MAUDSLEY LEARNING WEBINAR SERIES:
The Psychiatry of Pandemics

Webinar 3: The Psychopharmacology of COVID-19 - Q&A

12th May 2020

Speaker panel:

- Dr Sotiris Posporelis
- Dr Siobhan Gee

To watch the webinar recording, click here.

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Question 1: Are Vitamin D supplements recommended in children?

Answer:
(Dr Siobhan Gee):
The data we have on the risk of respiratory infection with low vitamin D levels pertain to adults. The data on severity of COVID-19 infection and vitamin D levels are also in adult patients. The NHS recommends that adults and children over the age of 5 should be given 10mcg vitamin D daily (outside of the current pandemic).

Question 2: With regards to vitamin D is there sufficient evidence to supplement mental health patients who don't have psychosis e.g. bipolar or depressed patients?

Answer:
(Dr Siobhan Gee):
We are recommending that all adult mental health inpatients should receive vitamin D supplementation. The data on the severity of COVID-19 and vitamin D deficiency applies to all adults, regardless of a mental health diagnosis.

Question 3: There are some suggestions in the press that smoking protects against contracting COVID-19, and it may be because of the nicotine it contains. This is an exciting avenue for research: if NRT proves to be protective against COVID-19 it bodes well for our inpatients... Is there any evidence to support these suspicions?

Answer:
(Dr Siobhan Gee):
Surprisingly low levels of smoking have been observed in published Chinese COVID-19 positive cohorts (around 10%). It has been suggested that the nicotinic-acetylcholinesterase receptor may be involved in the hyperinflammatory response seen in some patients with COVID-19 infection, and that nicotine would prevent this. Smoking cigarettes causes significant harm to health, largely due to the inhalation of tar and other chemicals. Drugs targeting nicotinic receptors may play a future role in COVID-19 treatment or prevention, but cigarette smoking should still be discouraged.

Question 4: What about Vitamin D and Mediterranean paradox, I mean is any benefit to use Vitamin D supplement in Mediterranean region the COVID period? And in what dosage?

Answer:
(Dr Siobhan Gee):
I am not aware of data specifically looking at vitamin D levels in patients living in Mediterranean countries. The data we have relate to those living in the UK. Data on the severity of COVID-19 and vitamin D deficiency are coming from countries outside the UK where you would expect sunnier weather (Indonesia, the Philippines) but they did not measure vitamin D levels in the total population (only in those already with COVID-19) and we don't have a breakdown of numbers for patients with mental illness. At the Maudsley we are recommending 4000 IU daily for 4 weeks.

Question 5: Is the recommendation to give vitamin D to all patients with psychosis only for patients with deficiency or insufficiency, or everyone regardless (i.e. even if serum vit D is sufficient)?

Answer:
(Dr Siobhan Gee):
The recommendation is to replace vitamin D in the presence of a deficiency or insufficiency, not to necessarily oversupplement people with normal vitamin D levels. However, it is practically difficult and potentially dangerous to take plasma levels for all patients at the moment. We are recommending that ideally, patients should have a plasma level taken first. If this isn't possible, then patients should receive vitamin D supplementation regardless of the absence of a level. Note that the NHS recommends that all UK residents should take a vitamin D supplement over the winter months (until late March/early April) without requesting a plasma level first.

Question 6: Is there a set dose for vitamin D when using as prophylaxis? What is the management of oral hypoglycaemics for Type 1 diabetics? Does COVID have an effect on thrombosis?

Answer:
(Dr Siobhan Gee):
The NHS recommends that all UK residents should take a vitamin D supplement over the winter months (until late March/early April), at a dose of 10 mcg daily. At the Maudsley we are recommending a dose of 4000 IU daily for 4 weeks for inpatients; this is a loading regimen that then does not require patients to continue to obtain vitamin D after the regimen is finished.

Diabetes, alongside cerebrovascular and cardiovascular disease, is one of the comorbidities more often found in patients who die from or suffer severe symptoms of COVID-19. Patients with COVID-19, in common with other infections, are likely to experience poor glycaemic control. There are as yet no data describing blood glucose levels in patients taking clozapine who have COVID-19 infection, but it is likely that these will increase.

