# NOUS REPTES EN L'ELECCIÓ D'UN PSICOFÀRMAC
## Aspectes clínics, afavorint l'adherència

**A. MANÉ**


etep
Estudi i Tractament d'Episodis Psicòtics

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- Evolució del tractament antipsicòtic oral i eficàcia
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- Estratègies d 'actuació per evitar recaigudes:
    - Entrevista motivacional
    - Psicoeducació
    - Antipsicòtics llarga durada
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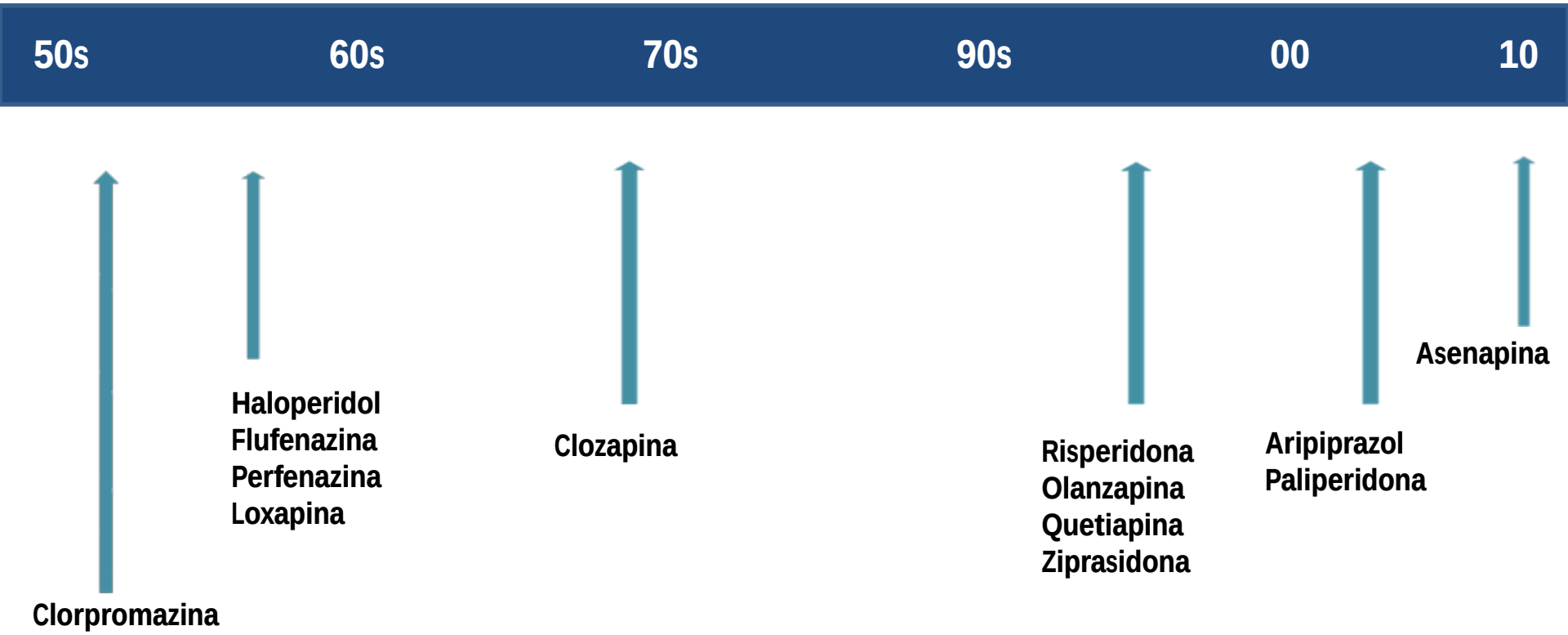
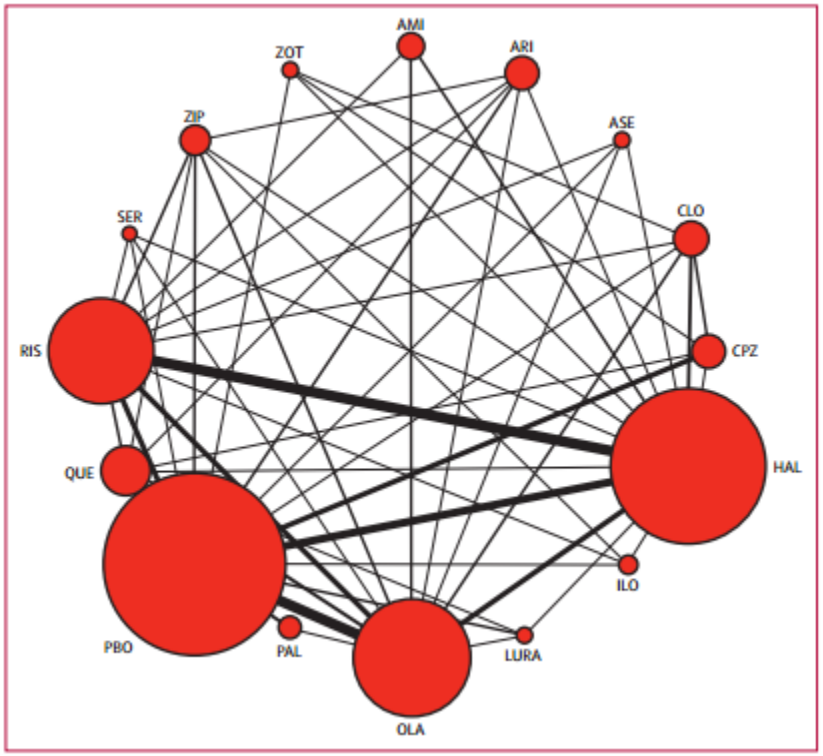
# Evolució tractaments antipsicòtics (orals)



# Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis

*Stefan Leucht, Andrea Cipriani, Loukia Spineli, Dimitris Mavridis, Deniz Örey, Franziska Richter, Myrto Samara, Corrado Barbui, Rolf R Engel, John R Geddes, Werner Kissling, Marko Paul Stapf, Bettina Lässig, Georgia Salanti, John M Davis*




Petites diferencies en eficàcia però possiblement clínicament rellevants

Diferent perfil d'efectes secundaris

La decisió terapèutica s'hauria de basar en avaluació dels diferents dominis:

- -Eficàcia
- - Discontinuació
- - Augment de pes
- - Increment de prolactina
- - S. Extrapiramidals
- - Augment del QTc
- - Sedació

# PREVALENÇA RECAIGUDES ESQUIZOFRENIA

**N=104**

***Años desde el primer episodio psicótico.**

| *Años | Recaídas | Intervalo 95%. Superior | Inferior | Pacientes en riesgo al final del año |
|---|---|---|---|---|
| 1 | 16.2 | 8.9 | 23.4 | 80 |
| 2 | 53.7 | 43.4 | 64.0 | 39 |
| 3 | 63.1 | 52.7 | 73.4 | 22 |
| 4 | 74.7 | 64.2 | 85.2 | 9 |
| 5 | **81.9** | 70.6 | 93.2 | 4 |

Robinson, D. et al. Arch. Gen. Psychiatr., 1999. 56: 241-247.

