1st International Congress on Neurobiology and Clinical Psychopharmacology

&

European Psychiatric Association Conference on Treatment Guidance

Dual Congress

November 19th - 22nd, 2009

Makedonia Palace Hotel, Thessaloniki, Greece

www.psychiatry.gr

Scientific Program & Abstract Book

Accredited with 20 CME credits by UEMS/EACCME

INTERNATIONAL SOCIETY of NEUROBIOLOGY & PSYCHOPHARMACOLOGY

2008 • ISNP

WPA section on Private Practice Psychiatry

European Psychiatric Association

Under the auspices of :

School of Medicine, Aristotle University of Thessaloniki, Greece

INV 29/10.09 www.foh.gr

Για συνταγογραφικές πληροφορίες βλέπε εσωτερική σελίδα

JANSSEN-CILAG
ΦΑΡΜΑΚΕΥΤΙΚΗ Α.Ε.Β.Ε.

• Λεωφόρος Ειρήνης 56, 151 21, Πεύκη, Αθήνα, Τηλ.: 210 8090000
• 12,5 χλμ. Θεσσαλονίκης-Μουδανιών, 570 01, Κόμβος Θέρμης, Θεσσαλονίκη, Τηλ.: 2310 470800

INVEGA®
PALIPERIDONE
Δισκία παρατεταμένης αποδέσμευσης

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΪΟΝΤΟΣ

ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ: • INVEGA® 3 mg δισκία παρατεταμένης αποδέσμευσης • INVEGA® 6 mg δισκία παρατεταμένης αποδέσμευσης • INVEGA® 9 mg δισκία παρατεταμένης αποδέσμευσης
ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ: Κάθε δισκίο παρατεταμένης αποδέσμευσης περιέχει 3 mg παλιπεριδόνης. Κάθε δισκίο παρατεταμένης αποδέσμευσης περιέχει 6 mg παλιπεριδόνης. Κάθε δισκίο παρατεταμένης αποδέσμευσης περιέχει 9 mg παλιπεριδόνης. Για τα δισκία των 3 mg: Έκδοχο: Κάθε δισκίο περιέχει 13,2 mg λακτόζη.
ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ: Δισκίο παρατεταμένης αποδέσμευσης • 3 mg:Τριών στρώσεων κυλινδρικού σχήματος επιμήκη λευκά δισκία (σε σχήμα καψακίων) με ανάγλυφη επιγραφή "PAL 3". • 6 mg: Τριών στρώσεων κυλινδρικού σχήματος επιμήκη μπεζ δισκία (σε σχήμα καψακίων) με ανάγλυφη επιγραφή "PAL 6". • 9 mg: Τριών στρώσεων κυλινδρικού σχήματος επιμήκη ροζ δισκία (σε σχήμα καψακίων) με ανάγλυφη επιγραφή "PAL 9".
ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ : Θεραπευτικές ενδείξεις: Το INVEGA® ενδείκνυται για τη θεραπεία της σχιζοφρένειας. **Δοσολογία και τρόπος χορήγησης:** ***Ενήλικες:*** Το INVEGA® προορίζεται για από του στόματος χορήγηση. Η συνιστώμενη δόση του INVEGA® είναι 6 mg μία φορά την ημέρα, χορηγούμενο κατά τις πρωινές ώρες. Η χορήγηση του INVEGA® πρέπει να τυποποιηθεί σε σχέση με τη λήψη της τροφής. Ο ασθενής πρέπει να συμβουλεύεται να λαμβάνει πάντα το INVEGA® σε κατάσταση νηστείας ή να το λαμβάνει πάντα μαζί με το πρόγευμα και να μην εναλλάσσει τη λήψη του μεταξύ της κατάστασης νηστείας ή της λήψης τροφής. Δεν απαιτείται αρχική δοσολογία τιτλοποίησης. Μερικοί ασθενείς μπορεί να ωφεληθούν από χαμηλότερες ή υψηλότερες δόσεις εντός του συνιστώμενου δοσολογικού εύρους των 3 έως 12 mg μία φορά την ημέρα. Η προσαρμογή της δοσολογίας, εφόσον ενδείκνυται, πρέπει να πραγματοποιείται μόνο μετά από κλινική επανεκτίμηση. Όταν ενδείκνυται αυξήσεις στη δόση, συνιστώνται προσαυξήσεις των 3 mg/ημέρα και γενικά πρέπει να πραγματοποιούνται σε διαστήματα μεγαλύτερα των 5 ημερών. Τα δισκία του INVEGA® πρέπει να καταπίνονται ολόκληρα με υγρό και να μη μασώνται, διασπώνται ή εκθλίβονται. Η δραστική ουσία περιέχεται εντός ενός μη απορροφήσιμου περιβλήματος, το οποίο έχει σχεδιαστεί ώστε να απελευθερώνει τη δραστική ουσία με ελεγχόμενο ρυθμό. Το περίβλημα του δισκίου, μαζί με αδιάλυτα συστατικά του πυρήνα, αποβάλλεται από τον οργανισμό. Οι ασθενείς δεν πρέπει να ανησυχήσουν εάν περιστασιακά διαπιστώσουν στα κόπρανά τους κάτι που μοιάζει με δισκίο. ***Ασθενείς με ηπατική δυσλειτουργία:*** Δεν απαιτείται προσαρμογή της δόσης σε ασθενείς με ήπια ή μέτρια ηπατική δυσλειτουργία. Καθώς το INVEGA® δεν έχει μελετηθεί σε ασθενείς με σοβαρή ηπατική δυσλειτουργία, συνιστάται προσοχή σε τέτοιους ασθενείς. ***Ασθενείς με νεφρική δυσλειτουργία:*** Για ασθενείς με ήπια νεφρική δυσλειτουργία (κάθαρση κρεατινίνης ≥ 50 έως < 80 ml/min), η αρχική συνιστώμενη δόση είναι 3 mg μία φορά την ημέρα. Η δόση μπορεί να αυξηθεί στα 6 mg μία φορά την ημέρα με βάση την κλινική ανταπόκριση και ανοχή. Για ασθενείς με μέτρια έως σοβαρή νεφρική δυσλειτουργία (κάθαρση κρεατινίνης ≥ 10 έως < 50 ml/min), η συνιστώμενη αρχική δόση του INVEGA είναι 1,5 mg κάθε ημέρα, η οποία μπορεί να αυξηθεί σε 3 mg μια φορά την ημέρα μετά από κλινική επανεκτίμηση. Καθώς το INVEGA® δεν έχει μελετηθεί σε ασθενείς με κάθαρση κρεατινίνης κάτω από 10 ml/min, η χρήση του δε συνιστάται σε τέτοιους ασθενείς. ***Ηλικιωμένοι:*** Οι προτεινόμενες δοσολογίες σε ηλικιωμένους ασθενείς με φυσιολογική νεφρική λειτουργία (≥ 80 ml/min) είναι οι ίδιες όπως και για τους ενήλικες με φυσιολογική νεφρική λειτουργία. Ωστόσο, επειδή οι ηλικιωμένοι ασθενείς μπορεί να εμφανίζουν ελαττωμένη νεφρική λειτουργία, μπορεί να απαιτηθεί προσαρμογή της δοσολογίας ανάλογα με την κατάσταση της νεφρικής τους λειτουργίας (βλέπε ανωτέρω, Ασθενείς με Νεφρική Δυσλειτουργία). Το INVEGA® πρέπει να χορηγείται με προσοχή σε ηλικιωμένους ασθενείς με άνοια με παράγοντες κινδύνου για αγγειακό εγκεφαλικό επεισόδιο (βλέπε παράγραφο Ειδικές προειδοποιήσεις και ειδικές προφυλάξεις κατά τη χρήση). ***Παιδιατρικός πληθυσμός:*** Η ασφάλεια και η αποτελεσματικότητα του INVEGA® σε ασθενείς < 18 ετών δεν έχουν μελετηθεί. Δεν υπάρχει εμπειρία στα παιδιά. ***Άλλοι ειδικοί πληθυσμοί:*** Δε συνιστάται προσαρμογή της δοσολογίας του INVEGA® με βάση το φύλο, τη φυλή ή το αν το άτομο καπνίζει ή όχι. (Για τις έγκυες γυναίκες και τις θηλάζουσες μητέρες, βλέπε παράγραφο Κύηση και γαλουχία). ***Αλλαγή σε άλλα αντιψυχωσικά φαρμακευτικά προϊόντα:*** Δεν υπάρχουν συστηματικά συλλεγμένα δεδομένα που να αφορούν ειδικά στην αλλαγή της θεραπείας ασθενών από το INVEGA® σε άλλα αντιψυχωσικά φαρμακευτικά προϊόντα. Εξαιτίας των διαφορετικών φαρμακοδυναμικών και φαρμακοκινητικών ιδιοτήτων ανάμεσα σε αντιψυχωσικά φαρμακευτικά προϊόντα, χρειάζεται επίβλεψη από θεράποντα ιατρό όταν η αλλαγή σε άλλο αντιψυχωσικό προϊόν θεωρείται ιατρικά κατάλληλη. **Αντενδείξεις:** Υπερευαισθησία στη δραστική ουσία, στη ρισπεριδόνη ή σε κάποιο από τα έκδοχα. **Ειδικές προειδοποιήσεις και ειδικές προφυλάξεις κατά τη χρήση:** ***Διάστημα QT:*** Όπως και με τα άλλα αντιψυχωσικά, απαιτείται προσοχή κατά τη χορήγηση του INVEGA® σε ασθενείς με γνωστή καρδιαγγειακή νόσο ή με οικογενειακό ιστορικό παράτασης του QT, και κατά τη συγχορήγησή του με άλλα φάρμακα που θεωρείται ότι παρατείνουν το διάστημα QT. ***Νευροληπτικό κακόηθες σύνδρομο:*** Το Νευροληπτικό Κακόηθες Σύνδρομο (NMS), το οποίο χαρακτηρίζεται από υπερθερμία, μυϊκή ακαμψία, αστάθεια του αυτόνομου νευρικού συστήματος, μεταβληθείσα συνείδηση και αυξημένα επίπεδα ορού της κρεατινοφωσφοκινάσης, έχει αναφερθεί ότι παρατηρείται με τα αντιψυχωσικά, περιλαμβανομένης και της παλιπεριδόνης. Επιπρόσθετα κλινικά σημεία μπορεί να περιλαμβάνουν μυοσφαιρινουρία (ραβδομυόλυση) και οξεία νεφρική ανεπάρκεια. Εάν ένας ασθενής εκδηλώσει σημεία ή συμπτώματα που υποδηλώνουν την παρουσία NMS, όλα τα αντιψυχωσικά, περιλαμβανομένου και του INVEGA®, πρέπει να διακοπούν. ***Βραδυκινησία:*** Τα φάρμακα που διαθέτουν ιδιότητες ανταγωνισμού των υποδοχέων της ντοπαμίνης έχουν σχετιστεί με την επαγωγή βραδυκινησίας, η οποία χαρακτηρίζεται από ρυθμικές, ακούσιες κινήσεις, κυρίως της γλώσσας και/ή του προσώπου. Εάν εμφανιστούν σημεία και συμπτώματα βραδυκινησίας, μπορεί να χρειαστεί η διακοπή όλων των αντιψυχωσικών, περιλαμβανομένου και του INVEGA®. ***Υπεργλυκαιμία:*** Σπάνιες περιπτώσεις ανεπιθύμητων ενεργειών που σχετίζονται με τη γλυκόζη, π.χ. αυξημένα επίπεδα γλυκόζης αίματος, έχουν αναφερθεί σε κλινικές δοκιμές με το INVEGA®. Όπως συμβαίνει και με τα άλλα αντιψυχωσικά, συνιστάται η κατάλληλη κλινική παρακολούθηση σε διαβητικούς ασθενείς και σε ασθενείς με παράγοντες κινδύνου για την ανάπτυξη σακχαρώδους διαβήτη. ***Ορθοστατική υπόταση:*** Η παλιπεριδόνη μπορεί να προκαλέσει ορθοστατική υπόταση σε μερικούς ασθενείς εξαιτίας της ανασταλτικής της δράσης στους α- υποδοχείς. Με βάση συγκεντρωτικά δεδομένα από τις τρεις, ελεγχόμενες με εικονικό φάρμακο, διάρκειας 6 εβδομάδων, σταθερής δόσης κλινικές δοκιμές με INVEGA® (3, 6, 9 και 12 mg), η ορθοστατική υπόταση αναφέρθηκε στο 2.5% των ασθενών που ελάμβαναν θεραπεία με INVEGA®, συγκριτικά με το 0.8% των ασθενών που ελάμβαναν θεραπεία με εικονικό φάρμακο. Το INVEGA® πρέπει να χορηγείται με προσοχή σε ασθενείς με γνωστή καρδιαγγειακή νόσο (π.χ. καρδιακή ανεπάρκεια, έμφραγμα ή ισχαιμία μυοκαρδίου, διαταραχές της αγωγιμότητας), διαταραχή των αγγείων του εγκεφάλου ή καταστάσεις που προδιαθέτουν τον ασθενή σε υπόταση (π.χ. αφυδάτωση και υποογκαιμία). ***Επιληπτικοί σπασμοί:*** Το INVEGA® πρέπει να χορηγείται με προσοχή σε ασθενείς με ιστορικό επιληπτικών σπασμών ή άλλων καταστάσεων που ελαττώνουν δυνητικά τον ουδό των σπασμών. ***Ενδεχόμενη εντερική απόφραξη του γαστρεντερικού σωλήνα:*** Επειδή τα δισκία του INVEGA® δεν παραμορφώνονται και δεν αλλάζουν σημαντικά σχήμα όταν βρεθούν εντός του γαστρεντερικού σωλήνα, το INVEGA® δεν πρέπει κανονικά να χορηγείται σε ασθενείς με προϋπάρχουσα σοβαρή γαστρεντερική στένωση (παθολογική ή ιατρογενή) ή σε ασθενείς με δυσφαγία ή σημαντική δυσχέρεια κατά την κατάποση δισκίων. Έχουν υπάρξει σπάνιες αναφορές αποφρακτικών συμπτωμάτων σε ασθενείς με γνωστές στενώσεις σε συνδυασμό με πρόσληψη φαρμάκων σε μη παραμορφούμενες μορφές ελεγχόμενης αποδέσμευσης. Εξαιτίας του σχεδιασμού της φαρμακοτεχνικής μορφής ελεγχόμενης αποδέσμευσης, το INVEGA® πρέπει να χορηγείται μόνο σε ασθενείς που είναι σε θέση να καταπίνουν ολόκληρο το δισκίο. ***Καταστάσεις με ελάττωση του χρόνου μετάβασης από το γαστρεντερικό σωλήνα:*** Καταστάσεις που οδηγούν σε βράχυνση του χρόνου μετάβασης από το γαστρεντερικό σωλήνα, π.χ. νοσήματα που συνοδεύονται από χρόνια σοβαρή διάρροια, μπορεί να έχουν ως αποτέλεσμα μειωμένη απορρόφηση της παλιπεριδόνης. ***Νεφρική δυσλειτουργία:*** Οι συγκεντρώσεις της παλιπεριδόνης στο πλάσμα είναι αυξημένες σε ασθενείς με νεφρική δυσλειτουργία και, επομένως, μπορεί να χρειαστεί να γίνει προσαρμογή της δόσης σε μερικούς ασθενείς (βλέπε παράγραφο Δοσολογία και τρόπος χορήγησης). Δεν υπάρχουν διαθέσιμα στοιχεία για ασθενείς με κάθαρση κρεατινίνης κάτω από 10 ml/min. Η παλιπεριδόνη δεν πρέπει να χρησιμοποιείται σε ασθενείς με κάθαρση κρεατινίνης κάτω από 10 ml/min. ***Ηπατική δυσλειτουργία:*** Δεν υπάρχουν διαθέσιμα στοιχεία για ασθενείς με σοβαρή ηπατική δυσλειτουργία (τάξη C κατά Child Pugh). Συνιστάται προσοχή εάν πρόκειται να χρησιμοποιηθεί παλιπεριδόνη σε τέτοιους ασθενείς. ***Ηλικιωμένοι ασθενείς με άνοια:*** Το INVEGA® δεν έχει μελετηθεί σε ηλικιωμένους ασθενείς με άνοια. Ωστόσο, μέχρι τα δεδομένα αποδειχτούν διαφορετικά, η εμπειρία από τη ρισπεριδόνη θεωρείται ότι ισχύει επίσης για την παλιπεριδόνη. • ***Συνολική θνησιμότητα:*** Σε μια μετα-ανάλυση 17 ελεγχόμενων κλινικών δοκιμών, οι ηλικιωμένοι ασθενείς με άνοια που έλαβαν θεραπεία με άλλα άτυπα αντιψυχωσικά, περιλαμβανομένης της ρισπεριδόνης, της αριπιπραζόλης, της ολανζαπίνης και της κουετιαπίνης, εμφάνισαν αυξημένο κίνδυνο θνησιμότητας συγκριτικά με το εικονικό φάρμακο. Μεταξύ αυτών που ανοικοδόθησαν αγωγή με ρισπεριδόνη, η θνησιμότητα ήταν 4% σε σύγκριση με 3,1% για το εικονικό φάρμακο. • ***Ανεπιθύμητες ενέργειες από διαταραχές των αγγείων του εγκεφάλου:*** Ένας περίπου τριπλάσια αυξημένος κίνδυνος ανεπιθύμητων ενεργειών από διαταραχές των αγγείων του εγκεφάλου έχει παρατηρηθεί σε τυχαιοποιημένες, ελεγχόμενες με εικονικό φάρμακο κλινικές δοκιμές στον πληθυσμό ασθενών με άνοια με μερικά άτυπα αντιψυχωσικά, περιλαμβανομένης της ρισπεριδόνης, της αριπιπραζόλης και της ολανζαπίνης. Ο μηχανισμός για αυτό τον αυξημένο κίνδυνο δεν είναι γνωστός. Το INVEGA® πρέπει να χρησιμοποιείται με προσοχή σε ηλικιωμένους ασθενείς με άνοια οι οποίοι έχουν παράγοντες κινδύνου για αγγειακό εγκεφαλικό επεισόδιο. ***Νόσος Parkinson και άνοια με σωμάτια Lewy:*** Οι ιατροί πρέπει να αξιολογούν τους κινδύνους έναντι των οφελών όταν χορηγούν αντιψυχωσικά φάρμακα, περιλαμβανομένου και του INVEGA®, σε ασθενείς με Νόσο του Parkinson ή Άνοια με σωμάτια Lewy (DLB), αφού και οι δύο πληθυσμοί ασθενών μπορεί να διατρέχουν αυξημένο κίνδυνο εμφάνισης Νευροληπτικού Κακοήθους Συνδρόμου, καθώς και να εμφανίζουν αυξημένη ευαισθησία στα αντιψυχωσικά. Οι εκδηλώσεις αυτής της αυξημένης ευαισθησίας μπορεί να περιλαμβάνουν σύγχυση, θόλωση της συνείδησης, αστάθεια θέσης του σώματος με συχνές πτώσεις, επιπρόσθετα των εξωπυραμιδικών συμπτωμάτων. ***Priapismός:*** Τα φάρμακα με αναστολική δράση στους α-αδρενεργικούς υποδοχείς έχουν αναφερθεί ότι προκαλούν priapismό. Μολονότι δεν έχουν αναφερθεί περιπτώσεις priapismού στις κλινικές δοκιμές του INVEGA®, η παλιπεριδόνη εμφανίζει αυτή τη φαρμακολογική δράση και για το λόγο αυτό μπορεί να σχετίζεται με αυτό τον κίνδυνο. ***Ρύθμιση της θερμοκρασίας του σώματος:*** Η παρεμβολή στην ικανότητα του σώματος να ελαττώνει την κεντρική του θερμοκρασία έχει αποδοθεί σε αντιψυχωσικά φάρμακα. Συνιστάται η κατάλληλη προσοχή κατά τη συνταγογράφηση του INVEGA® σε ασθενείς που αναμένεται να εμπλακούν σε καταστάσεις, οι οποίες μπορεί να συμβάλλουν σε αύξηση της κεντρικής θερμοκρασίας του σώματος, π.χ. πολύ έντονη σωματική άσκηση, έκθεση σε πολύ υψηλές θερμοκρασίες, συγχορήγηση φαρμάκων με αντιχολινεργική δράση ή αφυδάτωση. ***Αντιεμετική δράση:*** Κατά τις προκλινικές μελέτες της παλιπεριδόνης παρατηρήθηκε μια αντιεμετική δράση. Η δράση αυτή, εφόσον εμφανίζεται στον άνθρωπο, μπορεί να καλύψει τα σημεία και συμπτώματα της υπερδοσολογίας με ορισμένα φάρμακα ή ορισμένων καταστάσεων όπως η εντερική απόφραξη, το σύνδρομο Reye και ο όγκος του εγκεφάλου. ***Περιεκτικότητα σε λακτόζη (ισχύει μόνο για τα δισκία των 3 mg):*** Οι ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στη γαλακτόζη, ανεπάρκεια λακτάσης Lapp ή κακή απορρόφηση γλυκόζης-γαλακτόζης δεν πρέπει να πάρουν αυτό το φάρμακο. **Αλληλεπιδράσεις με άλλα φαρμακευτικά προϊόντα και άλλες μορφές αλληλεπίδρασης:** Συνιστάται προσοχή κατά τη συνταγογράφηση του INVEGA® μαζί με φάρμακα που είναι γνωστό ότι παρατείνουν το διάστημα QT, όπως π.χ. τα αντιαρρυθμικά τάξης IA (π.χ. κινιδίνη, δισοπυραμίδη) και τα αντιαρρυθμικά τάξης III (π.χ. αμιοδαρόνη, σοταλόλη), μερικά αντίσταμινικά, μερικά άλλα αντιψυχωσικά και ορισμένα ανθελονοσιακά (π.χ. μεφλοκίνη). ***Πιθανότητα του INVEGA® να επηρεάζει άλλα φάρμακα:*** Η παλιπεριδόνη δεν αναμένεται να προκαλέσει κλινικά σημαντικές φαρμακοκινητικές αλληλεπιδράσεις με φάρμακα, τα οποία μεταβολίζονται από τα ισοένζυμα του κυτοχρώματος P450. Δεδομένων των κύριων δράσεων της παλιπεριδόνης στο ΚΝΣ (βλέπε παράγραφο Ανεπιθύμητες Ενέργειες), το INVEGA® πρέπει να χρησιμοποιείται με προσοχή σε συνδυασμό με άλλα κεντρικώς δρώντα φάρμακα, π.χ. αγχολυτικά, τα περισσότερα αντιψυχωσικά, υπνωτικά, οπιοειδή, κ.λπ. ή με αλκοόλ. Η παλιπεριδόνη μπορεί να ανταγωνίζεται τη δράση της λεβοντόπα και άλλων αγωνιστών της ντοπαμίνης. Εφόσον ο συνδυασμός αυτός θεωρείται απαραίτητος, ειδικά σε νόσο του Parkinson τελικού σταδίου, πρέπει να χορηγείται η ελάχιστη αποτελεσματική δόση κάθε φαρμάκου. Εξαιτίας της πιθανότητας πρόκλησης ορθοστατικής υπότασης (βλέπε παράγραφο Ειδικές προειδοποιήσεις και ειδικές προφυλάξεις κατά τη χρήση), μπορεί να παρατηρηθεί αθροιστική δράση όταν το INVEGA® χορηγείται μαζί με άλλους θεραπευτικούς παράγοντες που έχουν αυτή την πιθανή δράση, π.χ. άλλα αντιψυχωσικά, τρικυκλικά. Συνιστάται προσοχή εάν η παλιπεριδόνη συνδυάζεται με άλλα φάρμακα που είναι γνωστό ότι ελαττώνουν τον ουδό των σπασμών (δηλ. φαινοθειαζίνες ή βουτυροφαινόνες, τρικυκλικά ή εκλεκτικούς αναστολείς επαναπρόσληψης της σεροτονίνης (SSRIs), τραμαδόλη, μεφλοκίνη, κ.λπ.). ***Πιθανότητα άλλων φαρμάκων να επηρεάζουν το INVEGA®:*** *In vitro* μελέτες έδειξαν ότι τα ένζυμα του κυτοχρώματος CYP2D6 και CYP3A4 μπορεί να συμμετέχουν ελάχιστα στο μεταβολισμό της παλιπεριδόνης, δεν υπάρχουν όμως ενδείξεις, ούτε *in vitro* ούτε *in vivo*, ότι τα ισοένζυμα αυτά διαδραματίζουν σημαντικό ρόλο στο μεταβολισμό της παλιπεριδόνης. Η συγχορήγηση του INVEGA® μαζί με παροξετίνη, έναν ισχυρό αναστολέα του CYP2D6, δεν έδειξε καμία κλινικά σημαντική επίδραση στη φαρμακοκινητική της παλιπεριδόνης. *In vitro* μελέτες έδειξαν ότι η παλιπεριδόνη είναι ένα υπόστρωμα της P-γλυκοπρωτεΐνης (P-gp). Η συγχορήγηση INVEGA® μία φορά την ημέρα με καρβαμαζεπίνη 200 mg δύο φορές ημερησίως προκάλεσε μία μείωση κατά περίπου 37% στη μέση Cmax και AUC της παλιπεριδόνης στη σταθερή κατάσταση. Η μείωση αυτή προκαλείται, σε σημαντικό βαθμό, από μία αύξηση κατά 35% της νεφρικής κάθαρσης της παλιπεριδόνης, πιθανόν ως αποτέλεσμα επαγωγής της P-gp από την καρβαμαζεπίνη. Μία ήσσονος σημασίας μείωση της αμετάβλητης ποσότητας της δραστικής ουσίας που εκκρίνεται στα ούρα, υποδηλώνει ότι υπήρξε μικρή δράση στο μεταβολισμό του CYP ή στη βιοδιαθεσιμότητα της παλιπεριδόνης κατά τη διάρκεια της συγχορήγησης καρβαμαζεπίνης. Μεγαλύτερες μειώσεις στις συγκεντρώσεις της παλιπεριδόνης στο πλάσμα μπορεί να παρουσιασθούν με υψηλότερες δόσεις καρβαμαζεπίνης. Κατά την έναρξη της καρβαμαζεπίνης, η δόση του INVEGA® πρέπει να επαναξιολογείται και να αυξάνεται εάν είναι αναγκαίο. Απαιτούνται 2-3 εβδομάδες προκειμένου να επιτευχθεί πλήρης επαγωγή και με τη διακοπή του επαγωγέα η δράση μειώνεται βαθμιαία για ανάλογη χρονική περίοδο. Άλλα φαρμακευτικά προϊόντα ή βότανα τα οποία είναι επαγωγείς, π.χ. η ριφαμπικίνη και το Βαλσαμόχορτο (St John´s wort -*Hypericum perforatum*) μπορεί να έχουν παρόμοια επίδραση στην παλιπεριδόνη. Τα φαρμακευτικά προϊόντα που επηρεάζουν το χρόνο μετάβασης από το γαστρεντερικό σύστημα μπορεί να επηρεάσουν την απορρόφηση της παλιπεριδόνης, π.χ. η μετοκλοπραμίδη. ***Ταυτόχρονη χορήγηση του INVEGA® με ρισπεριδόνη:*** Η ταυτόχρονη χορήγηση του INVEGA με από του στόματος χορηγούμενη ρισπεριδόνη δε συνιστάται καθώς η παλιπεριδόνη είναι ο δραστικός μεταβολίτης της ρισπεριδόνης και ο συνδυασμός των δύο μπορεί να οδηγήσει σε αθροιστική έκθεση στην παλιπεριδόνη. **Κύηση και γαλουχία:** Δεν υπάρχουν επαρκή στοιχεία από τη χρήση της παλιπεριδόνης κατά τη διάρκεια της κύησης. Η παλιπεριδόνη δεν ήταν τερατογόνος σε μελέτες σε ζώα, παρατηρήθηκαν όμως άλλες μορφές τοξικότητας της αναπαραγωγικής ικανότητας. Η χρήση αντιψυχωσικών φαρμάκων κατά το τελευταίο τρίμηνο της κύησης έχει οδηγήσει σε μακροπρόθεσμες, αλλά ανασταρέψιμες νευρολογικές διαταραχές εξωπυραμιδικού τύπου στο νεογνό. Το INVEGA® δεν πρέπει να χρησιμοποιείται κατά τη διάρκεια της κύησης, εκτός αν είναι σαφώς απαραίτητο. Εάν καταστεί απαραίτητη η διακοπή κατά τη διάρκεια της κύησης, αυτή δεν πρέπει να γίνει απότομα. Η παλιπεριδόνη απεκκρίνεται στο μητρικό γάλα σε τέτοιο βαθμό ώστε είναι πολύ πιθανές οι επιδράσεις στο θηλάζον βρέφος όταν χορηγούνται θεραπευτικές δόσεις σε θηλάζουσες γυναίκες. Το INVEGA® δεν πρέπει να χορηγείται κατά την περίοδο του θηλασμού. **Επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανών:** Η παλιπεριδόνη μπορεί να έχει μικρή ή μέτρια επίδραση στην ικανότητα οδήγησης και χειρισμού μηχανών, εξαιτίας των πιθανών επιδράσεων στο νευρικό σύστημα και στην όραση (βλέπε παράγραφο Ανεπιθύμητες Ενέργειες). Επομένως, θα πρέπει να συνιστάται στους ασθενείς να μην οδηγούν ή να μην χειρίζονται μηχανές, μέχρι να γίνει γνωστή η ευαισθησία του κάθε ατόμου στο INVEGA®.
Ανεπιθύμητες ενέργειες: Οι πιο συχνά αναφερόμενες ανεπιθύμητες ενέργειες φαρμάκου (ΑΕΦ) στις κλινικές δοκιμές ήταν κεφαλαλγία, ταχυκαρδία, ακαθησία, φλεβοκομβική ταχυκαρδία, εξωπυραμιδική διαταραχή, υπνηλία, ζάλη, καταστολή, τρόμος, υπερτονία, δυστονία, ορθοστατική υπόταση και ξηροστομία. Οι ΑΕΦ που φάνηκε να είναι δοσοεξαρτώμενες, περιλάμβαναν αύξηση σωματικού βάρους, κεφαλαλγία, υπερέκκριση σιέλου, εμέτους, δυσκινησία, ακαθησία, δυστονία, εξωπυραμιδική διαταραχή, υπερτονία και Παρκινσονισμό. Ακολουθούν όλες οι ανεπιθύμητες ενέργειες φαρμάκου που αναφέρθηκαν κατά τις κλινικές δοκιμές σε ασθενείς που έλαβαν θεραπεία με INVEGA®. Χρησιμοποιούνται οι ακόλουθοι όροι και συχνότητες: *πολύ συχνές* (≥ 1/10), *συχνές* (≥ 1/100 έως <1/10), *όχι συχνές* (≥ 1/1000 έως < 1/100), *σπάνιες* (≥ 1/10.000 έως < 1/1000) και *πολύ σπάνιες* (< 1/10.000). Εντός κάθε ομάδας συχνοτήτων εμφάνισης, οι ανεπιθύμητες ενέργειες παρατίθενται με σειρά μειούμενης σοβαρότητας.

