

Update on the role of antipsychotics in the treatment of Tourette syndrome

Daniel Huys
Katja Hardenacke
Pia Poppe
Christina Bartsch
Burak Baskin
Jens Kuhn

Department of Psychiatry and
Psychotherapy, University of Cologne,
Cologne, Germany

Head: Prof. Dr. Joachim Klosterkötter

Abstract: Tourette syndrome (TS) is a neuropsychiatric disorder with typical onset in childhood and characterized by chronic occurrence of motor and vocal tics. The disorder can lead to serious impairments of both quality of life and psychosocial functioning, particularly for those individuals displaying complex tics. In such patients, drug treatment is recommended. The pathophysiology of TS is thought to involve a dysfunction of basal ganglia-related circuits and hyperactive dopaminergic innervations. Congruently, dopamine receptor antagonism of neuroleptics appears to be the most efficacious approach for pharmacological intervention. To assess the efficacy of the different neuroleptics available, a systematic, keyword-related search in PubMed (National Library of Medicine, Washington, DC) was undertaken. Much information on the use of antipsychotics in the treatment of TS is based on older data. Our objective was to give an update and therefore we focused on papers published in the last decade (between 2001 and 2011). Accordingly, the present review aims to summarize the current and evidence-based knowledge on the risk-benefit ratio of both first and second generation neuroleptics in TS.

Keywords: Tourette, Tourette syndrome, neuroleptics, antipsychotics

Introduction

Tourette syndrome (TS) is a serious, often intractable neuropsychiatric disorder characterized by enduring though waxing and waning phonic (vocal) and motor tics. Contrary to the earlier perception of TS as a psychogenic disorder, its neurobiological basis has been proven, although the exact mechanisms are not yet fully understood.¹ Once tics have emerged, usually by the age of about 6–8 years, they reach a maximum at around 12 years. About 40% of all TS patients show a gradual to complete spontaneous remission of symptoms in early adulthood.² Drug treatment is recommended for children who suffer from severe tics and adults with persistent and significantly impairing symptoms as a result of TS.

The pathophysiology is thought to involve a dysfunction of basal ganglia-related circuits and hyperactive dopaminergic innervations.³ Studies supporting the strong hypothesis of an imbalance in the dopaminergic system have shown an increased number of striatal⁴ and cortical⁵ dopamine receptors, as well as altered dopamine binding properties in the basal ganglia.^{6,7} Therefore, the main action of drugs used in the treatment of tics is the modulation of the dopaminergic metabolism. In this context, research is still focusing on the D₂ receptor system⁵ and congruently D₂ receptor antagonism appears to be the most efficacious approach for pharmacological intervention.⁸ For 40 years, the beneficial effects of D₂ receptor blocking in the treatment of tics have been reported, with an average success rate of 70%.⁹ In general, typical or first generation

Correspondence: Daniel Huys
Department of Psychiatry and
Psychotherapy, University of Cologne,
Kerpener Strasse 62, 50924 Cologne,
Germany
Tel +49 221 478 8621 |
Fax +49 221 478 6605
Email daniel.huys@uk-koeln.de

antipsychotics are thought to have a very high dopamine blocking potency. Hence, they are thought to be very effective in ameliorating tics.¹⁰ However, these agents might be associated with severe adverse events, because a strong D₂ receptor antagonism is connected with high rates of extrapyramidal symptoms (parkinsonism, akathisia, tardive dyskinesia) or even hyperprolactinemia. Furthermore, they also alter cholinergic, serotonergic, histaminergic, and alpha-adrenergic transmission and thereby might lead to weight gain, drowsiness, and excessive sedation. Atypical or second generation neuroleptics usually have a greater affinity for 5-HT₂ receptors than for D₂ receptors which is associated with fewer extrapyramidal side effects¹¹ than seen under typical neuroleptics.

As a result of frequent adverse events caused by antipsychotics, attempts have been made to use other medications for the treatment of TS such as noradrenergic agents (clonidine, guanfacine, atomoxetine) or tetrabenazine, nicotine, tetrahydrocannabinol, talipexole, clonazepam, baclofen, levetiracetam, topiramate, lithium, or naloxone (as shown in the paper by Roessner et al⁹). As well as pharmacological treatment, psychotherapy or rather, habit reversal training¹² can be helpful if patients are willing to engage in it. Finally, deep brain stimulation should be considered for therapy-resistant patients because it can successfully expand the limits of medication-based treatment options.¹³

Methods

Given the big impact of neuroleptics in the treatment of TS, the intention of this review is to give an update on the evidence-based, risk-benefit ratio of the different available antipsychotics.