# CONSEQÜÈNCIES DE LA RECAIGUDA

- Conseqüències del propi episodi (personal, familiar, situaciones de risc)
- Impacte en la recuperació funcional (acadèmica, social)
- Major resistència al tractament
- Impacte econòmic (major en psicosis no estable)
- S'han associat a alteracions cerebrals

*1- Emsley et al Sch Research 2013; 2. Almond et al. Br J Psychiatry 2004.*

# Natural Course of Schizophrenic Disorders: A 15-Year Followup of a Dutch Incidence Cohort

*by Durk Wiersma, Fokko J. Nienhuis, Cees J. Slooff, and Robert Giel*

*Schizophrenia Bulletin*, Vol. 24, No. 1, 1998

- **1/6 no remet després d'un episodi, independentment quin episodi es tracta**
- **1/5 remet parcialment, amb persistència símptomes negatius**

**Cronicitat augmenta de ¼ després 1r episodi a ½ després del quart**

- **Augment progressiu de la durada de l'episodi (9 a 27 mesos)**

# CONSEQÜÈNCIES DE LA RECAIGUDA

- Conseqüències del propi episodi (personal, familiar, situaciones de risc)
- Impacte en la recuperació funcional (acadèmica, social)
- Contribució en l'estigma
- Major resistència al tractament
- Impacte econòmic (major en psicosis no estable)
- S'han associat a alteracions cerebrals

*1- Emsley et al Sch Research 2013; 2. Almond et al. Br J Psychiatry 2004.*

BRITISH JOURNAL OF PSYCHIATRY (2004), 184, 346–351

# Relapse in schizophrenia: costs, clinical outcomes and quality of life

STEPHEN ALMOND, MARTIN KNAPP, CLEMENT FRANCOIS, MONDHER TOUMI and TRAOLACH BRUGHA

**Table 5** Mean 6-month service use and costs (£, 1998) per patient by relapse status

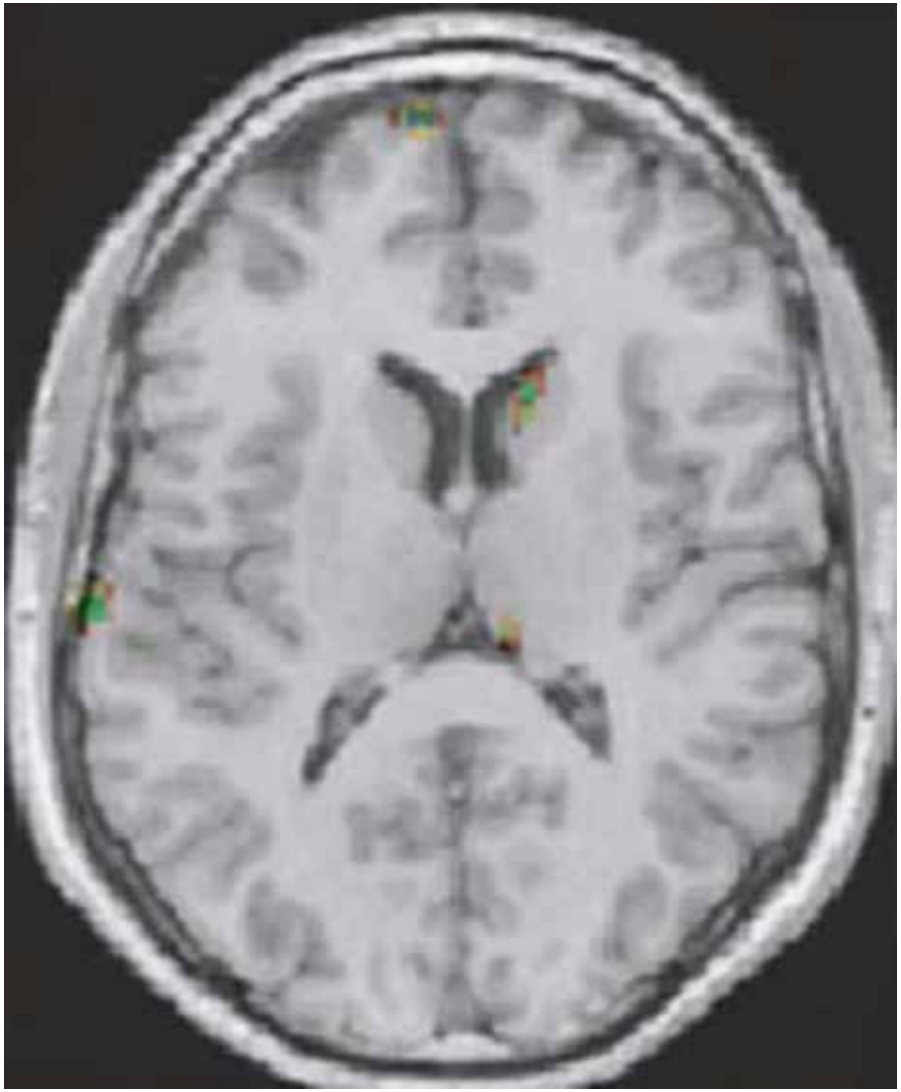
| Service | Non-relapse ($n$=68) | | Relapse ($n$=77) | |
|---|---|---|---|---|
| | Mean usage | Costs (£) | Mean usage | Costs (£) |
| In-patient care (days)[1] | 0.0 | 0 | 57.8 | 6451 |
| Out-patient | | | | |
| Psychiatric visits[1] | 1.4 | 135 | 2.1 | 209 |
| Other[2] | 0.1 | 8 | 0.3 | 19 |
| Day hospital (visits)[2] | 2.3 | 133 | 2.1 | 126 |
| Community mental health centre (visits)[2,3] | 2.4 | 44 | 1.4 | 25 |
| Day care centre (visits)[1] | 5.9 | 106 | 0.9 | 15 |
| Group therapy[2,3] | 0.4 | 6 | 0.1 | 2 |
| Sheltered workshop[3] | 1.1 | 45 | 0.0 | 0 |
| Specialist education[2,3] | 2.9 | 52 | 0.0 | 0 |
| Other (not specified)[3] | 0.6 | 12 | 0.0 | 0 |
| Visits by | | | | |
| Psychiatrist[1] | 2.5 | 103 | 2.3 | 269 |
| Psychologist[3] | 0.0 | 0 | 0.0 | 2 |
| General practitioner[3] | 1.8 | 217 | 1.6 | 152 |
| District nurse[3] | 0.1 | 1 | 0.0 | 0 |
| Community psychiatric nurse[3] | 12.6 | 1014 | 5.2 | 791 |
| Social worker[3] | 0.1 | 24 | 0.4 | 106 |
| Occupational therapist[3] | 0.0 | 1 | 0.8 | 44 |
| Home help/care worker[3] | 0.4 | 0 | 0.6 | 0 |
| Total costs[1] | | 1899 | | 8212 |

# CONSEQÜÈNCIES DE LA RECAIGUDA

- Conseqüències del propi episodi (personal, familiar, situaciones de risc)
- Impacte en la recuperació funcional (acadèmica, social)
- Major resistència al tractament
- Impacte econòmic ( major en psicosis no estable)
- S'han associat a alteracions cerebrals

*1- Emsley et al Sch Research 2013; 2. Almond et al. Br J Psychiatry 2004.*

# Focal Gray Matter Changes in Schizophrenia across the Course of the Illness: A 5-Year Follow-Up Study



**Canvis frontals associats al nº d' hospitalizacions**

**Menor canvis en tto amb olanzapina i clozapina**

*1- Van Haren et al. Psychopharmacology 2007*

Published in final edited form as:
*Am J Psychiatry*. 2013 June 1; 170(6): . doi:10.1176/appi.ajp.2013.12050674.