Κατηγορία Οργάνου Συστήματος	Ανεπιθύμητη Ενέργεια Φαρμάκου		
	Συχνότητα		
	Πολύ συχνές	Συχνές	Όχι Συχνές
Διαταραχές του ανοσοποιητικού συστήματος			αναφυλακτική αντίδραση
Διαταραχές του μεταβολισμού και της θρέψης			αυξημένη όρεξη
Ψυχιατρικές διαταραχές			εφιάλτης
Διαταραχές του νευρικού συστήματος	κεφαλαλγία	εξωπυραμιδική διαταραχή, παρκινσονισμός, τρόμος, υπερτονία, δυστονία, ακαθησία, ζάλη, καταστολή, υπνηλία	σπασμός γενικευμένης επιληψίας, συγκοπή, δυσκινησία, ζάλη θέσης
Οφθαλμικές διαταραχές			κίνηση των οφθαλμών
Καρδιακές διαταραχές		ταχυκαρδία, φλεβοκομβική ταχυκαρδία, σκελικός αποκλεισμός, κολποκοιλιακός αποκλεισμός 1ου βαθμού, βραδυκαρδία	αίσθημα παλμών, φλεβοκομβική αρρυθμία
Αγγειακές διαταραχές		ορθοστατική υπόταση	Ισχαιμία, υπόταση
Διαταραχές του γαστρεντερικού συστήματος		έμετος, άλγος άνω κοιλιακής χώρας, υπερέκκριση σιέλου, ξηροστομία	
Διαταραχές του μυοσκελετικού συστήματος, του συνδετικού ιστού και των οστών			μυϊκή ακαμψία
Διαταραχές του αναπαραγωγικού συστήματος και του μαστού			αμηνόρροια, γαλακτόρροια, στυτική δυσλειτουργία, γυναικομαστία, έκκριση μαστού, έμμηνος ρύση ακανόνιστη
Γενικές διαταραχές		εξασθένιση, κόπωση	οίδημα
Έρευνες		αυξημένο σωματικό βάρος	ηλεκτροκαρδιογράφημα μη φυσιολογικό

Η παλιπεριδόνη είναι ένας ενεργός μεταβολίτης της ρισπεριδόνης. Οι ακόλουθες ανεπιθύμητες ενέργειες είναι μια λίστα των πρόσθετων ΑΕΦ που έχουν αναφερθεί με τη ρισπεριδόνη.

Κατηγορία Οργάνου Συστήματος	Ανεπιθύμητη Ενέργεια
Λοιμώξεις και παρασιτώσεις	δερματίτιδα από ακάρεα, βρογχίτιδα, βρογχοπνευμονία, κυτταρίτιδα, κυστίτιδα, λοίμωξη του ωτός, λοίμωξη του οφθαλμού, γρίπη, εντοπισμένη λοίμωξη, ρινοφαρυγγίτιδα, ονυχομυκητίαση, μέση ωτίτιδα, χρόνια μέση ωτίτιδα, φαρυγγίτιδα, πνευμονία, λοίμωξη του αναπνευστικού συστήματος, ρινίτιδα, κολπίτιδα, αμυγδαλίτιδα, τραχειοβρογχίτιδα, λοίμωξη του ανώτερου αναπνευστικού συστήματος, ουρολοίμωξη, ιογενής λοίμωξη
Διαταραχές του αιμοποιητικού και του λεμφικού συστήματος	αναιμία, κοκκιοκυτταροπενία, ουδετεροπενία, θρομβοπενία
Διαταραχές του ανοσοποιητικού συστήματος	υπερευαισθησία σε φάρμακο, υπερευαισθησία
Διαταραχές του ενδοκρινικού συστήματος	υπερπρολακτιναιμία, απρόσφορη έκκριση αντιδιουρητικής ορμόνης
Διαταραχές του μεταβολισμού και της θρέψης	ανορεξία, μειωμένη όρεξη, διαβητική κετοξέωση, πολυδιψία
Ψυχιατρικές διαταραχές	διέγερση, ανοργασμία, άγχος, αμβλύ συναίσθημα, συγχυτική κατάσταση, αϋπνία, γενετήσια ορμή μειωμένη, νωθρότητα, μανία, αϋπνία κατά τη μέση του ύπνου, νευρικότητα, ανησυχία, διαταραχή ύπνου
Διαταραχές του νευρικού συστήματος	ακινησία, διαταραχή ισορροπίας, βραδυκινησία, εγκεφαλική ισχαιμία, αγγειακό εγκεφαλικό επεισόδιο, διαταραχή των αγγείων του εγκεφάλου, ακαμψία με σημείο οδοντωτού τροχού, επιληπτικός σπασμός, μη φυσιολογικός συντονισμός, επηρεασμένο επίπεδο συνείδησης, διαβητικό κώμα, διαταραχή στην προσοχή, ακούσια εκροή σιέλου από το στόμα, δυσαρθρία, υπερβολικός ύπνος, υπαισθησία, υποκινησία, λήθαργος, απώλεια συνείδησης, καθηλωμένο προσωπείο, διαταραχή κίνησης, μυϊκές συσπάσεις ακούσιες, νευροληπτικό κακόηθες σύνδρομο, παρκινσονικός τρόμος πρεμίας, διαταραχή του λόγου, βραδυκινησία, παροδικό ισχαιμικό επεισόδιο, μη ανταπόκριση σε ερεθίσματα
Οφθαλμικές διαταραχές	επιπεφυκίτιδα, ξηροφθαλμία, οφθαλμικό έκκριμα, συστροφή του οφθαλμικού βολβού, οίδημα του οφθαλμού, εφελκίδα του χείλους του βλεφάρου, οίδημα βλεφάρου, γλαύκωμα, δακρύρροια αυξημένη, υπεραιμία του οφθαλμού, φωτοφοβία, όραση θαμπή, οπτική οξύτητα μειωμένη
Διαταραχές του ωτός και του λαβυρίνθου	ωταλγία, εμβοές
Καρδιακές διαταραχές	κολπική μαρμαρυγή, κολποκοιλιακός αποκλεισμός
Αγγειακές διαταραχές	έξαψη
Διαταραχές του αναπνευστικού συστήματος, του θώρακα και του μεσοθωράκιου	βήχας, δυσφωνία, δύσπνοια, επίσταξη, υπεραερισμός, ρινική συμφόρηση, ρινικό οίδημα, φαρυγγολαρυγγικό άλγος, πνευμονία από εισρόφηση, παραγωγικός βήχας, πνευμονική συμφόρηση, ρόγχοι, διαταραχή αναπνευστικού συστήματος, συμφόρηση αναπνευστικής οδού, ρινόρροια, συμφόρηση κόλπων του προσώπου, σύνδρομο άπνοιας κατά τον ύπνο, συριγμός
Διαταραχές του γαστρεντερικού συστήματος	κοιλιακή δυσφορία, κοιλιακό άλγος, ξηροστομία, χειλίτιδα, δυσκοιλιότητα, διάρροια, δυσπεψία, δυσφαγία, ακράτεια κοπράνων, κόπρωμα, γαστρίτιδα, εντερική απόφραξη, οίδημα χειλών, ναυτία, δυσφορία του στομάχου
Διαταραχές του ήπατος και των χοληφόρων	ίκτερος
Διαταραχές του δέρματος και του υποδόριου ιστού	ακμή, αγγειονευρωτικό οίδημα, πιτυρίδα, ξηροδερμία, ερύθημα, υπερκεράτωση, κνησμός, εξάνθημα, εξάνθημα ερυθηματώδες, εξάνθημα γενικευμένο, εξάνθημα κηλιδοβλατιδώδες, εξάνθημα βλατιδώδες, σμηγματορροϊκή δερματίτιδα, δυσχρωματισμός δέρματος, διαταραχή δέρματος, βλάβη δέρματος
Διαταραχές του μυοσκελετικού συστήματος και του συνδετικού ιστού	αρθραλγία, οσφυαλγία, δυσκαμψία άρθρωσης, μυϊκοί σπασμοί, μυϊκές δεσμιδώσεις, μυϊκή αδυναμία, μυοσκελετικός πόνος του θώρακα, μυοσκελετική δυσκαμψία, μυαλγία, αυχενάλγία, άλγος στα άκρα, στάση σώματος μη φυσιολογική, ραβδομυόλυση, ραιβόκρανο
Διαταραχές των νεφρών και των ουροφόρων οδών	δυσουρία, ενούρηση, συχνουρία, ακράτεια ούρων
Διαταραχές του αναπαραγωγικού συστήματος και του μαστού	διόγκωση μαστού, διαταραχές εκσπερμάτισης, αποτυχία εκσπερμάτισης, διαταραχές εμμήνου ρύσης, πριαπισμός, παλίνδρομη εκσπερμάτιση, σεξουαλική δυσλειτουργία, κολπικό έκκριμα
Γενικές διαταραχές	ανεπιθύμητη ενέργεια φαρμάκου, θωρακική δυσφορία, θωρακικό άλγος, ρίγη, δυσφορία, σύνδρομο από απόσυρση φαρμάκου, οίδημα προσώπου, αίσθηση μη φυσιολογική, βάδισμα ανώμαλο, γενικευμένο οίδημα, γριπώδης συνδρομή, αίσθημα κακουχίας, περιφερικό οίδημα, περιφερική ψυχρότητα, οίδημα με εντύπωμα, πυρεξία, νωθρότητα, δίψα
Έρευνες	αμινοτρασφεράση της αλανίνης αυξημένη, ασπαρτική αμινοτρανσφεράση αυξημένη, κρεατινοφωσφοκινάση αίματος αυξημένη, γλυκόζη αίματος αυξημένη, αρτηριακή πίεση μειωμένη, προλακτίνη αίματος αυξημένη, θερμοκρασία σώματος μειωμένη, θερμοκρασία σώματος αυξημένη, ηλεκτροκαρδιογράφημα με διάστημα QT παρατεταμένο, αριθμός ηωσινοφίλων αυξημένος, αιματοκρίτης μειωμένος, αιμοσφαιρίνη μειωμένη, καρδιακή συχνότητα αυξημένη, τρανσαμινάσες αυξημένες, αριθμός λευκοκυττάρων μειωμένος

Ηλικιωμένοι: Σε μια μελέτη που διεξήχθη σε ηλικιωμένους ασθενείς με σχιζοφρένεια, το προφίλ ασφάλειας ήταν παρόμοιο με αυτό που διαπιστώθηκε σε μη ηλικιωμένους ασθενείς. Το INVEGA® δεν έχει μελετηθεί σε ηλικιωμένους με άνοια. Σε κλινικές δοκιμές με ορισμένα άλλα άτυπα αντιψυχωσικά έχουν αναφερθεί αυξημένοι κίνδυνοι θανάτου και αγγειακά εγκεφαλικά επεισόδια (βλέπε παράγραφο Ειδικές προειδοποιήσεις και ειδικές προφυλάξεις κατά τη χρήση). ***Περιπτώσεις Ιδιαίτερου ενδιαφέροντος για την κατηγορία - Εξωπυραμιδικά Συμπτώματα (EPS):*** Στις κλινικές δοκιμές δεν παρατηρήθηκε καμία διαφορά μεταξύ του εικονικού φαρμάκου και των δόσεων των 3 και 6 mg του INVEGA®. Εξάρτηση της δόσης από τα EPS παρατηρήθηκε για τις δύο υψηλότερες δόσεις του INVEGA® (9 και 12 mg). Τα EPS περιλάμβαναν μια συγκεντρωτική ανάλυση των ακόλουθων όρων: δυσκινησία, δυστονία, υπερκινησία, Παρκινσονισμός και τρόμος. ***Αύξηση σωματικού βάρους:*** Στις κλινικές δοκιμές, συγκρίθηκαν τα ποσοστά των ασθενών που πληρούσαν το κριτήριο αύξησης βάρους κατά ≥ 7% του σωματικού βάρους αποκαλύπτοντας μια παρόμοια συχνότητα εμφάνισης αύξησης βάρους για το INVEGA® 3 mg και 6 mg συγκριτικά με το εικονικό φάρμακο και μια μεγαλύτερη συχνότητα εμφάνισης αύξησης βάρους για το INVEGA® 9 mg και 12 mg συγκριτικά με το εικονικό φάρμακο. ***Εργαστηριακές εξετάσεις - Προλακτίνη ορού:*** Στις κλινικές δοκιμές παρατηρήθηκαν μεσαίες αυξήσεις της προλακτίνης στον ορό με το INVEGA® στο 67% των ασθενών. Ανεπιθύμητες ενέργειες που μπορεί να αφορούν αυξήσεις των επιπέδων της προλακτίνης (π.χ. αμηνόρροια, γαλακτόρροια, γυναικομαστία) αναφέρθηκαν συνολικά στο 2% των ασθενών. Οι μέγιστες μέσες αυξήσεις των επιπέδων της προλακτίνης στον ορό παρατηρήθηκαν γενικά κατά την Ημέρα 15 της θεραπείας, παρέμειναν όμως πάνω από τα επίπεδα κατά την έναρξη μέχρι το καταληκτικό σημείο της μελέτης. ***Δράσεις της κατηγορίας:*** Παράταση του διαστήματος QT, κοιλιακή αρρυθμία (κοιλιακή μαρμαρυγή, κοιλιακή ταχυκαρδία), αιφνίδιος θάνατος άγνωστης αιτιολογίας, καρδιακή ανακοπή και κοιλιακή ταχυκαρδία δίκην ριπιδίου (Torsade de pointes) μπορεί να συμβούν με αντιψυχωσικά. **Υπερδοσολογία:** Σε γενικές γραμμές, τα αναμενόμενα σημεία και συμπτώματα είναι αυτά που προκύπτουν από την υπερβολική έκφραση των γνωστών φαρμακολογικών ιδιοτήτων της παλιπεριδόνης, δηλαδή υπνηλία και καταστολή, ταχυκαρδία και υπόταση, παράταση του διαστήματος QT, και εξωπυραμιδικά συμπτώματα. Στην περίπτωση οξείας υπερδοσολογίας, πρέπει να λαμβάνεται υπόψη η πιθανότητα ταυτόχρονης λήψης πολλών φαρμακευτικών προϊόντων. Πρέπει να λαμβάνεται υπόψη η φύση της παρατεταμένης αποδέσμευσης του προϊόντος όταν εκτιμώνται οι θεραπευτικές ανάγκες και η ανάρρωση. Δεν υπάρχει ειδικό αντίδοτο για την παλιπεριδόνη. Εφαρμόζονται μόνο γενικά υποστηρικτικά μέτρα. Εξασφαλίζεται και διατηρείται βατός αεραγωγός και εξασφαλίζεται επαρκής οξυγόνωση και αερισμός. Πρέπει να αρχίσει άμεσα καρδιαγγειακή παρακολούθηση και πρέπει να περιλαμβάνει συνεχή ηλεκτροκαρδιογραφική παρακολούθηση για πιθανές αρρυθμίες. Η υπόταση και η κυκλοφορική κατάπληξη πρέπει να αντιμετωπίζονται με τα κατάλληλα μέτρα, όπως η ενδοφλέβια χορήγηση υγρών και/ή συμπαθητικομιμητικών φαρμάκων. Πρέπει να λαμβάνεται υπόψη η πλύση στομάχου (μετά από διασωλήνωση εφόσον ο ασθενής έχει απώλεια συνείδησης) και η χορήγηση ενεργού άνθρακα μαζί με καθαρτικό. Σε περίπτωση σοβαρών εξωπυραμιδικών συμπτωμάτων πρέπει να χορηγηθούν αντιχολινεργικοί παράγοντες. Η στενή επίβλεψη και παρακολούθηση πρέπει να συνεχιστούν μέχρι να αναρρώσει ο ασθενής.

ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:
Janssen- Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Βέλγιο.

ΑΡΙΘΜΟΣ(ΟΙ) ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: EU/1/07/395/001-095

ΗΜΕΡΟΜΗΝΙΑ ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ: 12.01.2009

Λεπτομερή πληροφοριακά στοιχεία για το προϊόν είναι διαθέσιμα στην ιστοσελίδα του Ευρωπαϊκού Οργανισμού Φαρμάκων (EMEA) http://www.emea.europa.eu/.

ΤΡΟΠΟΣ ΔΙΑΘΕΣΗΣ: Φαρμακευτικό προϊόν για το οποίο απαιτείται ιατρική συνταγή.

ΣΥΣΚΕΥΑΣΙΕΣ/ΤΙΜΕΣ:

Περιεκτικότητα	Συσκευασία	Νοσοκομειακή Τιμή	Λιανική Τιμή
3 mg/TAB	BT x 28	85,70 €	144,96 €
6 mg / TAB	BT x 28	91,43 €	154,64 €
9 mg/TAB	BT x 28	121,25 €	205,08 €

Bini, Lucio
(1908-1964)

Carlsson, Arvid
(1923-)

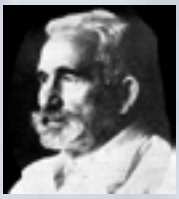
Cerleti, Ugo
(1877 - 1963)

Delay, Jean
(1907-1987)

Deniker, Pier
(1917-1999)

Janssen, Paul
(1926-2003)

Kline, Nathan
(1916-1982)



Kreapelin, Emil
(1856-1926)

Kuhn, Roland
(1912-2005)

Papez, James
(1883-1958)

Pavlov, Ivan
(1849-1936)

Schou, Mogens
(1918-2005)

Dear colleagues,

It's a great pleasure to invite you to the "1st International Congress on Neurobiology and Clinical Psychopharmacology & European Psychiatric Association on Treatment Guidance", which will take place in Thessaloniki, Greece, on November 19th - 22nd, 2009.

This dual congress aims on giving new perspectives into the newest innovations in our field and their impact on diagnoses, treatment, and rehabilitation of patients with mental disorders. It aims to be both focused and enriched; the same time to be useful for the clinician who fights in the first line. Indeed, our goal is to provide a global and comprehensive update of the newest contributions of Neurosciences to Psychiatry, as well as to the clinical application and use of informed treatment with psychopharmacological agents in a truly multidisciplinary approach. Many leading international experts have been invited to share with us their knowledge and experience under the support and guidance of the European Psychiatric Association and the World Psychiatric Association and the Auspices of the School of Medicine, Aristotle University of Thessaloniki, Greece.

Although the congress will embrace high tech research concerning psychopathology, new treatment methods, genetics, and molecular biology, it also aims on putting emphasis on the human factor, both the therapist and the patient. Today, in an all the more complex and technologically advanced environment, the human factor emerges again as the most valuable one, the factor that determines the final outcome.

Apart from the humanistic tradition of psychiatry and life sciences, the continuous and unconditional investment on the high level training of professionals and education of patients and their families, emerged as a significant challenge during the last few decades. Medical scientists and public health policy makers are increasingly concerned that the scientific discoveries are failing to be translated efficiently into tangible human benefit.

We also count on your active participation through the presentation of your work on any of the thematic topics of the Congress. Your submissions will be most welcomed and your contribution highly appreciated.

As hosts and organizers, we will do our best to make your participation scientifically rewarding and meaningful and your stay in Thessaloniki as enjoyable as possible.

We are looking forward to welcoming you in the hospitable city of Thessaloniki.

Cordially yours,

Konstantinos N. Fountoulakis
Assist. Professor of Psychiatry,
Aristotle University of Thessaloniki, Greece

Chair of the Organizing Committee
1st International Congress on Neurobiology
and Clinical Psychopharmacology &
European Psychiatric Association Conference on Treatment Guidance

ALAPIS PHARMA

Topepil®

TOPIRAMATE

25mg/50mg/100mg/200mg

Πριν τη συνταγογράφηση συμβουλευτείτε την Περίληψη Χαρακτηριστικών του Προϊόντος.
Για περισσότερες πληροφορίες σχετικά με το προϊόν απευθυνθείτε στην εταιρεία ALAPIS PHARMA ΑΒΕΕ

Καρτσιβάνη 6, Παλαιό Φάληρο, Αττική - Τηλ.: (+30) 2130175066, Fax: (+30) 210 9238675

TUDK01.07_09

TUDOR®

VENLAFAXINE

CR CAPS 75MG
CR CAPS 150 MG

Πριν την συνταγογράφηση συμβουλευτείτε την Περίληψη Χαρακτηριστικών του Προϊόντος.
Για περισσότερες πληροφορίες σχετικά με το Tudor απευθυνθείτε στην εταιρεία.

