

Pharmacologic Treatment of Hospitalized Patients With Schizoaffective Disorder

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This study examined changes in the pharmacologic treatment of 70 patients who were hospitalized with a diagnosis of schizoaffective disorder at some time during a six-year period. An increasing use of divalproex sodium and atypical antipsychotics instead of lithium and conventional antipsychotics

was observed. The use of a combination of an antipsychotic and a thymoleptic medication was more common than monotherapy, and physicians tended to continue antidepressants if patients had a history of depression. Patients with a new diagnosis of schizoaffective disorder were stabilized less quickly than those with a previous diagnosis. The use of divalproex sodium and newer antipsychotics did not reduce the time to stabilization in routine clinical practice. (*Psychiatric Services* 53:94–96, 2002)

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be delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms. In addition, the mood symptoms are present for a substantial proportion of the period of illness (1).

Schizoaffective disorder is often chronic (2). Treatment may include multiple hospitalizations and multiple psychotropic medications (3,4). For patients who present with exacerbations of illness, the extent to which clinicians select medications on the basis of current presentation rather than historical information is unclear. It is also unclear whether the duration of illness, the number of previous hospitalizations, or a change in diagnosis to schizoaffective disorder during a hospital admission influences the clinician's choice of medication or the time to stabilization.

In recent years, valproic acid has shown efficacy similar to that of lithium in the treatment of bipolar disorder.

The essential feature of schizoaffective disorder is an uninterrupted period of illness during which, at some time, there is a major depressive, manic, or mixed episode concurrent with the symptoms that meet criterion A for schizophrenia. During the same period of illness, there must

der (5,6) and has been used in the treatment of schizoaffective disorder (7). Newer—atypical—antipsychotics are also being used (8). One study showed a decline in the use of lithium and an increase in the use of valproic acid between 1989 and 1994 (9). It is unclear whether this trend has continued and whether the use of newer agents has substantially affected stabilization rates in routine clinical practice. Also, it has been suggested that the thymoleptic properties of the atypical antipsychotics may result in their use as monotherapy for patients who have schizoaffective disorder (3,10), but it is unclear whether this proposed method of treatment has been adopted by clinicians. This study examined whether pharmacologic treatment of patients with schizoaffective disorder changed over a six-year period and whether these changes led to improved rates of stabilization.

Methods

The first two authors retrospectively reviewed all available inpatient hospitalization records of patients who received a discharge diagnosis of schizoaffective disorder between September 1993 and October 1999. If both researchers did not agree that a particular record documented symptoms consistent with *DSM-IV* criteria for schizoaffective disorder, that record was excluded from further analysis. To avoid overrepresentation of patients with refractory illness, data for patients who had had multiple hospitalizations during the study period were obtained only for the first hospitalization.

Demographic data, diagnosis, age at onset of psychiatric illness, number of previous admissions, presence or absence of psychosis, and data on primary mood symptoms at admission, recent drug or alcohol use, and psychotropic medications at discharge were extracted from the medical charts.

The time to stabilization was determined by counting the number of days from admission to the attainment of ward and hospital status. Ward status was assigned when the patient was no longer imminently dangerous and could participate in group treatment activities. Hospital status was assigned when the patient

was deemed ready for transfer to a noninpatient level of care. Throughout hospitalization, ward or hospital status was determined by the multidisciplinary treatment team's assessments of dangerousness, cognitive processes, and ability to conform behavior to the unit and hospital norms.

For the statistical analyses, the Mantel-Haenszel chi square test was used for linear by linear analysis. Comparisons of continuous variables between groups were made with the nonparametric Mann-Whitney U test, because group data were not normally distributed.

The research protocol was reviewed by the research review service and approved by the department of clinical investigation of the Walter Reed Army Medical Center.

Results

During the study period, 114 hospitalized patients were discharged with a diagnosis of schizoaffective disorder. On the basis of chart data, 70 patients met the inclusion criteria, which represented 1.6 percent of all patients admitted to the psychiatric inpatient units during the study period.

