Abstract: The hypothesis that chronic inflammation may play a role in psychosis receives increasing attention. In this study, we aim to investigate whether the use of steroidal anti-inflammatory drugs is associated with a decreased risk of psychosis.

A longitudinal nested case-control study was performed investigating the association of glucocorticosteroid (GCS) consumption with a new diagnosis of a psychotic disorder. Significantly reduced odds ratios of 0.52 (95% confidence interval, 0.36–0.75) were found for GCS in men only (odds ratio in women, 0.84 [95% confidence interval, 0.590–1.20]). Similar risk reductions were present for the inhaled and systemic GCSs. A dose-response relationship was present. Our finding of an inverse relation between GCS consumption and new psychotic episodes may promote further research into inflammation in schizophrenia.

Key Words: schizophrenia, psychosis, inflammation, glucocorticosteroids

Ccurrent treatment in psychosis focuses on the antagonism of the dopaminergic and serotoninergic receptors. As many cases relapse, there is ample interest in alternative mechanisms in psychosis, one of them being inflammation. We previously showed a protective effect of nonsteroidal anti-inflammatory drugs (NSAIDs) on the risk of psychosis in male subjects. Moreover, 2 randomized clinical trials showed a beneficial effect of the NSAID celecoxib on schizophrenic complaints. There is also a direct evidence of inflammation in schizophrenia, as elevated levels of several inflammatory cytokines in patients with schizophrenia are reported. Furthermore, serum cortisol levels have shown to be elevated in schizophrenia, indicating inflammation and stress.

Because glucocorticosteroids (GCSs) are potent inhibitors of inflammation, we expect these drugs to be associated with a decreased risk of psychosis. In this study, we aim to investigate this association longitudinally by linking pharmacy records from a health insurance company to data obtained from a psychiatric case register.

METHODS

We performed a longitudinal nested case-control study on the association between psychosis and GCSs. This was done by linking the database of the Psychiatric Case Register Middle Netherlands (PCR-MN) covering the midwest part of the province of Utrecht, The Netherlands, to that of a regional health insurance company. Among other characteristics, the case register recorded personal level admissions to psychiatric wards and Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition diagnoses made from 1999 onward. The present analyses used data collected from 60,000 persons with at least one contact with the psychiatric healthcare system. The Agis Health Insurance Company (Agis) recorded all medications used by its participants except for medications prescribed to inpatients.

In this study, we defined a new psychosis as a person in the case register with a psychotic episode in the years 2002 to 2005, where no such episode was recorded before. A psychotic episode was defined as a recorded Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition diagnosis with codes 295.1 to 295.7, 293.81, 293.82, 297.1, 297.3, 298.8, or 298.9.

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analysis while controlling for age and sex. Differences in associations across subgroups of age and sex were tested as statistical interactions in regression models.

**RESULTS**

Of 3872 cases from the PCR-MN case register with a psychotic episode between 2002 and 2005 and no such episode recorded before, 47.8% (n = 1849) could be linked to the insurance database. Cases that could and could not be linked did not materially differ on demographic characteristics. Cases were matched to 7396 controls. Subsequently, 486 cases (26.3%) and 2777 (37.6%) controls were excluded because they were not insured at Agis during the complete index year, leaving 1363 cases (median age, 41.8 years; 56.8% men) and 4617 controls (median age, 41.8 years; 61.3% men) for analysis.

The prevalence of systemic, inhaled, and any GCS use in the control population were 4.6%, 4.7%, and 5.3%, respectively, during the index years. In the cases, these percentages were 3.3, 2.9, and 4.2, respectively. Case patients were prescribed medication approximately twice the quantity of other drugs during the index year compared with the control population (1279 vs 609 DDDS).

Compared with those not using these medications, the ORs of psychosis were significantly lower in men using systemic, inhaled, or any GCS (Table 1). For women, a similar OR was observed for inhaled GCS, although this was not statistically significant. The lower ORs for psychosis associated with GCS use in the youngest subgroups seemed to be slightly more pronounced than those in the total group, but the interaction by age group was not significant (P = 0.42). A significant P value for interaction by sex is present for the systemic GCS only. Total DDD prescriptions did not confound the associations. For example, the OR for any GCS changed from 0.65 (0.51–0.85) to 0.61 (0.47–0.79). When the GCS prescriptions during the year preceding the index year only were analyzed, all ORs were closer to unity, with neither of them being statistically significant.

