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STRUCTURE AND METHODS OF MODERN THERAPY FOR PARANOID SCHIZOPHRENIA

Resume: The article is devoted to the study of the influence of therapeutic resistance states in patients with paranoid schizophrenia with an attack-progredient type of course on the process of remission formation. Based on a comparative analysis of clinical and catamnestic observation data in patients with signs of resistance to psychopharmacotherapy and without signs of resistance, the authors have identified the main features of the period of remission formation, their duration, quality, and typology. According to the results of the correlation analysis, it was found that in therapeutically resistant patients, remissions are unstable, of poor quality, with an increase in negative symptoms and pronounced social maladaptation.

Keywords: therapeutic resistance, paranoid schizophrenia, psychopharmacotherapy, remissions, psychopathological disorders.

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СТРУКТУРА И МЕТОДЫ СОВРЕМЕННОЙ ТЕРАПИИ ПРИ ПАРАНОИДНОЙ ШИЗОФРЕНИИ

Резюме: Статья посвящена изучению влияния состояний терапевтической резистентности у больных параноидной шизофренией с приступообразно-прогредиентным типом течения на процесс формирования ремиссий. На основании сравнительного анализа данных клинико-катамнестического наблюдения у больных с признаками

устойчивости к психофармакотерапии и без признаков резистентности авторами выделены основные особенности периода становления ремиссий, их длительность, качество, типология.

По результатам корреляционного анализа установлено, что у терапевтически резистентных больных ремиссии отличаются нестойкостью, низким качеством, с нарастанием негативной симптоматики и выраженной социальной дезадаптацией.

Ключевые слова: терапевтическая резистентность, параноидная шизофрения, психофармакотерапия, ремиссии, психопатологические расстройства.

Relevance. Many authors note that in paranoid schizophrenia, which is a characteristic example of a progrediently ongoing endogenous process and requires continuous long-term treatment, therapeutic resistance is observed in a significant number of cases [2,5].

At the same time, an important factor for the development of resistance to therapy is the ratio of positive and negative disorders, which is extremely diverse and depends on both the type of course of the disease and the stage of its development. In the first attacks, bright productive symptoms usually dominate, the condition is characterized by instability, polymorphism of manifestations and a sufficiently high sensitivity to therapy. During the transition to a more advanced course, the severity of negative symptoms gradually increases, the range of actual positive disorders narrows, they become more formed and stable, fluctuations in the state are less frequent.

At this stage, therapeutic resistance is often formed, intensification of psychopharmacotherapy is required, longer periods are needed to achieve the effect. In the later stages of the course of the disease, negative (deficit) symptoms, as a rule, come to the fore, the condition acquires a stable

monotonous character, and positive disorders are simplified and often found in the form of individual individual symptoms or are represented by persistent encapsulated psychopathological formations. As a result of resistance to therapy, patients develop repeated exacerbations of the disease, as a result, the severity of chronic psychopathological disorders increases, a defect condition is formed, most of these patients are repeatedly and repeatedly, in a short time, re-hospitalized in psychiatric hospitals [4,7].

The most unfavorable course of the disease is observed when patients are resistant to antipsychotic drugs. In this case, treatment does not effectively affect psychopathological symptoms and does not restrain the progression of the endogenous process [1,6]. Along with the negative phenomena that occur during the formation of therapeutically resistant states, the long-term consequences are no less important [3,5]. Questions about the influence of resistance to treatment on the degree of progrediency of the schizophrenic process and the clinical and dynamic characteristics of emerging remissions require further study.

The purpose of the study. The aim of the study was to establish the clinical features of remissions in therapeutically resistant patients with paranoid schizophrenia based on a comparative analysis of the duration, quality, and typology of improvement states in patients with signs of resistance to psychopharmacotherapy and without them.

Materials and methods of research. The study was conducted on the material of 63 male patients aged 20 to 55 years (average age – 41.9±9.46 years) with a diagnosis of paranoid schizophrenia in remission. In order to exclude the influence of the gender factor and increase the homogeneity of the studied cohort, the study was conducted only on male individuals. The average age of the disease manifestation was 22.2 ± 4.2 years, the average duration of the disease was 18.9±9.5 years. In the examined cohort, the majority of patients (57.1%; 36 people) had a disease duration of more than 15 years, 11.1% (7

people) - from 10 to 15 years, 17.5% (11 people) - from 5 to 10 years, and 14.3% (9 people) - up to 5 years.

The results of the study. According to the data of the catamnestic study, against the background of maintenance therapy, most of the examined patients showed a further reduction in psychopathological symptoms, which at the same time had certain differences in the studied groups. Evaluation of the PANSS scale indicators in dynamics (3, 6, 12 and 18 months after the end of inpatient treatment) indicated that during the first 3 months, the reverse dynamics of symptoms in both groups was observed mainly on the subscale of general psychopathological syndromes. At the same time, it is significantly significant (according to the degree of reduction) it prevailed in the comparison group - 10.2% versus 4.4% in the main group ($p<0.05$).

