Case Study – Restarting Clozapine in a Patient With Treatment Resistant Schizophrenia

Dr Sabaritha Subramania Pillai and Dr Chris Sage

Kent and Medway NHS and Social Care Partnership Trust, Kent, United Kingdom

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Aims: Clozapine is the most effective treatment in patients with treatment resistant Schizophrenia as recommended by the National Institute of Health and Care Excellence (NICE). This case study aims to explore a patient's journey in mental health services during the relapse of his mental illness and the significance of reconsidering clozapine in patients who responded well to the medicine before.

Methods: 35-year-old male diagnosed with Paranoid Schizophrenia admitted to the acute ward following relapse of his mental illness. He had many admissions under sections in the past and was tried on several antipsychotics. Historically he has shown non-compliance with his medications and poor engagement with the mental health services. In the current presentation, he was found to be floridly psychotic with paranoid and persecutory delusions. He mentioned that people were coming to his flat through the walls and injected him with drugs. He was prescribed clozapine in his last admission as he met the criteria for treatment resistant Schizophrenia. During his stay, we tried him on a combination of non-clozapine antipsychotics due to the history of poor drug compliance. Since he didn't show any response after trying other antipsychotics for a longer period of time, the team decided to restart him with clozapine. Patient showed a good response following this.

Results: In the above case scenario, though the patient previously responded well to clozapine, the team was reluctant to restart clozapine because of the following reasons: history of poor drug concordance, sudden withdrawal of clozapine leads to various side effects like withdrawal associated psychosis and catatonia, cholinergic rebound and rarely it causes serotonergic symptoms. The pharmacological profile of clozapine is complex as it induces a range of neuronal changes at the receptors particularly when taken for a prolonged period of time. Evidence suggests that these neuronal changes are responsible for the occurrence of withdrawal symptoms on clozapine discontinuation.

Conclusion: Evidence suggests that one third of patients with schizophrenia are treatment resistant and clozapine is the treatment of choice for refractory psychosis. Although the literature says that sudden stoppage of clozapine is associated with an array of withdrawal symptoms, it is important to consider restarting the patient with clozapine, especially if they showed a good response in the past. This case study also highlights the good practice for communicating with patients about the significance of clozapine, its effect and withdrawal symptoms due to discontinuation which helps treatment adherence.

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A Case Series Demonstrating the Feasibility of Microdosing as a Bridging Method to Enable a Comfortable and Effective Transition From Prescribed Methadone to Buprenorphine ORT (Opiate Replacement Therapy), Without Initial Methadone Dose Reduction or Cessation, in UK Community Addiction Settings

Dr Zelda Summers, Dr Jennie Rankine and Dr Stuart Fisher

Cardiff and Vale University Health Board, Cardiff, United Kingdom

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Aims: For patients prescribed methadone wishing to access buprenorphine ORT, the current practice is to reduce the methadone dose to 30/40 ml and cessation of methadone for 48 hrs prior to the switch. This exposes these patients to risk of psychological, physical distress or relapse into non-prescribed opiate use.

Using guidance published by the Canadian Journal of Addiction we adapted this to a local UK setting to evaluate its implementation into regular service provision.

We aim to demonstrate effective transition, in a series of patients prescribed methadone onto sl (sublingual) buprenorphine, without adverse effects/precipitated withdrawal or the requirement of methadone dose reduction nor 48 hour abstinence from methadone, in community-based settings.

Methods: We collected outcomes on 12 patients (dose range 26 ml – 90 ml of methadone daily), 12 of whom successfully transitioned from methadone to buprenorphine ORT via buprenorphine Microdosing Bridging Method.

We enquired and assessed for precipitated opiate withdrawal symptoms using a daily modified SOWS/COWS and psychological response throughout the transition period.

Patients were initiated onto buprenorphine initially using transdermal 20 mcg/24 hr buprenorphine patches over the first 48 hrs of treatment, after which urine was tested. Once the urine screen showed buprenorphine, oral initiation of sublingual buprenorphine began on Day 1 at 400 mcg daily and increased according to the following schedule:

Day 2: Usual dose methadone daily, buprenorphine 0.8 mg.
Day 3: Usual dose methadone daily, buprenorphine 1.2 mg.
Day 4: Usual dose methadone daily, buprenorphine 1.6 mg.
Day 5: Usual dose methadone daily, buprenorphine 2.0 mg.
Day 6: Usual dose methadone daily, buprenorphine 4 mg daily.
Day 7: Usual dose methadone daily, buprenorphine 6 mg daily.

Throughout this period, the patients' methadone dose remained at their pre-transition dose. The last dose of methadone was administered when the patients were administered 6 mg sl buprenorphine daily on Day 6. The following day, patients were administered 8 mg sl buprenorphine with subsequent dose titration to achieve optimal daily dose.

Results: 12 patients achieved the transition from methadone to buprenorphine without experience of precipitated opiate withdrawal or adverse psychological effect.