7. Disturbo borderline di personalità

Question: Should haloperidol vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Haloperidol	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
2[1]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none[3]	58	56	-	SMD 0.07 higher (0.3 lower to 0.43 higher)	⊕⊕OO LOW	CRITICAL
Psychotc symptoms (Better indicated by lower values)												
2[4]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	58	56	-	SMD 0.44 lower (1.09 lower to 0.2 higher)	⊕⊕OO LOW	CRITICAL
Depression (Better indicated by lower values)												
2[5]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious	none	58	56	-	SMD 0.09 lower (0.87 lower to 0.68 higher)	⊕⊕OO LOW	CRITICAL
Leaving the study early												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	9/67 (13.4%)	7/63 (11.1%)	RR 1.15 (0.45 to 2.92)	17 more per 1000 (from 61 fewer to 213 more)	⊕⊕OO LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010
[2] Total sample size is 104 patients. CI ranges from substantial benefit with haloperidol to substantial benefit to placebo.
[3] Funnel plot not reported
[4] From comparison 12 of Stoffers 2010
[5] From comparison 14 of Stoffers 2010

Question: Should aripiprazole vs placebo be used in adults with borderline personality disorder?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aripiprazole	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	very serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	26	26	-	SMD 1.84 lower (2.49 to 1.18 lower)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
1	randomised trials	very serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	26	26	-	SMD 1.05 lower (1.64 to 0.47 lower)	⊕OOO VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	very serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	26	26	-	SMD 1.25 lower (1.85 to 0.65 lower)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
0	No evidence available					none	-	-	-	-		CRITICAL
Self mutilating behaviour												
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	very serious[5]	none	2/26 (7.7%)	7/26 (26.9%)	RR 0.29 (0.07 to 1.25)	191 fewer per 1000 (from 250 fewer to 67 more)	⊕OOO VERY LOW	CRITICAL

[1] From comparison 5 of Stoffers 2010
[2] Bias due to conflict of interest is unclear
[3] Number of drop out is unclear; measures of efficacy not based on randomised patients
[4] The overall number of individuals included is less than 100
[5] Total sample size is less than 100 patients. CI ranges from benefit with aripiprazole to benefit with placebo

Question: Should olanzapine vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

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		
Impulsivity (Better indicated by lower values)												
2[1]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	166	174	-	SMD 0.18 lower (0.4 lower to 0.03 higher)	⊕⊕⊕O MODERATE	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
3	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	310	321	-	SMD 0.18 lower (0.34 to 0.03 lower)	⊕⊕⊕O MODERATE	CRITICAL
Depression (Better indicated by lower values)												
2[4]	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision[6]	none	294	302	-	MD 0.39 higher (0.2 lower to 0.97 higher)	⊕⊕OO LOW	CRITICAL
Leaving the study early												
6[7]	randomised trials	serious[8]	serious[9]	no serious indirectness	no serious imprecision	none	155/384 (40.4%)	149/383 (38.9%)	RR 0.97 (0.72 to 1.29)	12 fewer per 1000 (from 109 fewer to 113 more)	⊕⊕OO LOW	CRITICAL
Self mutilating behaviour												
1[10]	randomised trials	serious[11]	no serious inconsistency	no serious indirectness	serious[12]	none	6/12 (50%)	5/12 (41.7%)	RR 1.20 (0.5 to 2.88)	83 more per 1000 (from 208 fewer to 783 more)	⊕⊕OO LOW	CRITICAL

[1] From comparison 5.2 of Stoffers 2010

[2] CI ranges from benefit with olanzapine to no benefit

[3] Dropout rate is more than 30 % in one study; bias due to conflict of interest is unclear

[4] From comparison 14.3 of Stoffers 2010

[5] Dropout rate is more than 30%; bias due to conflict of interest is unclear

[6] CI includes no effect
[7] From comparison 18 of Stoffers 2010
[8] Dropout rate is more than 30 % in the majority of studies; bias due to conflict of interest is unclear
[9] Heterogeneity I squared=54%
[10] From comparison 8 of Stoffers 2010
[11] Dropout rate is around 50% in the majority of studies; bias due to conflict of interest is unclear
[12] The upper CI crosses a risk of 2.0