ALAPIS PHARMA

ALAPIS PHARMA A.B.E.E. Καρτσιβάνη 6, 175 64 Π. Φάληρο, Τηλ.: 2130-175064

Velpine XR

Venlafaxine XR

37.5, 75,150mg

Η **αξιόπιστη**
επιλογή
στη **θεραπεία**
της **κατάθλιψης**

Παστέρ 6, Αθήνα 115 21 • Τηλ: 210 6413160 • Fax: 210 6445375
Κων. Καραμανλή 145, Θεσσαλονίκη 542 49 • Τηλ: 2310 300869
e-mail: greece@medochemie.com • www.medochemie.com

MEDOCHEMIE
HELLAS A.E.

Velpine XR

Venlafaxine XR **37.5, 75,150mg**

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΪΟΝΤΟΣ

ΕΜΠΟΡΙΚΗ ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ: VELPINE® XR 37.5 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές, VELPINE® XR 75 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές, VELPINE® XR 150 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές, ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ: Κάψουλα παρατεταμένης αποδέσμευσης, σκληρή. VELPINE® XR 37.5 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές. Λευκά έως υπόλευκα κοκκία μέσα σε μία κάψουλα με πορτοκαλί το πάνω μισό και διαφανές το άλλο κάτω μισό της κάψουλας. VELPINE® XR 75 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές. Λευκά έως υπόλευκα κοκκία μέσα σε μία κάψουλα με κίτρινο το πάνω μισό και διαφανές το άλλο κάτω μισό της κάψουλας. VELPINE® XR 150 mg κάψουλες παρατεταμένης αποδέσμευσης, σκληρές. Λευκά έως υπόλευκα κοκκία μέσα σε μία κάψουλα με χρώμα κίτρινο ώχρα το πάνω μισό και διαφανές το άλλο κάτω μισό της κάψουλας. ΚΛΙΝΙΚΑ ΣΤΟΙΧΕΙΑ: Θεραπευτικές ενδείξεις: Θεραπεία των μειζόνων καταθλιπτικών επεισοδίων, Για την πρόληψη της επανεμφάνισης νέων επεισοδίων μείζονος κατάθλιψης, Θεραπεία της Κοινωνικής Αγχώδους Διαταραχής. Δοσολογία και τρόπος χορήγησης: Επεισόδια μείζονος κατάθλιψης Η συνιστώμενη δόση έναρξης της βενλαφαξίνης παρατεταμένης αποδέσμευσης είναι 75 mg, χορηγούμενη μία φορά ημερησίως. Οι ασθενείς που δεν ανταποκρίνονται στην αρχική δόση των 75 mg/ημέρα, μπορεί να ωφεληθούν από αυξήσεις στη δόση μέχρι τη μέγιστη δόση των 375 mg/ημέρα. Οι αυξήσεις της δόσης μπορεί να γίνονται ανά διαστήματα 2 εβδομάδων ή περισσότερο. Οι ασθενείς πρέπει να υποβάλλονται σε θεραπεία για αρκετό χρονικό διάστημα, συνήθως αρκετούς μήνες ή περισσότερο. Η θεραπεία πρέπει να επαναξιολογείται τακτικά και εξατομικευμένα. Κοινωνική Αγχώδης Διαταραχή (ΚΑΔ) Η συνιστώμενη δόση της βενλαφαξίνης παρατεταμένης αποδέσμευσης είναι 75 mg, χορηγούμενη μία φορά ημερησίως. Δεν υπάρχουν δεδομένα ότι υψηλότερες δόσεις θα οδηγήσουν σε επιπρόσθετο όφελος. Ωστόσο,σε μεμονωμένους ασθενείς που δεν ανταποκρίνονται στην αρχική δόση των 75 mg/ημέρα, μπορεί να απαιτούνται αυξήσεις μέχρι τη μέγιστη δόση των 225 mg/ημέρα. Οι αυξήσεις της δόσης μπορεί να γίνονται ανά διαστήματα 2 εβδομάδων ή περισσότερο. Χορήγηση σε ηλικιωμένους ασθενείς Δεν θεωρείται απαραίτητη καμία προσαρμογή στη δόση της βενλαφαξίνης για τους υπερήλικες εξαιτίας της ηλικίας τους μόνο. Χορήγηση σε παιδιά και εφήβους κάτω των 18 ετών. Δεν συνιστάται η χορήγηση της βενλαφαξίνης σε παιδιά και εφήβους. Χορήγηση σε ασθενείς με ηπατική ανεπάρκεια. Σε ασθενείς με ήπια έως μέτρια ηπατική ανεπάρκεια, γενικώς η δόση πρέπει να μειωθεί κατά 50%. Χορήγηση σε ασθενείς με νεφρική ανεπάρκεια. Αν και δεν χρειάζεται προσαρμογή της δόσης σε ασθενείς με ρυθμό σπειραματικής διήθησης (GFR) μεταξύ 30-70 ml/min, συνιστάται προσοχή. Σε ασθενείς που χρειάζονται αιμοκάθαρση και σε ασθενείς με σοβαρή νεφρική ανεπάρκεια, η δόση πρέπει να μειωθεί κατά 50%. Σύνδρομο στέρησης που εμφανίζεται με τη διακοπή της βενλαφαξίνης. Η απότομη διακοπή πρέπει να αποφεύγεται. Συνιστάται η λήψη των καψακίων παρατεταμένης αποδέσμευσης βενλαφαξίνης με τροφή, περίπου την ίδια ώρα κάθε ημέρα. Τα καψάκια πρέπει να καταπίνονται ολόκληρα με τη βοήθεια υγρού και δεν πρέπει να διαιρούνται, να θρυμματίζονται να μασσώνται ή να διαλύονται. Τα καψάκια παρατεταμένης αποδέσμευσης βενλαφαξίνης περιέχουν σφαιρίδια, τα οποία αποδεσμεύουν αργά τη δραστική ουσία μέσα στο πεπτικό σύστημα. Το αδιάλυτο τμήμα αυτών των σφαιριδίων αποβάλλεται και μπορεί να εμφανισθεί στα κόπρανα. Αντενδείξεις Υπερευαισθησία στη δραστική ουσία ή σε οποιοδήποτε από τα έκδοχα. Η συγχορήγηση με μη αναστρέψιμους αναστολείς της μονοαμινοξειδάσης (ΜΑΟ) αντενδείκνυται λόγω του κινδύνου εμφάνισης του συνδρόμου σεροτονίνης με συμπτώματα όπως διέγερση, τρόμος και υπερθερμία. Ιδιαίτερες προειδοποιήσεις & ιδιαίτερες προφυλάξεις κατά τη χρήση. Η κατάθλιψη σχετίζεται με αυξημένο κίνδυνο αυτοκτονικών σκέψεων, αυτοτραυματισμού και αυτοκτονίας. Ο κίνδυνος αυτός παραμένει έως όπου επιτευχθεί σημαντική ύφεση. Καθώς μπορεί να μη σημειωθεί βελτίωση κατά τη διάρκεια των πρώτων λίγων εβδομάδων θεραπείας ή περισσότερων, οι ασθενείς θα πρέπει να παρακολουθούνται στενά έως όπου επιτευχθεί τέτοια βελτίωση. Κατά τη γενική κλινική εμπειρία, ο κίνδυνος αυτοκτονίας μπορεί να αυξηθεί κατά τα πρώιμα στάδια της ανάρρωσης. Ασθενείς με ιστορικό επεισοδίων σχετιζόμενων με αυτοκτονία, ή εκείνοι που παρουσιάζουν σημαντικού βαθμού αυτοκτονικό ιδεασμό πριν από την έναρξη της θεραπείας, είναι γνωστό ότι διατρέχουν μεγαλύτερο κίνδυνο αυτοκτονικών σκέψεων ή αποπειρών αυτοκτονίας και γι΄αυτό θα πρέπει να παρακολουθούνται προσεκτικά κατά τη διάρκεια της θεραπείας. Χορήγηση σε παιδιά και εφήβους κάτω των 18 ετών: Το Velpine δεν πρέπει να χορηγείται για τη θεραπεία παιδιών και εφήβων κάτω των 18 ετών. Σύνδρομο σεροτονίνης. Όπως και με άλλους σεροτονινεργικούς παράγοντες, το σύνδρομο σεροτονίνης, μια κατάσταση πιθανώς απειλητική για τη ζωή, μπορεί να παρατηρηθεί με τη θεραπεία με βενλαφαξίνη, ειδικά κατά την ταυτόχρονη χρήση άλλων παραγόντων,όπως αναστολείς ΜΑΟ, που μπορεί να επιδρούν στα συστήματα σεροτονινεργικών νευροδιαβιβαστών. Γλαύκωμα κλειστής γωνίας. Μπορεί να παρατηρηθεί μυδρίαση, που σχετίζεται με τη βενλαφαξίνη. Συνιστάται να παρακολουθούνται στενά οι ασθενείς με αυξημένη ενδοφθάλμια πίεση ή ασθενείς σε κίνδυνο για γλαύκωμα κλειστής γωνίας. Αρτηριακή πίεση. Δοσοεξαρτώμενες αύξήσεις της αρτηριακής πίεσης έχουν αναφερθεί συχνά με βενλαφαξίνη. Καρδιακή συχνότητα. Μπορεί να συμβούν αυξήσεις της καρδιακής συχνότητας, ιδιαίτερα με υψηλότερες δόσεις. Καρδιοπάθεια και κίνδυνος αρρυθμίας Η βενλαφαξίνη δεν έχει αξιολογηθεί σε ασθενείς με πρόσφατο ιστορικό εμφράγματος του μυοκαρδίου ή ασταθούς καρδιοπάθειας. Σπασμοί. Μπορεί να παρατηρηθούν σπασμοί με τη θεραπεία βενλαφαξίνης. Όπως και όλα τα αντικαταθλιπτικά, η βενλαφαξίνη θα πρέπει να χορηγείται με προσοχή σε ασθενείς με ιστορικό σπασμών. Υπονατριαιμία. Με τη βενλαφαξίνη μπορεί να παρατηρηθεί υπονατριαιμία και/ή Σύνδρομο απρόσφορης έκκρισης αντιδιουρητικής ορμόνης (SIADH). Μη φυσιολογικές αιμορραγικές εκδηλώσεις Φάρμακα που αναστέλλουν την πρόσληψη σεροτονίνης μπορεί να οδηγήσουν σε διαταραχές της συσσώρευσης των αιμοπεταλίων. Χοληστερόλη στον ορό. Κατά τη διάρκεια μακρόχρονης θεραπείας, πρέπει να εξετάζεται το ενδεχόμενο παρακολούθησης των επιπέδων χοληστερόλης. Μανία/υπομανία. Μανία/υπομανία μπορεί να εκδηλωθεί σε μικρό ποσοστό ασθενών με διαταραχές διάθεσης οι οποίοι λάμβαναν αντικαταθλιπτικά, συμπεριλαμβανομένης της βενλαφαξίνης. Επιθετικότητα. Επιθετικότητα μπορεί να εκδηλωθεί σε μικρό αριθμό ασθενών στους οποίους χορηγήθηκαν αντικαταθλιπτικά, συμπεριλαμβανομένης της βενλαφαξίνης. Αυτό αναφέρθηκε στην έναρξη, στις αλλαγές της δόση και στη διακοπή της θεραπείας. Διακοπή της θεραπείας. Όταν η θεραπεία διακόπτεται παρατηρούνται συχνά τα συμπτώματα στέρησης, ειδικά εάν η διακοπή είναι απότομη. Ακαθισία/Ψυχοκινητική ανησυχία. Η χρήση βενλαφαξίνης έχει συνδεθεί με την εμφάνιση ακαθησίας, χαρακτηριζόμενη από υποκειμενική δυσάρεστη ή δυσχερή ανησυχία και την ανάγκη για συχνή κίνηση, συνοδευόμενη από ανικανότητα να καθίσετε ή να σταθείτε ακίνητοι. Αυτό πιθανόν να συμβεί μέσα στις πρώτες εβδομάδες της θεραπείας. Σε ασθενείς που παρουσιάζουν αυτά τα συμπτώματα η αύξηση της δόσης μπορεί να είναι επιβλαβής. Ξηροστομία. Ξηροστομία αναφέρεται στο 10% των ασθενών που λαμβάνουν βενλαφαξίνη. Τα έκδοχα που περιέχονται στο κέλυφος της κάψουλας μπορεί να προκαλέσουν αλλεργικές αντιδράσεις. Επειδή οι κάψουλες περιέχουν σουκρόζη, ασθενείς με σπάνια κληρονομικά νοσήματα όπως δυσανεξία στην φρουκτόζη, δυσαπορρόφηση γλυκόζης – γαλακτόζης ή ανεπάρκεια ιμβερτάσης – ισομαλτάσης δεν θα πρέπει να παίρνουν το φάρμακο αυτό. Αλληλεπιδράσεις με άλλα φάρμακα & άλλες μορφές αλληλεπίδρασης: Η βενλαφαξίνη δεν πρέπει να χρησιμοποιείται σε συνδυασμό με Αναστολείς της ΜΑΟ. Σεροτονινεργικό σύνδρομο. Όπως και με άλλους σεροτονινεργικούς παράγοντες, κατά τη θεραπεία με βενλαφαξίνη μπορεί να παρατηρηθεί σύνδρομο σεροτονίνης, ιδιαίτερα με την ταυτόχρονη χρήση άλλων παραγόντων, που μπορεί να επηρεάζουν το σύστημα σεροτονινεργικής νευροδιαβίβασης. Αιθανόλη. Όπως με όλες τις ουσίες που επενεργούν στο ΚΝΣ, συνιστάται στους ασθενείς να μη γίνεται κατανάλωση αλκοόλ. Επίδραση άλλων φαρμάκων στη βενλαφαξίνη. Κετοκοναζόλη (αναστολέας του CYP3A4) Επομένως, απαιτείται προσοχή αν η θεραπεία του ασθενή περιλαμβάνει συγχορήγηση ενός αναστολέα του CYP3A4 και της βενλαφαξίνης. Κύηση και γαλουχία Δεν υπάρχουν επαρκή δεδομένα για τη χρήση της βενλαφαξίνης σε εγκύους γυναίκες. Γαλουχία: Η βενλαφαξίνη και ο ενεργός μεταβολίτης της, η Ο-δυσεμθυλβενλαφαξίνη απεκκρίνονται στο μητρικό γάλα. Δεν μπορεί να αποκλεισθεί ο κίνδυνος για τα μωρά που θηλάζουν. Επίδραση στην ικανότητα οδήγησης και χειρισμού μηχανημάτων Οποιοδήποτε ψυχοφάρμακο μπορεί να βλάψει την κρίση, τη σκέψη, και την κινητική δεξιότητα. Ωστόσο κάθε ασθενής που λαμβάνει βενλαφαξίνη πρέπει να είναι προσεκτικός όσον αφορά την ικανότητα του για οδήγηση ή χειρισμό επικίνδυνων μηχανημάτων. Ανεπιθύμητες ενέργειες Οι πιο συχνά (≥1/10) αναφερόμενες ανεπιθύμητες ενέργειες σε κλινικές μελέτες ήταν ναυτία, ξηροστομία, κεφαλαλγία, και εφίδρωση. Ανεπιθύμητες ενέργειες:Πολύ συχνές: Ξηροστομία (10,0%) Κεφαλαλγία (30,3%) Ναυτία (20,0%) Εφίδρωση (περιλαμβανομένων των νυκτερινών εφιδρώσεων)[12,2%] Συχνές: Υπερχοληστεριναιμία, απώλεια σωματικού βάρους, Μη φυσιολογικά όνειρα, Μειωμένη λίμπιντο, Ζάλη, Αυξημένος μυϊκός τόνος (υπερτονία), Αϋπνία, Νευρικότητα, Παραισθησία Καταστολή, Τρόμος, Σύγχυση, Αποπροσωποποίηση, Διαταραχή στην προσαρμογή, μυδρίαση, διαταραχές όρασης Υπέρταση, αγγειοδιαστολή (κυρίως εξάψεις), Αίσθημα παλμών, Χασμουρητό, Μειωμένη όρεξη (ανορεξία), Δυσκοιλιότητα, Έμετος Μη φυσιολογική εκσπερμάτιση/οργασμός (άνδρες), Ανοργασμία, Διαταραχή της στύσης (ανικανότητα), Διαταραχή της ούρησης (κυρίως δυστακτικότητα), Διαταραχές εμμήνου ρύσης που συνοδεύονται από αυξημένη αιμορραγία ή αυξημένη μη κανονική αιμορραγία (π.χ. μηνορραγία, μηνομητρορραγία), αυξημένη συχνότητα ούρησης, Αίσθημα αδυναμίας (κόπωση), Ρίγη Μη συχνές: Εκχύμωση Αιμορραγία Του γαστρεντερικού συστήματος, Αύξηση βάρους, Απάθεια, Ψευδαισθήσεις, Μυοκλονία, Διέγερση, Μείωση του συντονισμού και της ισορροπίας, Διαταραχές γεύσης, εμβόες, Ορθοστατική υπόταση, Συγκοπή, Ταχυκαρδία Τριγμός των δοντιών, Διάρροια Εξάνθημα, Αλωπεκία Μη Φυσιολογικός οργασμός (γυναίκες), Κατακράτηση ούρων Αντίδραση φωτοευαισθησίας Σπάνιες: Ακαθησία/ Ψυχοκινητική ανησυχία, Σπασμοί, Μανιακή αντίδραση Υπερδοσολογία & Συνιστώμενη θεραπεία Οι συχνότερα αναφερόμενες ενέργειες όσον αφορά την υπερδοσολογία περιλαμβάνουν ταχυκαρδία, αλλαγές στο επίπεδο της συνείδησης (που κυμαίνονται από υπνηλία σε κώμα), μυδρίαση, σπασμούς και έμετο. Συνιστώνται γενικά υποστηρικτικά και συμπτωματικά μέτρα, ενώ πρέπει να παρακολουθούνται ο καρδιακός ρυθμός και τα ζωτικά σημεία. Δεν είναι γνωστά ειδικά αντίδοτα για τη βενλαφαξίνη. Φαρμακοκινητικές Ιδιότητες: Η βενλαφαξίνη μεταβολίζεται εκτεταμένα, κυρίως στον ενεργό της μεταβολίτη Ο-δυσμεθυλβενλαφαξίνη (ODV). Ο χρόνος ημιζωής (μέσος όρος .SD) της βενλαφαξίνης και της ODVστο πλάσμα είναι 5±2 ώρες και 11±2 ώρες, αντίστοιχα. Οι συγκεντρώσεις σταθεροποιημένης κατάστασης της βενλαφαξίνης και της ODV επιτυχάνονται εντός 3 ημερών από την θεραπεία με πολλαπλές χορηγούμενες δόσεις από το στόμα. Η βενλαφαξίνη και η ODV διαθέτουν γραμμική κινητική σε δοσολογικό εύρος 75 mg έως 450 mg/ημέρα. Απορρόφηση Τουλάχιστον το 92% μιας απλής δόσης βενλαφαξίνης άμεσης αποδέσμευσης απορροφάται. Η απόλυτη βιοδιαθεσιμότητα είναι 40% με 45% εξαιτίας του προσυστηματικού μεταβολισμού. Μετά τη χορήγηση της βενλαφαξίνης σε καψάκια παρατεταμένης αποδέσμευσης, η μέγιστη συγκέντρωση στο πλάσμα της βενλαφαξίνης και της ODV επιτυγχάνονται στις 5,5 και στις 9,0 ώρες αντίστοιχα. Όταν χορηγούνται ισοδύναμες ημερήσιες δόσεις βενλαφαξίνης είτε ως δισκία άμεσης αποδέσμευσης ή ως καψάκια παρατεταμένης αποδέσμευσης, το καψάκιο παρατεταμένης αποδέσμευσης παρέχει βραδύτερο ρυθμό απορρόφησης, αλλά τον ίδιο βαθμό απορρόφησης σε σύγκριση με το δισκίο άμεσης αποδέσμευσης. Η τροφή δεν επηρεάζει τη βιοδιαθεσιμότητα της βενλαφαξίνης και της ODV. Κατανομή Ο όγκος κατανομής της βενλαφαξίνης σε σταθεροποιημένη κατάσταση είναι 4,4 ± 1,6 L/kg μετά την ενδοφλέβια χορήγηση. Μεταβολισμός Η βενλαφαξίνη υφίσταται εκτεταμένο μεταβολισμό στο ήπαρ. Σε μελέτες in vitro και in vivo φαίνεται ότι βενλαφαξίνη είναι ασθενής αναστολέας του CYP2D6. Η βενλαφαξίνη δεν αναστέλλει τα CYP1A2, CYP2C9, ή CYP3A4. Απέκκριση Η βενλαφαξίνη και οι μεταβολίτες της απεκκρίνονται κυρίως μέσω των νεφρών. Ιδιαίτερες προφυλάξεις κατά τη φύλαξη του προϊόντος: Αυτό το φαρμακευτικό προϊόν δεν απαιτεί ιδιαίτερες συνθήκες φύλαξης. Φύση και συστατικά του περιέκτη: 20, 28, 30, 50, 98, και 100 κάψουλες που συσκευάζονται σε κυψέλες (blisters PVC/Aluminium). Δεν είναι διαθέσιμες όλες οι συσκευασίες. ΚΑΤΟΧΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: MEDOCHEMIE HELLAS A.E. Παστέρ 6, Τ.Κ.: 115 21, Αθήνα Τηλ.: 210-6413160 ΑΡΙΘΜΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: VELPINE® XR 37.5 mg/cap: 52699/08/09-04-2009, VELPINE® XR 75 mg/cap: 52695/08/09-04-2009, VELPINE® XR 150 mg/cap: 52696/08/09-04-2009. ΗΜΕΡΟΜΗΝΙΑ ΤΗΣ ΠΡΩΤΗΣ ΑΔΕΙΑΣ

MEDOCHEMIE HELLAS A.E.

Main Topics

The main topics of the congress are the following:

- Animal Models
- Anxiety Disorders
- Basic Neuroscience
- Bioethics
- Biological Therapies
- Biological Rhythms
- Biomedical Technology
- Bipolar Disorders
- Childhood and Adolescence Disorders
- Clinical Psychiatry
- Clinical Psychopharmacology
- Cognitive Disorders
- Dementia
- Drug Development
- Eating Disorders
- Epidemiological Psychopharmacology
- Evidence-based Psychiatry
- Experimental Psychopharmacology
- Forensic Psychiatry
- Health Economics
- Information Technology and Neuroscience
- Learning Disabilities
- Major Disaster and Mental Health
- Methods in Behavioural Research
- Molecular Psychiatry
- Mood Disorders
- Neural Networks
- Neuroimaging
- Neuropsychology
- Neurophysiology
- Nosology and Classification
- Pharmacogenetics
- Psychiatric Genetics
- Psychobiology
- Psychoendocrinology
- Psychogeriatrics
- Psychoimmunology
- Psychometrics
- Psychopharmacology
- Psychophysiology
- Psychosocial and other Non-Biological Therapies and Interventions
- Quality of Life
- Schizophrenia
- Sexual Disorders
- Sleep
- Social and Community Psychiatry
- Stress
- Substance Abuse and Dependence
- Suicide
- Transcultural Psychiatry
- Treatment Guidelines

Honorary Chair of the Congress: Hans-Jürgen Möller (Germany)

Organizing Committee

Chairman: Fountoulakis K.N. (Greece)

Members:

Akiskal H. (USA)
Andreasen N. (USA)
Angelopoulos N. (Greece)
Angst J. (Switzerland)
Bech P. (Denmark)
Berati S. (Greece)
Bouras C. (Switzerland)
Buchsbaum M. (USA)
Carlsson A. (Sweeden)
Christodoulou G. (Greece)
Csernansky J. (USA)
Daniilidis M. (Greece)
Erfurth A. (Austria)
Figueira M. L. (Portugal)
Gaebel W. (Germany)
Gatzonis A. (Greece)
Gelenberg A. (USA)
Georgakas P. (Greece)
Giannacopoulos P. (Switzerland)
Gonda X. (Hungary)
Goodwin G. (UK)
Grunze H. (UK)
Halaris A. (USA)
Hantouche E. (France)
Höschl C. (Czech Republic)
Janca A. (Australia)
Kanistras A. (Greece)
Karakioulakis G. (Greece)
Kargopoulos Ph. (Greece)
Kasper S. (Austria)
Kokkas B. (Greece)
Koukopoulos A. (Italy)
Kouvelas D. (Greece)
Kuey L. (Turkey)
Liappas I. (Greece)
Livaditis M. (Greece)
Lopez-Ibor J. (Spain)
Lykouras L. (Greece)
Maj M. (Italy)
Marneros A. (Germany)
Mavreas V. (Greece)
Milev R. (Canada)
Möller H.-J. (Germany)
Moussaoui D. (Morocco)
Mironidou-Tzouveleki M. (Greece)
Okasha A. (Egypt)
Perugi G. (Italy)
Pinto O. (Brazil)
Rihmer Z. (Hungary)
Sartorius N. (Switzerland)
Simos G. (Greece)
Sitzoglou K. (Greece)
Sotiriou M. (Greece)
Souery D. (Belgium)
Stathakis I. (Greece)
Stein D. (South Africa)
Taskos N. (Greece)
Tsiptsios J. (Greece)
Vartzopoulos D. (Greece)
Vieta E. (Spain)
Vlaikidis N. (Greece)
Yamawaki S. (Japan)
Yesavage J. (USA)

Scientific Committee

Chairman: Akiskal H. (USA)

Members:

Agam G. (Israel)
Akdeniz F. (Turkey)
Anagnostopoulos D. (Greece)
Angelopoulos E. (Greece)
Anogiannakis G. (Greece)
Arboleda-Florez J. (Canada)
Azorin J.M. (France)
Bastas Ch. (Greece)
Bitsios P. (Greece)
Bitter I. (Hungary)
Botbol M. (France)
Botsis A. (Greece)
Bunevicius R. (Lithuania)
Chatzileontiadis L. (Greece)
Colom F. (Spain)
Degleris N. (Greece)
Den Boer J. (The Netherlands)
Dikaios D. (Greece)
Diler R.S. (USA)
Donchev T. (Bulgaria)
Douzenis A. (Greece)
Falkai P. (Germany)
Faludi G. (Hungary)
Fleischhacker W. (Austria)
Foroglou N. (Greece)
Galderisi S. (Italy)
Ginieri-Coccossis M. (Greece)
Gold G. (Switzerland)
Gournellis R. (Greece)
Grbesa G.B. (Serbia)
Grigoriadis N. (Greece)
Grigoriou P. (Greece)
Hatzimanolis I. (Greece)
Hauser P. (USA)
Havaki-Kontaxaki B. (Greece)
Hranov L. (Bulgaria)
Iscaacson G. (Sweden)
Janka Z. (Hungary)
Kahn R. (The Netherlands)
Kalampalikis V. (Greece)
Kaloterakis Ph. (Greece)
Karam E. (Lebanon)
Kastrup M. (Denmark)
Kimiskidis V. (Greece)
Koichev G. (Bulgaria)
Kokkevi A. (Greece)
Kollias K. (Greece)
Konstantinidis A. (Austria)
Kontaxakis V. (Greece)
Kostic V. (Serbia)
Koupidis S. (Greece)
Koutras V. (Greece)
Kovari E. (Switzerland)
Lainas S. (Greece)
Lazaratou E. (Greece)
Lazari M. (Greece)
Lecic Tosevski D. (Serbia)
Leotsakou Ch. (Greece)
Lerer B. (Israel)
Leucht S. (Germany)
Malliori M. (Greece)
Mantas Ch. (Greece)
Marazziti D. (Italy)
Margariti M. (Greece)
Mouzas O. (Greece)
Nemeth A. (Hungary)
Neroutsos E. (Greece)
Nierenberg A. (USA)
Oral T. (Turkey)
Oulis P. (Greece)
Ozerdem A. (Turkey)
Panas S. (Greece)
Pani L. (Italy)
Papageorgiou G. (Greece)
Papaioannou N. (Greece)
Papakostas G. (USA)
Papakostas Y. (Greece)
Papalianga M. (Greece)
Paraskevopoulos N. (Greece)
Pechlivanidis A. (Greece)
Petridis V. (Greece)
Pi E. (USA)
Pillilng S. (UK)
Pinder R. (The Netherlands)
Riba M. (USA)
Rohde A. (Germany)
Rotsika V. (Greece)
Rybakowski J. (Poland)
Sachs G. (USA)
Sakkas P. (Greece)
Samolis S. (Greece)
Shrivastava A. (Canada)
Silverstone P. (Canada)
Skapinakis P. (Greece)
Stefanis N. (Greece)
Stefanova E. (Serbia)
Stewart D. (Canada)
Stoforos P. (Greece)
Suh, G.H. (Korea)
Tandon R. (USA)
Tohen M. (USA)
Tomaras V. (Greece)
Touloumis Ch. (Greece)
Trivedi J.K. (India)
Tsalta E. (Greece)
Tsipas V. (Greece)
Typaldou M. (Greece)
Tzebelikos E. (Greece)
Vahip S. (Turkey)
Vaidakis N. (Greece)
Vaslamatzis G. (Greece)
Vazquez G. (Argentina)
Vidalis A. (Greece)
Vlassopoulou M. (Greece)
Xiromeritis A. (Greece)
Yazici O. (Turkey)
Yildiz A. (Turkey)
Zika Ch. (Greece)
Zohar J. (Israel)

ΟΝΟΜΑΣΙΑ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ: ENTACT 10mg επικαλυμμένα με λεπτό υμένιο δισκία, ENTACT 20mg επικαλυμμένα με λεπτό υμένιο δισκία. **ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ:** ENTACT 10mg: Κάθε δισκίο περιέχει 10mg escitalopram (ως οξαλικό άλας), ENTACT 20 mg: Κάθε δισκίο περιέχει 20 mg escitalopram (ως οξαλικό άλας). **ΑΝΤΕΝΔΕΙΞΕΙΣ:** Υπερευαισθησία στην escitalopram ή σε οποιοδήποτε από τα έκδοχα. Ταυτόχρονη χορήγηση με μη εκλεκτικούς, μη αναστρέψιμους αναστολείς της μονοαμινοξειδάσης (αναστολείς-ΜΑΟ). **ΙΔΙΑΙΤΕΡΕΣ ΠΡΟΕΙΔΟΠΟΙΗΣΕΙΣ ΚΑΙ ΙΔΙΑΙΤΕΡΕΣ ΠΡΟΦΥΛΑΞΕΙΣ ΚΑΤΑ ΤΗ ΧΡΗΣΗ:** Οι ακόλουθες ιδιαίτερες προειδοποιήσεις και προφυλάξεις ισχύουν για τη θεραπευτική κατηγορία των SSRIs. Χορήγηση σε παιδιά και εφήβους ηλικίας κάτω των 18 ετών: Το ENTACT δεν πρέπει να χρησιμοποιείται για την θεραπεία παιδιών και εφήβων κάτω των 18 ετών. Εάν, εντούτοις, αποφασιστεί να χορηγηθεί σχετική αγωγή, λόγω κλινικής ανάγκης, ο ασθενής πρέπει να παρακολουθείται με προσοχή για την πιθανότητα εμφάνισης αυτοκτονικών συμπτωμάτων. Παράδοξο άγχος: Μερικοί ασθενείς με διαταραχή πανικού μπορεί να βιώσουν αυξημένα συμπτώματα άγχους κατά την έναρξη θεραπείας. Αυτή η παράδοξη αντίδραση συνήθως υποχωρεί εντός δύο εβδομάδων αν συνεχιστεί η θεραπεία. Συνιστάται μία χαμηλή δόση έναρξης. Επιληπτικές Κρίσεις: Πρέπει να διακόπτεται η χορήγηση του φαρμάκου σε οποιονδήποτε ασθενή εμφανίσει επιληπτικές κρίσεις. Οι SSRIs θα πρέπει να αποφεύγονται σε ασθενείς με ασταθή επιληψία και οι ασθενείς με ελεγχόμενη επιληψία πρέπει να παρακολουθούνται προσεκτικά. Οι SSRIs πρέπει να διακόπτονται εάν αυξηθεί η συχνότητα των επιληπτικών κρίσεων. Μανία: Οι SSRIs πρέπει να χρησιμοποιούνται με προσοχή σε ασθενείς με ιστορικό μανίας/υπομανίας. Η αγωγή με SSRIs πρέπει να διακόπτεται εάν ο ασθενής εισέρχεται σε μανιακή φάση. Διαβήτης: Σε ασθενείς με διαβήτη, η αγωγή με κάποιον SSRI μπορεί να αποσταθεροποιήσει τον έλεγχο του σακχάρου (υπογλυκαιμία ή υπεργλυκαιμία). Ενδέχεται να χρειαστεί προσαρμογή της δόσης της ινσουλίνης ή/και των από του στόματος αντιδιαβητικών. Αυτοκτονία/Σκέψεις αυτοκτονίας: Η κατάθλιψη συσχετίζεται με αυξημένο κίνδυνο ιδεών αυτοκτονίας, αυτοκαταστροφής και αυτοκτονίας έως ότου επέλθει σημαντική πλήρης υποχώρηση των συμπτωμάτων. Οι ασθενείς θα πρέπει να παρακολουθούνται στενά, έως ότου επιτευχθεί ανάλογη βελτίωση. Ακαθισία/Ψυχοκινητική ανησυχία: Η χρήση των SSRIs/SNRIs έχει συσχετιστεί με την ανάπτυξη ακαθισίας, που χαρακτηρίζεται από μια υποκειμενικά δυσάρεστη ή ενοχλητική ανησυχία και ανάγκη για κίνηση που συχνά συνοδεύεται από αδυναμία να καθίσει κανείς ή να παραμείνει ακίνητος. Αυτή είναι πιο πιθανό να συμβεί κατά τη διάρκεια των πρώτων λίγων εβδομάδων της θεραπείας. Στους ασθενείς που εμφανίζουν τα συμπτώματα αυτά , η αύξηση της δοσολογίας μπορεί να είναι επιβλαβής. Υπονατριαιμία: Υπονατριαιμία, πιθανώς λόγω της απρόσφορης έκκρισης αντιδιουρητικής ορμόνης (SIADH), έχει σπάνια αναφερθεί κατά την χρήση των SSRIs. Η διαταραχή αυτή υποχωρεί με την διακοπή της θεραπείας. Πρέπει να δίνεται προσοχή στους ασθενείς που διατρέχουν κίνδυνο, όπως οι ηλικιωμένοι, ασθενείς με κίρρωση του ήπατος ή ασθενείς που λαμβάνουν ταυτόχρονα φάρμακα τα οποία μπορούν να προκαλέσουν υπονατριαιμία. Αιμορραγία: Υπήρξαν αναφορές αιμορραγιών στο δέρμα, όπως εκχυμώσεις και πορφύρα, κατά την αγωγή με SSRIs. Ασθενείς σε αγωγή με SSRIs πρέπει να παρακολουθούνται στενά ιδιαίτερα όταν λαμβάνουν ταυτόχρονα φάρμακα τα οποία επηρεάζουν τη λειτουργία των αιμοπεταλίων (π.χ. άτυπα αντιψυχωσικά και φαινοθειαζίνες, τα περισσότερα τρικυκλικά αντικαταθλιπτικά, το ακετυλοσαλικυλικό οξύ και τα μη στεροειδή αντιφλεγμονώδη φάρμακα (NSAIDs), τικλοπιδίνη και διπυριδαμόλη) ή εμφανίζουν προδιάθεση για αιμορραγίες. Ηλεκτροθεραπεία (ECT): Υπάρχει περιορισμένη κλινική εμπειρία συνεπώς συνιστάται προσοχή. Ανατρέψιμοι εκλεκτικοί αναστολείς της ΜΑΟ-Α: Ο συνδυασμός της escitalopram με αναστολείς της ΜΑΟ-Α γενικώς δεν συνίσταται δεδομένου του κινδύνου εμφάνισης σεροτονινεργικού συνδρόμου. Για συγχορήγηση με μη εκλεκτικούς, μη αναστρέψιμους αναστολείς ΜΑΟ. Σεροτονινεργικό Σύνδρομο: Συνιστάται προσοχή όταν συγχορηγείται escitalopram με φαρμακευτικά προϊόντα που παρουσιάζουν σεροτονινεργική δράση όπως η σουματριπτάνη ή άλλες τριπτάνες, τραμαδόλη, και τρυπτοφάνη. St John's Wort: Η ταυτόχρονη χορήγηση φυτικών θεραπειών που περιέχουν St John's Wort με SSRIs μπορεί να έχει ως αποτέλεσμα αύξηση στην εμφάνιση των ανεπιθύμητων ενεργειών. Συμπτώματα που παρατηρούνται όταν διακόπτεται η θεραπεία: Όταν η θεραπεία με αντικαταθλιπτικά διακόπτεται, συχνά εμφανίζονται συμπτώματα απόσυρσης ειδικά όταν η διακοπή γίνεται απότομα. Για το λόγο αυτό συνιστάται η escitalopram να μειώνεται σταδιακά όταν διακόπτεται η θεραπεία για ένα διάστημα αρκετών εβδομάδων ή μηνών ανάλογα με τις ανάγκες του ασθενούς. Στεφανιαία Νόσος: Συνιστάται προσοχή σε ασθενείς με στεφανιαία νόσο λόγω περιορισμένης κλινικής εμπειρίας. **ΑΝΕΠΙΘΥΜΗΤΕΣ ΕΝΕΡΓΕΙΕΣ:** Οι συχνότητες που καταγράφονται δεν έχουν υποστεί διόρθωση σε σχέση με το ποσοστό εμφάνισής τους στον πληθυσμό που έπαιρνε εικονικό φάρμακο. Διαταραχές του αίματος και του λεμφικού ιστού: Μη γνωστή συχνότητα: θρομβοκυτοπενία. Διαταραχές του ανοσοποιητικού συστήματος: Σπάνιες: αναφυλακτική αντίδραση. Ενδοκρινικές διαταραχές μη γνωστή συχνότητα: απρόσφορη έκκριση της ADH. Διαταραχές του μεταβολισμού και της θρέψης: Συχνές: αυξημένη όρεξη, μειωμένη όρεξη, μη γνωστή συχνότητα: Υπονατριαμία. Ψυχιατρικές Διαταραχές: Συχνές: Άγχος, ανησυχία, μη φυσιολογική όνειρα Άνδρες και γυναίκες :μειωμένη libido Γυναίκες:ανοργασμία. Όχι συχνές: Ακούσιος τριγμός των δοντιών, διέγερση, νευρικότητα, κρίσεις πανικού, κατάσταση σύγχυσης Σπάνιες: επιθετικότητα, αποπροσωποποίηση, ψευδαισθήσεις, σχετικά με αυτοκτονία συμβάματα Μη γνωστή συχνότητα: Μανία. Διαταραχές του νευρικού συστήματος: Συχνές: Αυπνία, υπνηλία, ζάλη, παραισθησία, τρόμος Όχι συχνές: Διαταραχές γεύσης, διαταραχές ύπνου, συγκοπή, Σπάνιες: Σεροτονινεργικό Σύνδρομο Μη γνωστή συχνότητα: Δυσκινησία, κινητικές διαταραχές, σπασμοί. Οφθαλμικές διαταραχές: Όχι συχνές: Μυδρίαση, οπτικές διαταραχές. Διαταραχές του ωτός και του λαβυρίνθου: Όχι συχνές: Εμβοές. Καρδιολογικές διαταραχές: Όχι συχνές Ταχυκαρδία, Σπάνιες: Βραδυκαρδία. Αγγειακές Διαταραχές: Μη γνωστή συχνότητα: Ορθοστατική υπόταση. Διαταραχές του Αναπνευστικού Συστήματος, του θώρακα και του Μεσοθωράκιου: Συχνές: παραρρινοκολπίτιδα, χάσμη Όχι συχνές: Ρινορραγία. Γαστρεντερικές διαταραχές: Πολύ συχνές: Ναυτία, Συχνές: Διάρροια, δυσκοιλιότητα, έμετος, ξηροστομία. Όχι συχνές: Γαστρεντερικές αιμορραγίες (συμπεριλαμβανομένης και της αιμορραγίας του ορθού). Διαταραχές ήπατος και χοληφόρων: Μη γνωστή συχνότητα Ηπατίτιδα. Διαταραχές του δέρματος και του υποδορίου ιστού: Συχνές: αυξημένη εφίδρωση. Όχι συχνές: Κνίδωση, αλωπεκία, εξάνθημα, κνησμός. Μη γνωστή συχνότητα Εχυμώσεις αγγειονευρωτικό οίδημα. Διαταραχές του μυοσκελετικού συστήματος, του συνδετικού ιστού και των οστών: Συχνές: Αρθραλγία, μυαλγία. Διαταραχές των νεφρών και του ουροποιητικού: Μη γνωστή συχνότητα: Κατακράτηση ούρων. Διαταραχές του αναπαραγωγικού συστήματος και των μαστών: Συχνές Άνδρες: διαταραχή εκσπερμάτισης, ανικανότητα. Όχι συχνές Γυναίκες: μητρορραγία, μηνορραγία. Μη γνωστή συχνότητα Άνδρες: priapism, γαλακτόρροια. Γενικές διαταραχές και καταστάσεις ανάλογα με την χορήγηση: Συχνές: Κόπωση, πυρεξία Όχι συχνές Οίδημα. Έρευνες: Συχνές Αύξηση σωματικού βάρους. Όχι συχνές: Μείωση σωματικού βάρους. Μη γνωστή συχνότητα: Παθολογικά ευρήματα στις ηπατικές δοκιμασίες. Οι ακόλουθες ανεπιθύμητες ενέργειες έχουν αναφερθεί για την θεραπευτική κατηγορία των SSRIs: ψυχοκινητική ανησυχία/ακαθησία και αναρεξία. Κατά την περίοδο της κυκλοφορίας στην αγορά έχουν αναφερθεί περιστατικά παράτασης του διαστήματος QT, κυρίως σε ασθενείς με προϋπάρχουσα καρδιακή νόσο. Δεν έχει τεκμηριωθεί κάποια αιτιολογική συσχέτιση. Συμπτώματα απόσυρσης τα οποία παρατηρήθηκαν κατά την διακοπή της θεραπείας: Η διακοπή των SSRIs/SNRIs (ιδιαίτερα όταν είναι απότομη) συνήθως οδηγεί σε συμπτώματα απόσυρσης. Ζάλη, διαταραχές αισθητικότητας (συμπεριλαμβανομένων της παραισθησίας και της αίσθησης ηλεκτρικού ρεύματος), διαταραχές του ύπνου (συμπεριλαμβανομένων της αυπνίας και των ζωηρών ονείρων), διέγερση ή άγχος, ναυτία και/ή έμετος, τρόμος, σύγχυση, εφίδρωση, κεφαλαλγία, διάρροια, αίσθημα παλμών, συναισθηματική αστάθεια, ευερεθιστότητα και διαταραχές της όρασης είναι οι πιο συχνά αναφερόμενες ανεπιθύμητες ενέργειες. **ΚΑΤΟΧΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** Η. Lundbeck A/S, Ottiliavej 9, DK-2500 Copenhagen- Valby Denmark. Περαιτέρω πληροφορίες διατίθενται από τον τοπικό αντιπρόσωπο του κατόχου της αδείας κυκλοφορίας: Lundbeck Hellas S.A. Κηφισίας 64, 151 25 Μαρούσι, Αθήνα, Τηλ.: 210 6105 036, Fax: 210 6105 039.

Επισκεφθείτε μας στο: **www.elpen.gr**

ELPEN Α.Ε. ΦΑΡΜΑΚΕΥΤΙΚΗ ΒΙΟΜΗΧΑΝΙΑ
Λεωφ. Μαραθώνος 95, Πικέρμι Αττικής 190 09,
Τηλ.: 210 6039326-9

ΓΡΑΦΕΙΑ ΕΠΙΣΤΗΜΟΝΙΚΗΣ ΕΝΗΜΕΡΩΣΗΣ
Σεβαστείας 11 - 115 28 Αθήνα, Τηλ.: 210 7488711
Εθν. Αντιστάσεως 114 - 551 34 Θεσσαλονίκη,
Τηλ.: 2310 459920-1

Lamotrix

lamotrigine 25,50,100,200mg

Ισορροπία στο συναίσθημα

Παστέρ 6, Αθήνα 115 21 • Τηλ: 210 6413160 • Fax: 210 6445375
Κων. Καραμανλή 145, Θεσσαλονίκη 542 49 • Τηλ: 2310 300869
e-mail: greece@medochemie.com • www.medochemie.com

MEDOCHEMIE
HELLAS A.E.

Lamotrix
lamotrigine 25,50,100,200mg

Περίληψη χαρακτηριστικών προϊόντος

ΕΜΠΟΡΙΚΗ ΟΝΟΜΑΣΙΑ: **LAMOTRIX** ΠΟΙΟΤΙΚΗ & ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ σε δραστικά συστατικά: Κάθε δισκίο LAMOTRIX περιέχει είτε 25mg, 50mg, 100mg ή 200mg lamotrigine. ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ: Δισκία. **Θεραπευτικές ενδείξεις**:1) **Επιληψία** Το LAMOTRIX είναι αντιεπιληπτικό φάρμακο που ενδείκνυται για τη θεραπεία της επιληψίας ως: α) Μονοθεραπεία σε ενήλικες και παιδιά ηλικίας άνω των 12 ετών με απλές ή σύνθετες εστιακές κρίσεις, δευτερογενώς γενικευόμενες τονικο-κλονικές κρίσεις και γενικευμένες τονικοκλονικές κρίσεις. Η μονοθεραπεία με το φάρμακο δεν συνιστάται σε παιδιά κάτω των 12 ετών. β) Συμπληρωματική θεραπεία σε ενήλικες και παιδιά ηλικίας άνω των 2 ετών με απλές εστιακές κρίσεις, σύνθετες εστιακές κρίσεις και δευτερογενώς γενικευόμενες τονικοκλονικές κρίσεις και σύνδρομο Lennox - Gastaut. 2) **Διπολική διαταραχή (ενήλικες 18 ετών και άνω)** Το LAMOTRIX συνιστάται για τη θεραπεία συντήρησης της διπολικής διαταραχής για να επιβραδύνει την εμφάνιση των διαταραχών της διάθεσης (κυρίως της κατάθλιψης), σε ασθενείς οι οποίοι λαμβάνουν τη συνήθη αγωγή για οξέα επεισόδια διαταραχών της διάθεσης. Η αποτελεσματικότητα του LAMOTRIX για τη θεραπεία συντήρησης της διπολικής διαταραχής, σε ασθενείς οι οποίοι λαμβάνουν τη συνήθη αγωγή για οξέα επεισόδια διαταραχών της διάθεσης, για να επιβραδύνει την εμφάνιση επεισοδίων μανίας, υπομανίας ή μικτών επεισοδίων δεν έχει αποδειχθεί. **Δοσολογία & τρόπος χορήγησης:** Τα δισκία καταπίνονται με νερό. Θα πρέπει να παρακολουθείται το βάρος του παιδιού και η δόση να αναπροσαρμόζεται όταν αλλάζει το σωματικό βάρος. Όταν διακοπεί η συγχορήγηση άλλων αντιεπιληπτικών φαρμάκων για να επιτευχθεί μονοθεραπεία με LAMOTRIX ή προστεθούν άλλα αντιεπιληπτικά φάρμακα σε θεραπευτικά σχήματα που περιέχουν LAMOTRIX θα πρέπει να ληφθεί υπ' όψη η δράση που αυτό μπορεί να έχει στην φαρμακοκινητική της λαμοτριγίνης. Σε περίπτωση που η υπολογισθείσα δόση λαμοτριγίνης, δεν ισοδυναμεί με την περιεκτικότητα ολόκληρου του δισκίου, τότε η δόση που πρέπει να χορηγείται είναι εκείνη που αντιστοιχεί στο μικρότερο αριθμό ολόκληρων δισκίων. **Επαναχορήγηση θεραπείας** Ο γιατρός θα πρέπει να εξετάσει την ανάγκη για μείωση της δόσης συντήρησης όταν η λαμοτριγίνη επαναχορηγείται σε ασθενείς που έχουν διακόψει τη λαμοτριγίνη για οποιοδήποτε λόγο, καθώς ο κίνδυνος για σοβαρό εξάνθημα σχετίζεται με υψηλές αρχικές δόσεις και υπέρβαση της συνιστώμενης κλιμακούμενης δόσης. Όσο μεγαλύτερο είναι το διάστημα από την προηγούμενη δόση, τόσο μεγαλύτερη προσοχή πρέπει να δίνεται για τη μείωση της δόσης συντήρησης. Όταν το διάστημα από τη διακοπή της λαμοτριγίνης υπερβαίνει πέντε ημιπεριόδους ζωής, η λαμοτριγίνη θα πρέπει γενικά να μειώνεται στη δόση συντήρησης σύμφωνα με το κατάλληλο σχήμα. Συνιστάται όπως η λαμοτριγίνη δεν επαναχορηγείται σε ασθενείς που έχουν διακόψει λόγω εξανθήματος σχετιζόμενου με προηγούμενη θεραπεία με λαμοτριγίνη, εκτός εάν το δυνητικό όφελος σαφώς υπερτερεί του κινδύνου. **ΕΠΙΛΗΨΙΑ Δοσολογία σε μονοθεραπεία:** Ενήλικοι και παιδιά ηλικίας άνω των 12 ετών (Βλέπετε τον πίνακα 1). Για τον αποτελεσματικό έλεγχο των κρίσεων σε ορισμένους ασθενείς χρειάστηκε να χορηγηθούν μέχρι 500 mg Lamotrix ημερησίως.

Πίνακας 1: Συνιστώμενη αύξηση της δοσολογίας του Lamotrix σε Ενήλικες και Παιδιά άνω των 12 ετών σε μονοθεραπεία.

1η, 2η Εβδομάδα	3η, 4η Εβδομάδα	Δόση Συντήρησης
25 mg (μία φορά ημερησίως)	50 mg (μία φορά ημερησίως)	100 – 200 mg (μία φορά ημερησίως ή σε δύο ίσες δόσεις). Για να επιτευχθεί η δόση συντήρησης, η δοσολογία θα πρέπει να αυξάνεται κατά 50 – 100 mg κάθε 1 – 2 εβδομάδες.

Λόγω του κινδύνου εξανθήματος, δεν πρέπει να γίνεται υπέρβαση της συνιστώμενης αρχικής δοσολογίας και της επακόλουθης αύξησης της δοσολογίας. *Παιδιά ηλικίας 2 – 12 ετών:* Τα υπάρχοντα δεδομένα από ελεγχόμενες μελέτες είναι ανεπαρκή για παιδιά ηλικίας κάτω των 12 ετών. **Δοσολογία σε συμπληρωματική θεραπεία:** Ενήλικες και παιδιά άνω των 12 ετών (Βλέπετε τον πίνακα 2).

Λόγω του κινδύνου εξανθήματος, δεν πρέπει να γίνεται υπέρβαση της συνιστώμενης αρχικής δοσολογίας και της επακόλουθης αύξησης της δοσολογίας. Όταν τα συγχορηγούμενα αντιεπιληπτικά φάρμακα πρόκειται να διακοπούν, για να επιτευχθεί μονοθεραπεία με το Lamotrix, πρέπει να δοθεί προσοχή στην επίδραση που αυτό θα έχει στη φαρμακοκινητική της λαμοτριγίνης και η δοσολογία θα πρέπει να ρυθμιστεί κατάλληλα. Παιδιά ηλικίας 2 – 12 ετών (Βλέπετε τον πίνακα 3).

