We used an individualized approach reducing the dose as much as feasible without recurrent symptoms; some patients discontinued, but most continued to receive a low dose. A fixed-dose approach puts the cart before the horse, returning to nonpersonalized treatment.

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Conflict of Interest Disclosures: None reported.

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Diabetes Risk Potentially Underestimated in Youth and Children Receiving Antipsychotics

To the Editor Analyzing a Medicaid database, Bobo et al[1] found an alarming 3-fold increased risk of diabetes in children and youth receiving antipsychotics, compared with those receiving other psychotropic medications. Increased risk was evident within the first treatment year, increased further with cumulative dose, and remained elevated 1 year after antipsychotic discontinuation. The disturbing findings of this landmark study provide strong evidence for an increasing burden of metabolic disease risk for young people treated with antipsychotics, because the impact of early-in-life diabetes on health and life expectancy concerns all. A further sobering issue is that in this study, as in clinical practice,[2] patients received antipsychotics for conditions where antipsychotics are either not the sole treatment option or where efficacy is unproven.

While an absolute rate of an additional 16 new cases of type 2 diabetes per 10 000 patient years was reported, with a number needed to harm of 633,[1] the study may not have accurately measured diabetes risk. First, controls were receiving other psychotropic medications, some of which also increase diabetes risk. Second, diabetes ascertainment was based on antidiabetic medication use, a serious limitation. Only 1 in 16 participants had "diabetes screening procedures." Without routine screening, only cases with symptomatic frank hyperglycemia were likely to be detected, since the renal glycosuria threshold exceeds 17 mmol/L. It is likely that many cases were not detected and noncases were misidentified. The study's observation that risk increased in the first year suggests antipsychotics either rapidly induce diabetes or rapidly progress undetected diabetes or prediabetes.

Nonetheless, the clinical implications of this article are, in our view, clear. Antipsychotics should be used with caution in children and youth, where indicated, and only when nonpharmacologic interventions and lower-risk nonantipsychotic options have failed. If still required, a low-risk antipsychotic should be selected. Further, routine metabolic complication monitoring is mandatory, as are lifestyle interventions to prevent diabetes.[3-5] Monitoring and preventive intervention should be components of the standard of care, instigated at antipsychotic initiation. Supporting the need for parity of physical health expectations for youth with severe mental illness, the Healthy Active Lives (HeAL) Declaration details principles to prevent premature cardiometabolic disease (www.iphys.org.au/media/HeAL_declaration.pdf), just as the St Vincent Declaration benchmarked diabetes care 2 decades ago.

All clinicians should be concerned about the preventable disease burden associated with antipsychotic use. Until risk-neutral antipsychotics are developed, we urge all medical practitioners to engage in protecting the physical health of young people with mental illness.

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Conflict of Interest Disclosures: None reported.

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