expected TD diagnosis rates per 1000 patients with an AP prescription at the MSA level. Estimated and expected TD diagnosis rates were aggregated at the state level. Underdiagnosis of TD was defined as the observed TD diagnosis rate being lower than the expected TD diagnosis rate.
Results. Among 572,314 people who met inclusion criteria, the mean observed TD diagnosis rate across 341 MSAs was 3.10 per 1000 patients with an AP prescription; 86 (25.2%) MSAs had no patients with a TD diagnosis. Over 50% of MSAs and states had an underdiagnosis of TD. MSAs with the highest expected TD diagnosis rates were Missoula, MT (5.47), Billings, MT (5.39), and Madison, WI (5.16). MSAs with the highest observed TD rates were Chambersburg-Waynesboro, PA (18.52), Napa, CA (13.70), and San Angelo, TX (13.07). MSAs with the largest negative differences between observed and expected TD diagnosis rates (ie, highest underdiagnosis rates) were Missoula, MT (−5.47), Billings, MT (−5.39), and Gainesville, FL (−4.39). States with the highest expected TD rates were Montana (5.28), Idaho (4.52), and Alaska (4.32). States with the highest observed TD rates were North Dakota (7.09), Idaho (5.85), and New Mexico (5.67). States with the highest underdiagnosis rates were South Dakota (−3.72), Vermont (−3.57), and Montana (−3.21).
Conclusions. Overall, this study showed that TD was underdiagnosed in >50% of US geographic regions. This research highlights opportunities for improved TD recognition in areas with TD underdiagnosis.
Funding. Teva Branded Pharmaceutical Products R&D, Inc.

A Literature Review of Antipsychotic-Associated Obsessive-Compulsive Disorder/ Obsessive Compulsive Symptoms in the Treatment of Schizophrenia

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Introduction. Co-occurrence of Obsessive compulsive symptoms (OCS)/Obsessive Compulsive disorder (OCD) and psychotic disorders is not uncommon affecting approximately 20% of the patients with psychotic disorders. The clinicians sometimes fail to recognize the comorbidity of these two conditions due to the overlapping symptoms and also due to under reporting by the patients until the symptoms become very severe. Timely recognition and treatment of obsessive symptoms are crucial for improving the outcomes of psychotic episodes. Our review aims to study the role of antipsychotics in causing OCD/OCS in schizophrenia. We also discuss the etiologies, pathophysiology, and treatment of OCD/OCS in schizophrenia.
Methods. A comprehensive literature search was conducted on PubMed and Google Scholar to identify relevant articles published between 2013-2023. The different search terms were "(Antipsychotics)", "(OCD in schizophrenia)" with connector AND. All review, case control, cohort, cross sectional, observational studies were included for the literature review. Based on the relevance of the topic and removal of duplicates, we chose 61 articles.
Results. The literature review revealed that several mechanisms could explain the temporal links between OCD/OCS and schizophrenia. Genetic factors, such as SLC1A1, BDNF, DLGAP3, and GRIN2B genes, have been studied. Serotonergic dysfunction in the cortical, striatal, and thalamic networks has been proposed by OCD pathogenic theories, supported by the therapeutic effects of SSRIs and CBT. Antipsychotic medications, particularly Clozapine, have been associated with a higher prevalence of OCS/OCD during treatment. Some second-generation antipsychotics, like risperidone and olanzapine, have also been linked to new-onset OCS. Treatment options for OCS/OCD in schizophrenia include SSRIs, atypical antipsychotics like Aripiprazole, Amisulpride, or Lamotrigine, CBT, and ECT.
Conclusion. Several studies have examined the link between the presence of OCS in relation to the use of antipsychotics. Among the APAs, the frequency of OCS/OCD is more in the patients using antipsychotics which have more anti serotonergic properties as compared to the ones having more anti dopaminergic properties. Of the second-generation antipsychotics, Clozapine, Olanzapine and Risperidone are the ones being documented most frequently, with clozapine being the most frequent. A dosage-dependent side effect may also be present based on correlations between OCS severity, dose, serum levels, and treatment duration. Various treatment approaches have been suggested, but further research is needed to determine the most effective strategies for managing OCS/OCD in schizophrenia. Clinicians must be aware of the potential comorbidity of these conditions to provide better care and improve patient outcomes.
Funding. No Funding

https://doi.org/10.1017/S1092852924001810 Published online by Cambridge University Press