# Relapse Duration, Treatment Intensity, and Brain Tissue Loss in Schizophrenia: A Prospective Longitudinal MRI Study

**Nancy C. Andreasen, M.D., Ph.D., Dawei Liu, Ph.D., Steven Ziebell, B.A., Anvi Vora, M.D., and Beng-Choon Ho, M.D.**

- Duració de la recaiguda associada a la pèrdua de volum cerebral total i substància gris frontal
- Intensitat del tractament (FGA i SGA) associada a disminució volum cerebral total

Recaiguda 1.55 cc/any (0.99 F) vs Tractament 0.55 cc/any

↓

**Prevenció recaiguda amb mínim dosi eficaç mantinguda**

# Efecte diferencial atípics versus típics?

## Atypical Neuroleptics Stimulate Neurogenesis in Adult Rat Brain

Chandramohan G. Wakade,[1,2] Sahebarao P. Mahadik,[3] Jennifer L. Waller,[4] and Fung-chow Chiu[1,2]*

## Neurotoxic potential of haloperidol in comparison with risperidone: implication of Akt-mediated signal changes by haloperidol

W. Ukai[1], H. Ozawa[2], M. Tateno[1], E. Hashimoto[1], and T. Saito[1]

ORIGINAL ARTICLE

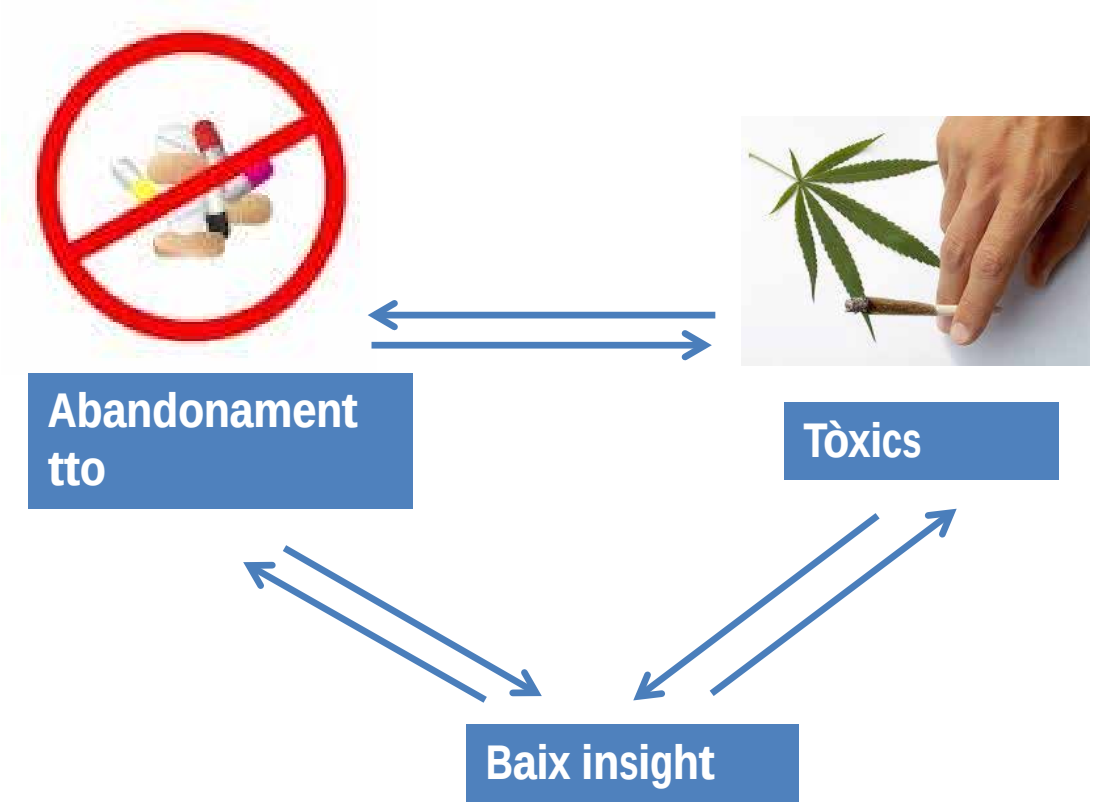
# Antipsychotic Drug Effects on Brain Morphology in First-Episode Psychosis

*Jeffrey A. Lieberman, MD; Gary D. Tollefson, MD, PhD; Cecil Charles, PhD; Robert Zipursky, MD; Tonmoy Sharma, MD; Rene S. Kahn, MD, PhD; Richard S. E. Keefe, PhD; Alan I. Green, MD; Raquel E. Gur, MD, PhD; Joseph McEvoy, MD; Diana Perkins, MD, MPH; Robert M. Hamer, PhD; Honglin Gu, PhD; Mauricio Tohen, MD, DrPH; for the HGDH Study Group*

**Table 2. Changes in MRI Volumes for Primary Regions of Interest by Treatment Group (Baseline to Weeks 12, 24, 52, and 104)**

