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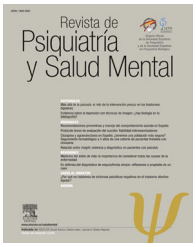

LETTERS TO THE EDITOR

Spanish consensus on the risks and detection of antipsychotic drug-related hyperprolactinaemia: Is there convergence with other clinical guidelines for the management of hyperprolactinaemia?☆

Consenso español sobre los riesgos y detección de la hiperprolactinemia iatrogénica por antipsicóticos: ¿existe convergencia con otras guías clínicas de manejo de la hiperprolactinemia?

In a recently published expert consensus on hyperprolactinaemia,[1] treating levels of prolactin higher than 50 ng/ml or levels with clinical impact is recommended. For levels higher than 100 ng/ml, it is specified that these cases should always receive intervention even though there is no amenorrhea-galactorrhea, because of the medium/long-term risk of osteoporosis, cardiovascular disease and possible increase in factors of risk for breast or endometrial cancer.

It is surprising to see that some recommendations depart from other national and international clinical guidelines that recommend treating only symptomatic hyperprolactinaemia. For example, other clinical guidelines for managing hyperprolactinaemia that include drug-related hyperprolactinaemia, such as those of the expert consensus from the Endocrine Society[2] and the Spanish Society of Endocrinology and Nutrition (Spanish acronym: SEEN),[3] recommend not treating asymptomatic hyperprolactinaemia. The indication for treatment based on the choice of a cut-off point in the analytical analyses, as recommended in this recent consensus,[1] departs from other clinical guidelines developed by endocrinology societies.

An important aspect of managing antipsychotic-drug-related hyperprolactinaemia is controlling bone mass and establishing preventative measures to avoid the risk of osteoporosis. A strategy that should be evaluated in cases with chronic hypogonadism (symptoms of hypogonadism or decreased bone mass) is administration of estrogen or testosterone supplements. This therapeutic option (recommended in the guidelines of both the la Endocrine Society[2] and the SEEN[3]) has only been developed slightly in the Spanish consensus, which focuses more on intervening in the antipsychotic treatment.

As for the role of hyperprolactinemia in the risk of some cancers, such as breast cancer, this is a controversial matter. Although *in vitro* studies suggest that prolactin stimulates cellular proliferation, survival and migration of cancerous breast cells,[4,5] systematic reviews and meta-analyses of human-based studies suggest that there is no relationship between hyperprolactinaemia and breast cancer risk.[6,7] Given that there is a local secretion of paracrine-form prolactin (dopamine independent), the studies that have explored prognostic aspects of breast cancer at tissue level cannot be extrapolated to the effects of systemic hyperprolactinaemia (plasma levels of elevated prolactin). Besides, in some of the studies reporting associations between prolactin levels and breast cancer, such as in the EPIC cohort,[8] the relationship is limited to the women receiving hormone replacement therapy (RHT) at the time of the study. Because RHT is a known risk factor for breast cancer,[9] it is consequently a poor idea to generalize the results on prolactin figures in a subsample of patients receiving this treatment to the population of patients with schizophrenia that receive antipsychotic treatment. As some authors defend,[7] other risk factors for breast cancer such as nulliparity, obesity, diabetes mellitus and an unhealthy life style (drug, alcohol or tobacco use, limited physical activity) probably play a more relevant role than prolactin if we focus on the risk of breast cancer in women with schizophrenia.

I completely agree with the consensus on the importance of controlling complications of chronic hyperprolactinaemia, such as hypogonadism, the risk of osteoporosis (by performing bone densitometries) and sexual dysfunction. In many cases, these adverse effects are present but not evident unless they are explored in detail. For this reason, it is important to act at the therapeutic point of view considering the impact of hyperprolactinaemia on each patient (especially in the case of symptomatic

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hyperprolactinaemia) instead of placing a prolactin plasma value above this. Considering the current scientific evidence, we should be prudent when generating conclusions about some risks such as the association between antipsychotic drug-related hyperprolactinaemia and the risk of cancer, because the studies on this matter show inconsistent results.

Conflicts of interest

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Shared decision making in mental health: Myths, barriers, and benefits☆

Las decisiones compartidas en salud mental: mitos, barreras y beneficios

Sirs,

Shared decision making consists of an interactive clinical relationship process in which the professional helps their patients to choose the best treatment considering their values, preferences and clinical circumstances. Many myths have been considered about this type of healthcare relationship (the patient finally decides himself or herself, or they even let the professional make the decision, they do not want to get involved, etc.).[1] In addition, barriers have been found in the professionals that make applying it difficult, such as the concern that psychiatric patients might not be competent to decide for themselves.[2] However, perhaps the most significant problem is that of insight.[3] Such difficulties can also be seen in the patients: passive patients, ones not interested in the decision or those who think that their negative response constitutes in itself an *active attitude*.[4] At any rate, all of this can represent a paternalistic stance.[5]

In spite of this, reality shows that applying shared decision making in the sphere of mental health leads to an increase in the patients' quality of life, better communication with the professionals and, consequently, better therapeutic alliance and even greater drug adherence.[6]

But it is important not to think that the process stops with merely giving information about the various treatments and their adverse reactions. Deep down, patients want to be heard and to have their desires incorporated in the decision. That means that the professionals need to have communication skills to improve this shared decision: motivational interviews, negotiation processes, etc.[6] Although this is not an easy task, a tool to make it possible to ascertain and evaluate how the decision was taken has been created and validated in Spanish.[7] It consists of a 9-question test given to the patient about the experience he or she has had in the consultation with the professional.

It is understandable that there are clear situations in which a paternalistic model is justified, such as ''life or death'' decisions or those in which the ''best interest'' may be applicable.[6] However, the objective has to be promoting decision making shared with the patients. A valuable way to encourage them to decide is by anticipation of the decisions, such as (for example) an advanced directives document, which has also been shown to have positive effects (both clinical and ethical).[8]

Consequently, we have to urge the professionals to carry out *aware psychiatry*[9] that goes beyond the biomedical, biological reductionist paradigm and centres on the individual, their needs and their wishes. Shared decisions, whether advance or not, will aid this type of psychiatry, which must be based on both *technical values* and *moral values*.[10] This

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