

Antipsychotic agents: efficacy and safety in schizophrenia

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Abstract: Antipsychotics have provided a great improvement in the management of people with schizophrenia. The first generation antipsychotics could establish the possibility of managing many psychotic subjects in an outpatient setting. With the advent of the second (SGA) and third generation antipsychotics (TGA), other psychiatric disorders such as bipolar depression, bipolar mania, autism, and major depressive disorder have now been approved for the use of these drugs for their treatment. Also, the administration of more specific assessment tools has allowed for better delineation of the repercussions of these drugs on symptoms and the quality of life of patients who use antipsychotic agents. In general, the SGA share similar mechanisms of action to achieve these results: dopamine-2 receptor antagonism plus serotonin-2A receptor antagonism. The TGA (eg, aripiprazole) have partial agonist activity at the dopamine-2 receptor site, and are also called dopaminergic stabilizers. The pharmacological profile of SGA and TGA may provide better efficacy against negative symptoms, and are less likely to produce extrapyramidal symptoms; however, the SGA and TGA are associated with many other adverse events. The clinician has to balance the risks and benefits of these medications when choosing an antipsychotic for an individual patient.

Keywords: antipsychotic agents, schizophrenia, pharmacology, safety

Introduction

Schizophrenia is a chronic disorder with serious physical, social, and economic consequences, with an impact on public health that has been unappreciated. Thus, it is a devastating illness that reflects in the productivity of individuals affected by it and requires permanent spending with hospitalizations, treatments, and rehabilitations.^{1,2} This chronic disorder is characterized by an onset in early adulthood, a lifelong course, debilitating symptoms, deterioration of functional ability, and lack of social acceptability, making it among the most disabling and economically catastrophic disorders.³

In clinical research, five symptom clusters have been described in persons with schizophrenia. They include negative, positive, excitement, cognitive, and depression and anxiety dimensions of schizophrenic psychopathology.⁴

Positive symptoms are associated with hospital admission. They are identified as superimposed behaviors and principally involve delusions, hallucinations, and disorganized thinking. Generally, patients experience a combination of these positive symptoms. Delusions are the most common psychotic symptoms and occur in 65% of patients with schizophrenia.⁵⁻⁷ Hallucinations and disorganized thinking are present in 50% of these patients. Auditory hallucinations are the most common sensory disturbance, but visual, tactile, olfactory, and gustatory hallucinations may also be present.⁸

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Negative symptoms represent an absence of a normal function. They reflect a blunting or loss of a range of affective and cognitive functions. These symptoms comprise blunted affect, abulia, alogia, anhedonia, apathy, avolition, and asociality.⁷⁻⁹

Excitement symptoms are often related to a manic-like syndrome in patients with schizophrenia. They involve abnormalities in both the extent and nature of psychomotor activity. Particularly, they may be present in an acute phase of the disease and tend to respond well to pharmacological interventions. These symptoms are characterized by excitement, impulsivity, psychomotor activation, and uncooperativeness.^{7,10}

Cognitive domains are also affected by the disorder, and include deficits in attention, language, memory, executive function, processing speed, and social cognition. Cognitive impairments are strong predictors of poor social and vocational outcomes. They are present in the premorbid phase of schizophrenic illness and persist throughout the long-term.^{7,11}

Depression and anxiety symptoms are present in a majority of schizophrenia patients at some point during the course of the illness. Depression may be part of the prodrome or the florid phase; it may follow an acute psychotic episode, or occur between psychotic exacerbations. Anxiety could be considered as a comorbidity.⁷

Treatment of schizophrenia requires long-term administration of antipsychotic drugs. Lack of efficacy, poor patient compliance, extrapyramidal symptoms (EPS), weight gain, and sedation can interfere with long-term adherence to maintenance drug therapy.¹² Although atypical antipsychotic drugs have been associated with a lower risk of EPS, which include abnormal involuntary movements like parkinsonism, dystonia, akathisia, and tardive dyskinesia, these drugs pose a higher risk for the development of metabolic adverse events.¹³⁻¹⁶

Since the advent of chlorpromazine, there has been a great improvement in the treatment of people with schizophrenia. From that time, other antipsychotic agents were launched until the development of the second generation antipsychotics (SGA). These new drugs (also known as atypical antipsychotics) are thought to be more efficacious in treating negative symptoms and also produce fewer side effects (eg, less EPS) when compared to the first generation antipsychotics (FGA).¹⁷