Therefore, a systematic literature search was carried out in PubMed including articles published from 2001 to May 2011. The search terms were “antipsychotics and Tourette syndrome” plus “neuroleptics and Tourette syndrome”. By using a combination of these search terms we identified 175 articles published in German or English. In the first step, all titles and abstracts were screened carefully for aspects relevant to our main topic. Our second step was an analysis of the full texts to identify valuable information. In this process, we checked whether the information presented was collected in clinical studies with high methodological standards or from case reports or incidental findings. We used 43 articles in the present paper, found by using the research criteria described above; 132 articles were excluded. In addition, references for the identified articles were screened for further relevant literature not listed in PubMed or beyond our search period. In this way, another 89 articles were found and considered in the present review.

Results

Typical antipsychotics

Haloperidol

The butyrophenone haloperidol was the first drug used in treatment for TS and remains the most widely used agent for this indication worldwide. The first report on its empirical use in TS concerned an adult who had already undergone a frontal lobectomy.¹⁴ Haloperidol was approved by the Food and Drug Administration (FDA) for the treatment of adult TS patients in 1969 and for children in 1978.¹⁵ Due to its strong blocking effect on D₂ receptors, tic reductions of 78%–91% at a maximum dosage of 10 mg have been estimated.^{16,17} The most commonly observed adverse events are extrapyramidal reactions (parkinsonism, tardive dyskinesia), neuroleptic malignant syndrome, drowsiness, restlessness, and sexual dysfunction. In our search period, we were unable to find any valuable studies. The approval of haloperidol is based mainly on its effectiveness known from older comparison studies with pimozide, fluphenazine, and placebo. An early randomized, double-blind and placebo-controlled study showed that haloperidol and pimozide decrease tic frequency significantly.¹⁸ Some studies stated that haloperidol is superior to both placebo and pimozide.¹⁶ However, in another study including 22 patients the effect of haloperidol was described as inferior to pimozide and even to placebo.¹⁹ Yet another study suggested that treatment with haloperidol is more often discontinued than with pimozide, even though both drugs produced comparable relief of symptoms.²⁰ Additionally, haloperidol produced significantly more acute dyskinesia/dystonia than pimozide. Some studies suggested that other, similar, agents such as pimozide¹⁹ and fluphenazine²¹ may be as efficacious as haloperidol, but with fewer side effects and a slightly better patient tolerance.

Conclusion: Although the evidence is not consistent, based on clinical experience, haloperidol may be an effective agent for the treatment of TS. Older studies (data collection before 1997) suggested that it is less tolerable and is more often associated with adverse events than other typical neuroleptics. For this reason, haloperidol should be used mainly as a spare medication in severely diseased patients.²²

Pimozide

Pimozide is a D₂ receptor antagonist which in addition blocks calcium channels¹¹ and to a lesser extent D₁ receptors. It exhibits less noradrenaline (alpha1) antagonism than haloperidol, and less sedation.²² Pimozide can be associated with severe arrhythmia and prolongation of the QTc

interval.²³ The most recent article about the efficacy of pimozide is a comprehensive Cochrane review from 2009 reporting on six randomized controlled trials with a total of 162 participants.²⁴ The comparison between pimozide, haloperidol, and risperidone revealed inconsistent results. Pimozide, however, was shown to be considerably more effective than placebo. Inconsistency of results is brought about by three double-blind, placebo-controlled trials of pimozide versus haloperidol: one revealed equal efficacy, another found haloperidol slightly more effective than pimozide, while yet another showed pimozide to be superior to haloperidol. Pimozide is further described as having fewer side effects (including sedation and extrapyramidal symptoms) than haloperidol. In two trials comparing pimozide with risperidone, no significant differences between the two drugs in terms of efficacy or side-effect profile could be identified.^{25,26}

