10. Tollerabilità degli psicofarmaci nel paziente con comorbidità medica

Malattie cardiovascolari

Question: Should antidepressants vs placebo be used for depression in patients with coronary artery disease?

Bibliography: Baumeister H,Hutter N, Bengel J. Psychological and pharmacological interventions for depression in patients with coronary artery disease. Cochrane Database of Systematic Reviews 2011; Issue 9

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
Depression scores (measured with: change in scale scores after treatment; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	355	352	-	SMD 0.24 lower (0.38 to 0.09 lower)	⊕⊕⊕O MODERATE	CRITICAL
Depression remission												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	78/216 (36.1%)	51/213 (23.9%)	OR 1.80 (1.18 to 2.74)	122 more per 1000 (from 31 more to 224 more)	⊕⊕OO LOW	CRITICAL
All cause Mortality												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	2/245 (0.82%)	5/242 (2.1%)	OR 0.39 (0.07 to 2.02)	13 fewer per 1000 (from 19 fewer to 20 more)	⊕⊕OO LOW	CRITICAL
Recurrent non fatal MI												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	5/328 (1.5%)	10/325 (3.1%)	OR 0.56 (0.19 to 1.66)	13 fewer per 1000 (from 25 fewer to 19 more)	⊕⊕OO LOW	CRITICAL
Recurrent angina												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29/375 (7.7%)	33/369 (8.9%)	OR 0.84 (0.49 to 1.44)	13 fewer per 1000 (from 44 fewer to 34 more)	⊕⊕OO LOW	CRITICAL

[1] Allocation concealment is unclear; in two trials a double-blind method is stated, but it is not described who was blinded. Number of dropouts not reported

[2] 95% CI ranges from substantial benefit with antidepressants to substantial benefit with placebo

Question: Should risperidone vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Risperidone	Placebo	Relative (95% CI)	Absolute		
Cerebrovascular adverse events (follow-up mean 13 weeks; assessed with: number of cerebrovascular adverse events)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	37/1175 (3.1%)	8/779 (1%)	OR 3.64 (1.72 to 7.69)	26 more per 1000 (from 7 more to 64 more)	⊕⊕⊕⊕ HIGH	IMPORTANT

Question: Should olanzapine vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Olanzapine	Placebo	Relative (95% CI)	Absolute		
Cerebrovascular adverse events (follow-up mean 10 weeks; assessed with: number of cerebrovascular adverse events)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[2]	none	5/203 (2.5%)	0/94 (0%)	OR 5.94 (0.29 to 95.69)	-	⊕⊕OO LOW	IMPORTANT

[1] Heterogeneity not applicable, only one study included
[2] 95% CI ranges from substantial benefit with olanzapine to substantial benefit with placebo

Question: Should antidepressants vs placebo be used for depression after stroke?

Bibliography: Hackett ML, Anderson CS,House A, Xia J. Interventions for treating depression after stroke. Cochrane Database of Systematic Reviews 2008; Issue 4

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
Reduction in depressive symptoms (assessed with: HDRS - MADRS)												
5	randomised trials	very serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	78/209 (37.3%)	149/205 (72.7%)	OR 0.22 (0.09 to 0.52)	358 fewer per 1000 (from 146 fewer to 534 fewer)	⊕OOO VERY LOW	CRITICAL
Total dropouts												
6	randomised trials	serious[3]	no serious inconsistency[4]	no serious indirectness	serious[5]	none	61/268 (22.8%)	61/274 (22.3%)	OR 1.04 (0.69 to 1.59)	7 more per 1000 (from 58 fewer to 90 more)	⊕⊕OO LOW	CRITICAL
Recurrent stroke												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[6]	none	1/50 (2%)	1/55 (1.8%)	OR 1.14 (0.15 to 8.6)	2 more per 1000 (from 15 fewer to 119 more)	⊕⊕OO LOW	CRITICAL

[1] Allocation concealment is unclear; in 3 trials the methods of randomization and blinding are not clearly explained
[2] I-squared=73%
[3] Allocation concealment is unclear; in 2 trials the process of blinding is not clearly explained
[4] I-squared=8%
[5] 95% CI ranges from substantial benefit with antidepressants to substantial benefit with placebo
[6] 95% CI ranges from substantial benefit with antidepressants to substantial benefit with placebo; number of patients is less than 100

Question: Should aripiprazole/quetiapine vs olanzapine be used in patients with schizophrenia and neuroleptic-induced weight gain?