Although patients report preference for the SGA, we cannot forget the important side effects associated with their use (for instance, increased cardiometabolic risk). These drugs

have different pharmacological profiles and side effects that may differ from one agent to another.¹⁸

In addition to promoting antipsychotic action without producing significant EPS, other characteristics of the SGA that define their atypicality include an absence of hyperprolactinemia and greater efficacy in positive (at least in the case of clozapine), negative, and cognitive symptoms. From a pharmacological perspective, the SGA can be defined as antagonists of the serotonin-dopamine, D2-blockers with rapid dissociation and D2 or 5HT2 partial agonists.¹⁹

For some authors,²⁰⁻²² another class of antipsychotic agents for the pharmacological treatment of schizophrenia and other psychiatric disorders can be identified: the third generation antipsychotics (TGA). Aripiprazole, an example of a TGA, has functional antagonist activity under hyperdopaminergic conditions, and functional agonist properties under hypodopaminergic conditions. Aripiprazole seems to produce D2-mediated functional effects that involve a broad range of classic pharmacological intrinsic activities. These variations in both intrinsic activity and potency have suggested that aripiprazole may be “functionally selective” at D2 receptors, and not just as a simple partial agonist.²²

Clinical studies

The effectiveness of current drugs for the treatment of schizophrenia may occur in only about 50% of patients.²³⁻²⁵ Poor symptom response is associated with premature treatment discontinuation, symptom exacerbation, relapse, and increased risk of hospitalization with resultant higher costs of treatment.²⁶⁻²⁹ Predictors of antipsychotic response should evaluate the disease state at baseline (before the initiation of treatment) and at early symptom changes after beginning treatment. Cognitive function deficits,³⁰ poor premorbid functioning,³¹ earlier age of onset,³² duration of untreated psychosis,^{33,34} and male gender³⁵ are baseline factors that have been found to be associated with poor treatment response. Patients may remain as nonresponders if early nonresponse is observed at the first 2 weeks of treatment. Correll et al³⁶ reported that early nonresponse to treatment, as measured by a 20% reduction in the Brief Psychiatric Rating Scale (BPRS) total score at week 1 predicted nonresponse at 4 weeks for 100% of patients. Other studies have suggested the hypothesis that early nonresponse to treatment within the first 2 weeks of treatment initiation is a good indicator of treatment refractoriness.^{37,38}

Double-blind, controlled studies have compared SGA with FGA, most often favoring SGA insofar as greater

symptom reduction (particularly for negative, cognitive, and affective symptoms) and better tolerability (notably regarding motor adverse effects) have been noted. In response to these positive studies, most international evidence-based guidelines advocate first-line use of SGA.³⁹

In the Clinical Antipsychotic Trials of Intervention (CATIE) study,²⁴ the relative effectiveness of SGA was compared with that of perphenazine in a double-blind fashion. A total of 1493 patients with schizophrenia were recruited at 57 US sites and were randomly assigned to receive olanzapine (7.5 mg to 30 mg per day), perphenazine (8 mg to 32 mg per day), quetiapine (200 mg to 800 mg per day), or risperidone (1.5 mg to 6.0 mg per day) for up to 18 months. Ziprasidone (40 mg to 160 mg per day) was included after its approval by the Food and Drug Administration. The primary objective of the CATIE study was to discriminate between the differences in effectiveness of these five treatments. Before 18 months, 74% of patients discontinued the study medication (1061 of the 1432 patients who received at least one dose): 64% in the olanzapine group, 75% of those assigned to the perphenazine group, 82% of those randomized to the quetiapine group, 74% of those in the risperidone arm, and 79% of those who were assigned to the ziprasidone group. Time to the discontinuation of treatment for any cause was significantly longer in the olanzapine group than in the quetiapine ($P < 0.001$) or risperidone ($P = 0.002$) group, but not in the perphenazine ($P = 0.021$) or ziprasidone ($P = 0.028$) group. Time to discontinuation because of intolerable side effects was similar among the groups, but the rates differed ($P = 0.04$); olanzapine was associated with more discontinuation for weight gain or metabolic effects, and perphenazine was associated with more discontinuation for extrapyramidal effects. In conclusion, the majority of patients in each group discontinued their assigned treatment due to inefficacy, intolerable side effects, or for other reasons. Olanzapine was the most effective drug in terms of the rates of discontinuation, and the efficacy of the conventional antipsychotic agent, perphenazine, appeared to be similar to that of quetiapine, risperidone, and ziprasidone. However, olanzapine was associated with greater weight gain and increases in measures of glucose and lipid metabolism.