Question: Should ziprasidone vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ziprasidone	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	30	30	-	SMD 0.03 higher (0.48 lower to 0.53 higher)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
1[4]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	30	30	-	SMD 0.23 lower (0.74 lower to 0.28 higher)	⊕OOO VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1[5]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	30	30	-	SMD 0.30 lower (0.81 lower to 0.21 higher)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	17/30 (56.7%)	14/30 (46.7%)	RR 1.21 (0.74 to 1.99)	98 more per 1000 (from 121 fewer to 462 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010
[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear; dropout rate is more than 30%
[3] The number of individuals included is 60 (less than 100) and 95% CI ranges from substantial benefit with ziprasidone to substantial benefit with placebo
[4] From comparison 12 of Stoffers 2010
[5] From comparison 14 of Stoffers 2010

Question: Should valproate semisodium vs placebo be used in adults with borderline rsonality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Valproate semisodium	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
2[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	32	14	-	SMD 0.62 lower (1.48 lower to 0.24 higher)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Depression (Better indicated by lower values)												
2[4]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	32	14	-	SMD 0.66 lower (1.31 to 0.01 lower)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
2[4]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision[3]	none	19/32 (59.4%)	10/14 (71.4%)	RR 0.78 (0.4 to 1.53)	157 fewer per 1000 (from 429 fewer to 379 more)	⊕⊕OO LOW	CRITICAL
Self mutilating behaviour (Better indicated by lower values)												
1	randomised trials	very serious[2]	no serious inconsistency	serious[5]	very serious[6]	none	12	4	-	SMD 0.52 higher (0.63 lower to 1.67 higher)	⊕OOO VERY LOW	CRITICAL

[1] From comparison 5 of Stoffers 2010

[2] Dropout >30%; bias due to conflict of interest

[3] Number of included individuals is less than 100
[4] From comparison 18 of Stoffers 2010
[5] Suicidal ideation instead of self mutilating behaviour
[6] Number of included individuals is less than 100; 95% CI ranges from substantial benefit with valproate to substantial benefit with placebo

Question: Should lamotrigine vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Lamotrigine	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	18	9	-	SMD 1.62 lower (2.54 to 0.69 lower)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Depression												
0	No evidence available					none	-	-	-	-		CRITICAL
Leaving the study early												
2	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	7/33 (21.2%)	7/22 (31.8%)	RR 0.74 (0.22 to 2.48)	83 fewer per 1000 (from 248 fewer to 471 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010

[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear

[3] Number of included individuals is 27
[4] 95% CI ranges from substantial benefit with lamotrigine to substantial benefit with placebo

Question: Should topiramate vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Topiramate	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
2[1]	randomised trials	very serious[2]	serious[3]	no serious indirectness	serious[4]	none	41	30	-	SMD 3.36 lower (4.44 to 2.27 lower)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[5]	none	28	28	-	SMD 0.49 lower (1.02 lower to 0.05 higher)	⊕OOO VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[5]	none	28	28	-	SMD 0.51 lower (1.04 lower to 0.02 higher)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
3[6]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[7]	none	4/72 (5.6%)	6/61 (9.8%)	RR 0.55 (0.14 to 2.16)	44 fewer per 1000 (from 85 fewer to 114 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010
[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear
[3] I squared =51%
[4] Less than 100 individuals included in the analysis
[5] 95% CI ranges from substantial benefit with topiramate to substantial benefit with placebo
[6] From comparison 18 of Stoffers 2010
[7] 95% CI ranges from substantial benefit with topiramate to no difference

Question: Should carbamazepine vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Carbamazepine	Placebo	Relative (95% CI)	Absolute		
Impulsivity												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	7/10 (70%)	8/10 (80%)	RR 0.88 (0.53 to 1.46)	96 fewer per 1000 (from 376 fewer to 368 more)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	10	-	SMD 0.58 lower (1.5 lower to 0.35 higher)	⊕OOO VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	10	-	SMD 0.66 lower (1.59 lower to 0.27 higher)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/10 (20%)	0/10 (0%)	RR 5.00 (0.27 to 92.62)	-	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear
[2] Only 20 individuals included in the analysis; 95% CI ranges from substantial benefit with carbamazepine to substantial benefit with placebo

