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Overcoming the Clinical Challenges of Tardive Dyskinesia: A Practical Approach

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Learning Objective 1

Utilize appropriate assessment scales and tools for the accurate diagnosis of tardive dyskinesia

Learning Objective 2

Individualize evidence-based treatment approaches for tardive dyskinesia based on efficacy, patient characteristics, and tolerability

Chart Review

RECENT HISTORY/EVENTS LEADING UP TO THIS CLINICAL ENCOUNTER

The patient is a 63-year-old male. The only “record” I have is a prescription from his psychiatrist that states, “Refer to Dr. Carlos Singer to evaluate movement disorder.” The patient brings me a list of symptoms, which have been getting gradually worse over a period of the last 8 years, and they include the following in the order that he presented:

“***picking up my fingers, tapping of my feet, restless legs, clearing my throat all the time to where no one can live with me, excessive biting "ticks”, my elbows lift up as soon as they touch something, cannot remember what was said to me 2 seconds ago, cannot sit still, when eating meals food gets stuck in my throat, nervous energy, uncontrolled diabetes; My psychiatrist says I have a tic.***”

The neurologist tried a number of medications, namely gabapentin 900-1,200 t.i.d. and lamotrigine 200 mg at bedtime. Symptoms worsened, with pain in both hands and feet. The neurologist mentions that the patient's restless legs are bothersome to him throughout the day and night and that he has trouble sleeping at night.

CURRENT PRESENTATION

Chief Complaints: Picking up fingers, tapping of feet, restless legs, clearing throat all the time, excessive biting "ticks"

Psychiatric Interview Findings: Rational. Interactive. Not overtly depressed or anxious.

Physical Exam Findings:

Speech unremarkable, facial expressiveness minimally decreased. No rest tremor, postural tremor, or kinetic tremor. Slight non-cogwheel rigidity of right upper extremity only with reinforcement maneuvers. Finger tapping, hand opening, hand pronation and supination all adequately performed although somewhat slowly, scored as 1 throughout. Same can be said for foot tapping and heel tapping, scored as 1 throughout. Able to rise from a chair and arms-crossed posture is erect. Gait is brisk. Preserved postural stability. Slight decrease in right arm swing. No freezing.

He had frequent movements of foot tapping of mild amplitude and back-and-forth touching of the fingers between both hands. While performing motor tasks, jaw-opening movements were noted. The patient was able to suppress albeit partially the involuntary movements with a sense of urge to release in. Humming intermittently also noted.

PHYSICAL HISTORY, MEDICAL HISTORY, AND OTHER HISTORY

Psychiatric: The neurologist mentions a history of bipolar disease, which the patient confirms. The patient was diagnosed in New York many years before. The neurologist also mentions that the patient had been exposed to risperidone for a period of 27 years (since 1989) and that he had stopped taking it in 2016.

Medical: Diabetes, hypertension, hypercholesterolemia. Mentioned in the neurologist's note, long-standing hypogonadism, benign prostatic hypertrophy, and erectile dysfunction. There is also mention of left knee surgery and salivary gland surgery.

Neurologist: The neurologist, after full neurological workup, mentions memory loss. The neurologist also says the patient has noted problem with uncontrolled tapping of his feet over the past 6 years, restless legs at bedtime, constant shooting pain in both hands, difficulty bending the fingers of his hands, bifrontal headaches about 7 times a week in the last 15 minutes, and short- and long-term memory loss for the preceding 2 years. He may lose things, ask questions repeatedly, may forget important thing such as what a physician told him the day before. No delusions or hallucinations.

Family History

Father at age 83 died of 3 heart attacks
Mother at age 77 had 3 strokes,
Sister, age 69, in excellent health
One child, a daughter, in excellent health

Personal/Occupational Profile

The patient was born in Flushing, New York. He moved to Fairfield, Connecticut at age 10, graduated high school, and went to college (it took him 7 years to complete 2 years). He said he had some issues with taking calculus and eventually quit college. He went on to work primarily as a salesman at different department stores and worked 4 years at a video store. He eventually retired at age 42 with disability related to mental illness, namely bipolar disorder with emphasis on depression. There has been no social security for the most part. He is working as a crossing guard for the school of the City of Coconut Creek. The patient is divorced and apparently not in good relations with his daughter from his first marriage. He presented with his significant other (stable relationship for the past 8 years).

REVIEW OF SYSTEMS

General review of organs and systems reveals endorsement of weight gain, fatigue, blurred vision, hearing loss, voice changes, palpitations, history of clot or thrombosis, frequent coughing, stomach ulcer (in the past), frequent urination, burning during urination, urge incontinence, sexual difficulty, joint stiffness, weakness, muscle cramping, headaches, dizziness, numbness, loss of consciousness, memory loss, anxiety, and depression.

Mood scale 13/15 (patient under psychiatric care)

CURRENT MEDICATIONS

Gabapentin 300 mg capsules, unclear whether once a day or more
Lamotrigine 100 mg daily
Trazodone 300 mg a daily
Atorvastatin 20 mg daily
Metoprolol-XL 25 mg daily
Alfuzosin 10 mg daily
Pantoprazole 40 mg daily

DIAGNOSIS

- Involuntary movements appeared to cross the bridge between choreiform-like and tic-like but can be best described as likely representing a version of tardive dyskinesia, which has tic-like features and is related to the exposure to his risperidone
- History of memory loss is very suggestive that there is onset of cognitive dysfunction of a certain degree in someone who may have limited cognitive reserve to begin with and who, on top of that, is now a diabetic
- Painful syndrome of hands and feet with generalized areflexia and decreased vibration at the toes, compatible with diabetic neuropathy

PLAN

The patient was referred to me primarily for the movement disorder. I placed him on clonidine 0.1 mg p.o. daily for about a week and then 0.1 p.o. b.i.d. while we sort out potential causes for choreiform disorder although my main suspicion is it is tardive. We will order sedimentation rate, antinuclear antibody, serum creatine phosphokinase, Huntington's gene testing, complete blood count, complete metabolic profile, and antiphospholipid antibody panel. Most likely all of these will be negative and we can then see if we can provide him with relief with vesicular monoamine transporter 2 (VMAT2) inhibitors. Viewing this as likely tardive dyskinesia.

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

- Identify signs and symptoms of tardive dyskinesia for prompt patient referral to movement disorder specialist
- Improve physician-physician communication to deliver optimal patient-centered care