In the United Kingdom, the Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS)⁴⁰ concluded that FGA (largely sulpiride) and SGA (olanzapine, risperidone, amisulpride, and quetiapine) did not differ in terms of overall efficacy as measured by the Positive and Negative Syndrome Scale (PANSS), extrapyramidal side effects, quality of life, and patient preference over a period of 52 weeks.⁴⁰

Leucht et al¹⁵ published a meta-analysis comparing nine SGA and FGA for overall efficacy; positive, negative, and depressive symptoms; relapse; quality of life; EPS; sedation; and weight gain. Results showed that five SGA (aripiprazole, quetiapine, sertindole, ziprasidone, and zotepine) were not significantly different from FGA in their effects on overall, positive, and negative symptoms, whereas clozapine, amisulpride, olanzapine, and risperidone were more efficacious than FGA. Olanzapine, risperidone, and sertindole proved to be significantly better than FGA in terms of relapse prevention. With regard to quality of life, only clozapine, sertindole, and amisulpride were better than FGA.

One issue regarding the efficacy of antipsychotic agents has been pointed out by recent publications. Data from randomized clinical trials (RCT) of antipsychotics used in treating schizophrenia taken between 1991 and 2006, show that there is an increase in placebo response in more recent trials.⁴¹ Some of the contributing factors include specific participant characteristics (eg, gender, treatment resistance and previous exposure, adherence to drug treatment, diagnostic precision, and illness severity), site characteristics (eg, academic or commercial, experience and training of site staff, recruitment pressures and procedures, “recycling” of subjects), trial design issues (eg, entry requirements, timing of assessments, double-blind placebo lead-ins, concomitant medications), and other issues.⁴¹ Excessive placebo response in clinical trials includes expectancy bias (in patients and investigators), incentives, rater reliability, and data quality.⁴² Similar issues were observed in antidepressant RCT. The placebo response rate doubled between 1980 and 2000.⁴³ The relatively modest effects of antidepressants (in comparison with placebo) in contemporary RCT, as well as the lack of attention being paid to the contribution of placebo expectancy factors to individual outcomes, have often been underestimated. However, the modest benefits of antidepressants observed in grouped datasets may obscure large, specific, and very meaningful therapeutic effects for 10% to 20% of those treated with antidepressants.⁴⁴

On the other hand, the placebo-controlled trial is the standard method used to verify the efficacy and safety of antipsychotic agents for the treatment of schizophrenia.⁴⁵ Currently, superiority over placebo is the only acceptable and reliable proof of efficacy of new antipsychotic medications.^{46,47} Without the placebo-controlled design, one cannot show that improvements in symptoms do not represent nonspecific treatment effects or the natural course of the disease.⁴⁵ Also, in trials intended to show that a new drug is equivalent to established drugs, a variety of problems may reduce the power

to detect clinically significant differences between the new drug and the active comparator.^{48,49} Furthermore, without a placebo comparator, one cannot affirm whether the apparent equivalence of the standard and the new antipsychotic drug has occurred because the clinical population recruited for a study is nonresponsive to both drugs. In addition, if the experimental drug is ineffective and/or unsafe, the larger sample size required for noninferiority testing may expose more patients to harmful side effects or ineffective treatment compared with placebo-controlled designs.⁴⁵ The placebo-controlled trial can protect research participants from the harmful effects of ineffective drugs.⁵⁰

In terms of the clinical efficacy of antipsychotic agents, we are usually interested in treatment response and remission. In clinical trials, the efficacy of antipsychotics is measured through the use of scales like BPRS⁵¹ or PANSS.⁵² Among the available trials, there is no agreement in terms of when to consider a clinical response with an antipsychotic agent; different trials report that a response could be considered when reductions from the initial scores of 20%, 30%, 40%, 50%, and 60% are found.⁵³ Some studies using data from a large number of subjects,^{54–58} rated simultaneously with the BPRS/PANSS and the Clinical Global Impression Scale (CGI),⁵⁹ concluded that a 25% reduction in the BPRS/PANSS baseline scores is associated with a minimal improvement in the CGI score; moreover, a 50% reduction in the BPRS/PANSS scores would correspond with “much improved” scores in the CGI.

