Off-label prescribing of atypical antipsychotic medications

We write to thank the Journal for the publication of our survey findings into the use of off-label atypical antipsychotic medications (AAPs) in Canterbury and the editorial comments provided by Glue and Gale.

The principal motivation in undertaking this research was to obtain preliminary data to determine the extent and characteristics of off-label prescribing of AAPs in the Canterbury region, to place this in the context of a flourishing trend in off-label prescribing in general and to invite readers to consider, reflect and debate on what factors determine their choice to prescribe medications off-label.

As noted by Glue and Gale the study has a number of methodological limitations which makes interpretation of the findings difficult. We accept this without reservation, but we believe that despite these limitations the survey provides useful information that warrants further consideration; almost all psychiatrists (96% of respondents) prescribed AAPs off-label and 58% did so at least once a week, and therefore off-label prescribing is an integral and common aspect of current clinical practice.

Off-label prescribing is also common among cardiac medications (antianginals, antiarrhythmics, and anticoagulants), anticonvulsants and antiasthmatics. It is well recognised in the literature that there has been a rapid growth in the use of AAPs over the past 10–15 years. Such rapid increase in AAP use is justified if the populations treated suffers from psychosis or psychotic related conditions, including bipolar disorders (‘near label’ use), there is a strong evidence base for its use, and the treatment is cost effective compared to other treatments; however a number of international studies have highlighted that the expanded use of AAPs has not occurred under these circumstances and it is unclear what has driven current prescribing practices.

Part of the rapid diffusion of AAPs has been achieved by large increases in the rate of use in certain sub-populations, most notably youths for whom long term data on safety and efficacy are still lacking, and due to persisting use of AAPs over long periods of time (they therefore do not appear to be predominantly used as brief interventions).

Information on side-effects can take some time to come to light; for example the common off-label use of AAPs for the management of behavioural problems associated with dementia has come under fire as evidence accumulated of increased death rates associated with antipsychotic treatment in the elderly, after the introduction of ‘black box warning’ in this population there has been a sharp drop in the rate of their use.

Sophisticated, far reaching and illegal marketing practices have been employed by pharmaceutical companies to promote off-label use of medications in the USA, and although so far there has been no published data on the extent to which this influences
prescribing practices in New Zealand, it would be naïve to assume that it has not played a role.¹¹

There is a lack of head to head trials comparing quetiapine with either zopiclone or benzodiazepines for insomnia.¹² The National Institutes of Health statement regarding the treatment of insomnia does not recommend the use of antipsychotics (including quetiapine) for insomnia.¹³ We note that the use of atypical antipsychotics and quetiapine in particular for insomnia has occurred on the background of the usage of zopiclone having increased by 300% over the last ten years.¹⁴

The present situation is confusing and unsatisfactory, and prescribing trends in this area appear to be inconsistent with the current evidence base. Until there is more robust data into the efficacy and safety of AAP use in off-label conditions, particularly in the management of insomnia, anxiety and behavioural disturbance associated with dementia, we propose a more conservative and time limited approach to their use.

More considered discussion around general off-label prescribing in primary and specialised care settings is also welcome.

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References:

