

TD Podcast Series

Episode 1: Recognizing Tardive Dyskinesia: Symptoms and Screening

Length: 18:35 min

Script

**TITLE** Recognizing Tardive Dyskinesia: Symptoms and Screening

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**LEARNING OBJECTIVES:**

- Define TD and learn its signs and symptoms
- Understand the importance of regular TD assessment and recognition
- Discuss best practices for TD screening in person and in telehealth settings

**SCRIPT**

*Intro*

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*Opening*

**GM-** Hello, everyone, and welcome to our podcast!

I'm Gaetha Mills, a registered nurse with a certified neuroscience certification I've held for over 15 years. I've worked at a level 1 trauma hospital in Denver, Colorado in various neurological positions for 20 years. I currently manage the movement disorder program for our medical center and I work side by side with our functional neurosurgeon in the operating room to care for patients with medically refractory movement disorders including tardive syndromes.

**DM-** And I'm Desiree Mathews, a board-certified psychiatric nurse practitioner with seven years of experience working in community mental health, caring for adults with severe and persistent mental illness. Currently, I am based out of Charlotte, North Carolina and am the founder and CEO of Different MHP, a mental health practice providing telepsychiatry services to adults.

Today, we would like to dig deeper into tardive dyskinesia, or TD, an often underrecognized condition. In this podcast, we'll be exploring the various ways that TD can present in patients, the proactive role anyone can play in spotting the signs and symptoms, and our practical tips for screening patients for TD, whether it's in person or in a telehealth setting.

## ***Intro to TD – Definition and Risk Factors***

**GM-** Well let's start out by defining TD: according to the DSM-5-TR, TD is classified as a movement disorder characterized by abnormal, involuntary, repetitive movements of the tongue, jaw, trunk, or extremities, and it can develop with the prolonged use of dopamine-receptor blocking agents.

**DM-** That's right, Gaetha. So when we say dopamine-receptor blocking agents or DRBAs, we're talking about antiemetics such as metoclopramide, and antipsychotics that can be used to treat different psychiatric disorders like schizophrenia, bipolar disorder, and major depressive disorder.

**GM-** And here's the thing, with antipsychotics recently getting expanded indications and other off-label uses, the number of people at risk for developing TD is on the upswing. And while anyone exposed to antipsychotics can develop TD, there are also treatment- and patient-related factors that are associated with an increased risk.

**DM-** Absolutely, cumulative exposure and potency of the antipsychotics, increased age, anticholinergic treatment, a mood disorder diagnosis, and history of substance use disorder, are all risk factors for TD. So for all patients receiving antipsychotics, it's crucial that we keep our eyes peeled for any abnormal movements, especially for those who hold any of these risk factors.

**GM-** Regular monitoring is definitely key here.

## ***Visual Cues for TD Symptoms***

**DM-** So, the big question is, how do we recognize these TD movements? What do they look like and what should we be looking out for?

Well, the signs and symptoms of TD may typically include oro-buccal-lingual movements such as tongue twisting and protrusion, or lip smacking and puckering. You might also see some chewing or clenching movements in the jaw, which can look like as if someone is chewing on gum or sucking on hard candy. It's important to remember that TD can occur in one body region or in multiple body regions, which is quite common.

**GM-** I agree, I commonly see those abnormal movements of the facial muscles accompanied by choreic or dance-like movements in other body parts such as the limbs and the trunk. One classic TD symptom that comes to mind are the finger movements, which resemble the actions of playing the piano, hence the name, "piano playing fingers." This piano-playing movement isn't just limited to the fingers; they can be seen in the toes too.

**DM-** Good call out, it's easy to miss the toes!

**GM-** Absolutely. Foot tapping, flexion and extension of the limbs are other TD symptoms we should be looking out for. Oh, and let's not forget about the trunk; when TD occurs in the

truncal area, it may look like the patient is swaying side to side or shrugging their shoulders. What all these movements mentioned have in common is that they are involuntary, meaning that the patients are unable to suppress them for an extended period of time.

**DM-** You're right. Patients can't turn these movements off. TD symptoms are what I like to call "regularly irregular": the frequency at which these movements occur is irregular and not predictable from moment to moment as TD is known to wax and wane. Because of this, it can be helpful to observe the patients in different settings, at different times, such as when they are under stress versus when they aren't, or when they are distracted watching TV or walking.

**GM-** Yes and identifying these visual cues can be a bit tricky, given that TD manifests differently for each individual. Moreover, TD represents just one condition under the umbrella of other movement disorders caused by DRBAs. This underscores the importance of understanding how to differentiate DRBA-induced movement disorders from one another.

### ***Differential Diagnosis Based on Visual Cues – TD & Drug-Induced Parkinsonism***

**DM-** Great point, Gaetha. Let's delve into this a bit more. Let's take TD and drug-induced parkinsonism for instance. Without the right knowledge, differentiating symptoms between them can be quite challenging at first. Drug-induced parkinsonism, or DIP, is a DRBA-induced movement disorder that can be characterized by symptoms such as tremors, muscle rigidity, reduced blinking, drooling, and bradykinesia, which essentially means a slowness of movement; a kind of sluggishness that limits a person's ability to initiate and complete movements. You might also see that classic resting tremor of DIP not just in the extremities but also in the chin, which we often call the "rabbit syndrome" in practice.