Conclusion: In our opinion, pimozide is indicated for the suppression of tics in patients who have failed to respond satisfactorily to standard treatment with the frequently recommended agent risperidone. As a rather older compound with a considerable cardiac risk profile, we support the appraisal for pimozide as a reserve treatment especially because no substantial new data have been acquired in recent years. Singer favored pimozide as second choice medication in his helpful suggestions.¹¹

Fluphenazine

Fluphenazine acts as both a D₁ and D₂ receptor antagonist.¹¹ It has been used particularly in the US for many years to treat TS, though it has simply been studied systematically.⁹ Our search period included only a small amount of current data. A naturalistic follow-up study from 2004 including 41 patients indicated that treatment with fluphenazine for at least one year was safe and effective.²⁷ A retrospective review from 2009 also showed fluphenazine to be an effective and well-tolerated therapy.²⁸ The main data were collected in a few older studies including placebo-controlled, double-blind trials between 1982 and 1985 which revealed that fluphenazine is effective in controlling tics, while having fewer side effects than haloperidol (small, open-label studies).²⁹⁻³¹

Conclusion: Although fluphenazine has been shown to be an effective and well-tolerated therapy for TS, we would not unconditionally recommend its use due to the lack of recent studies comparing this drug to newer medications such as atypical antipsychotics. Yet, it is also favored by Singer as second choice medication.¹¹

Atypical antipsychotics

Benzamide

The benzamides (tiapride, sulpiride, and amisulpride) are a class of amides of benzoic acid and further selective D₂ receptor antagonists.³² Substituted benzamides are effective in the treatment of tics and it seems that the occurrence of extrapyramidal side effects is unusual.²²

In Germany, benzamides (especially tiapride) are used as first-line medication in the treatment of TS, particularly in children and young adults. The lack of studies investigating the efficacy of these agents might be explained by the fact that tiapride and sulpiride are not available in the US.⁸

Tiapride

Tiapride has a selective antagonistic effect on D₂ receptors, especially in the ventral striatum and in parts of the limbic system.⁹ Although this drug is in general well-suited for the treatment of hyperkinetic movement disorders which are associated with functional dopamine hyperactivity³³ and is even considered as first choice in European guidelines,⁹ no clinical studies focusing on the treatment with tiapride in humans were found in our search period. There is only one case report from 2004 about a patient with severe side effects such as massive weight gain, hyperprolactinemia, amenorrhea, and sedation under therapy with tiapride.³⁴ Nevertheless, there are two animal studies investigating the effects of tiapride, suggesting that this drug does not lead to long-lasting alterations of dopamine concentration or other severe short- and long-term adverse reactions in young rats.^{35,36} Thus evidence for its clinical efficacy in humans is mostly based on older studies. Since the 1970s, some case reports and placebo-controlled studies have reported the success of TS treatment with tiapride.³⁷⁻³⁹ Only one randomized, double-blind, and placebo-controlled crossover study from 1988 investigated the effects of tiapride in 17 children. The results yielded beneficial therapeutic effects on tic symptomatology, while no adverse effects on children's cognitive functioning were reported.⁴⁰ Drowsiness, modest transient hyperprolactinemia, and moderate weight gain have been observed as side effects.

Conclusion: Despite the lack of actual studies, the treatment of TS with tiapride should still be considered, especially because of its moderate side effects, which have been confirmed by translational studies and clinical experience.⁹ Nevertheless, further well-designed studies and head-to-head comparisons would be desirable.

Sulpiride

Sulpiride is a highly selective D_2 and D_3 receptor antagonist with antipsychotic and antidepressant mechanisms as well as anxiolytic effects.⁴¹ It was first used for the treatment of TS in 1970.⁴² Usually, few adverse events are reported with its use (eg, sedation and sustained drowsiness in up to 25%).³² Less frequent side effects are restlessness, as well as sleep problems⁴³ and depressive symptoms, which occur despite the antidepressant and mood-stabilizing effects of sulpiride.⁴⁴ Increased appetite and as a consequence weight gain may occur, which is probably attributable to the stimulating effects of prolactin secretion causing galactorrhea and amenorrhea.^{45,46} Due to its rare extrapyramidal and vegetative side effects, sulpiride is probably one of the most prescribed medications in the treatment of tics in TS in Europe.¹⁸