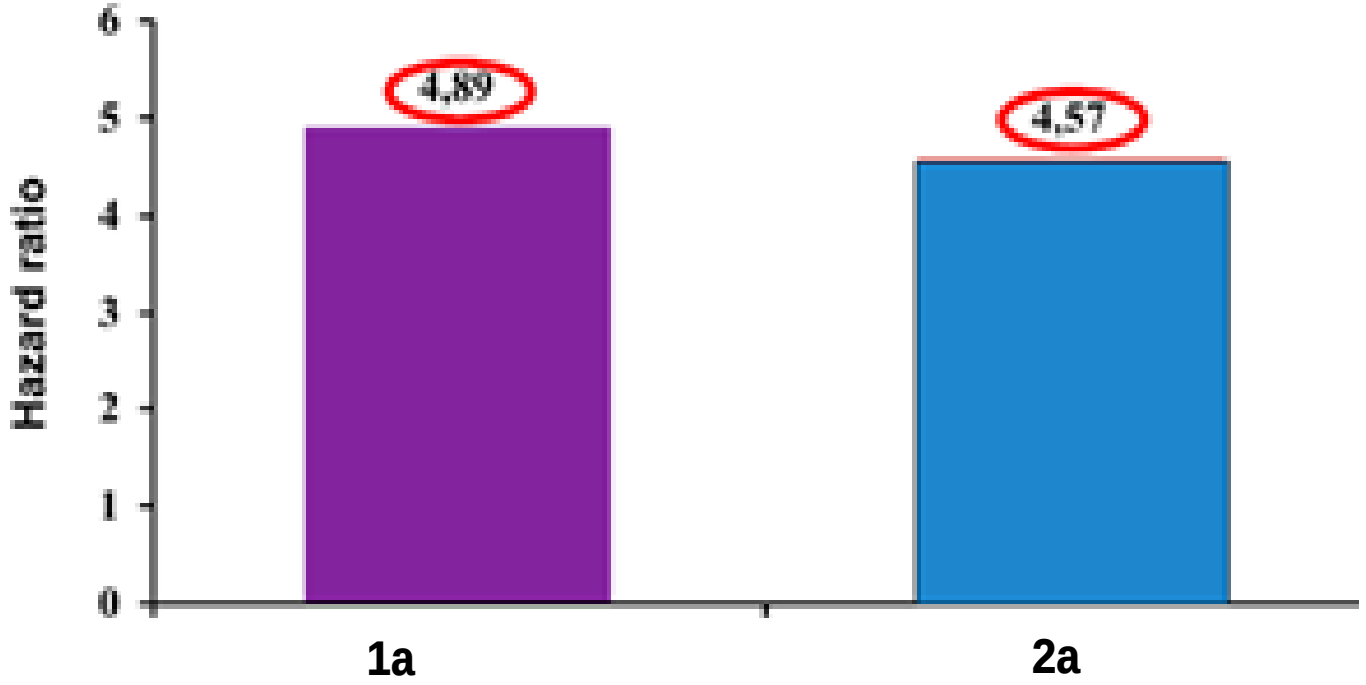
| | | | | Observed Case Mean Changes From Baseline and Mixed-Model *P* Values | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Baseline | | Week 12 | | | | Week 24 | | |
| ROI | Therapy | N | Mean (SE), cm³ | N | Mean (SE), cm³ | *P* Value* | *P* Value† | N | Mean (SE), cm³ | *P* Value |
| WB | Olz | 82 | 1155.01 (14.38) | 73 | 4.74 (2.82) | .10 | .66 | 65 | 2.30 (2.64) | .05 |
| | Hal | 79 | 1155.76 (13.16) | 69 | −3.26 (2.93) | | .28 | 47 | −6.22 (3.58) | |
| | Con | 52 | 1181.93 (17.16) | 52 | 1.74 (3.30) | | | | | |
| WBGM | Olz | 82 | 683.99 (8.78) | 73 | 2.65 (1.97) | .002 | .93 | 65 | −0.88 (2.05) | .002 |
| | Hal | 79 | 685.79 (8.23) | 69 | −5.85 (1.92) | | .005 | 47 | −10.36 (2.48) | |
| | Con | 52 | 699.24 (10.29) | 52 | 2.01 (2.28) | | | | | |
| WBWM | Olz | 82 | 471.01 (5.98) | 73 | 2.08 (1.88) | .39 | .55 | 65 | 3.18 (2.22) | .63 |
| | Hal | 79 | 469.97 (5.38) | 69 | 2.59 (2.23) | | .17 | 47 | 4.13 (2.69) | |
| | Con | 52 | 482.69 (7.33) | 52 | −0.28 (2.13) | | | | | |
| WBF | Olz | 82 | 226.07 (4.05) | 73 | 2.77 (1.55) | .14 | .63 | 65 | 6.89 (1.42) | .56 |
| | Hal | 79 | 230.75 (3.87) | 69 | 6.67 (1.80) | | .18 | 47 | 5.70 (2.45) | |
| | Con | 52 | 231.33 (4.78) | 52 | 2.80 (2.51) | | | | | |
| LV | Olz | 80 | 20.74 (0.97) | 71 | −0.05 (0.33) | .08 | .86 | 64 | −0.31 (0.36) | .27 |
| | Hal | 77 | 20.78 (1.29) | 68 | 0.68 (0.33) | | .01 | 46 | 0.62 (0.55) | |
| | Con | 52 | 20.46 (1.18) | 52 | −0.28 (0.23) | | | | | |
| CN | Olz | 80 | 8.89 (0.19) | 71 | −0.36 (0.13) | .12 | .18 | 64 | −0.23 (0.15) | .03 |
| | Hal | 77 | 8.62 (0.15) | 68 | 0.03 (0.13) | | .92 | 46 | −0.04 (0.14) | |
| | Con | 52 | 9.09 (0.16) | 52 | −0.01 (0.15) | | | | | |

# FACTORS DE RISC DE RECAIGUDA




*Thomas P. Encephale 2013*

# INCUMPLIMENT AUGMENTA EL RISC DE RECAIGUDA



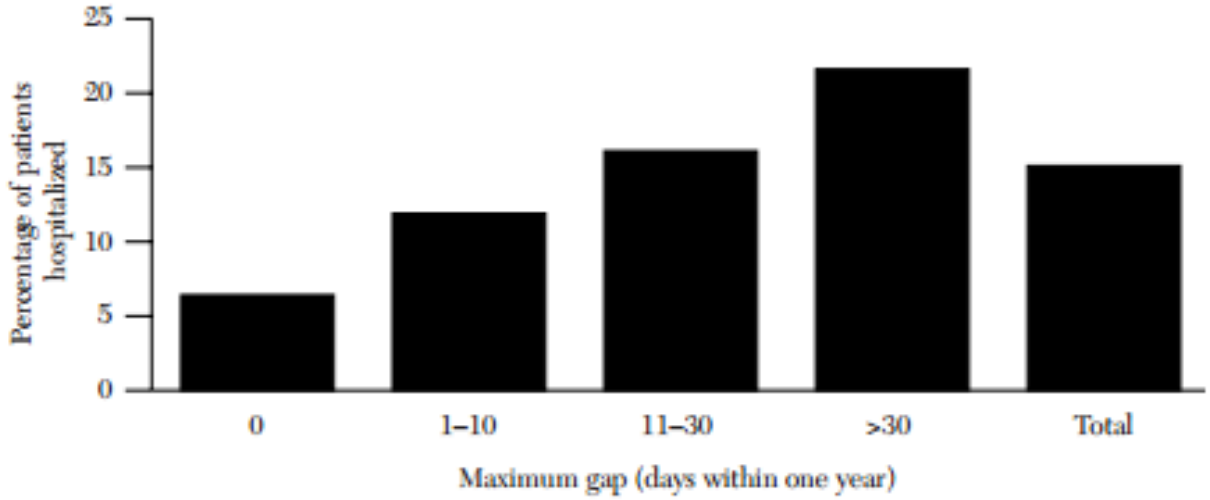

*Robinson D et al Arch Gen Psy 1999*

# Partial Compliance and Risk of Rehospitalization Among California Medicaid Patients With Schizophrenia

**Peter J. Weiden, M.D.**
**Chris Kozma, Ph.D.**
**Amy Grogg, Pharm.D.**
**Julie Locklear, Pharm.D., M.B.A.**

***Figure 1***

Percentage of patients with schizophrenia who were rehospitalized, by maximum gap in therapy[a]




| OR hospitalització | |
|---|---|
| 1-10 | 1.98 |
| 11-30 | 2.81 |
| >30 | 3.96 |

