Editorial: Evidence-Based Therapeutics—Introducing the Cochrane Corner

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Therapeutic advances in schizophrenia are challenging, and novel drug development strategies that target diverse mechanisms are wanting. The drug discovery process has diverged little from the initial strategy of targeting D2 dopamine receptors following the discovery of the antipsychotic effect of chlorpromazine. The superior efficacy of clozapine in treatment-resistant patients was touted as a big advance in schizophrenia therapeutics promising superior effectiveness of the second-generation drugs in treating psychosis as well as other symptom domains and cognition impairments of schizophrenia. As suggested by the commercial success of these drugs, clinicians and consumers enthusiastically bought into this promise, in spite of the controversy regarding efficacy and effectiveness of recently marketed antipsychotic drugs compared to older drugs. The questions regarding the superiority of the newer drugs have been highlighted by the recent Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE)1 and Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS)2 reports. Would an objective and comprehensive evaluation of clinical trials have clarified the evidence, permitting a more rational approach to evidence-based pharmacotherapy?

Clinical trials for a number of psychosocial, behavioral, and cognitive therapies are reported, but only a small minority of patients receive treatments with proven effectiveness. Reports are in a wide range of journals making systematic and comprehensive access difficult for individual clinicians. Information is not disseminated with strong financial backing from industry, so an important resource and influence is lost. Would easy access to comprehensive and objective evaluation of the efficacy and effectiveness data increase the implementation of evidence-based nonpharmacological therapeutics?

Evaluation of the superiority of a particular therapy based on a single trial is difficult and is better served by a comprehensive and systematic review of all existing data sets. This view resulted in a potent systematic review of perinatal trials in the mid-80s, subsequent formation of The Cochrane Collaboration in 1993, and launch of The Cochrane Library in 1996. The resources made available by The Cochrane Library are highly regarded throughout medicine. The Cochrane Schizophrenia Group was formed in 1994, and the first review concerned with schizophrenia was reported in 1999.3 The Cochrane Library can be accessed on the Web that provides abstracts of the reviews (http://www.mrw.interscience.wiley.com/cochrane/). Subscriptions to access full reports are available (http://www.library.nhs.uk/Default.aspx). Metaanalytic methodology for Cochrane reviews is sophisticated, and extensive efforts are made to minimize publication bias and determine consistency of findings. Critical commentary is included with reviews, but the primary contribution is an objective analysis of studies that meet quality criteria. The results can assist the clinician and service director in the implementation of evidence-based therapeutics. However, it is our impression that most clinicians and medical service directors do not access this information. In the pharmacology area, information is far more likely to come from marketing personnel or educational programs supported by commercial entities. In the psychosocial and behavioral therapeutics, methods for successful dissemination of effective treatments are weak.

These comments are by way of introducing the latest Special Feature for the Schizophrenia Bulletin. When the OUP/MPRC partnership assumed responsibility for the Bulletin in 2005, we preserved the very successful first-person accounts and continue to place artwork from persons with schizophrenia on the Bulletin cover and to make the At Issue section available for brief presentation of controversial views or new hypotheses. In 2005, we added a special feature on the gene of the quarter and another feature on the environmental risk factor of the quarter. In 2006, we initiated 2 more special features: neuroscience concepts for the clinician and clinical concepts for the neuroscientist. All these have proven very popular judging by the attention they receive on the Web site and comments from numerous readers. This year, we are moving from quarterly to 6 issues a year, and we will alternate the translational concepts pieces. We are grateful to Mike Owen, Jim van Os, Paul Shepard, and Tom McGlashan for assuming editorial responsibility for these 4 special features.

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We now introduce the “Cochrane Corner” to the Special Features section. Our plan is to print a very brief piece where the field’s attention will be drawn to one or two recent Cochrane Library reviews with a summary of findings, implications for clinical care, and implications for research. We believe that by providing this material to Bulletin readers, critical assessment of evidence will start to have a greater impact in clinical thinking. The interested reader will be guided to the full reviews, and we also hope this increases interest in the many other reviews provided by The Cochrane Library.

Evidence-based practice requires a clear view of the evidence combined with wise integration of this information with other knowledge and experience in clinical decision making. There is a general concern that the evidence is often poorly understood or not known. Perhaps, a current example is the intense controversy over the results reported from the CATIE and CUtLASS trials. Many found the results surprising, and many others simply assume that flawed methods resulted in the failure to document the presumed second-generation drug superiority. However, there were few surprises for those who have kept up with the Cochrane reviews during the past few years.

Clive Adams has joined our editorial board and will be responsible for preparing the Cochrane Corner beginning with this issue. Our interest is broad, and reviews will range from supported employment to pharmacotherapy, from cognitive remediation to multifamily interventions. Treatments outside the mainstream will also be reviewed ranging from alternative medicine, to music therapy, to transcranial magnetic stimulation. We think this will make interesting reading and hope that it will mean that vital evidence will play a greater role in clinical care.

References