**GM-** One key point that I always like to emphasize is the nature of tremors in DIP. These tremors exhibit regular, rhythmic movements that are consistent and predictable. In contrast, TD movements are irregular and repetitive, but not rhythmic.

**DM-** These distinctions are so crucial. In my clinical experience, I've encountered numerous cases where patients with TD symptoms were misdiagnosed as having DIP and subsequently treated incorrectly with anticholinergics.

**GM-** Oh, that's really unfortunate, considering that anticholinergics can actually worsen TD symptoms.

**DM-** Exactly, this is why differential diagnosis is so important since each movement disorder has its own unique presentation and distinct treatment recommendations.

Well, I know we've been focusing on the physical symptoms of TD, but I'd like to touch on the broader impact of TD that can extend beyond these abnormal movements.

### ***Impact of TD On Patients***

**GM-** Absolutely. On top of the physical symptoms, TD can significantly impact a patient's overall quality of life and well-being. Patients with TD may experience functional challenges in their daily life, such as having trouble standing, walking, or eating. Simple activities like getting dressed, putting on makeup, or playing card games can become difficult when you're faced with these abnormal movements. These functional limitations, in turn, can extend to social and emotional burdens, compounding the challenges they face.

**DM-** Yeah, I certainly agree with that. TD has a lot of impact on patients beyond the movements themselves. It reminds me of one patient of mine, a gentleman who was living with schizophrenia since his 20's and was very stable on his antipsychotic.

Unfortunately, during the pandemic, he started developing abnormal movements and his primary care doctor diagnosed him with TD, telling him it was likely due to his medication. So he stopped taking his antipsychotic, and, obviously, had a relapse of his schizophrenia symptoms. He eventually was put back on his antipsychotic but his TD had gotten even worse.

He had tongue movements, "piano-playing" fingers, but worst of all, he was experiencing chewing movements that led him to chew on the inside of his cheeks, which eventually resulted in developing painful scar tissue in his mouth that made it difficult for him to eat. As a result, he lost a lot of weight and his mental health deteriorated to the point where he became very depressed, refusing to leave his house.

Good news is that, when he came to me, we were able to successfully treat his TD using a first-line recommended vesicular monoamine transporter 2, otherwise known as a VMAT2 inhibitor while still maintaining control of his schizophrenia with the antipsychotic. His chewing movements improved significantly, which allowed for an oral surgeon to remove the scar tissue, and he healed up quite well. His experience demonstrated to me the multi-faceted burdens of TD. It really makes me think how if we had recognized and addressed his TD earlier, we may have been able to prevent those outcomes.

**GM-** Wow, thanks so much for sharing that with us Desiree.

### ***Who Can Recognize TD***

**DM-** Of course. Well now that we've talked about the importance of timely TD recognition, who should be looking out for these signs and symptoms in patients at risk for TD?

**GM-** That's a great question. I believe that anybody interacting with the patient can play a role in identifying TD. In the clinical setting, it could be the doctors or nurses, but even student interns or medical assistants can be instrumental in early detection.

I recall a time when a certified nursing assistant approached me, expressing concern about a patient doing something unusual with their face. When I went to go see the patient, we discovered that it was TD. Despite not having any formal training in movement disorders, they

were able to raise awareness about the patient's abnormal movements and help get prompt and appropriate treatment for the patient.

**DM-** That's a powerful example. I've encountered similar situations in my past when I worked with a lot of group homes where many of the patients were at risk for developing TD due to antipsychotic use. We took a comprehensive approach and made it a point to educate not just the physician assistants and nurse practitioners, but all the staff members, including the front desk personnel, on the signs and symptoms they should be looking out for, since they interact with the patients every single day. While we didn't expect them to diagnose, they became our extra set of eyes, noticing movements that might otherwise go unnoticed.

**GM-** That's such a great initiative. I also think anyone in a patient's inner circle could potentially recognize TD. As we continue to highlight TD and educate the public more about it, this may enable a patient's friends and loved ones to notice some of the symptoms. I've had patients' caregivers share observations like, "I keep thinking that they have something in their mouth," bringing attention to TD symptoms that might have otherwise slipped by.

**DM-** And that's why I always like to say, if you observe something unusual, don't hesitate to speak up and bring it to the attention of a clinician.

**GM-** Exactly! Early TD recognition is a team effort, and every member can play a crucial role. I wholeheartedly agree that anybody can recognize or at least be on the lookout for abnormal movements that could be consistent with TD.

### ***Best practices for screening for TD***

**DM-** Now, for those of us who do conduct the more formal assessments for TD, would you mind sharing some of your best practices for TD screening, Gaetha?

