Abstracts

rates, remission rates and discontinuation rates due to adverse events were extracted and compared in a Bayesian meta-analysis. RESULTS: Three aripiprazole, 2 quetiapine and five olanzapine trials were identified together reporting on 2979 patients. Aripiprazole augmentation showed numerically higher efficacy rates compared to quetiapine and olanzapine. Response odds ratios (95% CI) compared to quetiapine and olanzapine were 1.34(0.82-2.06) and 1.52(1.00-2.19) respectively. Remission odds ratios compared to quetiapine and olanzapine were 1.30(0.78-2.07) and 1.26(0.77-1.92) respectively. Aripiprazole augmentation showed numerically lower discontinuation rates compared to quetiapine and olanzapine (OR = 0.99(0.24-2.62) and 0.77(0.23-1.89)). CONCLUSIONS: Amongst augmentation treatments with atypical antipsychotics in MDD, aripiprazole shows a tendency towards higher efficacy rates and lower discontinuation rates due to adverse events compared to quetiapine and olanzapine. More detailed studies are needed to assess the comparative efficacy and safety of adjunctive antipsychotics in MDD.

OUTCOME TRAJECTORIES IN THE LONG-TERM TREATMENT OF SCHIZOPHRENIA

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OBJECTIVES: This study aimed to determine distinct subgroups of schizophrenia patients based on their illness severity at baseline and characterize those who were most improved and those who worsened the most. METHODS: We used data from a large 3-year prospective, multi-site, observational non-interventional study of individuals treated for schizophrenia in the United States (US-SCAP). A hierarchical cluster analysis was used to group the patients, using baseline clinical, functional, and resource utilization measures. Improvement of outcome was determined based on the distance from the defined “worst baseline cluster” for each post-baseline measure. A trajectory analysis was used to group patients by improvement of outcome over the 3-year study. RESULTS: Almost all participants (99% or 872/880) with 3-year data were found in a single outcomes trajectory, characterized by minimal changes from baseline cluster over the 3-year study period. Approximately one-fourth of individuals moved to a better outcome cluster while about 17% moved to a worse outcome cluster at each year. Only 4% of patients moved from the worst/next to worst cluster to the best/next to best cluster and 16.6% moved from the best/next to best cluster to the worst/next to worst cluster. Most improved patients were more likely than all other patients to have case management, to live in a supervised housing arrangement, and get assistance with social services and benefits. DISCUSSION: The long-term outcome trajectory for almost all schizophrenia patients in this 3-year naturalistic observational study was stable, devoid of change from the baseline cluster. Only a very small subgroup of patients experienced marked improvements, and they were more likely to be engaged in psychosocial rehabilitation. Although current findings may affirm the value of psychosocial rehabilitation, results highlight the need to improve the relatively stagnant long-term illness trajectory of almost all chronically ill patients with schizophrenia.