Diagnosis: Schizophrenia

Criteria:
- Characteristic Symptoms: 2 or more for at least one month
  Delusions
  Hallucinations
  Disorganized speech
  Disorganized or catatonic behavior
  Negative symptoms (affective flattening, alogia or avolition)
- Dysfunction
- 6 months duration
- Modifiers
  Paranoid (preoccupation with hallucinations or delusions)
  Disorganized (disorganized speech or behavior, flat or inappropriate affect)
  Catatonic (motoric immobility-waxy flexibility, excessive motor activity, extreme negativism, peculiar voluntary movements-grimacing, posturing, stertotypic, echolalia or echopraxia)

Epidemiology:
- 1% lifetime prevalence
- worldwide and transcultural
- onset in adolescence or early adulthood
- men=women
- men present in early adulthood (early 20s)
- women present later (late 20s to early 30s)
- 3 phases
  acute florid psychosis (insidious onset in up to 50%)
  stabilization decreasing symptoms and possible remission with occurrence of affective symptoms
  stable continuation of positive symptoms

Etiology:
  **Biological:**
  - Post viral theory: winter birth
  - Genetic: increased risk with first degree relatives
  - 50% monozygotic concordance
  - 12% one parent
  - 40% both parents
  **Psychological:**
  - More likely to occur after a stressful event

Differential Diagnosis:
Medical:

- Substance induced
  Amphetamine
  Cocaine
  Alcoholic hallucinosis
  L-dopa
  Anticholinergic drugs (cogentin, artane)
- Neurological
  CNS tumor-temporal
  TLE
  Wilson’s
  Huntington’s disease
  Dementias
  Alzheimer’s
  Pick’s
  Lewy body
- Endocrine
  Addison’s disease
- Acute Intermittent Porphyria
- Infectious
  HIV
  Neurosyphilis
  HSV encephalopathy
  CJ
- Autoimmune
  SLE

Psychiatric:

- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizoaffective
- Delusional Disorder
- OCD
- Paranoid or Schizotypal PD
- Malingering
- Factitious
- Psychotic Depression
- Bipolar Disorder

Work-up:

- Good physical exam
- Consider head CT, labs, LP, EEG
- Family history
- Urine drug screen

Treatment:
Bio:
- Neuroleptics (dopamine hypothesis)
- Atypical neuroleptics (5HT2 and dopamine)
- ECT only in catatonia
- Adverse Drug Reactions (typical neuroleptics)
  - General treatment (decrease neuroleptic, add anti-EPS drugs, change drug)
  - Acute dystonia (benedryl, congentin)
  - Increased risk in young men
  - Extrapyramidal Side Effects (anticholinergics, amantadine)
  - Akathesia (inderal, benzodiazepines, anticholinergic)
- Neuroleptic Malignant Syndrome (bromocriptine, dantraline)
  - Autonomic instability, increased WBC, CPK, lead pipe rigidity, delirium
  - Tardive Dyskinesia (change to atypical)
  - Increased risk: elderly, female, long-term usage, high potency, mood disorder or head injury
  - Expect worsening of TD initially after stopping typical neuroleptic

Psycho:
- Not used alone
- Supportive and focused at first on therapeutic alliance and medication compliance with symptom reduction. Later focus can be social skills and adaptation to illness and environment

Social:
- Family involvement, education, focus to decrease expressed emotion (EE)
- Access to services
- NAMI

Prognosis:
- Variable course
- Better prognosis:
  - Female
  - Family history of affective disorder
  - No family history of schizophrenia
  - Good premorbid functioning
  - Married
  - Onset after a precipitating stressor
  - Positive symptoms
  - Advancing age
- Suicide
  - Leading cause of mortality (10%)
  - Up to 40% attempt
  - Associated with recent depressive symptoms
  - Young, male, early in course and post discharge