10 mg intramuscular olanzapine reduces acute agitation in schizophrenia more effectively than lower doses


**QUESTION:** What is the efficacy and safety of intramuscular olanzapine for acute agitation in schizophrenia? Is there a dose-response relationship?

**Main results**
All doses of olanzapine reduced excitement and agitation compared to placebo. There was a dose-response relationship. Olanzapine doses of 5mg, 7.5mg or higher had similar effects to 7.5mg haloperidol on most clinical scales. There were no significant differences in hypotension, the most commonly reported adverse effect, or clinically relevant changes in the QTc interval. Treatment emergent parkinsonism was more common in the haloperidol group (10.7% vs 0%–2.9% olanzapine and 0% placebo).

**Conclusions**
Olanzapine was as effective as haloperidol in reducing excitement and agitation among adults with schizophrenia.

**COMMENTARY**

Atypical antipsychotics such as olanzapine and risperidone are increasingly used as first-line therapy for schizophrenia and related disorders. Oral atypical antipsychotics have equal or superior efficacy to conventional antipsychotics, but conventional antipsychotics are still used extensively for two purposes: controlling agitation in acute treatment and long-term maintenance with depot preparations when there are adherence problems. Atypical antipsychotics have fewer adverse motor effects than most conventional antipsychotics. If safe and effective intramuscular preparations are developed, atypical antipsychotics are likely to supplant conventional antipsychotics for controlling agitation and depot maintenance therapy. Breier et al examine olanzapine versus haloperidol for acute agitation in people with schizophrenia or schizoaffective disorders. The authors used a sufficient sample and objective rating scale measures. Olanzapine doses of 5mg, 7.5mg or higher had similar clinical benefits to 7.5mg haloperidol and fewer adverse effects. Intramuscular olanzapine has also been found to reduce agitation in people with dementia and bipolar disorder.1,2 A similar study is being conducted in the United States, but results are not yet available. Participants did not receive treatment with their standard antipsychotic drugs during the one day study period. This affords a cleaner design, but is at variance with standard clinical practice. Another limit is the exclusion of violent patients who might not meet ethical consent criteria. Short-acting intramuscular olanzapine is not available for use in the United States. It awaits FDA approval after minor technical problems, presumably related to the injection vehicle substance. The next stage of development may be a depot form of olanzapine for long-term maintenance when adherence to treatment is unreliable. Several clinical trials have been completed with a depot form of risperidone, another atypical antipsychotic. This has yet to be approved for use in the United States by the FDA, although preliminary unpublished results suggest clinical efficacy and patient acceptance.

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**Mean PANSS-EC reductions (standard deviation in parenthesis)**

<table>
<thead>
<tr>
<th>Drug and dose</th>
<th>Mean PANSS-EC reductions 2 hours after first injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo (n=45)</td>
<td>2.9 (4.7)</td>
</tr>
<tr>
<td>2.5mg olanzapine (n=48)</td>
<td>5.5 (6.6) **</td>
</tr>
<tr>
<td>5.0mg olanzapine (n=45)</td>
<td>8.1 (5.3) **</td>
</tr>
<tr>
<td>7.5mg olanzapine (n=46)</td>
<td>8.7 (5.0) **</td>
</tr>
<tr>
<td>10mg olanzapine (n=46)</td>
<td>9.4 (4.9) **</td>
</tr>
<tr>
<td>7.5mg haloperidol (n=40)</td>
<td>7.5 (5.9) **</td>
</tr>
</tbody>
</table>

* placebo < olanzapine < haloperidol (p<0.05)
** placebo < olanzapine and haloperidol (p<0.05)
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