One recent prospective, open-label, study investigated the effect of low-dose sulpiride treatment of children and adolescents with TS or chronic tic disorder. The 189 treated patients demonstrated a significant reduction in tic symptomatology after a period of 6 weeks. The most common adverse events were sedation (16% of the patients), which often disappeared 1–2 weeks after treatment onset.⁴⁷ These promising results are supported by older studies. Robertson and colleagues for example documented in 1990 a positive effect of treatment with sulpiride in 59% of patients. Furthermore, besides tic reduction, a significant decrease in other phenomena such as echophenomena, aggression, subjective tension, and obsessive compulsive traits was found.⁴⁴ In a placebo-controlled crossover study the treatment effects of fluvoxamine and sulpiride in patients suffering from TS and obsessive compulsive disorders were compared. Sulpiride monotherapy was shown to reduce tics significantly.⁴⁸

Conclusion: Given the previously described data, the treatment of mild-to-moderate TS or chronic tic disorder with sulpiride can be recommended.^{9,44} Even in low doses, sulpiride seems to be effective and is usually associated with few adverse events.

Amisulpride

Amisulpride is a highly selective benzamide with 10× higher affinity to D_2 and D_3 receptors than sulpiride and with little activity at serotonergic, histaminergic, or muscarinic receptors.³² While the agonistic effects on presynaptic D_2/D_3 receptors prevail at lower doses (increased dopamine transmission), at higher doses, amisulpride acts preferentially on postsynaptic D_2/D_3 receptors, reducing dopaminergic transmission.³²

Randomized controlled studies on the treatment of TS with amisulpride are lacking. As far as we know, only three case reports have been published on the treatment of TS with amisulpride, of which one was published in French.⁴⁹ The second case report describes the effective treatment of TS with moderate doses of amisulpride (maximum 400 mg/day). One adverse event concerning amenorrhea was reported by a patient.⁵⁰ Another case report on a patient with atypical TS as a tardive dyskinesia, indicated a change of medication from olanzapine to amisulpride.⁵¹

Conclusion: Because of the lack of randomized controlled studies, amisulpride cannot be recommended as first-line medication for the treatment of TS. Amisulpride could be seen as a second-choice medication given several expert opinions.³² Further studies are necessary to obtain valid results on its effectiveness.

Clozapine

Clozapine was first introduced in Europe in 1971, and was approved by the FDA to treat refractory schizophrenia in 1989.⁵² It acts as a 5-HT_{2A}, 5-HT_{2C}, and 5-HT₃ antagonist and, to a lesser extent, as a D_1 antagonist.⁹ It has only a weak D_2 blocking effect and may therefore be less effective in treating tics than other antipsychotics. A few older studies reported successful reductions in tics during monotherapy (as shown by Jaffe et al⁵³ in the context of tardive TS) or in combination with propranolol or tetrabenazine.⁵⁴ However, clozapine has not been found helpful in the treatment of TS as stated by several case reports which also documented serious adverse events (eg, agranulocytosis) associated with this agent.⁵⁵ Furthermore, the occurrence of stuttering, facial tics, myoclonic seizures,⁵⁶ and even the exacerbation of tics seems to be related to the administration of clozapine.⁵⁷

Conclusion: Due to the lack of efficacy and its potentially severe side effects, we would not recommend clozapine for the treatment of TS symptoms.

Risperidone

Risperidone acts as a 5-HT₂ receptor antagonist at low doses and as a D_2 antagonist at higher doses.⁵⁸ It, too, has moderate-to-high affinity for α_1 -adrenergic, D_3 , D_4 , and H_1 -histamine receptors.¹¹ Risperidone can prolong the QTc interval, and weight gain can be an emerging problem.^{58–61} Our search period includes many well-executed studies. Bruggeman and colleagues suggest that risperidone may improve tic symptoms in 30%–62% of patients²⁵ although some studies have reported even greater success rates.⁶² The efficacy

of risperidone has been confirmed by two randomized, double-blind, placebo-controlled trials.^{63,64} Furthermore, risperidone was found to be equally effective or possibly slightly more effective than pimozide in two randomized, double-blind, crossover studies.^{25,26} Compared with haloperidol, risperidone showed slightly better tic reduction (28% vs 21%) but the difference in efficacy between the two drugs was not significant.⁶⁵ In a randomized, double-blind study, risperidone and clonidine appeared equally effective in the treatment of tics.⁶⁶ Additionally, many older studies reported a positive response⁶⁷⁻⁷⁰ with a similar efficacy to haloperidol. A high discontinuation rate seems to be one major drawback in the use of risperidone. It is suggested that only 20%–30% of patients can tolerate the use of this medication in the long term due to the associated side effects.⁷¹ Risperidone was also effective in treating obsessive–compulsive symptoms.^{25,66,72} Moreover, risperidone could also be useful in ameliorating aggressive behaviour.^{73,74}