Πίνακας 2: Συνιστώμενη αύξηση της δοσολογίας του Lamotrix σε Ενήλικες και Παιδιά άνω των 12 ετών σε συνδυασμένη θεραπεία.

	1η, 2η Εβδομάδα	3η, 4η Εβδομάδα	Δόση Συντήρησης
Βαλπροϊκό νάτριο σε συνδυασμό ή όχι με άλλα αντιεπιληπτικά που είναι επαγωγείς των ηπατικών ενζύμων	12,5 mg (χορήγηση 25 mg κάθε δεύτερη ημέρα)	25 mg (μία φορά την ημέρα)	100 – 200 mg (μία φορά την ημέρα ή σε δύο ίσες δόσεις) Για να επιτευχθεί η δόση συντήρησης, η δοσολογία θα πρέπει να αυξάνεται το πολύ κατά 25 – 50 mg κάθε 1 – 2 εβδομάδες.
Αντιεπιληπτικά που επάγουν ένζυμα* σε συνδυασμό ή όχι με άλλα αντιεπιληπτικά χωρίς όμως βαλπροϊκό	50 mg (μία φορά την ημέρα)	100 mg (σε δύο ίσες δόσεις των 50 mg)	200 – 400 mg (σε δύο ίσες δόσεις) Για να επιτευχθεί η δόση συντήρησης, η δοσολογία θα πρέπει να αυξάνεται το πολύ κατά 100 mg κάθε 1 – 2 εβδομάδες.

* π.χ. Φαινυτοΐνη, καρβαμαζεπίνη, φαινοβαρβιτόνη και πριμιδόνη. **ΣΗΜΕΙΩΣΗ:** Σε ασθενείς που λαμβάνουν αντιεπιληπτικά των οποίων οι φαρμακοκινητικές αλληλεπιδράσεις με τη λαμοτριγίνη δεν είναι γνωστές, θα πρέπει να χρησιμοποιηθεί η συνιστώμενη για το συνδυασμό με βαλπροϊκό αύξηση της δοσολογίας της λαμοτριγίνης.

Πίνακας 3: Συνιστώμενη δοσολογία του Lamotrix σε Παιδιά ηλικίας 2 – 12 ετών (συνολική ημερήσια δόση σε mg/kg βάρους σώματος), σε συνδυασμένη θεραπεία.

	1η, 2η Εβδομάδα	3η, 4η Εβδομάδα	Δόση Συντήρησης
Βαλπροϊκό νάτριο σε συνδυασμό ή όχι με άλλα αντιεπιληπτικά που είναι επαγωγείς των ηπατικών ενζύμων	0,15 mg/kg (μία φορά την ημέρα)	0,3 mg/kg (μία φορά την ημέρα ή σε δύο ίσες δόσεις ημερησίως)	Αύξηση κατά 0,3mg/kg κάθε 1 – 2 εβδομάδες για να επιτευχθεί η δόση συντήρησης 1 – 5 mg/kg, (μία φορά την ημέρα ή σε δύο ίσες δόσεις) με ανώτατη δόση τα 200 mg την ημέρα.
Αντιεπιληπτικά που επάγουν ένζυμα* σε συνδυασμό ή όχι με άλλα αντιεπιληπτικά χωρίς όμως βαλπροϊκό	0,6 mg/kg (σε δύο ίσες δόσεις)	1,2 mg/kg (σε δύο ίσες δόσεις)	Αύξηση κατά 1,2mg/kg κάθε 1 – 2 εβδομάδες για να επιτευχθεί η δόση συντήρησης 5 – 15 mg/kg, (σε δύο ίσες δόσεις) με ανώτατη δόση τα 400 mg την ημέρα.

* π.χ. Φαινυτοΐνη, καρβαμαζεπίνη, φαινοβαρβιτόνη και πριμιδόνη. **ΣΗΜΕΙΩΣΗ:** Σε ασθενείς που λαμβάνουν αντιεπιληπτικά των οποίων οι φαρμακοκινητικές αλληλεπιδράσεις με τη λαμοτριγίνη δεν είναι γνωστές, θα πρέπει να χρησιμοποιηθεί η συνιστώμενη για το συνδυασμό με βαλπροϊκό αύξηση της δοσολογίας της λαμοτριγίνης.

** **ΣΗΜΕΙΩΣΗ:** Σε περίπτωση που η υπολογιζόμενη ημερήσια δόση είναι μεταξύ 1-2 mg, τότε μπορούν να χορηγούνται 2 mg Lamotrix ημέρα παρά ημέρα για τις πρώτες 2 εβδομάδες. Σε περίπτωση που η υπολογιζόμενη ημερήσια δόση είναι μικρότερη από 1 mg, τότε δεν πρέπει να χορηγείται το Lamotrix. Λόγω του κινδύνου εξανθήματος, δεν πρέπει να γίνεται υπέρβαση της συνιστώμενης αρχικής δοσολογίας και της επακόλουθης αύξησης της δοσολογίας. Είναι πιθανό ασθενείς ηλικίας 2 – 6 ετών να χρειασθεί να λάβουν δόσεις συντήρησης που πλησιάζουν τις υψηλότερες της δοσολογικής κλίμακας. *Παιδιά ηλικίας κάτω των 2 ετών σε συμπληρωματική θεραπεία:* Τα δεδομένα για τη χορήγηση του Lamotrix σε συμπληρωματική θεραπεία σε παιδιά κάτω των 2 ετών είναι ανεπαρκή, και κατά συνέπεια δεν συνιστάται η χρήση του. **ΔΙΠΟΛΙΚΗ ΔΙΑΤΑΡΑΧΗ** Ενήλικοι ηλικίας 18 ετών και άνω Ο σκοπός της θεραπείας συντήρησης της διπολικής διαταραχής με Lamotrix είναι να επιβραδύνει την εμφάνιση των διαταραχών της διάθεσης (κυρίως κατάθλιψης), σε ασθενείς οι οποίοι λαμβάνουν τη συνήθη αγωγή για οξέα επεισόδια διαταραχών της διάθεσης. Η δόση-στόχος του Lamotrix είναι 200 mg/ημέρα (100 mg/ημέρα σε συνδυασμό με βαλπροϊκό και 400 mg/ημέρα σε συνδυασμό με καρβαμαζεπίνη ή άλλα φάρμακα επαγωγείς των ενζύμων). (Βλέπετε πίνακα 4).

Πίνακας 4: Ρύθμιση της Δοσολογίας του Lamotrix για ασθενείς με Διπολική διαταραχή

Θεραπευτική αγωγή	Εβδομάδες1-2	Εβδομάδες3-4	Εβδομάδα 5	Εβδομάδα 6	Εβδομάδα 7
Α) Συμπληρωματική θεραπεία για ασθενείς που δεν λαμβάνουν καρβαμαζεπίνη (ή άλλα φάρμακα επαγωγείς των ενζύμων) ή βαλπροϊκό	25 mg ημερησίως	50 mg ημερησίως	100 mg ημερησίως	200 mg ημερησίως	200 mg ημερησίως
Β) Συμπληρωματική θεραπεία για ασθενείς που λαμβάνουν βαλπροϊκό	25 mg μέρα παρά μέρα	25 mg ημερησίως	50 mg ημερησίως	100 mg ημερησίως	100 mg ημερησίως
Γ) Συμπληρωματική θεραπεία για ασθενείς που λαμβάνουν καρβαμαζεπίνη (ή άλλα φάρμακα επαγωγείς των ενζύμων) και ΔΕΝ λαμβάνουν βαλπροϊκό	50 mg ημερησίως	100 mg ημερησίως (σε διηρημένες δόσεις)	200 mg ημερησίως (σε διηρημένες δόσεις)	300 mg ημερησίως (σε διηρημένες δόσεις)	Μέχρι 400 mg ημερησίως (σε διηρημένες δόσεις)

Για ασθενείς που διακόπτουν το βαλπροϊκό, η δόση του Lamotrix πρέπει να διπλασιασθεί σε χρονικό διάστημα 2 εβδομάδων, σε ίσα διηρημένα εβδομαδιαία ποσά (Πίνακα 5). Για ασθενείς που διακόπτουν την καρβαμαζεπίνη ή άλλα φάρμακα επαγωγείς των ενζύμων, η δόση του Lamotrix πρέπει να παραμένει σταθερή για την πρώτη εβδομάδα και στη συνέχεια μπορεί να μειωθεί κατά το ήμισυ σε χρονικό διάστημα 2 εβδομάδων, σε ίσα διηρημένα εβδομαδιαία ποσά (βλέπε Πίνακα 5). Η δόση του Lamotrix μπορεί τότε να ρυθμισθεί περαιτέρω μέχρι τη δόση – στόχο των 200 mg, όπως κλινικά ενδείκνυται. Εάν άλλα φάρμακα προστίθενται στη συνέχεια στη θεραπεία, η δόση του Lamotrix μπορεί να χρειαστεί προσαρμογή. Ειδικότερα η προσθήκη του βαλπροϊκού απαιτεί μείωση της δόσης του Lamotrix. Λόγω του κινδύνου εξανθήματος δεν πρέπει να γίνεται υπέρβαση της συνιστώμενης αρχικής δοσολογίας και της επακόλουθης αύξησης της δοσολογίας.

Πίνακας 5: Προσαρμογή της δόσης του Lamotrix για ασθενείς με Διπολική διαταραχή μετά τη διακοπή χορήγησης ψυχοτρόπων φαρμάκων

Θεραπευτική αγωγή	Εβδομάδα 1	Εβδομάδα 2	Εβδομάδα 3 και μετά
Α) Μετά τη διακοπή χορήγησης ψυχοτρόπων φαρμάκων, εξαιρουμένων του βαλπροϊκού, της καρβαμαζεπίνης ή άλλων φαρμάκων επαγωγέων των ενζύμων	Διατηρήστε την τρέχουσα δόση του Lamotrix		
Β) Μετά τη διακοπή χορήγησης του βαλπροϊκού (τρέχουσα δόση του Lamotrix 100 mg/ημέρα)	150 mg/ημέρα	200 mg/ημέρα	
Γ) Μετά τη διακοπή χορήγησης της καρβαμαζεπίνης ή άλλων φαρμάκων επαγωγέων των ενζύμων (τρέχουσα δόση του Lamotrix 400 mg/ημέρα)	400 mg/ημέρα	300 mg/ημέρα	200 mg/ημέρα

Οι ασθενείς πρέπει περιοδικά να επαναξιολογούνται για να αποφασιστεί η ανάγκη χορήγησης της θεραπείας συντήρησης.**Διακοπή της λαμοτριγίνης σε ασθενείς με διπολική διαταραχή:** Όπως με άλλα αντιεπιληπτικά φάρμακα η λαμοτριγίνη δεν πρέπει να διακόπτεται απότομα. Σε κλινικές μελέτες, δεν παρατηρήθηκε αύξηση της συχνότητας, της σοβαρότητας ή του τύπου των ανεπιθύμητων συμβάντων μετά την αιφνίδια διακοπή της λαμοτριγίνης έναντι του εικονικού φαρμάκου. Συνιστάται η διακοπή της λαμοτριγίνης να περιλαμβάνει ένα διάστημα σταδιακής κατά βήματα μείωσης της δόσης, διάρκειας τουλάχιστον 2 εβδομάδων (περίπου 50% ανά εβδομάδα), εκτός εάν λόγοι ασφάλειας απαιτούν διάστημα πιο ταχείας διακοπής. Παιδιά ηλικίας μικρότερης των 18 ετών: Η ασφάλεια και η αποτελεσματικότητα της λαμοτριγίνης στη διπολική διαταραχή δεν έχει αξιολογηθεί σ' αυτή την ηλικιακή ομάδα. Ως εκ τούτου, δεν συνιστάται η χρήση του. **Αντενδείξεις** Το Lamotrix αντενδείκνυται σε άτομα με γνωστή υπερευαισθησία στη λαμοτριγίνη ή στα έκδοχα του προϊόντος. **Ιδιαίτερες προειδοποιήσεις & ιδιαίτερες προφυλάξεις κατά τη χρήση.** Αυτοκτονικός ιδεασμός και συμπεριφορά έχουν αναφερθεί σε ασθενείς υπό αγωγή με αντιεπιληπτικούς παράγοντες για διάφορες ενδείξεις. Μια μετα – ανάλυση τυχαιοποιημένων ελεγχόμενων με εικονικό φάρμακο κλινικών μελετών αντιεπιληπτικών φαρμάκων έχει επίσης δείξει μικρή αύξηση του κινδύνου εκδήλωσης αυτοκτονικού ιδεασμού και συμπεριφοράς. Οι μηχανισμοί ανάπτυξης αυτού του κινδύνου δεν είναι γνωστοί και τα διαθέσιμα δεδομένα δεν αποκλείουν την πιθανότητα εμφάνισης αυξημένου κινδύνου για το Lamotrix. Κατά συνέπεια οι ασθενείς θα πρέπει να παρακολουθούνται για συμπτώματα αυτοκτονικού ιδεασμού και συμπεριφορών και να εφαρμόζεται η κατάλληλη θεραπεία. Συνιστάται στους ασθενείς (και στους περιθάλποντες τους ασθενείς) να αναζητούν ιατρική συμβουλή σε περίπτωση εμφάνισης συμπτωμάτων αυτοκτονικού ιδεασμού ή συμπεριφοράς. Έχουν αναφερθεί ανεπιθύμητες δερματικές αντιδράσεις, που γενικώς συνέβησαν μέσα στις πρώτες 8 εβδομάδες μετά την έναρξη της χορήγησης λαμοτριγίνης. Η πλειονότητα των εξανθημάτων είναι ελαφριάς μορφής και αυτοϊώμενα, όμως έχουν αναφερθεί και σοβαρά, πιθανώς απειλητικά για τη ζωή, δερματικά εξανθήματα, συμπεριλαμβανομένων, του συνδρόμου Stevens-Johnson και της τοξικής επιδερμικής νεκρόλυσης. Σε ενήλικες που πήραν μέρος σε μελέτες χρησιμοποιώντας τις συνιστώμενες δόσεις Lamotrix, η συχνότητα σοβαρών δερματικών εξανθημάτων είναι περίπου 1 στους 500 επιληπτικούς ασθενείς. Οι μισές περίπου από αυτές τις περιπτώσεις έχουν αναφερθεί σαν σύνδρομο Stevens-Johnson (1 σε 1000). Σε κλινικές μελέτες σε ασθενείς με διπολική διαταραχή, η συχνότητα του σοβαρού εξανθήματος ήταν περίπου 1 ανά 1000. Ο κίνδυνος σοβαρού εξανθήματος είναι μεγαλύτερος στα παιδιά από ό,τι στους ενήλικες. Διαθέσιμα στοιχεία από έναν αριθμό μελετών δείχνουν ότι η συχνότητα εξανθημάτων στα παιδιά που σχετίζονται με εισαγωγή σε νοσοκομείο κυμαίνεται από 1 στα 300 έως 1 στα 100. Στα παιδιά, η αρχική εμφάνιση του εξανθήματος μπορεί να εκληφθεί ως λοίμωξη, για αυτό οι ιατροί θα πρέπει να λαμβάνουν υπόψη την πιθανότητα της φαρμακευτικής αντίδρασης σε παιδιά που εκδηλώνουν εξάνθημα και πυρετό κατά τις πρώτες 8 εβδομάδες της θεραπείας. Επιπροσθέτως τα υπάρχοντα στοιχεία υποδηλώνουν ότι ο κίνδυνος εμφάνισης εξανθήματος φαίνεται ότι συνδέεται στενά με: Υψηλές αρχικές δόσεις λαμοτριγίνης και υπέρβαση του δοσολογικού σχήματος αύξησης της λαμοτριγίνης. Συγχορήγηση βαλπροϊκού, το οποίο αυξάνει τη μέση ημιπερίοδο ζωής της λαμοτριγίνης περίπου στο διπλάσιο. Όλοι οι ασθενείς (ενήλικες και παιδιά) που αναπτύσσουν εξάνθημα, θα πρέπει να αξιολογούνται όσο το δυνατό συντομότερα και να διακόπτεται άμεσα η χορήγηση της λαμοτριγίνης, εκτός εάν το εξάνθημα μετά βεβαιότητας δεν σχετίζεται με το φάρμακο. Συνιστάται όπως η λαμοτριγίνη δεν επαναχορηγείται σε ασθενείς που έχουν διακόψει λόγω εξανθήματος σχετιζόμενου με προηγούμενη θεραπεία με λαμοτριγίνη, εκτός αν το δυνητικό όφελος σαφώς υπερτερεί του κινδύνου. Το εξάνθημα έχει επίσης αναφερθεί ως μέρος ενός συνδρόμου υπερευαισθησίας που σχετίζεται με ποικίλα συστηματικά συμπτώματα συμπεριλαμβανομένων πυρετού, λεμφαδενοπάθειας, οιδήματος του προσώπου και μη φυσιολογικών τιμών των εργαστηριακών εξετάσεων αίματος και ήπατος. Το σύνδρομο έχει μεγάλο εύρος κλινικής σοβαρότητας και μπορεί, σπάνια, να οδηγήσει σε διάχυτη ενδαγγειακή πήξη (DIC) και ανεπάρκεια πολλαπλών οργάνων. Είναι σημαντικό να ληφθεί υπόψη ότι πρώιμες ενδείξεις υπερευαισθησίας (π.χ. πυρετός, λεμφαδενοπάθεια) μπορεί να εκδηλωθούν ακόμη και χωρίς την εμφάνιση εξανθήματος. Εάν υπάρξουν τέτοιες ενδείξεις και συμπτώματα, ο ασθενής πρέπει να αξιολογηθεί άμεσα και το Lamotrix να διακοπεί, αν τα ανωτέρω δεν οφείλονται σε κάποια άλλη αιτία. Επειδή υπάρχει ο κίνδυνος εμφάνισης φωτοευαισθησίας, οι ασθενείς που λαμβάνουν λαμοτριγίνη δεν πρέπει να εκτίθενται στον ήλιο και σε υπεριώδη ακτινοβολία. Το Lamotrix αναστέλλει ασθενώς την αναγωγάση του διϋδροφιλικού οξέος και επομένως υπάρχει η πιθανότητα να επέμβει στο μεταβολισμό του φυλλικού κατά τη διάρκεια μακροχρόνιας θεραπείας. Πάντως, κατά την παρατεταμένη χορήγηση λαμοτριγίνης σε ανθρώπους, δεν προκλήθηκαν σημαντικές αλλαγές στη συγκέντρωση αιμοσφαιρίνης, στο μέσο όγκο ερυθρών και στις συγκεντρώσεις φυλλικού στον ορό και στα ερυθρά αιμοσφαίρια μέχρι ενός έτους και στις συγκεντρώσεις φυλλικού στα ερυθρά αιμοσφαίρια έως 5 έτη. Η λαμοτριγίνη μεταβολίζεται κυρίως με σύζευξη με γλυκουρονικό οξύ στο ήπαρ. Το Lamotrix δεν πρέπει να χορηγείται σε ασθενείς που βρίσκονται υπό θεραπεία με οποιοδήποτε άλλο σκεύασμα που περιέχει λαμοτριγίνη χωρίς τη συμβουλή γιατρού. Επιληψία Όπως και τα άλλα αντιεπιληπτικά φάρμακα, η απότομη διακοπή του Lamotrix μπορεί να προκαλέσει επανεμφάνιση κρίσεων. Η δόση του Lamotrix θα πρέπει να μειώνεται σταδιακά μέσα σε διάστημα 2 εβδομάδων, εκτός αν υπάρχουν ενδείξεις τοξικής δράσης (για παράδειγμα σοβαρές δερματικές αντιδράσεις) που απαιτούν άμεση διακοπή της θεραπείας. Όταν τα συγχορηγούμενα αντιεπιληπτικά φάρμακα διακοπούν ώστε να συνεχισθεί μονοθεραπεία με Lamotrix ή άλλα αντιεπιληπτικά φάρμακα χορηγηθούν ως συμπληρωματική θεραπεία σε μονοθεραπεία με Lamotrix, θα πρέπει να εξετασθεί η επίδραση που αυτά έχουν στη φαρμακοκινητική της λαμοτριγίνης. Έχει αναφερθεί στη βιβλιογραφία ότι σοβαρές κρίσεις σπασμών, συμπεριλαμβανομένου και του STATUS EPILEPTICUS, μπορεί να οδηγήσουν σε ραβδομυόλυση, δυσλειτουργία πολλών οργάνων και διάχυτη ενδαγγειακή πήξη, και τα οποία μπορεί να οδηγήσουν μερικές φορές στο θάνατο. Παρόμοιες περιπτώσεις έχουν συμβεί σε σχέση με τη χρήση με τη χρήση του Lamotrix. Διπολική διαταραχή Η πιθανότητα μιας απόπειρας αυτοκτονίας είναι σύμφυτη με τη διπολική διαταραχή και η φαρμακευτική θεραπεία θα πρέπει να συνοδεύεται από στενή παρακολούθηση των ασθενών. Αλληλεπιδράσεις με άλλα φάρμακα & άλλες μορφές αλληλεπίδρασης: Δεν υπάρχουν αποδεικτικά στοιχεία ότι η λαμοτριγίνη προκαλεί κλινικά σημαντική επαγωγή ή αναστολή οξειδωτικών ενζύμων του ήπατος που συμμετέχουν στο μεταβολισμό φαρμάκων. Όπως με την έναρξη κάθε χρόνιας θεραπείας σε ασθενείς που λαμβάνουν από του στόματος αντισυλληπτικά, ο ιατρός θα πρέπει να ενημερώνεται για κάθε αλλαγή του εμμηνορυσιακού κύκλου. Αναφορές μειωμένων επιπέδων λαμοτριγίνης μετά τη χορήγηση από του στόματος αντισυλληπτικών και αναφορές αυξημένων επιπέδων λαμοτριγίνης μετά τη διακοπή από του στόματος αντισυλληπτικών, έχουν ληφθεί από γυναίκες που έπαιρναν λαμοτριγίνη. Οι γιατροί θα πρέπει να χειρίζονται κλινικά κατάλληλα τις γυναίκες που αρχίζουν ή διακόπτουν από του στόματος αντισυλληπτικά κατά τη διάρκεια θεραπείας με λαμοτριγίνη. Η προσθήκη αντιεπιληπτικών φαρμάκων που επάγουν τα ένζυμα μεταβολισμού φαρμάκων στο ήπαρ (όπως η φαινυτοΐνη, η καρβαμαζεπίνη, η φαινοβαρβιτόνη και η πριμιδόνη) αυξάνουν το μεταβολισμό της λαμοτριγίνης και μειώνουν τα επίπεδά της στο πλάσμα (μείωση των συγκεντρώσεών της σε σταθεροποιημένη κατάσταση κατά 40% περίπου). Το βαλπροϊκό νάτριο που ανταγωνίζεται τη λαμοτριγίνη σε επίπεδο ηπατικών ενζύμων που μεταβολίζουν τα φάρμακα, μειώνει το μεταβολισμό της λαμοτριγίνης και αυξάνει τη μέση ημιπερίοδο ζωής της αποβολής της περισσότερο από δύο φορές. Έχουν αναφερθεί επιδράσεις στο κεντρικό νευρικό σύστημα όπως ζάλη, αταξία, διπλωπία, θάμβος οράσεως και ναυτία, σε ασθενείς που έλαβαν καρβαμαζεπίνη, μετά τη χορήγηση λαμοτριγίνης. Αυτές οι επιδράσεις συνήθως σταματούν, όταν μειωθεί η δόση της καρβαμαζεπίνης. Η φαρμακοκινητική του λιθίου μετά τη χορήγηση 2g άνυδρου γλυκονικού λιθίου χορηγούμενα δύο φορές την ημέρα σε 20 υγιή άτομα δεν μεταβλήθηκε από τη συγχορήγηση 100 mg λαμοτριγίνης/ημέρα. Η χορήγηση πολλαπλών δόσεων βουπροπιόνης από το στόμα δεν είχε σημαντική επίδραση στη φαρμακοκινητική μιας εφάπαξ δόσης λαμοτριγίνης 100 mg σε 12 άτομα και προκάλεσε μόνο ελαφρά αύξηση του AUC της γλυκουρονικής λαμοτριγίνης. Πειράματα αναστολής in vitro υπέδειξαν ότι ο σχηματισμός του κύριου μεταβολίτη της λαμοτριγίνης, του 2-N-γλυκουρονικού, επηρεάστηκε ελάχιστα από την ταυτόχρονη επώαση με αμιτριπτυλίνη, βουπροπιόνη, κλοναζεπάμη, αλοπεριδόλη ή λοραζεπάμη. Τα στοιχεία από το μεταβολισμό της βουφουραλόλης από τα μικροσωμάτια του ανθρώπινου ήπατος υπέδειξαν ότι η λαμοτριγίνη δεν μειώνει την κάθαρση των φαρμάκων που μεταβολίζονται από το CYP2D6. Τα στοιχεία από πειράματα in vitro υποδεικνύουν επίσης ότι η κάθαρση της λαμοτριγίνης είναι απίθανο να επηρεαστεί από την κλοζαπίνη, τη φαινελζίνη, τη φλουοξετίνη, τη ρισπεριδόνη, τη σερτραλίνη ή την τραζοδόνη. Κύηση και γαλουχία:Όπως συμβαίνει με άλλα φάρμακα, το Lamotrix δεν πρέπει να χρησιμοποιείται κατά τη διάρκεια της εγκυμοσύνης, εκτός εάν κατά τη γνώμη του ιατρού τα αναμενόμενα πλεονεκτήματα υπερτερούν έναντι των δυνητικών κινδύνων για το έμβρυο. Μητέρες που λαμβάνουν λαμοτριγίνη δεν πρέπει να θηλάζουν. Επίδραση στην ικανότητα οδήγησης και χειρισμού μηχανημάτων: Σε κλινικές μελέτες με λαμοτριγίνη, έχουν αναφερθεί ανεπιθύμητες ενέργειες νευρολογικού χαρακτήρα, όπως ζάλη και διπλωπία. Οι ασθενείς που λαμβάνουν λαμοτριγίνη δεν πρέπει να οδηγούν ή να χειρίζονται επικίνδυνα μηχανήματα. Ανεπιθύμητες ενέργειες Πολύ συχνά (›1/10), συχνά (›1/100, ‹1/10), όχι συχνά (›1/1000, ‹1/100), σπάνια (›1/10.000, ‹1/1000), πολύ σπάνια (‹1/10.000). ΕΠΙΛΗΨΙΑ Διαταραχές δέρματος και υποδορίου ιστού: Πολύ συχνά: Δερματικό εξάνθημα. Σπάνια: Σύνδρομο Stevens – Johnson Πολύ σπάνια: Τοξική επιδερμική νεκρόλυση. Η πιθανότητα εξανθήματος φαίνεται να συνδέεται στενά με: Υψηλές αρχικές δόσεις λαμοτριγίνης και υπέρβαση του συνιστώμενου δοσολογικού σχήματος αύξησης της λαμοτριγίνης. Συγχορήγηση βαλπροϊκού, που αυξάνει τη μέση ημιπερίοδο ζωής της λαμοτριγίνης περίπου στο διπλάσιο. Διαταραχές αίματος και λεμφικού συστήματος: Πολύ σπάνια: Αιματολογικές ανωμαλίες που περιλαμβάνουν, ουδετεροπενία, λευκοπενία, αναιμία, θρομβοκυτταροπενία, πανκυτταροπενία, απλαστική αναιμία, ακοκκιοκυτταραιμία. Διαταραχές ανοσοποιητικού συστήματος: Πολύ σπάνια: Σύνδρομο υπερευαισθησίας** (περιλαμβανομένων συμπτωμάτων όπως, πυρετός, λεμφαδενοπάθεια, οίδημα προσώπου, ανωμαλίες στο αίμα και το ήπαρ, διάχυτη ενδαγγειακή πήξη (DIC), πολυοργανική ανεπάρκεια). Ψυχιατρικές διαταραχές: Συχνά: Ευερεθιστότητα. Όχι συχνά: Επιθετικότητα. Πολύ σπάνια: Τικ, παραισθήσεις, σύγχυση. Διαταραχές νευρικού συστήματος: Πολύ συχνά: Κεφαλαλγία. Συχνά: Νευρικότητα, αϋπνία, ζάλη, τρόμος. Πολύ συχνά: Κεφαλαλγία, ζάλη. Συχνά: Νύσταγμος, τρόμος, αταξία, υπνηλία, αϋπνία. Πολύ σπάνια: Διέγερση, αστάθεια, κινητικές διαταραχές, επιδείνωση της νόσου του Parkinson, εξωπυραμιδικές δράσεις, χορειοαθέτωση, αύξηση της συχνότητας επιληπτικών σπασμών. Υπάρχουν αναφορές ότι το Lamotrix μπορεί να επιδεινώσει συμπτώματα Parkinson σε ασθενείς με προϋπάρχουσα νόσο του Parkinson και μεμονωμένες αναφορές εξωπυραμιδικών δράσεων και χορειοαθέτωσης σε ασθενείς χωρίς αυτήν την υποκείμενη πάθηση. Διαταραχές οφθαλμών Πολύ συχνά: Διπλωπία, θάμβος οράσεως. Σπάνια: Επιπεφυκίτιδα. Γαστρεντερικές διαταραχές: Κατά τη διάρκεια μονοθεραπείας σε κλινικές μελέτες: Συχνά: Ναυτία. Συχνά: Γαστρεντερική διαταραχή (περιλαμβανομένου εμέτου και διάρροιας). Διαταραχές ήπατος – χοληφόρων Πολύ συχνά: Αυξημένες τιμές στις ηπατικές δοκιμασίες, ηπατική δυσλειτουργία, ηπατική ανεπάρκεια. Η ηπατική δυσλειτουργία συνήθως εμφανίζεται μαζί με αντιδράσεις υπερευαισθησίας, αλλά μεμονωμένες περιπτώσεις έχουν αναφερθεί χωρίς φανερά σημεία υπερευαισθησίας. Διαταραχές μυοσκελετικού συστήματος και συνδετικού ιστού Πολύ σπάνια: Αντιδράσεις τύπου λύκου. Γενικές διαταραχές Συχνά: Κόπωση. ΔΙΠΟΛΙΚΗ ΔΙΑΤΑΡΑΧΗ Διαταραχές δέρματος και υποδορίου ιστού: Πολύ συχνά: Εξάνθημα δέρματος. Σπάνια: Σύνδρομο Stevens – Johnson Διαταραχές από το νευρικό σύστημα: Πολύ συχνά: Κεφαλαλγία. Συχνά: Διέγερση, αϋπνία, ζάλη. Διαταραχές από το μυοσκελετικό σύστημα και το συνδετικό ιστό Συχνά: Αρθραλγία. Γενικές διαταραχές και καταστάσεις από το σημείο χορήγησης Συχνά: Άλγος, άλγος ράχης. Υπερδοσολογία: Οξεία πρόσληψη δόσεων που υπερβαίνουν κατά 10 – 20 φορές την μέγιστη θεραπευτική δόση έχει αναφερθεί. Η υπερδοσολογία είχε ως αποτέλεσμα συμπτώματα όπως νύσταγμος, αταξία, ανεπάρκεια συνείδησης και κώμα. Αντιμετώπιση: Σε περίπτωση υπέρβασης της δοσολογίας, ο ασθενής πρέπει να εισαχθεί σε νοσοκομείο και να του δοθεί η κατάλληλη υποστηρικτική θεραπεία και παρακολούθηση. Μπορεί να υπάρξει ένδειξη για πλύση στομάχου. Φαρμακοκινητικές Ιδιότητες: Απορρόφηση: Η λαμοτριγίνη απορροφάται γρήγορα και πλήρως από το έντερο χωρίς σημαντικό μεταβολισμό πρώτης διόδου. Η μέγιστη συγκέντρωση στο πλάσμα επιτυγχάνεται περίπου 2,5 ώρες μετά τη χορήγηση του φαρμάκου από το στόμα. Ο χρόνος που χρειάζεται για να επιτευχθεί η μέγιστη συγκέντρωση επιβραδύνεται μετά τη λήψη τροφής, αλλά η έκταση της απορρόφησης δεν επηρεάζεται. Μεταβολισμός: Οι UDP – γλυκοϋρονυλ – τρανσφεράσες έχουν ανιχνευθεί ως τα υπεύθυνα για το μεταβολισμό της λαμοτριγίνης ένζυμα. Η λαμοτριγίνη επάγει το δικό της μεταβολισμό σ' ένα μέσο βαθμό ανάλογα με τη δόση. Η λαμοτριγίνη επηρεάζει τη φαρμακοκινητική των άλλων αντιεπιληπτικών (AEDs). Άλλα στοιχεία δείχνουν ότι αλληλεπιδράσεις μεταξύ της λαμοτριγίνης και φαρμάκων που μεταβολίζονται από ένζυμα του κυτοχρώματος P450, δεν είναι πιθανό να συμβούν. Η μέση ημιπερίοδος ζωής της απομάκρυνσης σε υγιείς ενήλικες είναι 24 με 35 ώρες. Η ημιπερίοδος ζωής της λαμοτριγίνης επηρεάζεται πολύ από ταυτόχρονα χορηγούμενα φάρμακα. Η ημιπερίοδος ζωής μειώνεται περίπου στις 14 ώρες, όταν δίδεται ταυτόχρονα με φάρμακα που επάγουν ένζυμα όπως η καρβαμαζεπίνη και η φαινυτοΐνη και αυξάνεται σε ένα μέσο όρο περίπου 70 ωρών όταν δίδεται ταυτόχρονα βαλπροϊκό νάτριο. Παιδιά: Η κάθαρση, διορθωμένη ως προς το σωματικό βάρος είναι μεγαλύτερη σε παιδιά παρά σε ενήλικες με τις μεγαλύτερες τιμές σε παιδιά κάτω των 5 ετών. ΦΑΡΜΑΚΕΥΤΙΚΑ ΣΤΟΙΧΕΙΑ:Κατάλογος των εκδόχων: Για όλες τις περιεκτικότητες: Λακτόζη μονοϋδρική, μικροκρυσταλλική κυτταρίνη, νατριούχο γλυκολικό άμυλο, πολυβινυλοπυρρολιδόνη, οξείδιο του σιδήρου (κίτρινο) E 172, στεατικό μαγνήσιο. Διάρκεια ζωής: 36 μήνες σε θερμοκρασία ≤ 30° C. Ιδιαίτερες προφυλάξεις κατά τη φύλαξη του προϊόντος: Δεν είναι απαραίτητες Φύση και συστατικά του περιέκτη: Για όλες τις περιεκτικότητες: Τα δισκία συσκευάζονται σε Blister και περιέχονται σε κουτί των 30 δισκίων (3 blisters x 10 δισκία για όλες τις περιεκτικότητες) μαζί με την οδηγία χρήσεως. LAMOTRIX TAB 100MG/TAB BTx30 (Blist 3x10) Χ.Τ. 21.21, Ν.Τ. 18.45, Λ.Τ. 31.21LAMOTRIX TAB 200MG/TAB BTx30 (Blist 3x10) Χ.Τ. 31.02, Ν.Τ. 26.99, Λ.Τ. 45.65LAMOTRIX TAB 25MG/TAB BTx30 (Blist 3x10) Χ.Τ. 5.76, Ν.Τ. 5.01, Λ.Τ. 8.48LAMOTRIX TAB 50MG/TAB BTx30 (Blist 3x10) Χ.Τ. 8.62, Ν.Τ. 7.50, Λ.Τ. 12.68 ΚΑΤΟΧΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: PHARMACYPRIA HELLAS A.E. Παστέρ 6, Τ.Κ.: 115 21, Αθήνα, Τηλ.: 210-6443964, 210-6443362, Fax.: 210-6445375 ΑΡΙΘΜΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: Lamotrix 25 mg/tab: 68367/12-12-2005, Lamotrix 50 mg/tab: 68365/12-12-2005, Lamotrix 100 mg/tab: 68364/12-12-2005, Lamotrix 200 mg/tab: 68370/12-12-2005. ΗΜΕΡΟΜΗΝΙΑ ΤΗΣ ΠΡΩΤΗΣ ΑΔΕΙΑΣ / ΑΝΑΝΕΩΣΗΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: 12-12-2005 ΗΜΕΡΟΜΗΝΙΑ ΤΗΣ (ΜΕΡΙΚΗΣ) ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ: 15-1-2009