I recommend that patients taking clozapine who have COVID-19 and a comorbid diagnosis of diabetes and who usually monitor their blood glucose at home should do so more frequently.

Consider the risk of blood glucose fluctuations in all patients taking clozapine who have COVID-19; advise patients of signs of hyper- and hypoglycaemia.

Patients with severe COVID-19 infection appear to be at increased risk of thrombosis. All inpatients should be assessed on admission for the risk of VTE (see NICE guideline 89). Patients who have reduced mobility plus another risk factor should receive anticoagulation. Risk factors include antipsychotics, and you may consider COVID to also be in this category.

Question 7: Vitamin D, East London Trust did audit, and they have policy to treat patients with Vitamin D prophylactically. Is there more evidence to support this hypothesis? Our place does not have any such policy yet. Hence why I am asking for vitamin D to be tested (inpatient admission). Is it possible to share evidence from Maudsley to share with our trust KMPT?

Answer:
(Dr Siobhan Gee):
We are happy to share our guidelines.

Question 8: Please could you comment on clozapine initiation: given that COVID is likely to be around for a while, can we realistically avoid initiation for those who need it?

Answer:
(Dr Siobhan Gee):
Starting clozapine in a patient who has, or is at risk of contracting, COVID-19 is potentially complicated by an overlap of COVID-19 symptoms and clozapine side-effects. It is not known whether clozapine itself affects the risk of contracting or developing complications of COVID-19. Particular difficulties with initiating clozapine (especially for the first time and particularly in community settings) during the COVID-19 pandemic include:

• The need for regular monitoring of vital signs necessitates increased contact with staff, increasing the risk of viral spreading

• Reduced ability to perform daily vital sign monitoring due to staffing restrictions risks missing signs of rare but serious complications (myocarditis, sepsis secondary to agranulocytosis)

• An overlap between the symptoms of COVID-19, benign side effects of clozapine and serious adverse effects of clozapine leading to diagnostic confusion

• An increased risk of developing pneumonia in general on clozapine treatment and specifically in the initial stages of treatment may increase the risks associated with contracting COVID-19, although no specific evidence is yet available.

I recommend that clinicians carefully evaluate the risks and benefits of clozapine initiation. The potential benefit to patients and families should be considered, acknowledging that no other drug treatment is likely to be as effective for symptom relief as clozapine could be. Further, failure to effectively treat psychosis may cause particular problems with managing mentally unwell patients during times of social distancing, added pressure on acute and mental health services, reduced staffing capacity and restricted inpatient bed availability.

<u>Recommendations</u>

• Avoid prescribing paracetamol for (the common and benign) clozapine-induced fever during initiation. This may mask symptoms of COVID-19.

• Consider carefully the risks versus the benefits of initiating clozapine, particularly for the first time and in community settings.

Question 9: VTE: we are testing new admissions. If mobility is less do, we initiate anticoagulant? (COVID – known for notorious thrombosis).

Answer:
(Dr Siobhan Gee):
Patients with severe COVID-19 infection appear to be at increased risk of thrombosis. All inpatients should be assessed on admission for the risk of VTE (see NICE guideline 89). Patients who have reduced mobility plus another risk factor should receive anticoagulation. Risk factors include antipsychotics, and you may consider COVID to also be in this category.

Question 10: In asymptomatic COVID-positive patients, any specific psychiatric aspects noted?

Answer:
(Dr Siobhan Gee):
Please refer to the other webinars in this series discussing the neuropsychiatric aspects of COVID-19. I am not aware of any specific medication-related issues in asymptomatic patients, other than the potential for clozapine (and other drug) plasma levels to rise.

Question 11: Please can you provide opinion on pregnancy and psychopharmacology?

Answer:
(Dr Siobhan Gee):
Taking psychotropic medication during pregnancy is a balance of risk versus benefit, and each case should be considered individually. Please refer to the Maudsley Prescribing Guidelines for detailed advice on different conditions and medications.