Conclusion: The effectiveness of risperidone has been proven in several studies with high methodical demands. It seems that this drug is as effective as haloperidol in treating tics and may be also effective in treating comorbidities like obsessive–compulsive and aggressive symptoms. Therefore, we recommend risperidone as standard therapy. An unfavorable aspect of risperidone is the high discontinuation rate which may be due to common adverse events like fatigue, somnolence, and weight gain.²²

Olanzapine

Olanzapine is an atypical neuroleptic with moderate-to-high affinity for D₂, D₄, 5-HT_{2A}, 5-HT_{2C}, and α-1 adrenergic receptors, as well as D₁ receptors.⁷⁵ Compared with other antipsychotics, olanzapine has greater activity at serotonin 5-HT₂ receptors than at D₂ receptors,⁷⁶ which may explain the few extrapyramidal effects. A lower incidence of hyperprolactinemia than with typical antipsychotic agents or risperidone could be explained by the presumption that this drug does not appear to block dopamine within the tuberoinfundibular tract. The most widely reported adverse reactions were drowsiness/sedation and increased appetite, frequently followed by weight gain.^{77,78} Because of metabolic adverse reactions, caution is recommended in case of hyperglycemia and diabetes. Recently published open-label trials have shown improvement in tic scores.^{76,77} In 60 children treated for 4 weeks with either olanzapine or haloperidol, efficacy in terms of tic severity reduction and global clinical impression was found to be 74% for both groups, though olanzapine was associated with fewer side effects.⁸¹ Other studies indicated that olanzapine leads to

significant reductions in tic severity and even in aggression. The only identified drawback was weight gain.⁷⁵ In an older, double-blind, crossover study, olanzapine seemed to be better at reducing tics in four patients with severe tics compared with low-dose pimozide.⁸⁰ In addition, several older case reports⁸¹⁻⁸⁴ and open-label studies^{85,86} have suggested efficacy of olanzapine in the treatment of TS in adolescents and adults.

Conclusion: The major drawback of olanzapine is the valid concern about adverse metabolic effects and weight gain as known from the treatment of schizophrenia and bipolar disorder. Apart from this, the early use of olanzapine to treat TS can be recommended based on studies which have shown olanzapine to be as effective as haloperidol or pimozide. Additionally, this drug can reduce symptoms of ADHD and aggression.²²

Quetiapine

Quetiapine antagonizes 5-HT_{1a}, 5-HT₂, D₂, histamine H₁, and α1 and α2 adrenergic receptors.¹¹ Up to now, its efficacy for tic suppression is based solely on case reports which include, for example, the effective treatment of two children with TS.⁸⁷ In an open-label trial with twelve children, quetiapine reduced tics significantly.⁸⁸ In the beginning, the main adverse event was sedation. During the 8 weeks under investigation, patients did not experience extrapyramidal adverse reactions and no statistically significant weight gain. Quetiapine reduced tic severity scores by over 60% after week 4 in a retrospective review of 12 patients of ages 8–18 years in which, contrary to the study mentioned before, the only noteworthy adverse reaction was increased weight.⁸⁹

Conclusion: The few available studies which mainly concentrate on patients under 18 years suggest that quetiapine could be effective in the treatment of TS and is associated with a tolerable side-effect profile, although weight gain and fatigue are fairly common. Due to the lack of methodologically well-executed studies, no further statement can be given.

