Depot fluspirilene for schizophrenia

Abhijnhan Akhil, Adams Clive E, David Anthony, Ozbilen Mehmet

Authors' objectives
Background: Antipsychotic drugs are the mainstay treatment for schizophrenia and similar psychotic disorders. Long-acting depot injections of drugs such as fluspirilene are extensively used as a means of long-term maintenance treatment. Objectives: To review the effects of depot fluspirilene versus placebo, oral anti-psychotics and other depot antipsychotic preparations for people with schizophrenia in terms of clinical, social and economic outcomes.

Search methods: We searched the Cochrane Schizophrenia Group's Register (September 2005), inspected references of all identified studies, and contacted relevant pharmaceutical companies.

Selection criteria: We included all relevant randomised trials focusing on people with schizophrenia where depot fluspirilene, oral anti-psychotics, other depot preparations, or placebo were compared. Outcomes such as death, clinically significant change in global function, mental state, relapse, hospital admission, adverse effects and acceptability of treatment were sought.

Data collection and analysis: Studies were reliably selected, quality rated and data extracted. For dichotomous data, we calculated relative risk (RR) with the 95% confidence intervals (CI). Where possible, the number needed to treat statistic (NNT) was calculated. Analysis was by intention-to-treat. We summated normal continuous data using the weighted mean difference (WMD). We presented scale data only for those tools that had attained pre-specified levels of quality.

Main results: We included twelve randomised studies in this update of which five are additional studies. One trial compared fluspirilene and placebo and did not report important differences in the global improvement (n=60, 1 RCT, RR "no important improvement" 0.97 CI 0.9 to 1.1). Though movement disorders (n=60, 1 RCT, RR 31.0 CI 1.9 to 495.6, NNH 4) were found only in the fluspirilene group, there were no convincing data showing the advantage of oral chlorpromazine or other depot antipsychotics over fluspirilene decanoate. We found no difference between depot fluspirilene and other oral antipsychotics with regard to relapses or to the number of people leaving the study early.

Global state data (CGI) were not significantly different, in the short term when comparing fluspirilene with other depots (n=90, 2 RCTs, RR "no important improvement" 0.80 CI 0.2 to 2.8). No significant difference were apparent between fluspirilene and other depots with respect to the number of people leaving the study early. Global state data (CGI) were not significantly different, in the short term when comparing fluspirilene with other depots (n=90, 2 RCTs, RR 0.55 CI 0.1 to 2.3) or relapse rates (n=109, 3 RCTs, RR 0.55 CI 0.1 to 2.3). Extrapyramidal adverse effects were significantly less prevalent in the fluspirilene groups (n=164, 4 RCTs, RR 0.50 CI 0.3 to 0.8, NNH 5). Other adverse effects were not significantly different. Attrition in the one comparison between fluspirilene in weekly versus biweekly administration (n=34, RR 3.00 CI 0.1 to 68.8) and relapse rates (n=34 RR 3.18 CI 0.1 to 83.8) were not significantly different. There were no significant difference for movement disorders in one short term study. No study reported on hospital and service outcomes or commented on participants' overall satisfaction with care.

Economic outcomes were not recorded by any of the included studies.

Authors' conclusions: Participant numbers in each comparison were small and we found no clear differences between fluspirilene and oral medication or other depots. The choice of whether to use fluspirilene as a depot medication and whether it has advantages over other depots cannot, at present, be informed by trial-derived data. Well-conducted and reported randomised trials are still needed to inform practice.


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