Bromperidol decanoate (depot) for schizophrenia

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

Search methods: For this 2012 update we searched the Cochrane Schizophrenia Group's Register (February 2012).

Selection criteria: We sought all randomised trials focusing on people with schizophrenia where depot bromperidol, oral antipsychotics or other depot preparations. Primary outcomes were clinically significant change in global function, service utilisation outcomes (hospital admission, days in hospital), relapse.

Data collection and analysis: For the 2011 update MP independently extracted data, CEA carried out the reliability check. We calculated fixed-effect risk ratios (RR) and 95% confidence intervals (CI) for dichotomous data, and calculated weighted or standardised means for continuous data. Where possible, we calculated the number needed to treat statistic (NNT). Analysis was by intention-to-treat. For the 2012 update, data collection and analysis was not carried out as no new studies were found.

Main results: The 2012 search found no new studies, we have therefore included no new trials in this 2012 update. The number of included trials remain 4 RCTs, total n = 117. A single, small study of six months' duration compared bromperidol decanoate with placebo injection. Similar numbers left the study before completion (n = 20, 1 RCT, RR 0.4 CI 0.1 to 1.6) and there were no clear differences between bromperidol decanoate and placebo for a list of adverse effects (n = 20, 1 RCT, RR akathisia 2.0 CI 0.21 to 18.69, RR increased weight 3.0 CI 0.14 to 65.9, RR tremor 0.33 CI 0.04 to 2.69). When bromperidol decanoate was compared with fluphenazine depot, we found no important change on global outcome (n = 30, RR no clinical important improvement 1.50 CI 0.29 to 7.73). People allocated to fluphenazine decanoate and haloperidol decanoate had fewer relapses than those given bromperidol decanoate (n = 77, RR 3.92 CI 1.05 to 14.60, NNH 6 CI 2 to 341). People allocated bromperidol decanoate required additional antipsychotic medication somewhat more frequently than those taking fluphenazine decanoate and haloperidol decanoate, but the results did not reach conventional levels of statistical significance (n = 77, 2 RCTs, RR 1.72 CI 0.7 to 4.2). The use of benzodiazepine drugs was very similar in both groups (n = 77, 2 RCTs, RR 1.08 CI 0.68 to 1.70). People left the bromperidol decanoate group more frequent than those taking other depot preparation due to any cause (n = 97, 3 RCTs, RR 2.17 CI 1.00 to 4.73). Anticholinergic adverse effects were equally common between bromperidol and other depots (n = 47, RR 3.13 CI 0.7 to 14.0) and additional anticholinergic medication was needed with equal frequency in both depot groups, although results did tend to favour the bromperidol decanoate group (n = 97, 3 RCTs, RR 0.80 CI 0.64 to 1.01). The incidence of movement disorders was similar in both depot groups (n = 77, 2 RCTs, RR 0.74 CI 0.47 to 1.17). Authors' conclusions: Minimal poorly reported trial data suggests that bromperidol decanoate may be better than placebo injection but less valuable than fluphenazine or haloperidol decanoate. If bromperidol decanoate is available it may be a viable choice, especially when there are reasons not to use fluphenazine or haloperidol decanoate. Well-conducted and reported randomised trials are needed to inform practice.


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