Question: Should amitriptyline vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amitriptyline	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	29	28	-	SMD 0.12 lower (0.64 lower to 0.4 higher)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms (Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[4]	none	29	28	-	SMD 0.43 lower (0.96 lower to 0.09 higher)	⊕OOO VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[5]	none	29	28	-	SMD 0.59 lower (1.12 to 0.06 lower)	⊕⊕OO LOW	CRITICAL
Leaving the study early												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/30 (3.3%)	1/29 (3.4%)	RR 0.97 (0.06 to 14.74)	1 fewer per 1000 (from 32 fewer to 474 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010

[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear

[3] Less than 100 individuals included in the analysis; 95% CI ranges from substantial benefit with amitriptyline to substantial benefit with placebo
[4] Less than 100 individuals included in the analysis; 95% CI ranges from substantial benefit with amitriptyline to no benefit
[5] Less than 100 individuals included in the analysis

Question: Should fluoxetine vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Fluoxetine	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	9	11	-	SMD 0.59 lower (1.5 lower to 0.31 higher)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Depression (Better indicated by lower values)												
2	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	22	20	-	SMD 0.12 higher (1.13 lower to 1.36 higher)	⊕OOO VERY LOW	CRITICAL
Leaving the study early												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	3/12 (25%)	2/13 (15.4%)	RR 1.63 (0.33 to 8.11)	97 more per 1000 (from 103 fewer to 1000 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour (Better indicated by lower values)												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	9	11	-	SMD 0.03 higher (0.85 lower to 0.92 higher)	⊕OOO VERY LOW	CRITICAL

[1] From comparison 5 of Stoffers 2010
[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear
[3] Less than 50 individuals included in the analysis; 95% CI ranges from substantial benefit with fluoxetine to substantial benefit with placebo

Question: Should fluvoxamine vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Fluvoxamine	Placebo	Relative (95% CI)	Absolute		
Impulsivity (Better indicated by lower values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	20	18	-	SMD 0.05 lower (0.68 lower to 0.59 higher)	⊕OOO VERY LOW	CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Depression												
0	No evidence available					none	-	-	-	-		CRITICAL
Leaving the study early												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/20 (5%)	2/18 (11.1%)	RR 0.45 (0.04 to 4.55)	61 fewer per 1000 (from 107 fewer to 394 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
0	No evidence available					none	-	-	-	-		CRITICAL

[1] From comparison 5 of Stoffers 2010

[2] Adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear

[3] Less than 100 individuals included in the analysis; 95% CI ranges from substantial benefit with fluvoxamine to substantial benefit with placebo

Question: Should mianserin vs placebo be used in adults with borderline personality disorders?

Bibliography: Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mianserin	Placebo	Relative (95% CI)	Absolute		
Impulsivity												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Depression												
0	No evidence available					none	-	-	-	-		CRITICAL
Leaving the study early												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/29 (41.4%)	8/29 (27.6%)	RR 1.50 (0.72 to 3.12)	138 more per 1000 (from 77 fewer to 585 more)	⊕OOO VERY LOW	CRITICAL
Self mutilating behaviour												
1	randomised trials	very serious[3]	no serious inconsistency	serious[4]	very serious[2]	none	20/29 (69%)	20/29 (69%)	RR 1.00 (0.71 to 1.41)	0 fewer per 1000 (from 200 fewer to 283 more)	⊕OOO VERY LOW	CRITICAL

[1] Dropout >30%

[2] Less than 100 individuals included in the analysis; 95% CI interval ranges from substantial benefit with mianserin to substantial benefit with placebo

[3] Dropout > 30%; adequate sequence generation is unclear; allocation concealment is unclear, blinding is unclear
[4] Suicidal ideation instead of self-mutilating behaviour

Bibliografia

Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. Cochrane Database of Systematic Reviews 2010; Issue 16.