An increasing amount of any GCS use was associated with lower ORs of psychosis (P = 0.017) when analyzed on a per DDD basis. Compared with no GCS consumption, the first, second, third, and fourth quartiles showed ORs of 0.73 (0.46–1.17), 0.70 (0.41–1.20), 0.70 (0.45–1.10), and 0.47 (0.26–0.84), respectively.

**DISCUSSION**

This study shows that GCSs are associated with a substantially lower risk of psychosis in men, with ORs around 0.50. The associations were similar for systemic and inhaled GCSs. In women, the magnitude of the associations was smaller, and they were not statistically significant. This sex difference was statistically significant. Decreasing risks were observed with increasing dose of GCS.

Although our results suggest a beneficial effect of GCSs, the use of GCSs has also been associated with psychiatric adverse effects including psychosis. Taken together, a complex relationship between exogenous GCSs and mental functioning is likely.

Besides a direct effect of GCS on the risk of psychosis, the observed association could have resulted from an association between a disease for which these drugs are prescribed and psychosis. However, in the absence of evidence for an inverse relation of psychosis with asthma, Crohn disorder, or other indications for GCS, this explanation seems unlikely.

Although our study provides evidence for a pathophysiological role of inflammation in psychosis, its nature remains unknown. We previously demonstrated an inverse relation between the use of NSAIDs and subsequent psychosis. The present study using a more reliable assessment of psychosis confirms a favorable effect of the inhibition of inflammation, again in men only. The sex specificity of the inverse relation might be due to the postulated protective effect of estrogen in female subjects.

Because the total prescription volume of all drugs was not confounding the observed relation, we consider it unlikely that it was the result of case patients being less likely to be prescribed any medication.

Approximately half of the case patients with a new psychotic episode had a positive match with a person in the Agis database. This proportion was anticipated in view of an approximately 50% overlap between those living in the PCR-MN region and those insured at Agis. Bias from incomplete linkage seems unlikely because cases that were and were not linked to Agis did not substantially differ.

The findings from this study may promote further research into inflammation in schizophrenia.

**AUTHOR DISCLOSURE INFORMATION**

All authors declare that they have no competing interests. All authors, external and internal, had full access to all of the data (including statistical reports and tables) in the study and can take public responsibility for the integrity of the data and the accuracy of the data analysis.

**REFERENCES**


## Table 1: Odds Ratios (95% Confidence Interval) of a Psychotic Episode for Corticosteroid Use and P value for Interaction by Sex and by Age Subgroup

<table>
<thead>
<tr>
<th></th>
<th>Systemic GCS</th>
<th>Inhaled GCS</th>
<th>Any GCS</th>
<th>Youngest Subgroup, Any GCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>0.51 (0.31–0.84)</td>
<td>0.58 (0.36–0.94)</td>
<td>0.52 (0.36–0.75)</td>
<td>0.41 (0.17–0.98)</td>
</tr>
<tr>
<td>Women</td>
<td>1.07 (0.68–1.67)</td>
<td>0.68 (0.41–1.11)</td>
<td>0.84 (0.59–1.20)</td>
<td>0.63 (0.21–1.88)</td>
</tr>
<tr>
<td>Total</td>
<td>0.74 (0.53–1.03)</td>
<td>0.62 (0.44–0.88)</td>
<td>0.65 (0.51–0.85)</td>
<td>0.48 (0.24–0.95)</td>
</tr>
<tr>
<td>P for interaction by sex</td>
<td>0.03</td>
<td>0.65</td>
<td>0.06</td>
<td>0.49</td>
</tr>
<tr>
<td>P for interaction by age group</td>
<td>0.47</td>
<td>0.55</td>
<td>0.42</td>
<td>—</td>
</tr>
</tbody>
</table>

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