Bibliography: Mukundan A, Faulkner G, Cohn T, Remington G. Antipsychotic switching for people with schizophrenia who have neuroleptic-induced weight or metabolic problems. Cochrane Database of Systematic Reviews 2010; Issue 12

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aripiprazole/quetiapine	Olanzapine	Relative (95% CI)	Absolute		
Body weight (follow-up mean 3-12 months; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	serious[3]	none	142	145	-	MD 1.94 lower (3.97 lower to 0.08 higher)	⊕OOO VERY LOW	CRITICAL
BMI (follow-up mean 3-12 months)												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	8/88 (9.1%)	28/85 (32.9%)	RR 0.28 (0.13 to 0.57)	237 fewer per 1000 (from 142 fewer to 287 fewer)	⊕OOO VERY LOW	CRITICAL
Fasting glucose (Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	138	142	-	MD 2.53 lower (2.94 to 2.11 lower)	⊕⊕OO LOW	IMPORTANT
Total dropouts (follow-up mean 3-12 months)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	69/153 (45.1%)	42/153 (27.5%)	RR 1.67 (1.22 to 2.28)	184 more per 1000 (from 60 more to 351 more)	⊕⊕OO LOW	CRITICAL

[1] Dropout rate higher than 30% in both trials
[2] I squared=0%
[3] 95% CI ranges from substantial harm with olanzapine to no difference
[4] Dropout rate higher than 30%
[5] The overall number of individuals included in the trial is less than 200

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Malattia di Parkinson

Question: Should SSRI vs placebo be used in Parkinson's disease patients with depression?

Bibliography: Skapinakis P, Bakola E, Salanti G, Lewis G, Kyritsis AP, Mavreas V. Efficacy and acceptability of selective serotonin reuptake inhibitors for the treatment of depression in Parkinson's disease: a systematic review and meta-analysis of randomized controlled trials. BMC Neurology 2010; 10: 49.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SSRI	Placebo	Relative (95% CI)	Absolute		
Responders (follow-up 4-10 weeks; assessed with: at least 50% reduction from the baseline score in the depression scale)												
6	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	34/94 (36.2%)	32/95 (33.7%)	RR 1.08 (0.75 to 1.55)	27 more per 1000 (from 84 fewer to 185 more)	⊕⊕OO LOW	CRITICAL
Total dropouts (follow-up 4-12 weeks; assessed with: number of patients leaving the study early)												
5	randomised trials	no serious risk of bias	serious[2]	no serious indirectness	very serious[1]	none	17/88 (19.3%)	12/89 (13.5%)	RR 1.28 (0.67 to 2.45)	38 more per 1000 (from 44 fewer to 196 more)	⊕OOO VERY LOW	CRITICAL

[1] 95% CI ranges from substantial benefit with SSRI to substantial benefit with placebo; number of patients less than 200
[2] Visual investigation of forest plot suggests some degree of heterogeneity; no formal test of heterogeneity is available

Question: Should SSRI vs TCA be used for Parkinson's disease patients with depression?

Bibliography: Skapinakis P, Bakola E, Salanti G, Lewis G, Kyritsis AP, Mavreas V. Efficacy and acceptability of selective serotonin reuptake inhibitors for the treatment of depression in Parkinson's disease: a systematic review and meta-analysis of randomized controlled trials. BMC Neurology 2010; 10: 49.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**SSRI**	**TCA**	**Relative (95% CI)**	**Absolute**		
Responders (follow-up 4-16 weeks; assessed with: at least 50% reduction from the baseline score in the depression scale)												
3	randomised trials	serious[1]	serious	no serious indirectness	very serious[2]	none	22/53 (41.5%)	35/61 (57.4%)	RR 0.75 (0.39 to 1.42)	143 fewer per 1000 (from 350 fewer to 241 more)	⊕OOO VERY LOW	CRITICAL
Dropouts (follow-up 4-16 weeks; assessed with: number of patients leaving the study early)												
3	randomised trials	serious[1]	serious[3]	no serious indirectness	serious[2]	none	-	-	Not estimable[4]	-	⊕OOO VERY LOW	CRITICAL

[1] Dropout rate higher than 30% in 1/3 studies
[2] 95% CI ranges from substantial benefit with SSRI to substantial benefit with placebo; number of patients less than 200
[3] Visual investigation of forest plot suggests some degree of heterogeneity; no formal test of heterogeneity is available
[4] Absolute numbers not reported; RR = 0.96 (95% CI 0.56 to 1.64)

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Epilessia

Per il presente argomento non sono state identificate revisioni sistematiche di studi randomizzati, pertanto non sono state prodotte tabelle GRADE. La raccomandazione è stata formulata sulla base della seguente letteratura.

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