Typical antipsychotics (conventional) (FGA)

- **Treats positive (+) symptoms only appropriate for the acute and chronic management of schizophrenia and psychosis.**
- **Non-selectively blocks dopamine D2 receptors, specifically in mesolimbic pathway; also blocks Ach (Muscarinic), histamine, NE**

Five main SE of FGAs

- Sedation
- Postural Hypotension
- Lower seizure threshold
- Anticholinergic side effects
- Photosensitive

Haloperidol-High-Appropriate for acute, severe agitation and aggression-Butyrophenones

- Initial oral dose 1-15mg/day (can give once daily or divide;
- Usual dose 1-40mg/day (orally);
- Max dose 100mg/day
- Tablets 0.5, 1, 2, 5, 10, 20mg; Concentrate 2mg/ml; Injection 5mg/ml
- Half-life 13-38
- Higher risk for EPS and TD
- **Avoid in older adults** due to increased risk of cerebrovascular accident (CVA), cognitive decline, and death in persons with dementia and with dementia-related psychosis.

Fluphenazine-Medium-Psychotic D/Os

- Initial oral dose 0.5-10mg/day divided doses;
- Usual dose 1-20mg day;
- Max dose40mg/day
- Tablet 1, 2.5, 5, 10mg; Elixer 2.5mg/ml; Concentrate 5mg/ml
- Half-life 15 hours

Thiothixene-Medium

- Initial dose 5-10mg/day;
- Usual dose 15-30mg/day;
- Max dose 60mg/day divided
- Capsules 2, 5, 10mg
- Half-life 3.4-34 hours

Thioridazine-Low-2nd line due to QTc issues

- Initial dose 50-100mg/3xday/increase gradually;
- Usual dose 200-800mg divided;
- Max dose 800mg/day
- Tablets 10, 15, 25, 50, 100mg
- Metabolized by CYP450 2D6

Chlorpromazine-Low-2nd line due to QTc issues -schizophrenia-DA 2 antagonist

- Usual dose 200-800mg divided; maximum 800mg/day

- Psychosis-increase dose until symptoms are controlled; after 2 weeks reduce to lowest effective dose
- Can improve in one week but may take several weeks for full effect on behavior
- Tablet 10, 25, 50, 100, 200mg
- Half-Life 8-33 hours
- Phenothyazine
- SXS-Dry mouth, pupil dilation, blurred vision, cog impair, constipation, urinary retention, tachycardia

Mesoridazine-Low-off market due to dangerous side effects, including irregular heartbeat and QT prolongation.

*Low potency meds require higher doses to achieve efficacy
*Low potency meds have more anticholinergic, antihistaminic, and α 1 properties resulting in more sedation than higher potency meds.
*High risk for developing hyperprolactinemia and EPS (negative symptoms aren't affected by FGAs only positive symptoms)

Neurolepsis is a term to describe antipsychotic medication effects on psychotic clients, with respect to cognition and behavior. Newer medications (SGA) do not necessarily have these same effects.

Neurolepsis syndrome has three major features. Examine the image below to learn more about the PEA acronym.

- P**sychomotor slowing** - extreme form of slowness or absence of motor movement (nigrostriatal pathway)

- E**motional quieting** - worsening of negative and cognitive symptoms (mesocortical pathways)

- A**ffective indifference** - worsening of affective symptoms (mesocortical pathway)

Atypical antipsychotics (SGA) Developed to treat both positive (+) and (-) negative symptoms

- SGAs are considered serotonin-dopamine antagonists, as they maintain D2 antagonism but also have simultaneous serotonin 5HT2A antagonism
- Lower affinity for D2 and higher affinity for 5HT
- Effective for treatment-resistant clients
- Does not increase prolactin levels
- Treats positive and negative symptoms
- Lower risk of EPS