The sample comprised 29 men and 41 women. The mean \pm SD age of the men at admission was 30.1 \pm 11.4 years, compared with 43 \pm 15.1 years for the women ($z=-3.437$, $p<.001$). Twenty-eight patients (40 percent) reported use of alcohol or illicit drugs in the month preceding admission. Sixty-six (94 percent) presented with psychotic symptoms, 37 (53 percent) with depressive symptoms, 11 (16 percent) with mania, and seven (10 percent) with mixed mood symptoms; 15 patients (21 percent) had no active mood symptoms on admission.

Sixty-three patients (90 percent) were treated with either a conventional or an atypical antipsychotic; 55 of these (87 percent) were also treated with a thymoleptic (antimanic or antidepressant) medication. No significant difference was found in the proportion of patients who were treated with monotherapy—four (6 percent) were treated with an atypical antipsychotic and four (6 percent) with a conventional antipsychotic. Of the 15 patients who presented without mood symptoms, 12 were discharged with a

prescription for the same thymoleptic medication that had been prescribed before admission.

Patients who had a previous diagnosis of schizoaffective disorder were compared with those who had a new diagnosis. Those with a new diagnosis were younger (32.6 \pm 11.7 years compared with 41.2 \pm 16.2 years; $z=-2.07$, $p<.01$), had a shorter duration of illness (7.5 \pm 10 years compared with 14.1 \pm 11.1 years; $z=-3.2$, $p<.01$), and had had fewer previous admissions (1.6 \pm 2.1 compared with 5.3 \pm 3.9; $z=-4.1$, $p<.01$). The patients with a previous diagnosis of schizoaffective disorder were more rapidly stabilized: 5.2 \pm 6.4 days compared with 9.6 \pm 10.3 days to ward status ($z=-2.02$, $p=.044$) and 10 \pm 9.2 days compared with 17.6 \pm 12.6 days to hospital status ($z=-3.49$, $p<.001$). No significant differences were found between the two diagnostic groups in the use of lithium as opposed to divalproex sodium or in the use of conventional as opposed to atypical antipsychotic medications.

Year-by-year examination of data revealed a statistically significant shift toward discharging patients with a prescription for atypical rather than conventional antipsychotic medications (linear-by-linear association [LL]=15.6, $df=1$, $p<.001$) and toward discharging patients with a prescription for divalproex instead of lithium (LL=4.67, $df=1$, $p=.031$). No significant differences were found in time to ward status or time to hospital status associated with treatment with conventional versus atypical antipsychotic medications or lithium versus divalproex sodium. No associations were found between substance abuse and the medication selected or the time to stabilization.

Discussion and conclusions

On admission to the hospital, a larger proportion of patients had psychotic symptoms than had mood symptoms. It was evident that in selecting a medication, clinicians relied on a history of mood symptoms rather than basing their decision on current mood symptoms; they maintained patients on their prehospitalization antidepressant or antimanic agents, even when significant mood symptoms were not present. Despite the theoretical ad-

vantage of using atypical antipsychotics for monotherapy, the data indicate that clinicians had not adopted that practice during the study.

To a large extent, atypical antipsychotics and divalproex sodium replaced conventional antipsychotics and lithium for the treatment of patients hospitalized with schizoaffective disorder during the study period. Although specific aspects of treatment were not controlled, there was no evidence of a decrease in the time to stabilization with the use of the newer medications.

The patients in this study had experienced a chronic course of psychiatric illness before receiving a diagnosis of schizoaffective disorder. Those who already had a diagnosis of schizoaffective disorder on admission to the hospital were more rapidly stabilized, even though this group of patients had a longer history of psychiatric illness and a greater number of previous hospitalizations. Thus a history of multiple hospitalizations and long-term outpatient management may provide some clarity in the management of patients with this disorder.

The results of this study also point to several aspects of schizoaffective

disorder that require further study. Because the rate of stabilization does not appear to change with newer medications, further analysis of changes in patients' adherence to regimens of the newer medications compared with the old ones may clarify the value of using the newer agents. Also, although the patients who had a diagnosis of schizoaffective disorder before hospitalization were stabilized more rapidly than those who received the diagnosis during admission, factors that affect the rate of stabilization—other than clarity of diagnosis—are areas for future study. ♦

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