Introduction
Newer Drugs for Older Patients

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The entry of chlorpromazine into the psychopharmacologic armamentarium against schizophrenia and other psychotic disorders in 1952 started a new era in psychiatric management of severely mentally ill people. Chlorpromazine and other neuroleptic or antipsychotic drugs that followed it controlled the positive symptoms of psychosis such as delusions and hallucination far better than any of the previous treatments ever did. Equally importantly, they markedly reduced the risk of relapse in patients with chronic schizophrenia, schizoaffective disorder, and related conditions. These drugs made it possible for people with schizophrenia and similar illnesses to be discharged from institutions and live in the community. This was no small achievement.

As the use of these agents became widespread, however, their limitations too became apparent. The so-called typical or conventional neuroleptics, which are all dopamine D_2-receptor blockers, have little effect on negative symptoms such as affective blunting, lack of motivation, and social withdrawal. These agents either do not affect cognitive impairment in schizophrenia or may even make it worse. Adverse reactions including extrapyramidal symptoms such as parkinsonism and akathisia, as well as anticholinergic side effects, are common. Particularly troublesome is persistent tardive dyskinesia. Those side effects are much more common in the elderly than in younger adults. For example, the cumulative annual incidence of tardive dyskinesia is about 6 times higher in older patients than in their younger counterparts.[1–3] The elderly are also more sensitive to anticholinergic toxicity, which may impact adversely on the already impaired cognition.

The newer atypical antipsychotics have opened a new era in psychopharmacology. Clozapine, risperidone, olanzapine, and quetiapine have provided better treatments in terms of greater therapeutic response and lower risk of serious side effects compared with typical neuroleptics. This class of drugs, which block dopamine as well as serotonin receptors, is of particular value for the elderly. Thus, the risk of tardive dyskinesia in older patients has been found to be significantly lower with risperidone than with haloperidol.[4]

At the same time, it is worth reminding ourselves that the newer atypical antipsychotics (with the exception of clozapine) have been with us for less than a decade; furthermore, although they are clearly superior to the conventional neuroleptics, the newer agents are not without some therapeutic limitations as well as side effects of their own. It is prudent, therefore, to use these powerful agents with due caution, especially in the vulnerable elderly population.

This supplement to *The Journal of Clinical Psychiatry* features 4 excellent articles by some of the leaders in the field. Kumar and Brecher review the topic of typical versus atypical antipsychotics in older patients and present data indicating efficacy as well as safety of

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The symposium "The Use of Newer Antipsychotic Medications in the Elderly" was held July 11, 1997, in Toronto, Canada, and was supported through an unrestricted educational grant from Janssen Pharmaceutica.

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risperidone in the elderly. Dodge and Goldberg discuss the importance of cognitive impairment in the etiopathology of tardive dyskinesia. Harvey focuses on the critical role of cognitive deficits in schizophrenia in relationship to adaptive functioning and the contribution of atypical antipsychotics in this regard. Finally, Bulow illustrates the perspective of a primary care physician in the management of elderly parents with psychosis or severe agitation.

I hope that this supplement will be of use to clinicians treating elderly people with psychotic disorders.

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