Subsequently, the dynamic features of painful disorders in the comparison group were characterized by a certain harmony, when signs of reduction were detected according to the indicators of all subscales - positive (after 6 months - 7.6%, after 12 months - 12.2%, after 18 months -12.9%), negative (4.5, 5.8 and 6.1%) and general psychopathological (12.7, 14.6 and 16.2%, respectively) of syndromes. In the main group, the progressive nature of the reverse development of symptoms was noted only on the subscale of general psychopathological syndromes (8,7, 10,2 and 11,1%), for positive disorders, an undulating type of reduction was characteristic (3,4, 2,9 and 4,8%), and with respect to negative manifestations of the disease, it was possible to talk about stabilization during the first year with a tendency to increase in subsequent (0.2, -0.1% and -1.3%, respectively).

The analysis of the duration of remission states in the groups showed that the average duration was significantly higher ($p<0.05$) in patients without signs of therapeutic resistance -17.4±8.6 months compared with 11.2±9.1 months in therapeutically resistant patients (Table 4). Statistically significant differences were found in the number of patients with short-term remissions: less than 3

months - in 11% of cases in the main group and only 2.9% in the comparison group ($p<0.01$); remissions from 3 to 6 months were also significantly more frequent ($p<0.05$) in therapeutically resistant patients (23.3 and 13.3%, respectively).

The reverse pattern was observed in patients with a remission duration of more than a year (17.8% of cases in the main and 25% in the comparison group - from one to one and a half years ($p<0.05$) and 9.5 and 19.1% - more than one and a half years ($p<0.01$), respectively).

The comparative analysis of the achieved remission states according to the main clinical manifestations was based on the systematics proposed by A.B. Smulevich (2006). In the main group, symptomatic (incomplete, with persistent positive symptoms) remissions prevailed statistically significantly ($p<0.05$) - 52.1% versus 33.8% in the comparison group (Table 5).

Accordingly, syndromic, indicating a sufficiently high effectiveness of therapy, remissions were significantly more frequent ($p<0.05$) in the comparison group of 66.2%, whereas in the main group they were observed only in 47.9% of patients. Statistically significant differences were found in the following clinical types of remissions: in the main group, paranoid and asthenic variants were noted more often than in the comparison group (31.5 vs. 8.8%, $p<0.01$ and 16.4 vs. 7.4%, $p<0.05$); pseudopsychopathic remission was significantly less common (20.6 versus 41.2%, respectively, $p<0.01$), the stenotic type was observed only in the comparison group (8.8% of cases).

As for the level of adaptive capabilities of patients, the selected clinical remission options can be ranked as follows. Sthenic, hypochondriac and obsessive remissions were attributed to favorable, they were significantly more frequent ($p<0.01$) in patients in the comparison group - 19.1% versus 5.6% in the main group. Less favorable (autistic, timopathic, psychasthenic) variants also prevailed in patients without signs of therapeutic resistance (55.9 vs. 35.6%, $p<0.05$).

Unfavorable (paranoid, asthenic, apathetic) types were characteristic of the patients of the main group, they accounted for more than half of the observations (58.9%), whereas in the comparison group - only 25% of cases ($p<0.01$). Comparison of the main characteristics of the social status (labor intensity, presence/absence of a disability group, family well-being, material security, the nature of the microsocial environment) of patients during the period of catamnestic observation allowed us to judge the severity of social maladaptation (Fig. 2). It is noteworthy that in the main group about half (47.9%) of patients had pronounced signs of social distress and when compared with the comparison group, in which this indicator was 23.5% of observations, significantly ($p<0.01$) prevailed. Significant, statistically significant differences were also found in the indicators of unexpressed (14.7% in the main versus 30.4% in the comparison group, $p<0.01$) and moderate (37.4 versus 46.1%, respectively, $p<0.05$) social maladjustment. Of course, an important influence on the formation of remission was exerted by such indicators as the regularity and nature of supportive therapy, compliance with the monitoring regime in the neuropsychiatric dispensary, compliance. In the main group of patients, psychopharmacotherapy in outpatient settings was carried out in 35.6% of cases with atypical antipsychotics and in 64.4% with traditional neuroleptics (about half of them received treatment with prolonged forms). In the comparison group, atypics were used somewhat less frequently (26.5% of cases), traditional neuroleptic therapy was carried out in 73.5% of patients, prolongations were used in a third of them. In some cases, neuroleptic therapy was combined with thymoanaleptic drugs.

When assessing the regularity of receiving maintenance therapy, attention was drawn to the fact that in the main group during the first 3 months of outpatient follow-up, patients in 78.1% of cases followed the recommended regimen of taking medications and visits to a district psychiatrist, subsequently this indicator steadily decreased and amounted to 56.2% after 6 months, 45.2%

after 12 months, 18 month - 39.7%. A slightly different trend was observed in the comparison group.

Thus, the majority of patients (76.5%) regularly took maintenance treatment during the first six months, then their number decreased slightly and amounted to 54.4% by the year, and in subsequent follow-up periods it practically did not change.

Conclusions. Thus, the data obtained indicate that states of therapeutic resistance have a distinct negative effect on the process of remission formation in patients with paranoid schizophrenia. In patients who show signs of resistance to psycho-pharmacotherapy, remissions are characterized by a less persistent nature, poor quality and a tendency to increase negative symptoms, indicating an increase in the progrediency of the disease. It has been established that these negative consequences practically do not depend on the regularity of supportive treatment and the nature of psychopharmacotherapy.

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