Switching to quetiapine fumarate monotherapy for treatment-resistant schizophrenia: A report of five cases

We assessed the efficacy and tolerance of switching to monotherapy with quetiapine fumarate (QF) in treatment-resistant schizophrenia with other antipsychotics, including atypical ones. QF treatment was maintained for 8 weeks. The PANSS scores improved at least 40% over this period. QF was well tolerated without the presence of serious adverse effects. Switching to QF in these patients may therefore be considered as optimal in response and tolerance.

Key words:
Schizophrenia, Treatment-resistant, Antipsychotics, Quetiapine fumarate

INTRODUCTION

It is estimated that approximately 40% of patients with schizophrenia do not respond to conventional antipsychotic treatment.1 Clozapine, the gold standard for treatment-resistant schizophrenia is effective in only half of these patients.2 In addition, it is known that the use of clozapine is limited by its potentially serious side effects, such as agranulocytosis or seizures, that require monitoring. That is why it is very interesting to evaluate efficacy and safety of atypical antipsychotics other than clozapine in treatment-resistant schizophrenia. Recent guidelines for treatment-resistant schizophrenia recommend attempting at least one atypical antipsychotic before initiating treatment with clozapine.3, 4, 5

Quetiapine fumarate (QF), a derivative of the substituted benzamide, is an atypical antipsychotic with high affinity for 5HT2A serotonin receptors and D1 and D2 dopamine receptors. The efficacy and tolerability of QF has widely demonstrated in the treatment of schizophrenia.6 Therefore, it would be of great interest to also know its efficacy in the treatment of previous treatment resistances, as an alternative to clozapine.

METHODOLOGY

We present a series of 5 cases of male patients who were nonresponders to treatment with two antipsychotics, at least one of which was atypical, at the recommended doses and times.1 The patients were selected consecutively from a Mental Health Rehabilitation Unit. All the patients gave their consent to participate in the study. At the time of their incorporation into the study, the antipsychotic treatment of the patients included different conventional antipsychotics or atypical antipsychotics in monotherapy or in combination (table 1). Only benzodiazepines were accepted as concomitant medication. The baseline antipsychotic medication was reduced progressively during 11.5 ± 4.1 days. QF was gradually introduced during the
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A cross-tapering period at doses of 600 mg/day \pm 183.8 mg/day. Treatment with QF in monotherapy was continued for the following 8 weeks.

The clinical status of the patients was evaluated at the baseline visit, before decreasing the previous antipsychotic agent, and at the end of the trial, after 8 weeks of monotherapy with QF. The Positive and Negative Symptoms Scale (PANSS) and its subscales (positive, negative and general psychopathology) were used. Response criteria were considered to be a decrease of at least 30% in the total score of the PANSS from the baseline visit to the end of the 8 weeks of monotherapy with QF. The Wilcoxon (signed-ranked) test for paired data was used for the statistical analysis.

RESULTS

Mean age of the patients was 35.6 years \pm 8 years, mean duration of disease 11.2 years \pm 7.1 years and mean number of previous hospitalizations 2.9 \pm 2.1. Four of the patients had never received treatment with clozapine and the remaining patients had received treatment with clozapine for 8 months with doses under 300 mg/day.

A 40% decrease in the total score of the PANSS was seen in four of the patients and 50% in the remaining patients. The subscales of the positive, negative and general psychopathology PANSS decreased by more than 30% in all of the patients (table 2). All of the differences were statistically significant (p<0.05). QF was well tolerated without the presence of relevant adverse effects. In two of the patients, somnolence and sedation having mild to moderate intensity appeared.

DISCUSSION AND CONCLUSION

Given the good results obtained, the hypothesis is suggested that QF could be, as previous treatment to the use of clozapine, a good strategy in monotherapy in patients with resistant schizophrenia. In spite of the clear methodological limitations of a case series, the improvement experienced by the patients, the "wash-out" of the drug on the neurochemical
level and the absence of relevant undesired effects would support, in our opinion, the performance of controlled clinical trials to document the efficacy of QF as an alternative to clozapine and other atypical antipsychotics in treatment-resistant schizophrenia.

REFERENCES


