Considerations in Continuing Clozapine in an Aging Medically Ill Patient with Treatment Refractory Schizophrenia: A Case Report

Syed Rashdi Ahmed, MD,1,2 Rusty Baik, MD,1,2
1. VA Greater Los Angeles Health Care System 2. UCLA, DGSOM

Background
Clozapine is associated with reduced all-cause mortality for patients with treatment resistant schizophrenia (TRS) (Wimberley, 2017). Clozapine is underutilized in patients with treatment refractory schizophrenia and particularly those with medical multimorbidity (Warnez, 2014). Guidance on managing specific side effects such as agranulocytosis is available through clozapine REMS program; however, managing clozapine in an acutely ill patient is less described. We describe a case of an aging veteran on long term clozapine maintenance and considerations in continuing clozapine during an inpatient medical hospitalization for cancer treatment.

Case
A 82 year-old male veteran with history of treatment refractory schizophrenia, stable on clozapine 400mg nightly for over 30 years, with medical comorbidities including hypertension, Type 2 Diabetes Mellitus, Chronic Kidney Disease stage 3, Asthma, Coronary Artery Disease was admitted for surgical resection of Squamous Cell Carcinoma of right ear. Patient underwent a total right auriclectomy, parotidectomy, and neck dissection. His post operative course was complicated by uncontrolled hypertension, ileus, delirium and a fall resulting in rib fractures treated with rib plating, intensive care unit (ICU) admissions for respiratory failure treated with mechanical ventilation, tracheostomy and subsequently aspiration pneumonia. Patient was maintained on clozapine 400 mg nightly upon admission with a baseline clozapine level of 368 mcg/L. After the development of ileus and in anticipation of interaction with erythromycin prescribed for gastric motility, clozapine was lowered to 300 mg po qhs resulting in a level of 176 mcg/L. Of note, Patient had a history of psychiatric decompensation 2 years prior in the context of clozapine dose reduction to 250 mg nightly with corresponding level of 175 mcg/L during an inpatient hospitalization for symptomatic COVID-19 pneumonia. ANC ranged from 6k-9k. Patient’s clozapine dose was gradually increased with close clinical follow up monitoring daytime sedation, sialorrhea, bowel movement patterns in correlation with clozapine levels.

Discussion
Acute Inpatient hospitalization in a geriatric patient with multimorbidity presents evolving challenges. This case demonstrates some of the challenges of managing clozapine. Beyond monitoring for agranulocytosis, monitoring for side effects such as gut hypomotility, drug-drug interactions ranging from QTc prolongation to effects on clozapine metabolism (Prior, 2003) anticholinergic burden contributing to delirium, sedation burden in context of post-surgical pain management, and aspiration risk are important.

Clinical Considerations

Conclusion
This case demonstrates some of the unique challenges in continuing clozapine during an inpatient admission. Through greater familiarity with these factors, Clozapine: A review of clinical practice guidelines and prescribing trends. BMC Psychiatry. 2014;14:102 psychiatrists can ensure ongoing access to a life saving medication for treatment resistant schizophrenia (TRS).

References