P02.20

Smooth and safe transition from intramuscular to oral olanzapine

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Objective: The efficacy and safety of transitioning patients from IM to oral olanzapine and haloperidol were compared.

Method: Acutely agitated schizophrenic inpatients were treated with 1–3 IM injections/24 hours of olanzapine (10.0mg/injection) or haloperidol (7.5mg/injection) followed by the oral formulations of the same medication (5–20mg/day) for 4 days.

Results: IM olanzapine reduced agitation (PANSS-excited component [PANSS-EC]), significantly more than IM haloperidol 15, 30, and 45 minutes after the first injection. Mean PANSS-EC changes for olanzapine- (n=122) and haloperidol-treated (n=116) patients, respectively, were -7.1 and -6.7 at the 24-hour IM endpoint, with further changes of -0.6 and -1.3 during oral therapy (not significantly different). Significantly more haloperidol- than olanzapine-treated patients spontaneously reported acute dystonia (4.3% vs. 0%, p=0.03), extrapyramidal syndrome (6.9% vs. 0.8%, p=0.02), and akathisia (5.2% vs. 0%, p=0.01) and met criteria for treatment-emergent akathisia (18.5% vs. 6.5%, p=0.02).

Conclusion: Olanzapine reduced agitation more rapidly than and as effective as haloperidol during the IM period. This reduced agitation was maintained by both agents during the transition from IM to oral therapy; however, haloperidol-treated patients experienced significantly more EPS-related adverse events.

P02.21

Risperidone and quetiapine for treatment-resistant schizophrenia

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The aim of our open label study was to investigate the efficacy and the tolerability of risperidone and quetiapine in the treatment of a group of patients with resistant schizophrenia to conventional antipsycotics. 35 patients (21 males and 14 females), aged between 21 and 51 years, were selected for risperidone or quetiapine treatment according to the following criteria: a) DSM IV diagnosis of schizophrenia; b) duration of illness more than 3 years; c) poor response to typical antipsycotics (i.e. persistence of positive and/or negative symptoms, intolerable side effects , especially extrapyramidal symptoms).

Of these thirty-five selected patients, 20 were treated with risperidone (dose 4 – 6 mg/d.), while 15 with quetiapine (dose 150 – 750 mg/d.) for 8 weeks.

Assessments were made at baseline, 4 and 8 weeks, including PANSS, CGI, ESRS and clinical laboratory tests.

The 8-week trial was completed by all the patients. At treatment endpoint both risperidone and quetiapine produced a statistically significant improvement from baseline in the total PANSS score, in all three subscale scores, as well as in CGI score. No significant differences between groups were evident in all efficacy scales, however the quetiapine patients had a better outcome for extrapyramidal side effects, assessed by means of the ESRS.

In conclusion our data indicate the equal effectiveness of quetiapine and risperidone with a better tolerability for quetiapine.

P02.22

Neurocognitive effects: aripiprazole vs olanzapine in stable psychosis

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This multicenter, open-label study compared neurocognitive effects and safety of aripiprazole, the first next-generation atypical antipsychotic, a novel dopamine-serotonin system stabilizer, with olanzapine. Outpatients with clinically stable schizophrenia or schizoaffective disorder were randomized to once-daily aripiprazole 30 mg (n=128) or olanzapine 15 mg (n=127). Neurocognitive assessments were conducted at baseline, weeks 8, and 26. Results were reduced into three factors: general cognition, secondary verbal memory, and executive functioning. The general cognitive factor improved significantly with both medications at week 8. Aripiprazole produced significant within-group improvements in secondary verbal memory at weeks 8 and 26 ($p<0.001$); olanzapine did not. There were no significant changes in executive functioning. There was one significant between-group effect for cognition: aripiprazole was superior to olanzapine on secondary verbal memory at both time points ($p<0.04$). Clinically significant weight gain (>7% increase from baseline) occurred more frequently with olanzapine (27%) than aripiprazole (7%). Aripiprazole demonstrated a significant reduction in mean cholesterol levels compared with olanzapine. The neurocognitive benefits of aripiprazole bode well for psychosocial rehabilitation and may result in health advantages, greater treatment adherence, and reduced relapse rates.

P02.23

Calming versus sedative effects of IM olanzapine in agitated patients

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Objective: Calming versus sedation among intramuscular olanzapine-treated patients were compared with IM haloperidol-, lorazepam-, and placebo-treated patients.

Method: In three double-blind studies, acutely agitated patients with schizophrenia (N=311), bipolar mania (N=201), or dementia (N=206) were treated with 1–3 IM injections of olanzapine 2.5 to 10.0 mg/injection, haloperidol 7.5 mg/injection, lorazepam 2.0 mg/injection, or placebo over 24 hours. Sedation was assessed using the Agitation-Calmness Evaluation Scale (ACES©) and treatment-emergent adverse events.

Results: Across all studies, only one patient (lorazepam-treated, bipolar) achieved an ACES score of unarousable. There were no significant between-group differences in ACES scores of deep sleep or unarousable at any time across each study. When patients who were asleep were excluded from the agitation analyses, PANSS-EC scores remained significantly reduced with olanzapine compared to placebo. The incidence of adverse events indicative of sedation was not significantly different with olanzapine versus active comparator or placebo.

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