Reviewer’s report

Title: Antipsychotic treatment of schizophrenia in Norwegian emergency wards, a cross-sectional national study.

Version: 1 Date: 1 February 2009

Reviewer: Stefan Weinmann

Reviewer’s report:

General comments:

This is an interesting survey on the type of antipsychotic treatment prescribed at discharge from selected Norwegian hospitals, and predictors for antipsychotic polypharmacy, doses and prescriptions of first generation antipsychotics. The aim is clearly outlined.

However, the study has substantial limitations. The authors have only inpatient data available, and the set of predictors is limited. Nevertheless the study is of interest and worth being published.

Unfortunately reasons for guideline non-adherence (patient or mental health system factors) could not be evaluated.

Major Compulsory revisions:

Specific points:

Abstract:

In “methods” the year of data collection should be mentioned. It should clearly outlined what it is meant by FGA prescriptions: prescription of at least one FGA or FGA monotherapy?

“Inpatient treatment the last 12 months” may be better formulated “previous inpatient treatment in the last 12 months before the index hospitalisation” or s.th. comparable. Conclusions: “. inpatient treatment reveals antipsychotic drug regimens that are to some degrees are at odds […] Patients with high relapse rates, comorbid […] are especially prone to be prescribed antipsychotic drugs regimens not supported by guidelines.”

GAF and HoNOS are not primarily symptom scales. The abbreviations should be explained when they are use for the first time.

Background:

page 3 line 14: “the second generation … as a group are….”

SGAs are recommended by most (or many) guidelines as first-line therapy (not by all).

Page 4: In my opinion the “association between increasing side effects and
poorer drug adherence” is not so well established as the authors write. there are studies showing other factors are at least equally important for non-adherence.

Page 4, line 8: What do the authors mean with “During admissions in psychiatric emergency wards the clinicians should evaluate and optimize the antipsychotic drug regime for the individual patient and these admissions represent unique opportunities to investigate the prescription patterns of antipsychotics” ? In my opinion hospital admissions are caused by many factors inadequate antipsychotic therapy is only one of them.

Methods

page 4 Which and what kind of hospitals have been involved? Psychiatric hospitals, general hospitals? Some words about the Swedish psychiatric inpatient system seem necessary to understand the message of the article.

Page 5: who rated the scales?

excluding prescriptions of low-potency antipsychotics is problematic. Guideline include low-potency antipsychotic in their AP monotherapy recommendations!! Did they contribute to the chlorpromazine equivalence doses? They should! MAY be the authors could give sensitivity analyses in- and excluding these low-potency AP prescriptions.

Results:

Page 7: It is noteworthy that in almost 5= of case with an SGA prescription at discharge an additional FGA (above 100 CPZ equivalents when low-potency FGA?) was prescribed concurrently.

Page 8: What means “GAF-S score”?

The authors may also evaluate predictors for polypharmacy at admission because this kind of guideline non-adherence is due to decisions in the ambulatory setting, and discharge prescriptions are under the control of the clinic.

Discussion

Page 12:

There are authors stating that antipsychotic dosas below 300 CPZ equivalents are not suboptimal. The trend at the moment is towards lower dosages.

It should be discussed that the 300-1000 CPZ recommendation has NO SCIENTIFIC foundation but was a consensus. There are studies showing that 300 and lower CPZ equivalents (esp. in first episode patients) are not inferior to higher doses.

Limits of guidelines may be somewhat discussed.

Conclusions:

For me no statement should be made about clozapine adequacy because we do not know anything about treatment resistance and adequacy of prior AP treatment in this population.
Minor essential revisions:

CE is not a usual abbreviation for chlorpromazine equivalence doses (better CPZ ?)

Statistics
Page 6: What means “in the logistic regression with use of FGA at discharge as the dependent variable recurrent illness and a comorbid diagnosis of mental retardation had to be excluded from the analysis due to stability reasons.”?
Line 19: the phrase in incomplete.

Table 1:
Sex (M/F) The numbers do not add to 486. Was not all data available?
GAF is a social functioning scale not a symptoms scale.

In Table 2 the references should be given where the authors took the Chlorpromazine equivalence dates.

References:
The format needs to be improves (remove: “Ref type Generic” etc.)

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**
I declare that I have no competing interests.