In most western industrialised countries, second generation (atypical) antipsychotics are recommended as first-line drug treatments for people with schizophrenia. In this review, we specifically examine how the efficacy and tolerability of one such agent - aripiprazole - differs from that of other comparable second generation antipsychotics. To review the effects of aripiprazole compared with other atypical antipsychotics for people with schizophrenia and schizophrenia-like psychoses. We searched the Cochrane Schizophrenia Group Trials Register (November 2012), inspected references of all identified studies for further trials and contacted relevant pharmaceutical companies, drug approval agencies and authors of trials for additional information. We included all randomised clinical trials (RCTs) comparing aripiprazole (oral) with oral and parenteral forms of amisulpride, clozapine, olanzapine, quetiapine, risperidone, sertindole, ziprasidone or zotepine for people with schizophrenia or schizophrenia-like psychoses. We extracted data independently. For dichotomous data we calculated risk ratios (RR) and their 95% confidence intervals (CI) on an intention-to-treat basis based on a random-effects model. Where possible, we calculated illustrative comparative risks for primary outcomes. For continuous data, we calculated mean differences (MD), again based on a random-effects model.
We assessed risk of bias for each included study and used GRADE approach to rate quality of evidence. We now have included 174 trials involving 17,244 participants. Aripiprazole was compared with clozapine, quetiapine, risperidone, ziprasidone and olanzapine. The overall number of participants leaving studies early was 30% to 40%, limiting validity (no differences between groups). When compared with clozapine, there were no significant differences for global state (no clinically significant response, n = 2132, 29 RCTs, low quality evidence); mental state (BPRS, n = 426, 5 RCTs, very low quality evidence); or leaving the study early for any reason (n = 240, 3 RCTs, very low quality evidence). Quality of life score using the WHO-QOL-100 scale demonstrated significant difference, favouring aripiprazole (n = 132, 2 RCTs, RR 2.59 CI 1.43 to 3.74, very low quality evidence). General extrapyramidal symptoms (EPS) were no different between groups (n = 520, 8 RCTs, very low quality evidence). No study reported general functioning or service use. When compared with quetiapine, there were no significant differences for global state (n = 991, 12 RCTs, low quality evidence); mental state (PANSS positive symptoms, n = 583, 7 RCTs, very low quality evidence); or leaving the study early for any reason (n = 168, 2 RCTs, very low quality evidence), or general EPS symptoms (n = 348, 4 RCTs, very low quality evidence). Results were significantly in favour of aripiprazole for quality of life (WHO-QOL-100 total score, n = 100, 1 RCT, MD 2.60 CI 1.31 to 3.89, very low quality evidence). No study reported general functioning or service use. When compared with risperidone, there were no significant differences for global state (n = 6381, 80 RCTs, low quality evidence); or leaving the study early for any reason (n = 1239, 12 RCTs, very low quality evidence). Data were significantly in favour of aripiprazole for improvement in mental state using the BPRS (n = 570, 5 RCTs, MD 1.33 CI 2.24 to 0.42, very low quality evidence); with higher adverse effects seen in participants receiving risperidone of general EPS symptoms (n = 2605, 31 RCTs, RR 0.39 CI 0.31 to 0.50, low quality evidence). No study reported general functioning, quality of life or service use. When compared with ziprasidone, there were no significant differences for global state (n = 442, 6 RCTs, very low quality evidence); mental state using the BPRS (n = 247, 1 RCT, very low quality evidence); or leaving the study early for any reason (n = 316, 2 RCTs, very low quality evidence). Weight gain was significantly greater in people receiving aripiprazole (n = 232, 3 RCTs, RR 4.01 CI 1.10 to 14.60, very low quality evidence). No study reported general functioning, quality of life or service use. When compared with olanzapine, there were no significant differences for global state (n = 1739, 11 RCTs, very low quality evidence); mental state using PANSS (n = 1500, 11 RCTs, very low quality evidence); or quality of life using the GQOLI-74 scale (n = 68, 1 RCT, very low quality evidence). Significantly more people receiving aripiprazole left the study early due to any reason (n = 2331, 9 RCTs, RR 1.15 CI 1.05 to 1.25, low quality evidence) and significantly more people receiving olanzapine gained weight (n = 1538, 9 RCTs, RR 0.25 CI 0.15 to 0.43, very low quality evidence). None of the included studies provided outcome data for the comparisons of 'service use' or 'general functioning'. Information on all comparisons is of limited quality, is incomplete and problematic to apply clinically. The quality of the evidence is all low or very low. Aripiprazole is an antipsychotic drug with an important adverse effect profile. Long-term data are sparse and there is considerable scope for another update of this review as new data emerge from ongoing larger, independent pragmatic trials.

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