Ziprasidone

Ziprasidone pharmacological actions work by D₂ and 5-HT antagonism and blocking other neurotransmitters such as norepinephrine, serotonin, and adrenaline. It also has a moderate affinity for H₁ receptors. The near absence of weight gain makes it attractive for the treatment of TS in obese patients.⁹⁰ Generally, ziprasidone has a higher risk for prolongation of the QT-interval than other compounds such as risperidone, olanzapine, or haloperidol.¹¹ The most frequently reported adverse event is a mild transient somnolence.^{91,92} An open-label study including

24 children and adolescents with tic disorders indicated that a single dose of ziprasidone was well tolerated without clinically significant effects on electrocardiogram.⁹³ Efficacy was evaluated in an older, randomized, double-blind, placebo-controlled study including 28 children and adolescents, where ziprasidone appeared to be significantly more effective than placebo in reducing tics and was well tolerated.⁹¹ A case report described the induction of tardive symptoms in a 28-year-old patient suffering from vocal tics secondary to treatment with ziprasidone. Additionally, anxiety and tension seemed to be aggravated by an increase in the drug. However, vocal tics resolved approximately 4 days after cessation.⁹⁴

Conclusion: Although the availability of recent data is too restricted to draw a final conclusion, ziprasidone could be used as an attempt if first-line medication was not effective. Apart from QT-prolongation, this drug has a favorable side-effect profile and initial promising results give hope for upcoming studies.

Aripiprazole

Aripiprazole is one of the newest antipsychotics with a unique mechanism of action since it works as a partial agonist on the D₂ receptors.²² It also has a high affinity with the serotonin receptor system, working as an antagonistic on 5-HT_{2A} receptors,^{95,96} and a partial agonistic on 5-HT_{2C} and 5-HT_{1a} receptors.⁹⁷ Despite the lack of randomized double-blind and placebo-controlled studies, since 2004 more than 200 cases in at least 25 mostly open studies have been published, reporting good efficacy of aripiprazole in the treatment of tics for both adults and children.^{95,98–120} For instance, one larger retrospective study describes tic reduction in 29 of the 37 patients, who all tolerated the drug and continued the treatment.⁹⁵ In general, aripiprazole is well tolerated and side effects (insomnia, fatigue, drowsiness, nausea, tremor, and agitation¹²¹) are usually mild-to-moderate and most often transient. At equivalent doses, aripiprazole is characterized by a safer cardiovascular profile than pimozide.²³ Weight gain during treatment with aripiprazole is controversial, however. While some studies report negligible weight gain,^{101,117} others have described weight increase in 22%⁹⁵ and up to 50%¹¹² of patients. Murphy and colleagues¹¹⁵ noticed a mean increase of 2.3 kg after a 6-week trial in an open-label, flexible-dose study with 16 children.

Conclusion: Despite the lack of studies with high methodological standards, the treatment of TS with aripiprazole seems possible to recommend as a second choice, due to its unique mechanism of action, its mostly harmless side-effect profile, and the good clinical experiences

reported. At least two studies have judged its effectiveness to be superior to that of previous pharmacological treatment options, even in refractory cases.^{9,98}

Discussion

The importance of neuroleptics in the treatment of tics and TS is illustrated by the fact that haloperidol and pimozide are the only drugs that are approved for therapy of these disorders by the FDA. This approval is based on older trials, however. As our research has shown, the trials representing the basis for the pharmacological treatment of TS with typical antipsychotics are rather old and vary in their results and methodological designs. For example, assessments range from subjective self-rating scales of varying complexity to standardized counting of tics based on video recordings. Furthermore, many studies include both children and adults which often results in the suggestion that both groups should be treated in similar ways, apart from drug dosages. At the same time, many experts prescribe these older drugs rather reluctantly due to the nature of their adverse events, especially when treating the typical patient population which consists of children and younger people. In line with this, the few existing guidelines for the pharmacological treatment of tics and TS^{9,122–124} and helpful papers with treatment advice and suggested strategies^{11,22} mainly recommend the use of atypical antipsychotics as first-line treatment rather than typical neuroleptics. The main reason for this preference for atypical antipsychotics seems to be their different side-effect profiles and their efficacy in the reduction of tic symptoms. But for the example of clozapine, in particular, as the present review shows, it would be wrong to assume this efficacy to be a group effect of antipsychotic agents in general. Among the atypical antipsychotics, risperidone is the best studied agent for the treatment of TS. This, in combination with its positive outcomes, makes this drug, in our and other experts' opinion, first choice.^{9,22,124}