**GM-** Well, first and foremost, I believe that all health care providers should be proactive about recognizing and treating TD by making screening a part of their clinical routine for all patients on DRBAs. The American Psychiatric Association actually recommends regular assessments for TD in all patients taking antipsychotics at every clinical encounter, and they recommend using a structured clinical exam, like the Abnormal Involuntary Movement Scale, or AIMS, at least once a year, and at least every 6 months in patients at a higher risk of TD.

I know that in the reality of our practice, we tend to be busy, but remember that we don't necessarily need to do a full AIMS score assessment at each visit. We can incorporate more informal assessments during patient visits, and these can take less than 3 minutes to conduct if that's all the time we have!

**DM-** I agree. And these screenings can become part of your check-up routine, starting right from when the patient is in the waiting room. When I am working in-person, I'll purposely go retrieve a patient from the waiting room and take a moment to peer in and look for any abnormal movements; looking at not just my current patient but also my next patients who

may be sitting there. Walking the patient to my office also gives me the opportunity to observe for any unusual movements. So it doesn't have to be a full on AIMS assessment, but I find value in doing something like that each time, even if my time with the patient is limited.

**GM-** I think that's a really good point. Walking them into the office is such an easy way to observe patients before they even know they're being assessed, and that can potentially help unveil any TD symptoms that may be suppressed during a more formal assessment.

In the actual exam room, I like to first ask my patients to remove their shoes and socks so I can see any foot or toe movements. I'll then have them sit upright on an armless chair and have them perform a mental task such as counting backwards by threes from 100 or something similar which serves as a distraction technique; while they do so, I'll conduct a body scan from top to bottom, assessing their face, shoulders, arms, trunk, legs, feet, and toes for any abnormal movements.

**DM-** What type of conversations do you like to have with the patient when performing these screenings?

**GM-** Well, on top of the physical assessments, it's important to dig deeper and ask the patient questions for a more comprehensive TD screening. I'll ask specific questions that could help reveal any functional impairments that they may be experiencing, since often times they may not realize that it is their TD that's causing those difficulties. I'll ask questions such as "Do you ever feel like you grit your teeth or have trouble swallowing?" "Do you have difficulty buttoning up your shirt?"

**DM-** That's so important. In my experience, I've noticed that patients find it helpful when I remind them that I'm asking these questions because their mental health medications can sometimes cause these types of movement issues, and that my goal is to take good care of them.

**GM-** I fully agree. One really great resource that I like to use when prompting these discussions is the MIND-TD questionnaire, which provides questions to help facilitate a dialogue about abnormal movements with your patients at risk for TD. It's a useful tool that can be found on [www.mind-td.com](http://www.mind-td.com) and can be used in person or remotely.

Speaking of remote appointments, we are seeing more and more of these, especially since the COVID pandemic. Desiree, aren't you primarily treating most of your patients through telehealth these days? Could you share with us some best practices for the telehealth setting?

### ***Screening for TD in telehealth settings***

**DM-** Yeah, of course. One non-negotiable for my telemedicine appointments is having both video and audio from my patients.

**GM-** Yes, in my experience, I've found that these virtual appointments may require just a bit more flexibility. If a patient's internet goes down, then we'll need to reschedule their telehealth appointment, as a phone call just won't be enough for an accurate assessment.

**DM-** Exactly. I'll ensure that my patients are informed ahead of time, so that they come prepared with essentials such as good lighting, a hard chair to sit in, and a high-speed internet connection. When I'm planning on doing a more structured full body assessment like the AIMS, I'll firstly make sure to schedule these appointments well in advance. I'll also coach them through what an AIMS assessment will look like through telemedicine and following up with a reminder such as, "Remember that I'm going to see you in one month and we'll be doing an AIMS exam. It would be helpful if your wife could be there to hold the camera for us for just a few minutes of the appointment."

Having a care partner there during the exam is incredibly valuable as they can help with the assessment by adjusting the camera as needed for the patient. But if one is not available, I'll work with the patient to set up a stable surface using a stack of books or a water bottle to prop up their phone. I'll often have them do this on a kitchen counter or a similar surface since it provides an ideal height for viewing and assessing the patient through the camera.

And of course, we have to keep in mind that when relying on a phone or laptop camera, these assessments may take a bit more time to focus on one body part at a time, compared to the efficiency of an in-person visit. If a patient is not suitable for telemedicine appointments, I would recommend that they see an in-person clinician for an exam at the proper intervals based on their individual risk and APA guidelines.

**GM-** Thanks so much for all those insights. That's very helpful.

### ***Conclusions/Wrap up***

**DM-** Of course. Well, that brings us to the end of this podcast. I hope our listeners here feel empowered that anyone can play a role in spotting TD and hopefully, have taken away a few valuable tips on how to screen for TD in-person and remotely.

**GM-** Remember that early recognition of TD is crucial in helping to address and mitigate its multi-faceted impact on patients. Healthcare providers can take a proactive approach by incorporating regular screenings as part of their routine for all patients on DRBAs. Anytime you spend observing for these movements is incredibly valuable if it means potentially catching it in a patient and initiating early treatment.

**DM-** Absolutely. Thank you all so much for joining us today on this important journey of tardive dyskinesia education and awareness!