Paroxia

Paroxetine

20, 30, 40mg

ΕΣΤΙΑΖΕΙ

στη θεραπεία της κατάθλιψης!

Παστέρ 6, Αθήνα 115 21 • Τηλ: 210 6413160 • Fax: 210 6445375
Κων. Καραμανλή 145, Θεσσαλονίκη 542 49 • Τηλ: 2310 300869
e-mail: greece@medochemie.com • www.medochemie.com

MEDOCHEMIE HELLAS A.E.

Paroxia

Paroxetine 20, 30, 40mg

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΪΟΝΤΟΣ

ΕΜΠΟΡΙΚΗ ΟΝΟΜΑΣΙΑ: PAROXIA.**ΠΟΙΟΤΙΚΗ & ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ:** Κάθε δισκίο περιέχει 20, 30 ή 40 mg παροξετίνης (ως άνυδρη υδροχλωρική παροξετίνη). **ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ:** Δισκίο. 20 mg: επίπεδο, με στρογγυλεμένα άκρα, υπόλευκο, στρογγυλό δισκίο με χαραγμένο το 20 στη μία πλευρά. Το δισκίο φέρει χαραγή και μπορεί να μοιραστεί σε δύο ίσα μέρη. 30 mg: επίπεδο με στρογγυλεμένα άκρα, υπόλευκο, στρογγυλό δισκίο με χαραγή. Το δισκίο μπορεί να μοιραστεί σε δύο ίσα μέρη. 40 mg: επιμήκη σε σχήμα κάψουλας, υπόλευκο δισκίο με χαραγή. Το δισκίο μπορεί να μοιραστεί σε δύο ίσα μέρη. Θεραπευτικές ενδείξεις: Θεραπεία των: Μείζων Καταθλιπτικό Επεισόδιο, Ιδεοληπτική Ψυχαναγκαστική Διαταραχή, Διαταραχή Πανικού με και χωρίς αγοραφοβία, Κοινωνικές Αγχώδεις Διαταραχές / Κοινωνική φοβία, Γενικευμένη Αγχώδεις Διαταραχή, Μετατραυματικό στρες. **Δοσολογία και τρόπος χορήγησης:** Συνιστάται η παροξετίνη να χορηγείται άπαξ ημερησίως το πρωί μαζί με το φαγητό. Το δισκίο θα πρέπει να καταπίνεται παρά να μασιέται. **ΜΕΙΖΟΝ ΚΑΤΑΘΛΙΠΤΙΚΟ ΕΠΕΙΣΟΔΙΟ** Η συνιστώμενη δόση είναι 20 mg ημερησίως. Γενικά, η βελτίωση του ασθενούς ξεκινά μετά από μια εβδομάδα, αλλά γίνεται εμφανής μόνο από τη δεύτερη εβδομάδα θεραπείας. Όπως με όλα τα αντικαταθλιπτικά ιατρικά προϊόντα, η δοσολογία θα πρέπει να αναθεωρείται και να προσαρμόζεται εάν αυτό απαιτείται εντός 3 έως 4 εβδομάδων από την έναρξη της θεραπείας και έκτοτε όπως κρίνεται κλινικά σωστό. Σε μερικούς ασθενείς με μη ικανοποιητική ανταπόκριση στα 20 mg, η δόση μπορεί να αυξηθεί σταδιακά μέχρι τη μέγιστη των 50 mg ημερησίως σε βήματα των 10 mg ανάλογα με την ανταπόκριση του ασθενή. Ασθενείς με κατάθλιψη θα πρέπει να θεραπεύονται για μία επαρκή περίοδο τουλάχιστον 6 μηνών για να εξασφαλιστεί ότι είναι ελεύθεροι συμπτωμάτων. **ΙΔΕΟΛΗΠΤΙΚΗ ΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ** Η συνιστώμενη δόση είναι 40 mg ημερησίως. Οι ασθενείς πρέπει να ξεκινούν με 20 mg/ημερησίως και η δόση μπορεί να αυξάνεται σταδιακά κατά 10 mg μέχρι την συνιστώμενη δόση. Εάν μετά από μερικές εβδομάδες στη συνιστώμενη δόση δεν παρατηρηθεί ικανοποιητική ανταπόκριση, μερικοί ασθενείς μπορεί να ωφεληθούν με αύξηση της δόσης τους σταδιακά έως μία μέγιστη 60 mg/ημερησίως. Οι ασθενείς με ιδεοληπτική ψυχαναγκαστική διαταραχή θα πρέπει να αντιμετωπίζονται για μία επαρκή περίοδο για να εξασφαλιστεί ότι είναι ελεύθεροι συμπτωμάτων. Αυτή η περίοδος μπορεί να είναι μερικοί μήνες ή ακόμα περισσότερο. **ΔΙΑΤΑΡΑΧΗ ΠΑΝΙΚΟΥ** Η συνιστώμενη δόση είναι 40 mg ημερησίως. Οι ασθενείς πρέπει να ξεκινούν με 10 mg/ημερησίως και η δόση σταδιακά να αυξάνεται με βήματα των 10 mg ανάλογα με την ανταπόκριση του ασθενούς μέχρι τη συνιστώμενη δόση. Μία χαμηλή δόση έναρξης συνιστάται για την ελαχιστοποίηση της πιθανότητας επιδείνωσης της συμπτωματολογίας, η οποία γενικά αναγνωρίζεται ότι μπορεί να συμβεί νωρίς κατά τη θεραπεία της διαταραχής. Εάν μετά από μερικές εβδομάδες στη συνιστώμενη δόση δεν παρατηρηθεί ικανοποιητική ανταπόκριση, μερικοί ασθενείς μπορεί να ωφεληθούν με αύξηση της δόσης τους σταδιακά έως μία μέγιστη 60 mg/ημερησίως. Ασθενείς με διαταραχή πανικού θα πρέπει να θεραπεύονται για μία επαρκή περίοδο για να εξασφαλιστεί ότι είναι ελεύθεροι συμπτωμάτων. Αυτή η περίοδος μπορεί να είναι μερικοί μήνες ή περισσότερο. **ΚΟΙΝΩΝΙΚΗ ΑΓΧΩΔΗΣ ΔΙΑΤΑΡΑΧΗ/ΚΟΙΝΩΝΙΚΗ ΦΟΒΙΑ** Η συνιστώμενη δόση είναι 20 mg ημερησίως. Εάν μετά από μερικές εβδομάδες στη συνιστώμενη δόση δεν παρατηρηθεί ικανοποιητική ανταπόκριση, μερικοί ασθενείς μπορεί να ωφεληθούν με αύξηση της δόσης τους σταδιακά με βήματα των 10 mg έως μία μέγιστη 50 mg/ημερησίως. Η μακροχρόνια χρήση θα πρέπει να αξιολογείται τακτικά. **ΓΕΝΙΚΕΥΜΕΝΗ ΑΓΧΩΔΗΣ ΔΙΑΤΑΡΑΧΗ** Η συνιστώμενη δόση είναι 20 mg ημερησίως. Εάν μετά από μερικές εβδομάδες στη συνιστώμενη δόση δεν παρατηρηθεί ικανοποιητική ανταπόκριση, μερικοί ασθενείς μπορεί να ωφεληθούν με αύξηση της δόσης τους σταδιακά με βήματα των 10 mg έως μία μέγιστη 50 mg/ημερησίως. Η μακροχρόνια χρήση θα πρέπει να αξιολογείται τακτικά. **ΜΕΤΑΤΡΑΥΜΑΤΙΚΟ ΣΤΡΕΣ** Η συνιστώμενη δόση είναι 20 mg ημερησίως. Εάν μετά από μερικές εβδομάδες στη συνιστώμενη δόση δεν παρατηρηθεί ικανοποιητική ανταπόκριση, μερικοί ασθενείς μπορεί να ωφεληθούν με αύξηση της δόσης τους σταδιακά με βήματα των 10 mg έως μία μέγιστη 50 mg/ημερησίως. Η μακροχρόνια χρήση θα πρέπει να αξιολογείται τακτικά. **Αντενδείξεις** Γνωστή υπερευαισθησία στην παροξετίνη ή οποιοδήποτε από τα έκδοχα. Η παροξετίνη αντενδείκνυται σε συνδυασμό με αναστολείς της μονοαμινιξειδάσης (ΜΑΟΙ). Η παροξετίνη δε θα πρέπει να χρησιμοποιείται σε συνδυασμό με τη θειοριδαζίνη. Η παροξετίνη δεν πρέπει να χρησιμοποιείται σε συνδυασμό με την πιμοζίδη. Ειδικές προειδοποιήσεις: **Αυτοκτονία/Αυτοκτονικές σκέψεις ή κλινική επιδείνωση:** Η κατάθλιψη συνδέεται με αυξημένο κίνδυνο αυτοκτονικών σκέψεων, αυτοκαταστροφής και αυτοκτονία (επεισόδια σχετιζόμενα με αυτοκτονία). Ο κίνδυνος αυτός εμμένει μέχρι την επίτευξη σημαντικής υποχώρησης της νόσου. Καθώς μπορεί να μη συμβεί βελτίωση κατά τη διάρκεια των πρώτων εβδομάδων οι ασθενείς θα πρέπει να παρακολουθούνται μέχρι να συμβεί βελτίωση. Η χρήση της παροξετίνης έχει συσχετιστεί με την ανάπτυξη ακαθισίας, η οποία χαρακτηρίζεται από μία εσωτερική αίσθηση ανησυχίας και ψυχοκινητικής διαταραχής όπως αδυναμία παραμονής στην καθιστή ή όρθια θέση και που συνήθως συνδέεται με υποκείμενο αίσθημα δυσφορίας. Αυτό είναι περισσότερο πιθανό να συμβεί εντός των πρώτων λίγων εβδομάδων της θεραπείας. Σε σπάνιες περιπτώσεις μπορεί να συμβεί ανάπτυξη του συνδρόμου σεροτονίνης ή συμβάντα προσομοιάζοντα με κακόηθες νευροληπτικό σύνδρομο σε συνδυασμό με τη θεραπεία με παροξετίνη, ειδικά όταν χορηγείται σε συνδυασμό με άλλα σεροτονινεργικά και/ή νευροληπτικά φάρμακα. Όπως με όλα τα αντικαταθλιπτικά, η παροξετίνη θα πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με ιστορικό μανίας. Συνιστάται προσοχή σε ασθενείς με σοβαρή νεφρική ανεπάρκεια ή σε εκείνους με ηπατική ανεπάρκεια. Σε ασθενείς με διαβήτη, η θεραπεία με έναν εκλεκτικό αναστολέα επαναπρόσληψης σεροτονίνης (SSRI) μπορεί να μεταβάλει τον γλυκαιμικό έλεγχο. Όπως και με άλλα αντικαταθλιπτικά, η παροξετίνη πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με επιληψία. Όπως και με άλλα SSRI, σπάνια η παροξετίνη μπορεί να προκαλέσει μυδρίαση και θα πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με γλαύκωμα κλειστής γωνίας, ή ιστορικό γλαυκώματος. Σπάνια έχει αναφερθεί υπονατριαιμία, κυρίως στους ηλικιωμένους. Συνιστάται προσοχή σε ασθενείς που λαμβάνουν SSRIs ταυτόχρονα με αντιπηκτικά από του στόματος, φάρμακα που είναι γνωστό ότι επηρεάζουν τη λειτουργία των αιμοπεταλίων ή άλλα φάρμακα τα οποία μπορεί να αυξήσουν τον κίνδυνο αιμορραγιών, καθώς επίσης σε ασθενείς με ιστορικό αιμορραγικών διαταραχών ή καταστάσεων που προδιαθέτουν σε αιμορραγία. Τα συμπτώματα εξ'αποστερήσεως όταν διακόπτεται η θεραπεία είναι συχνά ιδιαίτερα αν η διακοπή είναι απότομη. **Αλληλεπιδράσεις με άλλα φαρμακευτικά προϊόντα και άλλες μορφές αλληλεπίδρασης** Όπως και με άλλους SSRIs, η ταυτόχρονη χορήγηση με σεροτονινεργικά φάρμακα μπορεί να οδηγήσουν σε εμφάνιση αποτελεσμάτων που συνδέονται με την 5-ΗΤ (σύνδρομο σεροτονίνης). Αλκοόλη Όπως και με τα άλλα ψυχοτρόπα φάρμακα οι ασθενείς θα πρέπει να συμβουλεύονται να αποφεύγουν τη χρήση αλκοόλ ενώ λαμβάνουν παροξετίνη. **Από του στόματος αντιπηκτικά** Μπορεί να συμβεί μία φαρμακοδυναμική αλληλεπίδραση μεταξύ της παροξετίνης και των από του στόματος αντιπηκτικών. **Κύηση και γαλουχία** Η παροξετίνη θα πρέπει να χρησιμοποιείται κατά τη διάρκεια της κύησης μόνο όταν υπάρχει απόλυτη ένδειξη. Η παροξετίνη δε θα πρέπει να χρησιμοποιείται κατά τη διάρκεια της γαλουχίας εκτός εάν τα αναμενόμενα οφέλη για τη μητέρα δικαιολογούν τον πιθανό κίνδυνο για το βρέφος. **Επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανημάτων** Όπως με όλα τα ψυχοτρόπα φάρμακα, οι ασθενείς θα πρέπει να είναι επιφυλακτικοί σχετικά με την ικανότητά τους να οδηγήσουν ένα αμάξι και να χειριστούν ένα μηχάνημα. **Ανεπιθύμητες ενέργειες Συχνές:** ελάττωση της όρεξης, υπνηλία, αϋπνία, ανησυχία, αίσθημα ζάλης, τρόμος, θάμβος οράσεως, χασμουρητό, ναυτία, δυσκοιλιότητα, διάρροια, ξηροστομία, εφίδρωση, σεξουαλική δυσλειτουργία, αδυναμία, πρόσληψη βάρους, **Υπερδοσολογία- Θεραπεία** Δεν υπάρχει κάποιο συγκεκριμένο αντίδοτο. **Φαρμακοκινητικές Ιδιότητες:** Η παροξετίνη απορροφάται καλά μετά την από του στόματος χορήγηση και υφίσταται μεταβολισμό αρχικής φάσης. Τα συστηματικά επίπεδα σταθερής κατάστασης επιτυγχάνονται 7 με 14 ημέρες μετά την έναρξη της θεραπείας με τις μορφές άμεσης ή ελεγχόμενης απελευθέρωσης και οι φαρμακοκινητικές ιδιότητες δε φαίνεται να μεταβάλλονται κατά τη μακροχρόνια θεραπεία. Η παροξετίνη κατανέμεται ευρέως στους ιστούς και φαρμακοκινητικοί υπολογισμοί έχουν καταδείξει ότι μόνο το 1% της παροξετίνης στο σώμα βρίσκεται στο πλάσμα. Περίπου το 95% της παροξετίνης εμφανίζεται δεσμευμένη με την πρωτεΐνη στις θεραπευτικές συγκεντρώσεις. Περίπου το 36% της δόσης εκκρίνεται στα κόπρανα, πιθανά μέσω της χολής, από το οποίο η μη μεταβολισμένη παροξετίνη αντιπροσωπεύει λιγότερο του 1% της δόσης. Επομένως, η παροξετίνη απεκκρίνεται σχεδόν ολοκληρωτικά μέσω μεταβολισμού. **Διάρκεια ζωής** 3 χρόνια. Αυτό το φαρμακευτικό προϊόν δεν απαιτεί κάποιες ειδικές συνθήκες φύλαξης.**Φύση και συστατικά του περιέκτη** Τα δισκία συσκευάζονται σε κυψέλες (blisters) από πολυβινυλοχλωρίδιο (PVC) που είναι σφραγισμένες με φύλλο αλουμινίου (aluminium foil). Κουτιά που περιέχουν 30, 60 δισκία σε κυψέλες είναι διαθέσιμα. ΤΙΜΕΣ: PAROXIA TAB 20MG/TAB BTX30 ΧΤ 16.15, ΝΤ 14.05, ΛΤ 23.76, PAROXIA TAB 20MG/TAB BTX60 ΧΤ 28.42, ΝΤ 24.73, ΛΤ 41.82, PAROXIA TAB 30MG/TAB BTX30 ΧΤ 24.88, ΝΤ 21.65, ΛΤ 36.61, PAROXIA TAB 30MG/TAB BTX60 ΧΤ 43.79, ΝΤ 38.10,ΛΤ 64.44, PAROXIA TAB 40MG/TAB BTX30 ΧΤ 30.16, ΝΤ 26.24 ΛΤ 44.38 PAROXIA TAB 40MG/TAB BTX60 ΧΤ 53.08 ΝΤ 46.18 ΛΤ 78.11.**ΚΑΤΟΧΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ** MEDOCHEMIE HELLAS A.E. Παστέρ 6, Τ.Κ.: 115 21, Αθήνα, Τηλ.: 6413160 **ΑΡΙΘΜΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:**PAROXIA 20 mg, δισκία: 40508/14-6-2007, PAROXIA 30 mg, δισκία: 40509/14-6-2007, PAROXIA 40 mg, δισκία: 40510/14-6 2007. **ΗΜΕΡΟΜΗΝΙΑ ΤΗΣ ΠΡΩΤΗΣ ΑΔΕΙΑΣ / ΑΝΑΝΕΩΣΗΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** 14-6-2007

MEDOCHEMIE HELLAS A.E.