# INCOMPLIMENT A L'ESQUIZOFRÈNIA

Prevalença de 50% (4-72%)

Factors de risc :

•Relacionats amb pacient: edat, gènere masculí, símptomes positius, negatius i cognitius, **baix insight, consum tòxics**

•Ambientals: Pobre suport social, dificultats accés recursos sanitaris

•Relacionats amb el metge: mala relació terapèutica, inadequada planificació tractament, poca psicoeducació pacient i familiars

•Relacionats amb el tractament: posologia complicada, ineficàcia, efectes secundaris

*Acosta et al World J Psychiatry 2014*

# Estratègies per evitar recaigudes

# Estrategias de actuación para mejorar adherencia

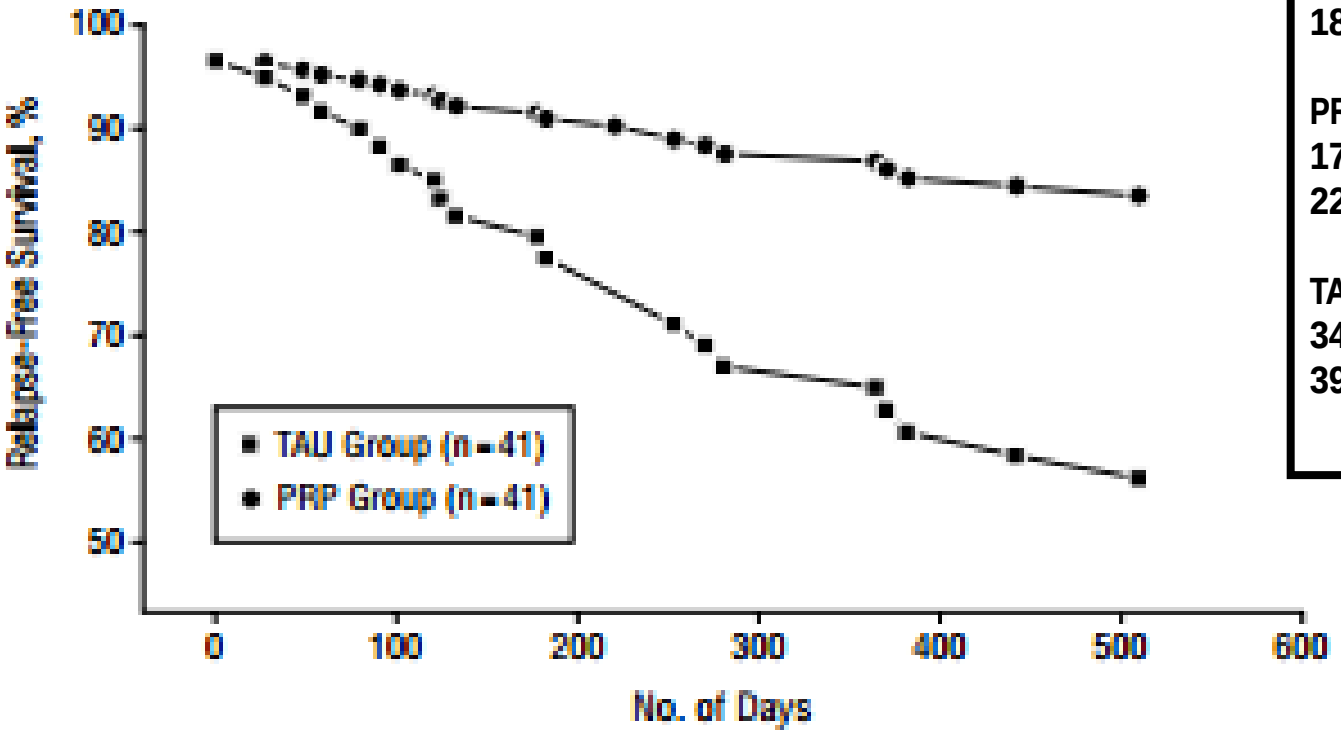

*1. Herz MI Arch Gen Psychiatry 2000. 2- Acosta et al Word J Psychiatry 2012. 3- Barkhof et al Sch Bulletin 2013*

ORIGINAL ARTICLE

# A Program for Relapse Prevention in Schizophrenia

## *A Controlled Study*

*Marvin I. Herz, MD; J. Steven Lamberti, MD; Jim Mintz, PhD; Ruth Scott, MS, RN, CS; Susan P. O'Dell, MS, RN, CS; Lisa McCartan, MA; Glen Nix, PhD*




**18 MESOS**

**PRP**
**17% Recaigudes**
**22% Hospitalitzacions**

**TAU**
**34% Recaigudes**
**39% Hospitalitzacions**

# Compliance therapy in psychotic patients: randomised controlled trial

Roisin Kemp, Peter Hayward, Grantley Applewhaite, Brian Everitt, Anthony David

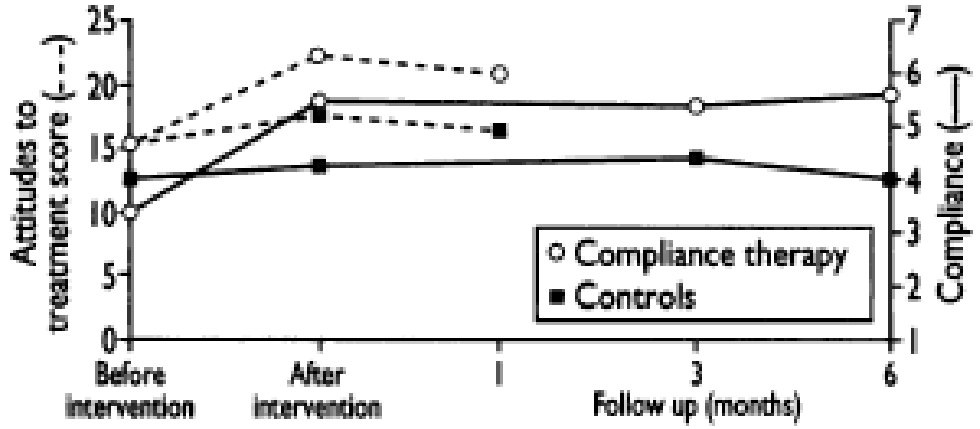



**Fig 1**—*Attitudes to treatment (drug attitudes inventory) and compliance over time in patients receiving compliance therapy or non-specific counselling (controls)*

# Antipsicòtics de llarga durada

- Facilita compliment
- **Transparència immediata del no compliment**
- Dosi mes estable en sang (evitant pic-vall)
- Facilita contacte freqüent amb equip assistencial

