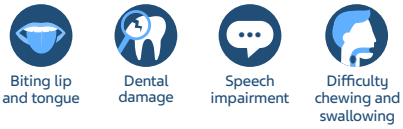
1 TD is a historically underrecognized and mis-diagnosed movement disorder caused by long-term exposure to dopamine receptor-blocking agents (DRAs)[1–3]

1 in 4 (25.3%) patients on antipsychotics develop TD[2]



2 The arrhythmic movements of TD can affect the entire body and remain indefinitely[4–8]

Orofacial dyskinesia: 60–80% of cases

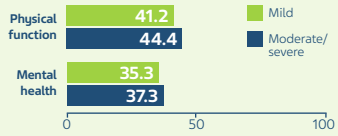


Dyskinesia of the trunk, limbs and extremities

Symptoms range from mild impairment to disabling or even life-threatening[4–6]

- Symptoms are chronic but may wax and wane over time[4]
- Severity does not necessarily correlate with functional and psychosocial impact[8]

Similar burden scores in patients with mild or moderate/severe TD movements[b,9]



3 TD affects daily functioning and well-being[10]

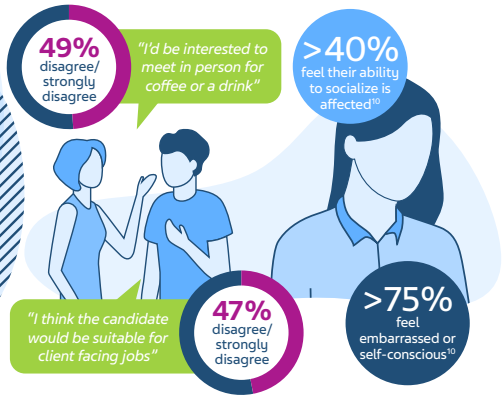
Patients report 'a lot' or 'some' impact of TD on:[10]

People with schizophrenia and TD have lower productivity and fewer are in paid employment than those without TD:[10,11]

54% with employment status 'disabled'[10]

4 Patients can feel uncomfortable in their own skin and unaccepted by society[12]

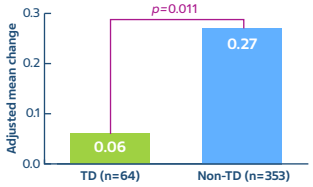
Patients face social stigma and discrimination[d,12,13]



5 TD negatively impacts psychological well-being and underlying psychiatric conditions[e,9,10,12,14]

6 TD is associated with reduced neurocognitive function[15,16]

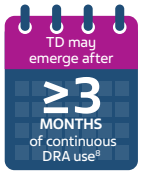
6-month change in cognitive composite Z-score[g,16]



including worse performance in:[15,16]

- Both simple and complex tasks
- Attention/simple decisions
- Visuospatial skill (speed)
- Grammatical reasoning (speed)
- Selective attention (accuracy)

7 Early recognition is essential for the management of TD[8]



Symptoms are easily mistaken for other movement disorders[4,5]

APA recommends all patients on APDs are regularly assessed with a structured instrument[8]

E.g. AIMS to assess the severity of movements associated with TD

Dose reduction or discontinuation of DRA often does not resolve TD[4,8]

- Can worsen underlying psychiatric condition
- Can trigger withdrawal-emergent dyskinesia

8 The APA recommends VMAT2 inhibitors for the treatment of moderate to severe or disabling TD[8,17,18]

With no requirement for DRA withdrawal/dose modification[17,18]

Two FDA-approved treatments:[h]

AIMS, Abnormal Involuntary Movement Scale; APA, American Psychiatric Association; APD, antipsychotic drug; DRA, dopamine receptor-blocking agent; EPS, extrapyramidal symptoms; FDA, Food and Drug Administration; VMAT2, vesicular monoamine transporter 2

[a]In 2016 data; [b]Mental and physical health status evaluated using SF12v2 and SF-36v2 Health Survey scores. Scores range from 0–100, with higher scores indicating better health status; [c]Relative percentage change in mean proportion of participants over 4 yearly assessments. Comparison between patients with schizophrenia with TD and without TD; [d]Survey responses after participants watched videos of actors simulating orofacial TD movements; [e]Data from different studies; [f]Compared with patients using antipsychotics without TD; [g]A neurocognitive composite score was calculated by creating a Z-score of the average of 5 standardized neurocognitive domain scores (verbal memory, working memory, processing speed, vigilance, and reasoning). Adjusted for baseline covariates; [h]Deutetrabenazine is contraindicated in patients with hepatic impairment, and those taking reserpine, monoamine oxidase inhibitors, tetrabenazine or valbenazine. Use in pregnancy may cause fetal harm (based on animal data). Please consult full prescribing information before use.

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https://vimeo.com/543054103/0568f97ef8

References

1. Dhir A, et al. Poster presented at the American Academy of Neurology 2017 Annual Meeting. April 22–28, Boston, Massachusetts, USA. **2.** Carbon M, et al. J Clin Psychiatry 2017;78:e264–78. **3.** Hansen TE, et al. Gen Hosp Psych 1992;14:340–4. **4.** Hauser RA, et al. CNS Spectr 2020;1–10. **5.** Ward KM, Citrome L. Neurol Ther 2018;7:233–48. **6.** Strassnig M, et al. CNS Spectr 2018;23:370–7. **7.** Chong SA, et al. J Clin Psychopharmacol. 2009;29:5–8. **8.** American Psychiatric Association. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. 3rd ed. https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890424841. Accessed February 2021. **9.** McEvoy J, et al. Qual Life Res 2019;28:3303–12. **10.** Caroff SN, et al. J Clin Psychopharmacol 2020;40:259–68. **11.** Ascher-Svanum H, et al. J Clin Psychiatry 2008;69:1580–8. **12.** Farrar M, et al. BMC Psychiatry 2021;21:94. **13.** Ayyagari R, et al. Presented at: 2019 Psych Congress; October 3–6, 2019; San Diego, CA. **14.** Loughlin et al. PLoS One. 2019;14:e0216044. **15.** Eberhard J, et al. Int Clin Psychopharmacol 2006;21:35–42. **16.** Caroff SN, et al. J Clin Psychiatry. 2011;72:10.4088/JCP.09m05793yel. **17.** Teva Pharmaceuticals. Austedo® (deutetrabenazine) tablets for oral use. Prescribing information, 2021.**18.** Neurocrine Biosciences. Ingrezza® (valbenazine) capsules for oral use. Prescribing information, 2017.

NPS-US-NP-00802 April 2021