SCIENTIFIC PROGRAM

Thursday November 19th 2009 — Alexandros Hall

13.00 **Registrations**

14.00-15.30 **Symposium**
MOLECULAR PHARMACOLOGY OF PAIN
Chairperson: **B. Kokkas** (Greece)

Tissue injury and inflammation
B. Kokkas (Greece)

Inflammation and pain
M. Mironidou-Tzouveleki (Greece)

Neuropeptides and pain
D. Molyva (Greece)

Drugs against pain-New concepts
P. Papaioannidou (Greece)

The symposium is organized by the 1st Laboratory of Pharmacology, School of Medicine, Aristotle University of Thessaloniki, Greece

15.30-17.00 **Symposium**
TRANSLATIONAL MEDICINE INFORMS TREATMENT GUIDANCE IN DEPRESSION
Chairpersons: **D. Taylor** (UK)
K. J. Aitchison (UK)

New guidelines on depression from NICE
R. I. Ohlsen (UK)

Clinical lessons from GENDEP for the treatment of depression
K. J. Aitchison (UK)

Using a preclinical approach to reveal potential mechanisms of ADRs to antidepressants in adolescents
E. M. Tsapakis (UK)

Insights from pharmacogenetic studies of antidepressants
L. Mandelli (Italy)

The symposium is organised by The MRC SGDP Centre, Institute of Psychiatry at King's College London, UK

17.00-17.30 **Lecture**
Chairperson: **J. K. Rybakowski** (Poland)

Is "freedom of the will" neutrally possible?
Ph. Kargopoulos (Greece)

17.30-19.00 **Symposium**

NEW TECHNOLOGIES IN BIPOLAR DISORDER

Chairperson: **Y. Malliaris** (UK)

Kraepelin digitised: New technologies for monitoring the course of bipolar disorder
Y. Malliaris (UK)

Enhancing adherence to mood charting with an online version of the NIMH life chart
D. Lieberman (USA)

MyiMonitor.com v.1.0: A user-friendly mobile electronic diary for bipolar patients
Y. Malliaris (UK)

Porcupines: Fine grained activity monitoring in psychiatry using accelerometer sensors
K. Van Laerhoven (Germany)

The symposium is organized by the Hellenic Bipolar Organization

19.00-19.30 Break

19.30-20.00 **Lecture**

Chairperson: **N. Degleris** (Greece)

Bipolar mood disorder and treatment-resistant depression
J. K. Rybakowski (Poland)

20.00-21.30 **Symposium (in Greek)**

ADDICTION IS A PERSONAL CHOICE - TREATMENT OF ADDICTION IS A COLLECTIVE EFFORT

Chairperson: **P. Georgakas** (Greece)

The nature of addiction and drug rehabilitation
Ph. Kaloterakis (Greece)

Addiction and guilt
N. Paraskevopoulos (Greece)

Alternative approaches of addiction and dominant scientific perspectives
S. Lainas (Greece)

The primary prevention in the service of addiction
V. Koutras (Greece)

The family's attitude towards addiction
V. Kalampalikis (Greece)

Truth and lies about the social rehabilitation of drug addiction
P. Georgakas (Greece)

The symposium is organized by the Psychiatric Hospital of Thessaloniki

Friday November 20th 2009 — Alexandros Hall

09.00-09.30 **Lecture**
Chairperson: **D. Vartzopoulos** (Greece)

Changes in the expenditure for psychopharmaca in the last 20 years in Greece
S. Koupidis (Greece)

09.30-11.00 **Symposium**
THE CLINICAL PSYCHOPHARMACOLOGY OF EICOSAPENTAENOIC ACID (EPA)
Chairpersons: **B. K. Puri** (UK)
M. Cocchi (Switzerland)

The structure, biosynthesis and functions of EPA: Biomolecular neuropsychiatric aspects
S. Tsaluchidu (Italy)

The pharmacotherapy of depression with EPA
B. K. Puri (UK)

EPA in schizophrenia and violence
I. H. Treasaden (UK)

EPA and the Perrin Technique: A combined approach to treating myalgic encephalomyelitis
R. Perrin (UK)

Running the hypothesis of a bio molecular approach to psychiatric disorder characterization and fatty acids therapeutical choices
M. Cocchi (Switzerland)

EPA and Huntington's chorea: Treatment and associated cerebral changes
B. K. Puri (UK)

11.00-12.30 **Symposium**
NEUROBIOLOGY OF TRAUMA
Chairperson: **L. Lykouras** (Greece)

Early neurobiological changes in childhood after traumatization
A. Vourdas (Greece)

Pertinent changes in adult brain neurobiology due to trauma
Ch. Tsopelas (Greece)

Psychological treatments of trauma consequences in mental health
I. Giannopoulou (Greece)

Pharmacological treatment in mental health disorders after trauma
Ath. Douzenis (Greece)

The symposium is organized by the Forensic Mental Health Section of the Greek Psychiatric Association

12.30-13.00 Break

13.00-14.30 **Symposium**

HOW TO DEAL WITH THE HUGE COMORBIDITY OF SOMATIC DISORDERS IN PATIENTS WITH SEVERE MENTAL DISORDERS

Chairperson: **H.-J. Möller** (Germany)

The general problem of increased somatic comorbidity in bipolar patients
J. Bobes (Spain)

Increased metabolic and cardiovascular morbidity in patients with schizophrenia. Recommendation for diagnoses and treatment
D. Cohen (The Netherlands)

Metabolic alterations in patients with depression and their relationship to the ethiology of depressive disorders
K. G. Kahl (Germany)

No health without mental health-Towards a holistic approach
M. Malliori (Greece)

The EPA/EADS/ESC position statement on diabetes and cardiovascular risk in patients with severe mental disorders
H.-J. Möller (Germany)

The symposium is organized by the European Psychiatric Association

14.30-15.30 Break

15.30-17.00 **Symposium**

NEUROBIOLOGY OF STRESS

Chairpersons: **J. Yesavage** (USA)
M. Sotiriou (Greece)

Effects of sleep apnea and APOE ε4 status on follow-up of veterans with PTSD from the Vietnam conflict
J. Yesavage (USA)

The mediating role of 5-HTTLPR in the background of stress vulnerability
X. Gonda (Hungary)

Stress in medical patients
St. Samolis (Greece)

Stress in special groups
M. Sotiriou (Greece)

17.00-17.30 **Lecture**

Chairperson: **K. N. Fountoulakis** (Greece)

Stigma by health and mental health professionals in comorbid states
L. Küey (Turkey)

The lecture is organized by the World Psychiatric Association

17.30-19.00 **Symposium**

RECOMMENDED GUIDANCE ON SCHIZOPHRENIA

Chairpersons: **W. Gaebel** (Germany)
C. Höschl (Czech Republic)

European treatment guidelines for schizophrenia
W. Gaebel (Germany)

WFSBP treatment guidelines and the problem of evidence grading
H.-J. Möller (Germany)

Recommended guidance beyond guidelines
C. Höschl (Czech Republic)

Guidance in the ages of neuroscience
L. Lykouras (Greece)

The symposium is organized by the European Psychiatric Association

19.00-19.30 Coffee break

19.30-20.00 **Lecture**

Chairperson: **C. Höschl** (Czech Republic)

The American Psychiatric Association Treatment Guideline for major depressive disorder: Process and content
A. J. Gelenberg (USA)

20.00-21.30 **Satellite Symposium**

AGOMELATINE: A NEW ERA IN THE TREATMENT OF DEPRESSION

Chairpersons: **H.-J. Möller** (Germany)
K. N. Fountoulakis (Greece)

Biological theory of depression in the light of new evidence
G. Papageorgiou (Greece)

Circadian rhythms: Strong evidence on how to approach depression
K. N. Fountoulakis (Greece)

Agomelatine: Relief ensured at each and every stage of depression
H.-J. Möller (Germany)

The symposium is organized by Servier

21.30 **Opening Ceremony**

Saturday November 21st 2009 — Alexandros Hall

09.00-09.30 **Lecture**
Chairperson: **G. Simos** (Greece)

Suicide among untreated and treated depressives: The role of compliance, drug-resistance and underlying bipolarity
Z. Rihmer (Hungary)

09.30-11.00 **Symposium**
TREATMENT GUIDANCE/GUIDELINES: HISTORY, CONCEPT, NEED, THEORETICAL SUPPORT
Chairpersons: **N. Sartorius** (Switzerland)
W. Gaebel (Germany)

Introduction to treatment guidance
N. Sartorius (Switzerland)

What makes good guidelines?
W. Gaebel (Germany)

NICE guidelines
St. Pilling (UK)

Guidelines for research: Requirements and challenges
S. Galderisi (Italy)

Concluding remarks
N. Sartorius (Switzerland)

The symposium is organized by the European Psychiatric Association

11.00-12.30 **Symposium**
FUTURE TRENDS IN SOCIAL PSYCHIATRY
Chairpersons: **J. Arboleda-Florez** (Canada)
D. Moussaoui (Morocco)

Impact of globalization on social psychiatry
M. Kastrup (Denmark)

Social Darvinism and psychopathology
A. Erfurth (Austria)

What research is needed in social psychiatry?
D. Moussaoui (Morocco)

Social rituals and onset of mental disorders
A. Janca (Australia)

The symposium is organized by the Euro-Mediterranean Network on Migration and Mental Health

12.30-13.00 Coffee break

13.00-14.30 **Satellite Symposium**
BIPOLAR DISORDER: FROM CLINICAL DATA TO REAL LIFE
Chairperson: **K. N. Fountoulakis** (Greece)

The global effect of aripiprazole monotherapy in the spectrum of symptoms in bipolar disorder: A meta-analysis
K. N. Fountoulakis (Greece)

Aripiprazole in Bipolar Disorder: Clinical strategies to maximize efficacy and tolerability
A. Fagiolini (Italy)

The symposium is organized by Bristol-Myers Squibb

14.30-15.30 Break

15.30-17.00 **Open discussion on Mental Health Care (session in Greek)**

The discussion is organized by the WPA Section on Private Practice Psychiatry and the Network on Dialogue for Mental Health Care

17.00-17.30 **Lecture**
Chairperson: **L. Lykouras** (Greece)

The neurobiology of subjective tolerability to antipsychotic medications in schizophrenia – Is it also relevant to the genesis of comorbid addiction?
G. Awad (Canada)

17.30-19.00 **Symposium**
TREATMENT GUIDANCE ON BIPOLAR DISORDER
Chairperson: **S. Kasper** (Austria)

Treatment guidelines for acute mania
J. Goigolea (Spain), **E. Vieta** (Spain)

Treatment guidelines for acute bipolar depression
K. N. Fountoulakis (Greece)

Long-term treatment of bipolar disorder
J. Cookson (UK)

How can guidelines help us in daily practice
S. Kasper (Austria)

The symposium is organized by the European Psychiatric Association

19.00-19.30 Coffee break

19.30-20.00 **Lecture**
Chairperson: **A. Gelenberg** (USA)

Integrating science and clinical practice in the understanding and treatment of mood disorders
H. Akiskal (USA)

The lecture is supported by an educational grant by Alapis Pharma

20.00-21.30 **Satellite Symposium**
CAN WE ACHIEVE EARLY AND LONG-TERM EFFECTIVE TREATMENT OF SCHIZOPHRENIA?
Chairpersons: **H.-J. Möller** (Germany)
K. N. Fountoulakis (Greece)

Why treating early, treating well, and treating for life is important in schizophrenia
R. Kahn (The Netherlands)

The need for efficient long-term neuroleptic treatment in schizophrenic patients and the place of long acting injectable antipsychotics
H.-J. Möller (Germany)

The role of RLAI in early schizophrenia treatment: Critical aspects regarding efficacy and safety
G. Papageorgiou (Greece)

The symposium is organized by Janssen-Cilag

21.30 **Award Ceremony**

Sunday November 22nd 2009 — Alexandros Hall

09.00-09.30 **Lecture**
Chairperson: **Ch. Touloumis** (Greece)

Polypharmacy in schizophrenia – therapeutic option or a sign of despair?
A. Konstantinidis (Austria)

09.30-11.00 **Symposium**
ETHICS, AESTHETICS AND PSYCHOPHARMACOLOGY
Chairpersons: **L. Câmara Pestana** (Portugal)
M. L. Figueira (Portugal)

New patients, new disorders, new drugs and the rise of prescriptions
L. Câmara Pestana (Portugal)

Are depressive residual symptoms independent of treatments?
M. L. Figueira (Portugal)

Psychopharmacology at the era of EMEA (European Medicines Agency)
L. Câmara Pestana (Portugal), **L. Ganança** (Portugal)

Medical care and long-term treatment of patients with schizophrenia: Ethical concerns
F. Simões do Couto (Portugal)

The symposium is organized by the Portuguese Association of Biological Psychiatry

11.00-12.30 **Symposium**
NEW INSIGHTS IN AFFECTIVE TEMPERAMENTS AND BIPOLAR SPECTRUM
Chairperson: **A. Koukopoulos** (Italy)

Temperament and major depressive disorder
E. Karam (Lebanon)

Clinical approach of alcoholism through affective temperaments
A. Erfurth (Austria)

Cyclothymic temperament and/or borderline personality disorder
G. Perugi (Italy)

Temperament and schema-focused diagnosis in soft bipolarity
E. Hantouche (France)

The symposium is organized by the European Bipolar Network

12.30-13.00 Break

13.00-14.30 **Symposium**

TREATMENT OF ALCOHOL AND SUBSTANCE USE DISORDERS IN PEOPLE WITH HEPATITIS C

Chairperson: **P. Hauser** (USA)

Brief interventions for reducing drinking in veterans with hepatitis C
B. Fuller (USA)

Medication treatment of alcohol use disorders in veterans with hepatitis C
P. Hauser (USA)

Chronic pain and substance use in patients with hepatitis C
B. Morasco (USA)

14.30-15.00 **Lecture**

Chairperson: **P. Grigoriou** (Greece)

Cross-Cultural psychopharmacology: A review
E. H. Pi (USA)

15:00-15.30 **Lecture**

Chairperson: **A. Soghoyan** (Armenia)

Specific inhibition of adenylyl-cyclase isoform 5 by mood stabilizers may be related to their mechanism of action
G. Agam (Israel)

15.30 **Closing Ceremony**

Το **ABILIFY®** ενδείκνυται για τη θεραπεία της σχιζοφρένειας. Πρόσφατα αποδείχθηκε πως **ενδείκνυται** και για τη θεραπεία ήπιων έως **σοβαρών μανιακών επεισοδίων** σε Διπολική Διαταραχή τύπου Ι, και για την **πρόληψη νέου μανιακού επεισοδίου** σε ασθενείς που εμφάνισαν κυρίως μανιακά επεισόδια, των οποίων τα μανιακά επεισόδια ανταποκρίθηκαν στη θεραπεία με **ABILIFY®**.

Υποστηρίζουμε τις σχέσεις, βελτιώνουμε τις ζωές

ABILIFY®
(aripiprazole)

Για την περίληψη των χαρακτηριστικών του προϊόντος ανατρέξτε σε άλλη σελίδα του τεύχους.

Bristol-Myers Squibb Otsuka Otsuka Pharmaceutical Europe Ltd.