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

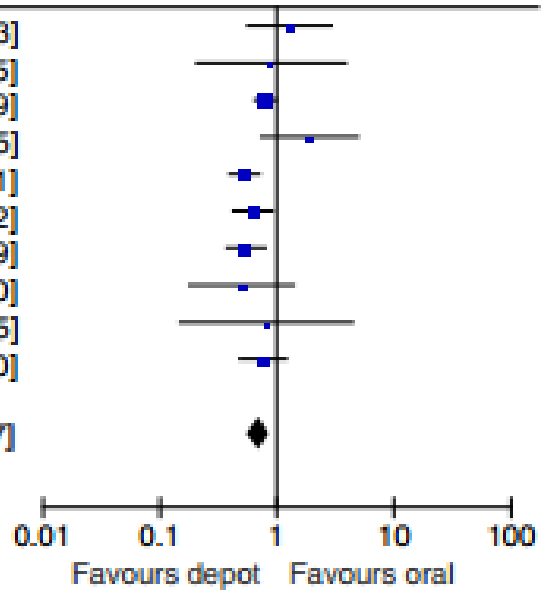
# Oral versus depot antipsychotic drugs for schizophrenia—A critical systematic review and meta-analysis of randomised long-term trials

Claudia Leucht [a], Stephan Heres [a], John M. Kane [c], Werner Kissling [a], John M. Davis [b], Stefan Leucht [a,*]

| Study or Subgroup | Depot Events | Depot Total | Oral Events | Oral Total | Weight | Risk Ratio M-H, Random, 95% CI |
|---|---|---|---|---|---|---|
| Arango 2005 | 10 | 26 | 6 | 20 | 5.2% | 1.28 [0.56, 2.93] |
| Barnes 1983 | 3 | 19 | 3 | 17 | 1.9% | 0.89 [0.21, 3.85] |
| Del Guidice 1975 | 21 | 27 | 30 | 31 | 22.8% | 0.80 [0.65, 0.99] |
| Falloon 1978 | 8 | 20 | 5 | 24 | 4.2% | 1.92 [0.74, 4.95] |
| Gaebel 2010 | 54 | 355 | 102 | 355 | 18.6% | 0.53 [0.39, 0.71] |
| Hogarty 1979 | 22 | 55 | 32 | 50 | 14.8% | 0.63 [0.43, 0.92] |
| Li 1996 | 32 | 155 | 52 | 137 | 15.1% | 0.54 [0.37, 0.79] |
| Potapov 2008 | 4 | 20 | 8 | 20 | 3.6% | 0.50 [0.18, 1.40] |
| Rifkin 1977 | 2 | 23 | 3 | 28 | 1.4% | 0.81 [0.15, 4.45] |
| Schooler 1979 | 26 | 143 | 35 | 147 | 12.4% | 0.76 [0.49, 1.20] |
| Total (95% CI) | | 843 | | 829 | 100.0% | 0.70 [0.57, 0.87] |
| Total events | 182 | | 276 | | | |

Heterogeneity: Tau² = 0.04; Chi² = 15.35, df = 9 (P = 0.08); I² = 41%

Test for overall effect: Z = 3.32 (P = 0.0009)



# Long-Acting Injectable vs Oral Antipsychotics for Relapse Prevention in Schizophrenia: A Meta-Analysis of Randomized Trials

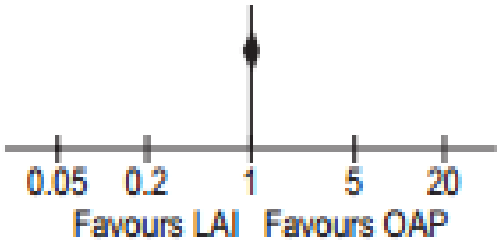
Taishiro Kishimoto[1,2], Alfred Robenzadeh[1], Claudia Leucht[3], Stefan Leucht[3], Koichiro Watanabe[2,4], Masaru Mimura[2], Michael Borenstein[5], John M. Kane[1,6,7,8], and Christoph U. Correll*[,1,6,7,8]

| | | | | | |
|---|---|---|---|---|---|
| **Total (95% CI)** | | **2556** | **2326** | **100.0%** | **1.03 [0.90, 1.18]** |
| Total events | 963 | 908 | | | |

Heterogeneity: $Tau^2 = 0.04$; $Chi^2 = 44.31$, df = 19 (P = 0.0009); $I^2 = 57\%$

Test for overall effect: Z = 0.45 (P = 0.65)

Test for subgroup differences: $Chi^2 = 2.29$, df = 4 (P = 0.68), $I^2 = 0\%$

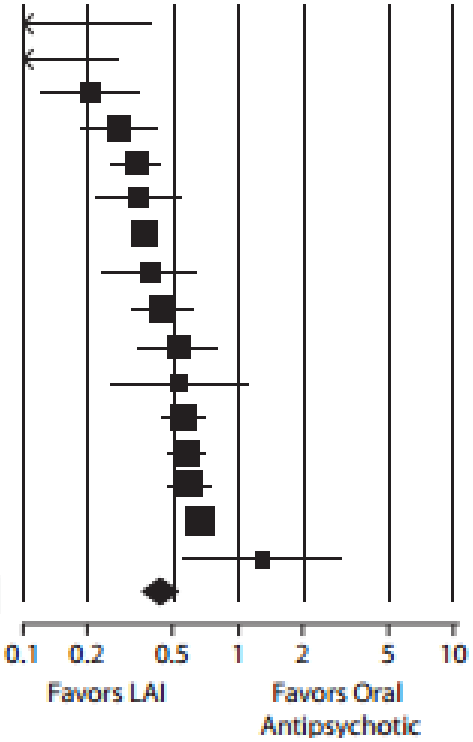


# Long-Acting Injectable Versus Oral Antipsychotics in Schizophrenia: A Systematic Review and Meta-Analysis of Mirror-Image Studies