Remission is defined as a lack of significant symptoms. To obtain a uniformly accepted definition of remission, a group of experts⁶⁰ proposed that a patient can be considered as being in remission if eight items on the PANSS⁵² or corresponding items on the BPRS,⁵¹ Scale for the Assessment of Positive Symptoms,⁶¹ or on the Scale for the Assessment of Negative Symptoms⁵⁶ are rated as being “mildly present” or better.⁶²

Other important outcome measures in schizophrenia trials include relapse and recovery. Relapse can be defined in different ways: exacerbation or recurrence of symptoms, change in functional status or change in treatment requirements, intensity of services, or locus of care.⁵³ Some studies define relapse when patients need to be hospitalized.^{63–69} We have to remember that hospitalization due to social causes should not be considered as relapse. Also, some patients can be treated when presenting with worsening symptoms while avoiding hospitalization. Recovery is the goal of the treatment of patients with schizophrenia, and improvement of symptoms requires improvement of functional measures.

Recovery is influenced by psychosocial treatments, family and community supports, supportive employment, and supportive education.⁵³

There are many scales that measure clinical efficacy in schizophrenia trials. The following scales evaluate clinical symptomatology:⁵³

- CGI Severity and Improvement Scale⁵⁹
- BPRS⁵¹
- PANSS⁵²
- Scale for the Assessment of Negative Symptoms⁶²
- Calgary Depression Rating Scale⁷⁰

Patient preference

The importance of subjective measures has been repeatedly addressed in studies on the quality of life of patients with schizophrenia.^{71,72} Improvement in quality of life and social functioning, with consequent reintegration into society, is clearly a major goal of treatment for schizophrenia.^{17,73}

Some studies have shown that the type of antipsychotic medication could influence treatment nonadherence. The use of atypical antipsychotics can improve adherence when compared with FGA. In some studies, the use of atypical antipsychotics was seen to be associated with greater treatment adherence relative to conventional neuroleptics.^{74–76}

It has been suggested that better control of negative symptoms and fewer EPS during treatment with SGA are associated with better adherence to treatment.⁷⁷ Moreover, some studies suggest that patients receiving SGA have better subjective responses to their current medication than those receiving conventional medications.^{78–80} However, a prospective study reported that there was no difference between SGA and FGA in terms of adherence to treatment.⁸¹

Patients' subjective well-being is one important variable in the evaluation of the effects of antipsychotics and can be critical in determining compliance in schizophrenia.⁸² Some studies have indicated that the severity of depressive symptoms can be associated with subjective well-being.^{83–85} The evidence of the association between improvements in positive and negative symptoms is less consistent, suggesting that the identification and treatment of depressive symptoms in schizophrenic patients may affect perceptions of their own well-being.^{86,87} We can use self-report scales to measure patient outcomes, such as:⁵³

- Drug Attitudes Inventory⁸⁸
- Subjective Wellbeing under Neuroleptic Treatment Scale (original/short form)⁸⁹
- 36-Item Short Form Health Survey⁹⁰

- EuroQol⁹¹
- Sheehan Disability Scale⁹²
Other efficacy outcome scales will focus on cognitive impairment in schizophrenia:
- Measurement and Treatment to Improve Cognition in Schizophrenia⁹³
- CGI of Cognition in Schizophrenia⁹⁴
- CogState Schizophrenia Battery⁹⁵
- CogState 12-Minute Battery⁹⁶
- Schizophrenia Cognition Rating Scale⁹⁷
- Repeatable Battery for Assessment of Neuropsychological Status⁹⁸
- Brief Assessment of Cognition in Schizophrenia⁹⁹
- Brief Cognitive Assessment Tool for Schizophrenia¹⁰⁰
- 5-minute Digit Symbol Coding Task¹⁰¹

Safety and tolerability

The effectiveness of a drug is characterized by its efficacy, tolerability, safety, function, and acceptability. Many patients drop out of treatment due to the side effects of the medications. The most common side effects are EPS and sedation.¹⁰²

Extrapyramidal side effects

SGA produce fewer EPS than FGA; however, when doses of SGA are increased, there is a possibility of emergence of EPS. Clozapine and quetiapine have lower affinities for the dopamine receptors, resulting in a rare association with EPS. In therapeutic dosages, clozapine only has a dopamine D2 receptor blockage of 40%.¹⁰² In doses of 450 and 750 mg/day, quetiapine has D2 receptor occupancies of 30% and 41%.¹⁰³ Also, these antipsychotic drugs have an antagonistic effect on the 5HT2A receptor and a partial agonistic effect on the 5HT1A receptor, which seems to aid in the production of low levels of EPS, and gives these medications the character of atypicality.¹⁰²

