Ir/cmj

1 October 2004

Mr Jeff Watling
Queen Alexandra Hospital
Southwick Road
Cosham
Portsmouth
Hants

Dear Jeff

Following my presentation of the business case for Aripiprazole at the last APC, I was asked to present the meeting with further information clarifying the circumstances in which this drug would be prescribed. I have attached the current prescribing guidelines into which Aripiprazole would be incorporated. As these suggest, the standard management of schizophrenia is for a patient to be started on Risperidone or Amisulpride and, if they don't respond, switched to the other of this pair. If they don't respond to either, they should be switched to Clozapine. Variance from this treatment pathway occurs as a result of adverse effects and patient choice and the guidelines set out the parameters within which these treatment decisions should be made.

It is proposed that Aripiprazole is used in two circumstances. It will be the first-choice treatment for patients unable to tolerate Risperidone or Amisulpride because of hyperprolactinaemia and will be used in ahead of Quetiapine, the current first-choice in these circumstances, because of its lower cost. Quetiapine will become the second-choice treatment for this group of patients. Biochemical hyperprolactinaemia has been shown to occur in 15-80% of patients on antipsychotics (1,2) but there are no studies showing what proportion of these have clinically significant symptoms and so it is impossible to estimate the frequency with which Aripiprazole will be prescribed because of hyperprolactinaemia. If Aripiprazole is not on the formulary, Quetiapine will continue to be prescribed, at greater cost (£106 vs £102 per 28 days). Another consequence of aripiprazole not being on the formulary is that patients most sensitive to antipsychotic-induced hyperprolactinaemia will not be able to have trials of two antipsychotics prior to consideration of clozapine, as recommended in local and NICE guidelines.

Aripiprazole will also be the first-choice treatment of patients who develop QT prolongation on ECG with other antipsychotics. It is the only antipsychotic that has been shown to be superior in this regard and so our current guidelines do not include recommendations for this contingency. QT prolongation is estimated to occur in around 1-3% of patients taking antipsychotics (3) but is not routinely screened for in clinical practice in the Portsmouth district so again it is impossible to estimate how often Aripiprazole will be prescribed for this reason. If it is prescribed in these circumstances following adherence to the treatment guidelines, it is likely to be in place of Risperidone (£72-109 per 28 days) or Amisulpride (£62-123). The high rate of hyperprolactinaemia compared with the low rate of QT prolongation suggests that relatively few patients will be started on Aripiprazole for this latter reason.

Please can you put this correspondence on the agenda of the next meeting of the APC.

Thanks for your help

Dr Ian Rodin
Consultant Psychiatrist

1 Hummer M. & Huber J. Hyperprolactinaemia and antipsychotic therapy in schizophrenia. [Review]. Current Medical Research & Opinion. 20(2):189-97, 2004.
2 Kinon BJ, Gilmore JA, Liu H & Halbreich UM. Prevalence of hyperprolactinemia in schizophrenic patients treated with conventional antipsychotic medications or Risperidone. Psychoneuroendocrinology. 28 Suppl 2:55-68, 2003 Apr.
3 Welch R. & Chue P. Antipsychotic agents and QT changes. Journal of Psychiatry & Neuroscience. 25(2):154-60, 2000 Mar.