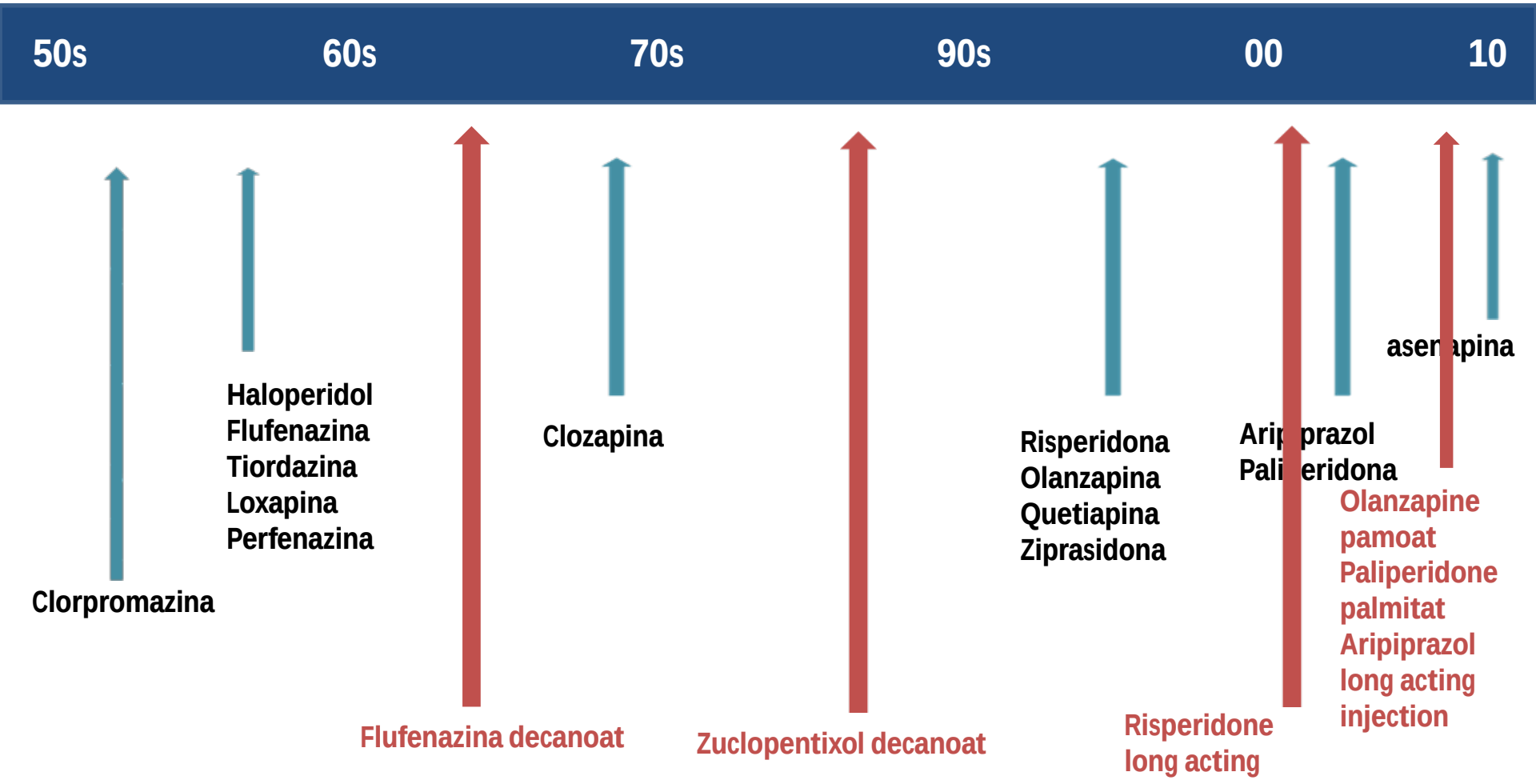
*Taishiro Kishimoto, MD; Masahiro Nitta, MS; Michael Borenstein, PhD; John M. Kane, MD; and Christoph U. Correll, MD*

**Figure 2. Hospitalization Risk**

| Study | Risk Ratio | Lower Limit | Upper Limit | *Z* Value | *P* Value |
|---|---|---|---|---|---|
| Girardi et al, 2010[22] | 0.024 | 0.001 | 0.397 | −2.609 | .0091 |
| Beauclair et al, 2005[26] | 0.092 | 0.030 | 0.282 | −4.166 | .0000 |
| Aratό and Erdős, 1979[32] | 0.204 | 0.119 | 0.350 | −5.761 | .0000 |
| Devito et al, 1978[33] | 0.281 | 0.183 | 0.430 | −5.844 | .0000 |
| Denham and Adamson, 1971[39] | 0.333 | 0.254 | 0.438 | −7.884 | .0000 |
| Morritt, 1974[37] | 0.343 | 0.214 | 0.550 | −4.440 | .0000 |
| Lam et al, 2009[24] | 0.369 | 0.327 | 0.415 | −16.569 | .0000 |
| Lindholm, 1975[35] | 0.391 | 0.232 | 0.660 | −3.515 | .0004 |
| Peng et al, 2011[20] | 0.452 | 0.321 | 0.636 | −4.554 | .0000 |
| Gottfries and Green, 1974[36] | 0.529 | 0.341 | 0.822 | −2.831 | .0046 |
| Rosa et al, 2012[17] | 0.529 | 0.251 | 1.116 | −1.672 | .0944 |
| Chang et al, 2012[16] | 0.557 | 0.437 | 0.711 | −4.697 | .0000 |
| Johnson and Freeman, 1972[38] | 0.570 | 0.461 | 0.704 | −5.203 | .0000 |
| Crivera et al, 2011[18] | 0.597 | 0.463 | 0.768 | −4.003 | .0001 |
| Ren et al, 2011[19] | 0.663 | 0.611 | 0.720 | −9.746 | .0000 |
| Svestka et al, 1984[28] | 1.286 | 0.541 | 3.056 | 0.569 | .5694 |
| | 0.430 | 0.350 | 0.527 | −8.074 | .0000 |



# Evolució tractaments antipsicòtics



# LAI disponibles

| | Emmagatzament | Administració | Efectes secundaris |
|---|---|---|---|
| **Flufenazina decanoat** | Suspensió oliosa | 2-5 setmanes | Símptomes extrapiramidals, somnolencia |
| **Zuclopentixol decanoat** | Suspensió oliosa | 2-4 setmanes | Símptomes extrapiramidals, somnolencia |
| **Risperidona llarga durada** | Microsfera en solucio aquosa | Quinzenal. Precisa refrigeració previa i suplementació oral. | Cefalea, s.extrapiramidals, mareig, acatisia, sedació, augment de pes, dolor extremitats |
| **Olanzapina pamoat** | Solució aquosa | 2-4 setmanes. Adminsitració hospitalaria (3h). Síndrome postinjecció. | Sedació, augment de pes, vòmits, diarrea, cefalea |
| **Paliperidona Palmitat** | Solució aquosa | Mensual. Inici Injeccio dia 1 i 8 | Dolor al lloc de la injecció, mareig somnolencia, parquinsonisme, acaitisia |
| **Aripiprazol llarga durada** | Solució aquosa | Precisa suplementació oral | Acatisia |