On the other hand, amisulpride has a high affinity for D2/D3 receptors, no significant binding to 5HT2 receptors, and also shows lower risk of EPS. This is because amisulpride is a unique SGA that selectively blocks D2-like receptors presynaptically in the frontal cortex, possibly enhancing dopaminergic transmission, as well as postsynaptically in the limbic areas, possibly reducing dopaminergic transmission in this region.¹⁰⁴ In this case, an occupancy of 5HT2A receptors is not the cause of atypicality of the amisulpride, but it is likely that a fast dissociation from D2 receptors makes this drug more accommodating to physiological dopamine transmission, which permits an antipsychotic effect without EPS.¹⁰⁵

The monitoring of EPS is important because these neurologic symptoms have been associated with poor compliance, reduced quality of life, increased suicide rates, and increased risks of developing tardive dyskinesia.¹⁰²

Cardiovascular and metabolic side effects

Since the beginning of the antipsychotic era, these drugs have been known to be associated with sudden death. Prolongation of the QT interval to more than 500 ms has been associated with an increased risk of developing the potential fatal cardiac arrhythmia, Torsade de Pointes. However, this mechanism may be responsible (to a minor degree) for the increased mortality rate seen in patients with schizophrenia. The antipsychotic-induced metabolic changes such as weight gain, increased risk of developing diabetes, and dyslipidemia are far more important. Clozapine, olanzapine, and quetiapine are the SGA that cause the worst metabolic changes. Disturbances in glucose metabolism and diabetes mellitus can occur with the use of SGA, and are associated with increases in insulin resistance and visceral adiposity with reduced responsiveness of pancreatic beta cells to glucose.¹⁰⁶ For olanzapine and clozapine, a direct diabetogenic effect regardless of weight gain has been established. Diabetic ketoacidosis can occur as an acute complication of antipsychotic treatment. Olanzapine and clozapine seem to have the highest prevalence of ketoacidosis, but most cases are reversible when discontinuing the offending drug.

Glycosylated hemoglobin (HbA1c) is often elevated in these patients, and decreased levels of high-density lipoprotein and increased levels of triglycerides are associated with an increased risk of insulin resistance. Dyslipidemia increases the risk of cardiovascular disease due to arteriosclerosis, and it should be noted that SGA affect both triglycerides and cholesterol levels. Results from the CATIE study suggest that clozapine, olanzapine, and quetiapine affect triglycerides and cholesterol levels the most.²⁴ Patients with antipsychotic-induced dyslipidemia might benefit from lifestyle interventions, or they may switch to a more metabolically tolerable antipsychotic drug.

The metabolic side effects of SGA were investigated in a meta-analysis of studies comparing the metabolic side effects of the following SGA in a head-to-head comparison: amisulpride, aripiprazole, clozapine, olanzapine, quetiapine, risperidone, sertindole, ziprasidone, and zotepine.¹⁰⁷ The authors found 48 studies with 105 treatment arms. Olanzapine was more likely to produce weight gain than risperidone, risperidone more than amisulpride, and sertindole more than risperidone. Olanzapine was more likely to produce an increase in cholesterol levels than aripiprazole,

risperidone, and ziprasidone; no differences with amisulpride, clozapine, and quetiapine were found. Quetiapine produced a greater increase in cholesterol levels than risperidone and ziprasidone. Olanzapine produced a greater increase in glucose than amisulpride, aripiprazole, quetiapine, risperidone, and ziprasidone; no difference was found with clozapine. The authors concluded that some atypical antipsychotics produced more metabolic side effects than others. The clinician should take these side effects into consideration when choosing an atypical drug for each individual patient.

Correll et al¹⁰⁸ investigated patients with bipolar disorder and schizophrenia who were treated with SGA. The authors concluded that these patients have similarly high rates of metabolic syndrome. The authors suggested a shared susceptibility to antipsychotic-related metabolic deregulation not primarily related to psychiatric diagnosis or concomitant mood stabilizer treatment.

Conclusion

Progress in the treatment of psychosis has occurred in the last few decades, and more recently with the introduction of new antipsychotic agents. Some new challenges are now important points that should be taken into account by the clinician, such as the safety and tolerability of antipsychotics. Ultimately, choosing the best treatment for an individual patient can result in greater adherence to medication and more success in clinical outcomes.

Disclosure

The authors report no conflicts of interest in this work.

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