Yet this review of the literature shows that there is currently insufficient evidence-based data on the available second-generation antipsychotics, apart from risperidone (Figure 1). Maybe the fact that TS in adulthood is a relatively rare disorder could partially explain why the pharmaceutical industry seems to be making only a marginal effort to approve modern antipsychotics for the treatment of TS. This is regrettable especially given the promising results for aripiprazole and olanzapine in methodologically "low level" studies. The efficacy of other promising compounds has not yet been studied either. Asenapine^{125,126} and sertindole¹²⁷ are, based on their mechanism of action, possibly capable of reducing tics. But up to now

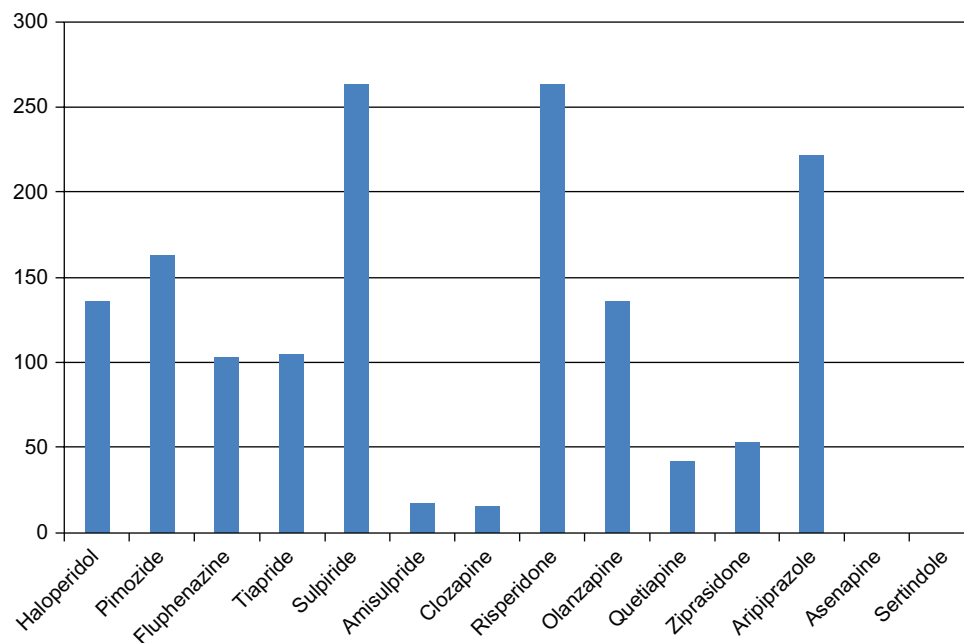


Figure 1 Number of patients* with TS, treated with each specific agent in studies and case reports published until May 2011.

Notes: *Due to the lack of proper documentation of some of the reviewed studies and limited access to some articles on this topic, the literature review presented here is not exhaustive. The number of patients listed here should therefore be understood as a minimum of patients treated with this drug. It is possible that some of the investigated agents were prescribed to more patients in the context of further studies that were not included in this literature review.

there is no evidence-based information available on these agents in the treatment of TS. Further research is needed.

The usual fluctuation in both severity and nature of symptoms over time, known as “waxing and waning”, complicates the objective measurement of symptom severity in studies. In addition, it is necessary to know that long-term treatment with neuroleptic, antiepileptic medication, or stimulants can cause tardive TS, which is characterized by the occurrence of multiple motor and vocal tics as well.¹²⁸ As well as neuroleptics, some experts suggest that alpha-agonists such as clonidine or even guanfacine as first-line therapy have fewer adverse events.¹²⁹ The existing data for these agents are relatively limited, however, and mainly ascribable to smaller, placebo-controlled studies.^{130,131} Thus we lack empirical data in support of alpha-agonists, compared with antipsychotics, and on atypical antipsychotics in general. Large, double-blind, placebo-controlled studies and well executed head-to-head comparisons are urgently required, especially those referring to modern, evidence-based criteria. Multicenter studies and independent, well-trained video-raters could be useful to consider larger numbers of patients, and to collect more reliable information on the reduction of Tourette symptoms.

Limitations

The fact that we have only searched PubMed could cause a certain bias in the collection of considered publications, but

we assume that all relevant papers are available in PubMed because all highly renowned journals are listed in this database. For many agents presented, the data found were too poor to allow any specific conclusions about a drug. We assume this problem to be caused by the generally limited evidence-based data dealing with TS and tics rather than our search criteria.

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