*Citrome L. Expert Rev. Neurother, 2013*

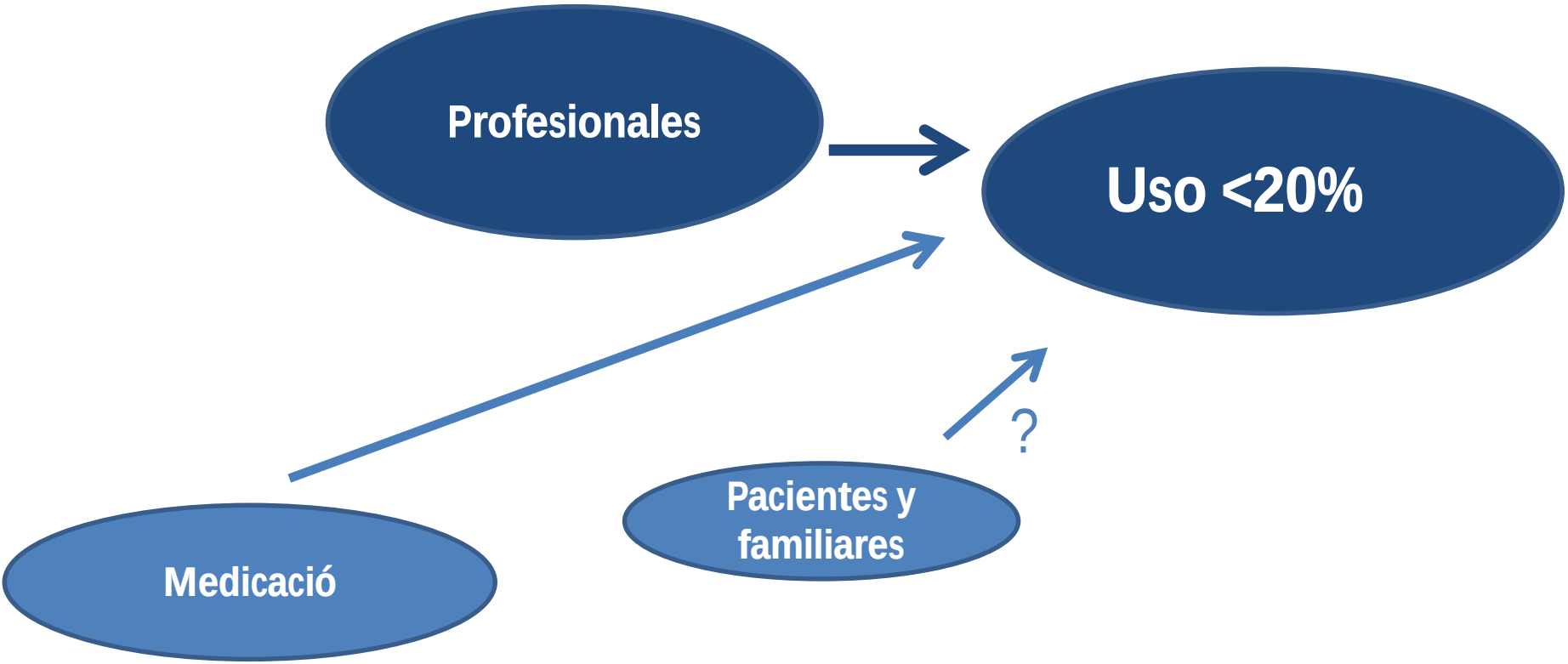
# Elecció?

Individualitzat. Considerar:

- Resposta prèvia
- Perfil efectes secundaris
- Interaccions
- Preu (estudis cost-eficàcia llarg plaç necessaris)

*Citrome L. Expert Rev. Neurother, 2013*

# Barreras




*1-Kane J-. Jclin psy 2014. 2- Kirchner et al Am Clin Psychiatry 2013*

# CONCLUSIONS

Les recaigudes en els pacients amb esquizofrènia tenen greus conseqüències personals, socials, laborals, cerebrals, pronòstiques

L' incompliment del tractament es un dels principals determinants de la recaiguda

La combinació de psicoeducació, entrevista motivacional, antipsicòtics de llarga durada permet millorar l'adherència

Els antipsicòtics de llarga durada han mostrat efectivitat en la disminució de les recaigudes, tot i això, encara són poc utilitzats, en part pels propis professionals i les limitacions en disponibilitat.

Son necessaris més estudis farmacoeconòmics a llarg plaç dels diferents LAI i antipsicòtics orals

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# Comparative Effectiveness of Risperidone Long-Acting Injectable vs First-Generation Antipsychotic Long-Acting Injectables in Schizophrenia: Results From a Nationwide, Retrospective Inception Cohort Study.

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## Abstract

**OBJECTIVE:** To compare in a generalizable sample/setting objective outcomes in patients receiving first-generation antipsychotic long-acting injectables (FGA-LAIs) or risperidone-LAI (RIS-LAI).

**METHODS:** Nationwide, retrospective inception cohort study of adults with International Classification of Diseases-10 schizophrenia using Danish registers from 1995 to 2009 comparing outcomes between clinician's/patient's choice treatment with FGA-LAIs or RIS-LAI. Primary outcome was time to psychiatric hospitalization using Cox-regression adjusting for relevant covariates. Secondary outcomes included time to all-cause discontinuation and psychiatric hospitalization in patients without LAI possession gap >28 days, and number of bed-days after psychiatric hospitalization.

**RESULTS:** Among 4532 patients followed for 2700 patient-years, 2078 received RIS-LAI and 2454 received FGA-LAIs (zuclopenthixol decanoate = 52.2%, perphenazine decanoate = 37.2%, haloperidol decanoate = 5.0%, flupenthixol decanoate = 4.4%, fluphenazine decanoate = 1.3%). RIS-LAI was similar to FGA-LAIs regarding time to hospitalization (RIS-LAI = 246.2±323.7 days vs FGA-LAIs = 276.6±383.3 days; HR = 0.95, 95% confidence interval (CI) = 0.87-1.03, P = 0.199) and time to all-cause discontinuation (RIS-LAI = 245.8±324.0 days vs FGA-LAIs = 287.0±390.9 days; HR = 0.93, 95% CI = 0.86-1.02, P = 0.116). Similarly, in patients without LAI discontinuation, RIS-LAI and FGA-LAIs did not differ regarding time to hospitalization (RIS-LAI = 175.0±268.1 days vs FGA-LAIs = 210.7±325.3 days; HR = 0.95, 95% CI = 0.86-1.04, P = 0.254). Finally, duration of hospitalization was also similar (incidence rate ratio = 0.97, 95% CI = 0.78-1.19, P = 0.744). Results were unchanged when analyzing only patients treated after introduction of RIS-LAI.

**CONCLUSIONS:** In this nationwide cohort study, RIS-LAI was not superior to FGA-LAIs regarding time to psychiatric hospitalization, all-cause discontinuation, and duration of hospitalization. Given the cost of hospitalization and second-generation antipsychotic (SGA)-LAIs, these findings require consideration when making treatment choices, but also need to be balanced with the individual relevance of adverse effects/patient centered outcomes. In future, head-to-head trials and additional nationwide database studies including other SGA-LAIs is needed.

# Decline in hospitalization risk and health care cost after initiation of depot antipsychotics in the treatment of schizophrenia

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**Purpose:** To assess change in hospitalization and cost of care from 6 months pre- to 6 months post-initiation on any depot antipsychotic among schizophrenia patients.

**Patients and methods:** Using a large United States commercial claims and encounters database, patients younger than 65 years diagnosed with schizophrenia were identified. Patients initiated on a depot antipsychotic were studied in a mirror-image design to assess change in hospitalization rates, mean duration hospitalized, and hospitalization cost. McNemar's test and paired *t*-tests compared the proportions of patients hospitalized and the mean duration. Paired *t*-test and bootstrapping methods compared costs.

**Results:** In these patients (n = 147), psychiatric hospitalizations declined from 49.7% pre-initiation to 22.4% post-initiation ($P < 0.001$), and the mean hospitalized duration for psychiatric purposes numerically declined from 7.3 to 4.7 days ($P = 0.05$). Total health care costs declined from \$11,111 to \$7884 ($P < 0.05$) driven by reduction in costs for psychiatric hospitalizations from \$5384 to \$2538 ($P < 0.05$).

**Conclusion:** Initiation of depot antipsychotic therapy appeared to be associated with a decline in hospitalization rates and costs. Current findings suggest that treatment with depot antipsychotics may be a cost-effective option for a subgroup of patients with schizophrenia who are at high risk of nonadherence with their oral antipsychotic medication regimen.