ABIL ADV 05/2008

1. ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ: ABILIFY 10 mg, δισκία, ABILIFY 15 mg, δισκία, ABILIFY 30 mg, δισκία, ABILIFY 10 mg, διασπειρόμενα στο στόμα δισκία, ABILIFY 15 mg, διασπειρόμενα στο στόμα δισκία, ABILIFY 1 mg/ml πόσιμο διάλυμα. **2. ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ:** ΔΙΣΚΙΑ: ABILIFY 10 mg: Κάθε δισκίο περιέχει 10 mg αριπιπραζόλης. Έκδοχο: 62,18 mg λακτόζης ανά δισκίο. ABILIFY 15 mg: Κάθε δισκίο περιέχει 15 mg αριπιπραζόλης. Έκδοχο: 57 mg λακτόζης ανά δισκίο. ABILIFY 30 mg: Κάθε δισκίο περιέχει 30 mg αριπιπραζόλης. Έκδοχο: 186,54 mg λακτόζης ανά δισκίο. ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ. ABILIFY 10 mg: Κάθε διασπειρόμενο στο στόμα δισκίο περιέχει 10 mg αριπιπραζόλης. Έκδοχο: 2 mg ασπαρτάμη (E951) ανά διασπειρόμενο στο στόμα δισκίο. ABILIFY 15 mg: Κάθε διασπειρόμενο στο στόμα δισκίο περιέχει 15 mg αριπιπραζόλης. Έκδοχο: 3 mg ασπαρτάμη (E951) ανά διασπειρόμενο στο στόμα δισκίο. ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ. Κάθε ml πόσιμου διαλύματος ABILIFY περιέχει 1 mg αριπιπραζόλης. Έκδοχα: 200 mg φρουκτόζη ανά ml, 400 mg σακχαρόζη ανά ml, 1,8 mg παραϋδροξυβενζοϊκός μεθυλεστέρας (E218) ανά ml, 0,2 mg παραϋδροξυβενζοϊκός προπυλεστέρας (E216) ανά ml. Για τον πλήρη κατάλογο των εκδόχων, βλ. παράγραφο 6.1. **3. ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ:** Δισκίο 10 mg: Ορθογώνιο και ρόζ, χαραγμένο με «A-008» και «10» στη μια πλευρά. Δισκίο 15 mg: Στρογγυλό και κίτρινο, χαραγμένο με «A-009» και «15» στη μια πλευρά. Δισκίο 30 mg: Στρογγυλό και ρόζ, χαραγμένο με «A-011» και «30» στη μια πλευρά. Διασπειρόμενο στο στόμα δισκίο 10 mg: Στρογγυλό και ρόζ, επισημασμένο με «A» πάνω από «640» στη μια πλευρά και 10 στην άλλη. Διασπειρόμενο στο στόμα δισκίο 15 mg: Στρογγυλό και κίτρινο, επισημασμένο με «A» πάνω από «641» στη μια πλευρά και 15 στην άλλη. Πόσιμο διάλυμα: Διαυγές, άχρωμο έως ανοικτό κίτρινο υγρό. **4. ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ:** *4.1 Θεραπευτικές ενδείξεις:* Το ABILIFY ενδείκνυται για τη θεραπεία της σχιζοφρένειας. Το ABILIFY ενδείκνυται για τη θεραπεία ήπιων έως σοβαρών μανιακών επεισοδίων σε Διπολική Διαταραχή τύπου Ι και για την πρόληψη νέου μανιακού επεισοδίου σε ασθενείς που εμφάνισαν κυρίως μανιακά επεισόδια και των οποίων τα μανιακά επεισόδια αντιμετωπίστηκαν στη θεραπεία με αριπιπραζόλη (βλέπε παράγραφο 5.1). *4.2 Δοσολογία και τρόπος χορήγησης:* Από στόματος χρήση. Σχιζοφρένεια: Η συνιστώμενη δόση έναρξης του ABILIFY είναι 10 ή 15 mg/ημέρα, (δηλαδή για το πόσιμο διάλυμα 10 ή 15 ml διαλύματος/ημέρα) με δόση συντήρησης 15 mg/ημέρα, χορηγούμενα μια φορά ημερησίως, ανεξαρτήτως των γευμάτων. Το ABILIFY είναι αποτελεσματικό σε ένα εύρος δόσεων από 10 έως 30 mg/ημέρα (δηλαδή για το πόσιμο διάλυμα 10 έως 30 ml διαλύματος/ημέρα). Δεν έχει αποδειχθεί αυξημένη αποτελεσματικότητα με δόσεις μεγαλύτερες μιας ημερήσιας δόσης 15 mg αν και μεμονωμένοι ασθενείς μπορεί να ωφεληθούν από μια μεγαλύτερη δόση. Η μέγιστη ημερήσια δόση δεν πρέπει να ξεπερνά τα 30 mg. Μανιακά επεισόδια: Η συνιστώμενη δόση έναρξης του ABILIFY είναι 15 mg (δηλαδή για το πόσιμο διάλυμα 15 ml διαλύματος/ημέρα) χορηγούμενα με πρόγραμμα λήψης μιας φοράς την ημέρα ανεξαρτήτως γευμάτων ως μονοθεραπεία ή θεραπεία συνδυασμού (βλέπε παράγραφο 5.1). Ορισμένοι ασθενείς μπορεί να ωφεληθούν από υψηλότερη δόση. Η μέγιστη ημερήσια δόση δεν πρέπει να υπερβαίνει τα 30 mg. Πρόληψη υποτροπής μανιακών επεισοδίων στην Διπολική Διαταραχή τύπου Ι: Για την πρόληψη της υποτροπής μανιακών επεισοδίων σε ασθενείς που λαμβάνουν αριπιπραζόλη, συνεχίστε τη θεραπεία στην ίδια δόση. Ρυθμίσεις της ημερήσιας δοσολογίας, περιλαμβανομένης μείωσης της δόσης, πρέπει να εξετάζονται με βάση την κλινική κατάσταση. ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ. Το διασπειρόμενο στο στόμα δισκίο πρέπει να τοποθετείται μέσα στο στόμα επάνω στη γλώσσα, όπου και θα διασπαρεί γρήγορα στο σίελο. Μπορεί να ληφθεί με ή χωρίς υγρά. Η απομάκρυνση του άθικτου διασπειρόμενου στο στόμα δισκίου από το στόμα είναι δύσκολη. Επειδή το διασπειρόμενο στο στόμα δισκίο είναι εύθραυστο, πρέπει να λαμβάνεται αμέσως μετά το άνοιγμα της κυψέλης. Εναλλακτικά, διασπείρετε το δισκίο σε νερό και πιείτε το εναιώρημα που προκύπτει. Τα διασπειρόμενα στο στόμα δισκία μπορούν να χρησιμοποιηθούν εναλλακτικά με τα δισκία ABILIFY για τους ασθενείς που έχουν δυσκολία στην κατάποση δισκίων ABILIFY (βλέπε επίσης παράγραφο 5.2). ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ. Το πόσιμο διάλυμα ABILIFY μπορεί να χρησιμοποιηθεί ως εναλλακτικό των δισκίων ABILIFY στους ασθενείς που έχουν δυσκολία να καταπιούν τα δισκία ABILIFY (βλέπε παράγραφο 5.2). Ένα βαθμονομημένο κύπελλο μέτρησης από πολυπροπυλένιο περιλαμβάνεται στο κουτί. Παιδιά και έφηβοι: δεν υπάρχει εμπειρία στα παιδιά και στους εφήβους κάτω των 18 ετών. Ασθενείς με ηπατική δυσλειτουργία: δεν απαιτείται ρύθμιση της δοσολογίας σε ασθενείς με ήπια έως μέτρια ηπατική δυσλειτουργία. Σε ασθενείς με σοβαρή ηπατική δυσλειτουργία, τα δεδομένα που υπάρχουν είναι ανεπαρκή για να καθορίσουν συγκεκριμένες σύστασεις. Στους ασθενείς αυτούς η ρύθμιση της δοσολογίας θα πρέπει να γίνεται με προσοχή. Ωστόσο, η μέγιστη ημερήσια δόση των 30 mg θα πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με σοβαρή ηπατική δυσλειτουργία (βλέπε παράγραφο 5.2). Ασθενείς με νεφρική δυσλειτουργία: δεν απαιτείται ρύθμιση της δοσολογίας σε ασθενείς με νεφρική δυσλειτουργία. Ηλικιωμένοι: η αποτελεσματικότητα του ABILIFY για τη θεραπεία της σχιζοφρένειας και της Διπολικής Διαταραχής τύπου Ι σε ασθενείς 65 ετών ή μεγαλύτερους δεν έχει αποδειχθεί. Λόγω αυξημένης ευαισθησίας της πληθυσμιακής αυτής ομάδας, θα πρέπει να εξετάζεται η χορήγηση μικρότερης δόσης έναρξης όταν κλινικοί παράγοντες το δικαιολογούν (βλέπε παράγραφο 4.4). Φύλο: δεν απαιτείται ρύθμιση της δοσολογίας για τις γυναίκες ασθενείς, σε σύγκριση με τους άνδρες ασθενείς (βλέπε παράγραφο 5.2). Καπνιστές: σύμφωνα με την μεταβολική οδό της αριπιπραζόλης, δεν απαιτείται ρύθμιση της δοσολογίας για τους καπνιστές (βλέπε παράγραφο 4.5). Όταν υπάρχει ταυτόχρονη χορήγηση ισχυρών αναστολέων των CYP3A4 ή CYP2D6 με αριπιπραζόλη, η δόση της αριπιπραζόλης θα πρέπει να ελαττώνεται. Όταν ο αναστολέας του CYP3A4 ή CYP2D6 αποσύρεται από τη θεραπεία συνδυασμού, η δόση της αριπιπραζόλης θα πρέπει μετά να αυξάνεται (βλέπε παράγραφο 4.5). Όταν υπάρχει ταυτόχρονη χορήγηση ισχυρών επαγωγέων του CYP3A4 με αριπιπραζόλη, η δόση της αριπιπραζόλης θα πρέπει να αυξάνεται. Όταν ο επαγωγέας του CYP3A4 αποσύρεται από τη θεραπεία συνδυασμού, η δόση της αριπιπραζόλης θα πρέπει μετά να μειώνεται στη συνιστώμενη δόση (βλέπε παράγραφο 4.5). *4.3 Αντενδείξεις:* Υπερευαισθησία στη δραστική ουσία ή σε κάποιο από τα έκδοχα. *4.4 Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση:* Κατά την αντιψυχωσική θεραπεία, η βελτίωση της κλινικής κατάστασης του ασθενούς, μπορεί να χρειαστεί αρκετές ημέρες ή και εβδομάδες. Σε όλη την περίοδο αυτή οι ασθενείς πρέπει να βρίσκονται υπό στενή παρακολούθηση. Η εμφάνιση αυτοκτονικών συμπεριφορών είναι εγγενής σε ψυχωσικές νόσους και διαταραχές διάθεσης και σε ορισμένες περιπτώσεις έχει αναφερθεί λίγο μετά την έναρξη ή την αλλαγή της θεραπείας, περιλαμβανομένης θεραπείας με αριπιπραζόλη (βλέπε παράγραφο 4.8). Στενή παρακολούθηση των ασθενών υψηλού κινδύνου πρέπει να συνοδεύει την αντιψυχωσική θεραπεία. Αποτελέσματα μιας επιδημιολογικής μελέτης έδειξαν ότι μεταξύ ασθενών με διπολική διαταραχή δεν υπήρχε αυξημένος κίνδυνος απόπειρας αυτοκτονίας με την αριπιπραζόλη σε σύγκριση με άλλα αντιψυχωσικά. Καρδιαγγειακές διαταραχές: η αριπιπραζόλη θα πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με διαγνωσμένη καρδιαγγειακή νόσο (ιστορικό εμφράγματος του μυοκαρδίου ή ισχαιμική καρδιοπάθεια, καρδιακή ανεπάρκεια, ή διαταραχές αγωγιμότητας), αγγειοεγκεφαλική νόσο, καταστάσεις που θα προδιέθεταν τους ασθενείς για εκδήλωση υπότασης (αφυδάτωση, υποογκαιμία, και αγωγή με αντιϋπερτασικά φάρμακα) ή υπέρτασης, συμπεριλαμβανομένων της ταχέως εξελισσόμενης ή της κακοήθους. Διαταραχές αγωγιμότητας: σε κλινικές δοκιμές της αριπιπραζόλης, η επίπτωση της παράτασης του διαστήματος QT ήταν συγκρίσιμη με εκείνη του εικονικού φαρμάκου. Όπως με άλλα αντιψυχωσικά, η αριπιπραζόλη θα πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με οικογενειακό ιστορικό παράτασης QT. Ουψιμη Δυσκινησία (Tardive Dyskinesia): σε κλινικές δοκιμές διάρκειας ενός έτους ή λιγότερο, υπήρχαν όχι συχνές αναφορές δυσκινησίας που απαιτούσαν επείγουσα θεραπεία κατά τη διάρκεια της θεραπείας με αριπιπραζόλη. Αν κάποιος ασθενής παρουσιάσει σημεία και συμπτώματα όψιμης δυσκινησίας ενώ λαμβάνει θεραπεία με ABILIFY, πρέπει να εξετασθεί η μείωση της δόσης ή και η διακοπή της λήψης. Τα συμπτώματα αυτά μπορεί προσωρινά να υποχωρήσουν ή ακόμα μπορεί και να ενταθούν, μετά τη διακοπή της θεραπείας. Κακόηθες Νευροληπτικό Σύνδρομο (Neuroleptic Malignant Syndrome, NMS): το NMS είναι ένα δυνητικά θανατηφόρο σύνθετο σύμπτωμα, σχετιζόμενο με αντιψυχωσικά φαρμακευτικά προϊόντα. Σε κλινικές δοκιμές, αναφέρθηκαν σπάνιες περιπτώσεις NMS κατά τη διάρκεια της θεραπείας με αριπιπραζόλη. Οι κλινικές εκδηλώσεις του NMS είναι υπερπυρεξία, μυϊκή ακαμψία, αλλαγή της πνευματικής κατάστασης και σημεία αυτόνομης αστάθειας (ακανόνιστος σφυγμός ή αρτηριακή πίεση, ταχυκαρδία, διαφόρηση και καρδιακή δυσρυθμία). Πρόσθετα σημεία μπορεί να περιλαμβάνουν αυξημένη κρεατινοφωσφοκινάση, μυοσφαιρινουρία (ραβδομυόλυση) και οξεία νεφρική ανεπάρκεια. Ωστόσο, έχουν επίσης αναφερθεί αυξημένη κρεατινοφωσφοκινάση και ραβδομυόλυση, όχι απαραίτητα σχετιζόμενες με NMS. Εάν ο ασθενής παρουσιάσει σημεία και συμπτώματα ενδεικτικά του NMS, ή εμφανίσει ανεξήγητο υψηλό πυρετό χωρίς πρόσθετες κλινικές εκδηλώσεις για NMS, όλα τα αντιψυχωσικά φαρμακευτικά προϊόντα, συμπεριλαμβανομένου και του ABILIFY πρέπει να διακόπτονται. Επιληπτικές κρίσεις: σε κλινικές δοκιμές, αναφέρθηκαν όχι συχνές περιπτώσεις επιληπτικών κρίσεων κατά τη διάρκεια της θεραπείας με αριπιπραζόλη. Κατά συνέπεια, η αριπιπραζόλη πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με ιστορικό διαταραχής επιληπτικών κρίσεων ή σε ασθενείς που έχουν προϋποθέσεις που σχετίζονται με επιληπτικές κρίσεις. Ηλικιωμένοι ασθενείς με ψύχωση που σχετίζεται με άνοια: Αυξημένη θνησιμότητα: σε τρεις ελεγχόμενες με εικονικό φάρμακο δοκιμές (n= 938, μέση ηλικία: 82,4 έτη, εύρος: 56-99 έτη) της αριπιπραζόλης σε ηλικιωμένους ασθενείς με ψύχωση που σχετίζεται με νόσο του Alzheimer, οι ασθενείς που έλαβαν αριπιπραζόλη είχαν αυξημένο κίνδυνο θανάτου σε σχέση με το εικονικό φάρμακο. Το ποσοστό του θανάτου στους ασθενείς που έλαβαν αριπιπραζόλη ήταν 3,5% σε σύγκριση με το 1,7% της ομάδας του εικονικού φαρμάκου. Αν και οι αιτίες θανάτου διέφεραν, οι περισσότεροι θάνατοι φάνηκε ότι ήταν είτε καρδιαγγειακής (π.χ. καρδιακή ανεπάρκεια, αιφνίδιος θάνατος) είτε λοιμώδους φύσεως (π.χ. πνευμονία). Αγγειακά εγκεφαλικά ανεπιθύμητα συμβάματα: στις ίδιες δοκιμές, αγγειακά εγκεφαλικά ανεπιθύμητα συμβάματα (π.χ. εγκεφαλικό επεισόδιο, παροδικό ισχαιμικό επεισόδιο), περιλαμβανομένων και θανάτων, αναφέρθηκαν στους ασθενείς (μέση ηλικία: 84 έτη, εύρος: 78-88 έτη). Συνολικά, το 1,3% των ασθενών που ελάμβαναν αριπιπραζόλη ανέφεραν αγγειακές εγκεφαλικές ανεπιθύμητες ενέργειες συγκρινόμενοι με το 0,6% των ασθενών που ελάμβαναν το εικονικό φάρμακο στις δοκιμές αυτές. Η διαφορά αυτή δεν ήταν στατιστικά σημαντική. Ωστόσο, σε μια από τις δοκιμές αυτές, μια μελέτη καθορισμένης δόσης, υπήρξε σημαντική σχέση δοσοεξάρτησης για τις αγγειακές εγκεφαλικές ανεπιθύμητες ενέργειες σε ασθενείς που ελάμβαναν αριπιπραζόλη. Το ABILIFY δεν έχει εγκριθεί για τη θεραπεία ψύχωσης που σχετίζεται με την άνοια. Υπεργλυκαιμία και Σακχαρώδης Διαβήτης: έχει αναφερθεί υπεργλυκαιμία, μερικές φορές ακραία και σχετιζόμενη με κετοξέωση ή υπερωσμωτικό κώμα ή θάνατο, σε ασθενείς που έλαβαν άτυπες αντιψυχωσικές ουσίες, συμπεριλαμβανομένου του ABILIFY. Παράγοντες κινδύνου που πιθανόν να προδιαθέσουν τους ασθενείς έναντι σοβαρών επιπλοκών, συμπεριλαμβάνουν παχυσαρκία και οικογενειακό ιστορικό διαβήτη. Σε κλινικές δοκιμές με αριπιπραζόλη, δεν υπήρχαν σημαντικές διαφορές στα ποσοστά εμφάνισης ανεπιθύμητων συμβαμάτων που σχετίζονται με υπεργλυκαιμία (περιλαμβανομένου του σακχαρώδους διαβήτη) ή με μη-φυσιολογικές εργαστηριακές τιμές γλυκαιμίας σε σύγκριση με το εικονικό φάρμακο. Ακριβείς εκτιμήσεις κινδύνου ανεπιθύμητων συμβαμάτων που σχετίζονται με υπεργλυκαιμία σε ασθενείς που έλαβαν ABILIFY και με άλλους αντιψυχωσικούς παράγοντες, δεν είναι διαθέσιμες για να επιτρέψουν άμεσες συγκρίσεις. Οι ασθενείς που λαμβάνουν οποιονδήποτε αντιψυχωσικό παράγοντα περιλαμβανομένου και του ABILIFY, πρέπει να παρακολουθούνται για σημεία και συμπτώματα υπεργλυκαιμίας (όπως πολυδιψία, πολυουρία, πολυφαγία και εξασθένηση) και οι ασθενείς με σακχαρώδη διαβήτη ή με παράγοντες κινδύνου για σακχαρώδη διαβήτη πρέπει να παρακολουθούνται τακτικά για επιδείνωση του ελέγχου της γλυκόζης. Αύξηση βάρους: αύξηση βάρους παρατηρείται συχνά στους πάσχοντες από σχιζοφρένεια και διπολική μανία λόγω συν-νοσηρότητας, χρήσης αντιψυχωσικών που είναι γνωστό ότι προκαλούν αύξηση βάρους, κακής διαχείρισης του τρόπου ζωής, και ενδέχεται να οδηγήσει σε σοβαρές επιπλοκές. Αύξηση βάρους έχει αναφερθεί μεταξύ ασθενών που έλαβαν ABILIFY, μετά την κυκλοφορία. Όταν παρατηρείται, συμβαίνει συνήθως σε εκείνους με σημαντικούς παράγοντες κινδύνου όπως ιστορικό διαβήτη, διαταραχή του θυρεοειδούς ή αδένωμα της υπόφυσης. Σε κλινικές δοκιμές η αριπιπραζόλη δεν φάνηκε να προκαλεί κλινικά σημαντική αύξηση βάρους (βλέπε παράγραφο 5.1). Δυσφαγία: η υποκινητικότητα του οισοφάγου και η εισρόφηση έχουν συσχετισθεί με τη χρήση αντιψυχωσικών φαρμάκων, συμπεριλαμβανομένου του ABILIFY. Η αριπιπραζόλη και τα άλλα αντιψυχωσικά φάρμακα θα πρέπει να χρησιμοποιούνται με προσοχή σε ασθενείς με κίνδυνο πνευμονίας από εισρόφηση. ΔΙΣΚΙΑ. Λακτόζη: ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στη γαλακτόζη, ανεπάρκεια λακτάσης Lapp ή δυσαπορρόφηση γλυκόζης-γαλακτόζης δεν πρέπει να παίρνουν αυτό το φαρμακευτικό προϊόν. ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ. Ασθενείς με φαινυλκετονουρία: τα διασπειρόμενα στο στόμα δισκία ABILIFY περιέχουν ασπαρτάμη, μια πηγή φαινυλαλανίνης που μπορεί να είναι επιβλαβής σε άτομα με φαινυλκετονουρία. ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ. Δυσανεξία: Το πόσιμο διάλυμα περιέχει φρουκτόζη. Ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στη φρουκτόζη δεν πρέπει να πάρουν το φαρμακευτικό προϊόν αυτό. Το πόσιμο διάλυμα περιέχει παραϋδροξυβενζοϊκό μεθυλεστέρα και παραϋδροξυβενζοϊκό προπυλεστέρα που μπορεί να προκαλέσουν αλλεργικές αντιδράσεις (πιθανόν καθυστερημένες). Το πόσιμο διάλυμα περιέχει σακχαρόζη. Ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στη φρουκτόζη, δυσαπορρόφησης γλυκόζης-γαλακτόζης ή ανεπάρκειας σακχαράσης-ισομαλτάσης δεν πρέπει να πάρουν το πόσιμο διάλυμα. Υπερευαισθησία: όπως με άλλα φάρμακα, είναι δυνατή η εκδήλωση αντιδράσεων υπερευαισθησίας, που χαρακτηρίζονται από αλλεργικά συμπτώματα, με την αριπιπραζόλη (βλέπε παράγραφο 4.8). *4.5 Αλληλεπιδράσεις με άλλα φαρμακευτικά προϊόντα και άλλες μορφές αλληλεπίδρασης:* Λόγω του ανταγωνισμού του με τους α1-ανδρεργικούς υποδοχείς, η αριπιπραζόλη έχει τη δυνατότητα να ενισχύει την ενέργεια ορισμένων αντιυπερτασικών παραγόντων. Επειδή η αριπιπραζόλη δρα κυρίως στο ΚΝΣ, θα πρέπει να εφιστάται η προσοχή όταν η αριπιπραζόλη λαμβάνεται μαζί με οινόπνευμα (αλκοόλ) ή άλλα φαρμακευτικά προϊόντα του ΚΝΣ με αλληλοεπικαλυπτόμενες ανεπιθύμητες ενέργειες όπως η καταστολή (βλέπε παράγραφο 4.8). Θα πρέπει να εφιστάται η προσοχή εάν η αριπιπραζόλη χορηγηθεί ταυτόχρονα με φάρμακα που είναι γνωστό ότι προκαλούν παράταση του QT ή ηλεκτρολυτικές διαταραχές. Δυνατότητα άλλων φαρμακευτικών προϊόντων να επηρεάσουν το ABILIFY: Ένας αποκλειστής του γαστρικού οξέος, ο ανταγωνιστής Η2 φαμοτιδίνη, μειώνει την ταχύτητα απορρόφησης της αριπιπραζόλης, αλλά η δράση αυτή δεν θεωρείται ως κλινικά σημαντική. Η αριπιπραζόλη μεταβολίζεται με πολλαπλές οδούς, στις οποίες συμμετέχουν τα ένζυμα CYP2D6 και CYP3A4 αλλά όχι τα ένζυμα CYP1A. Επομένως, δεν απαιτείται προσαρμογή της δόσης για τους καπνιστές. Σε μια κλινική δοκιμή με υγιείς εθελοντές, ένας ισχυρός αναστολέας του CYP2D6 (κινιδίνη) αύξησε την AUC της αριπιπραζόλης κατά 107%, ενώ η Cmax παρέμεινε αναλλοίωτη. Η AUC και η Cmax της δεϋδρο-αριπιπραζόλης, που είναι ο ενεργός μεταβολίτης, μειώθηκαν κατά 32% και 47%. Η δόση του ABILIFY θα πρέπει να μειωθεί περίπου στο μισό της συνταγογραφούμενης, όταν υπάρχει συγχορήγηση του ABILIFY με κινιδίνη. Άλλοι ισχυροί αναστολείς του CYP2D6, όπως φλουοξετίνη και παροξετίνη, μπορεί να αναμένεται να έχουν παρόμοιες ενέργειες και γι' αυτό θα πρέπει να γίνονται παρόμοιες μειώσεις στη δόση. Σε μια κλινική δοκιμή σε υγιείς εθελοντές, ένας ισχυρός αναστολέας του CYP3A4 (κετοκοναζόλη) αύξησε την AUC και τη Cmax της αριπιπραζόλης κατά 63% και 37%, αντιστοίχως. Η AUC και η Cmax της δεϋδρο-αριπιπραζόλης, αυξήθηκαν κατά 77% και 43%, αντιστοίχως. Η ταυτόχρονη χρήση ουσιών που προκαλούν ασθενή μεταβολισμό στο CYP2D6, συγχρόνως με ισχυρούς αναστολείς του CYP3A4 μπορεί να οδηγήσει σε υψηλότερες συγκεντρώσεις αριπιπραζόλης στο πλάσμα σε σύγκριση με εκείνες τις ουσίες που προκαλούν εκτεταμένο μεταβολισμό στο CYP2D6. Όταν εξετάζεται ταυτόχρονη χορήγηση κετοκοναζόλης ή άλλου ισχυρού αναστολέα CYP3A4 με το ABILIFY, τα ενδεχόμενα οφέλη θα πρέπει να υπερκαλύπτουν τους ενδεχόμενους κινδύνους για τον ασθενή. Όταν υπάρχει ταυτόχρονη χορήγηση κετοκοναζόλης με ABILIFY, η δόση του ABILIFY θα πρέπει να ελαττώνεται περίπου στο μισό της συνταγογραφούμενης. Άλλοι ισχυροί αναστολείς του CYP3A4, όπως η ιτρακοναζόλη και οι αναστολείς πρωτεάσης του HIV, μπορεί να αναμένεται ότι θα έχουν παρόμοιες ενέργειες και γι' αυτό θα πρέπει να γίνονται παρόμοιες μειώσεις της δόσης. Μόλις διακοπεί η χορήγηση αναστολέα του CYP2D6 ή 3A4, η δόση του ABILIFY θα πρέπει να αυξάνεται στο επίπεδο που ήταν πριν από την έναρξη της θεραπείας με το συνδυασμό. Όταν χρησιμοποιούνται ασθενείς αναστολείς του CYP3A4 (π.χ. διλτιαζέμη ή εσιταλοπράμη) ή του CYP2D6 ταυτόχρονα με το ABILIFY, είναι πιθανός αναμενόμενες μικρές αυξήσεις των συγκεντρώσεων της αριπιπραζόλης. Μετά την ταυτόχρονη χορήγηση καρβαμαζεπίνης, ενός ισχυρού επαγωγέα CYP3A4, οι γεωμετρικές μέσες τιμές της Cmax και της AUC της αριπιπραζόλης ήταν 68% και 73% χαμηλότερες, αντίστοιχα, σε σύγκριση με αυτές όταν η αριπιπραζόλη (30 mg) εχορηγήτο σε μονοθεραπεία. Παρομοίως, οι γεω-

μετρικές μέσες τιμές της Cmax και της AUC της δεύδρο-αριπιπραζόλης μετά από συγχορήγηση με καρβαμαζεπίνη ήταν 69% και 71% χαμηλότερες, αντίστοιχα, σε σύγκριση με αυτές μετά από μονοθεραπεία με αριπιπραζόλη. Η δόση του ABILIFY θα πρέπει να διπλασιάζεται όταν υπάρχει ταυτόχρονη χορήγηση του ABILIFY με καρβαμαζεπίνη. Άλλοι ισχυροί επαγωγείς του CYP3A4 (όπως ριφαμπικίνη, ριφαμπουτίνη, φαινυτοΐνη, φαινοβαρβιτάλη, πριμιδόνη, εφαβιρένζη, νεβιραπίνη και υπερικό (St. John's Wort)) μπορεί να αναμένεται να έχουν παρόμοιες ενέργειες και γι' αυτό θα πρέπει να γίνονται παρόμοιες αυξήσεις στη δόση. Μόλις διακοπεί η χορήγηση των ισχυρών επαγωγέων του CYP3A4, η δοσολογία του ABILIFY θα πρέπει να μειώνεται στη συνιστώμενη δόση. Όταν συγχορηγήθηκαν είτε βαλπροϊκό είτε λίθιο μαζί με αριπιπραζόλη, δεν υπήρξε κλινικώς σημαντική αλλαγή στις συγκεντρώσεις της αριπιπραζόλης. Δυνατότητα του ABILIFY να επηρεάζει άλλα φαρμακευτικά προϊόντα: Σε κλινικές μελέτες, δόσεις αριπιπραζόλης 10-30 mg ημερησίως, δεν είχαν σημαντική επίδραση στο μεταβολισμό των υποστρωμάτων CYP2D6 (αναλογία δεξτρομεθορφάνης/3-methoxymorphinan), 2C9 (βαρφαρίνη), 2C19 (ομεπραζόλη) και 3A4 (δεξτρομεθορφάνη). Επιπλέον, η αριπιπραζόλη και η δεύδρο-αριπιπραζόλη δεν έδειξαν ότι μπορούν να μεταβάλουν το μεταβολισμό που γίνεται με τη μεσολάβηση του CYP1A2, in vitro. Ως εκ τούτου, η αριπιπραζόλη είναι απίθανο να προκαλέσει με φαρμακευτικά προϊόντα κλινικώς σημαντικές αλληλεπιδράσεις που πραγματοποιούνται με τη μεσολάβηση αυτών των ενζύμων. Όταν η αριπιπραζόλη χορηγήθηκε ταυτόχρονα είτε με βαλπροϊκό ή λίθιο, δεν υπήρξε κλινικά σημαντική μεταβολή στις συγκεντρώσεις του βαλπροϊκού ή του λιθίου. *4.6 Κύηση και γαλουχία:* Δεν έχουν πραγματοποιηθεί επαρκείς και καλά ελεγχόμενες δοκιμές με αριπιπραζόλη σε εγκύους γυναίκες. Μελέτες σε πειραματόζωα δεν αποκλείουν πιθανή αναπτυξιακή τοξικότητα (βλέπε παράγραφο 5.3). Οι ασθενείς πρέπει να ενημερώνονται ότι πρέπει να αναφέρουν στο γιατρό τους εάν μείνουν έγκυες ή προτίθενται να μείνουν έγκυες κατά τη διάρκεια της θεραπείας με αριπιπραζόλη. Λόγω ανεπαρκούς πληροφόρησης για την ασφάλεια στον άνθρωπο και των ερωτηματικών που δημιουργήθηκαν από τις μελέτες αναπαραγωγής σε πειραματόζωα, το φαρμακευτικό αυτό προϊόν δεν πρέπει να χρησιμοποιείται σε περίπτωση κύησης εκτός εάν το αναμενόμενο όφελος δικαιολογεί σαφώς τον πιθανό κίνδυνο για το έμβρυο. Η αριπιπραζόλη απεκκρίθηκε στο γάλα των αρουραίων στους οποίους χορηγήθηκε αριπιπραζόλη, κατά την περίοδο της γαλουχίας. Δεν είναι γνωστό εάν η αριπιπραζόλη απεκκρίνεται στο ανθρώπινο γάλα. Οι ασθενείς θα πρέπει να ενημερώνονται ότι δεν πρέπει να θηλάζουν εάν λαμβάνουν αριπιπραζόλη. *4.7 Επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανών:* Δεν πραγματοποιήθηκαν μελέτες σχετικά με τις επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανών. Ωστόσο, όπως και με άλλα αντιψυχωσικά φάρμακα, θα πρέπει να εφιστάται η προσοχή των ασθενών που χειρίζονται επικίνδυνες μηχανές συμπεριλαμβανομένων των αυτοκινήτων μέχρι να βεβαιωθούν επαρκώς ότι η αριπιπραζόλη δεν τους επηρεάζει δυσμενώς. *4.8 Ανεπιθύμητες ενέργειες:* Οι ακόλουθες ανεπιθύμητες ενέργειες εμφανίσθηκαν περισσότερο συχνά (≥ 1/100) από ό, τι με το εικονικό φάρμακο ή θεωρήθηκαν ως ενδεχομένως ιατρικώς σημαντικές ανεπιθύμητες αντιδράσεις (*): Η συχνότητα που αναφέρεται παρακάτω ορίζεται χρησιμοποιώντας την ακόλουθη σύμβαση: συχνές (> 1/100, < 1/10), και όχι συχνές (> 1/1.000, < 1/100). Καρδιακές διαταραχές. Όχι συχνές: ταχυκαρδία*. Διαταραχές του νευρικού συστήματος. Συχνές: εξωπυραμιδική διαταραχή, ακαθησία, τρόμος, ζάλη, υπνηλία, καταστολή, κεφαλαλγία. Οφθαλμικές διαταραχές. Συχνές: θαμπή όραση. Διαταραχές του γαστρεντερικού. Συχνές: δυσπεψία, έμετος, ναυτία, δυσκοιλιότητα, υπερέκκριση σιέλου. Αγγειακές διαταραχές. Όχι συχνές: ορθοστατική υπόταση*. Γενικές διαταραχές και καταστάσεις της οδού χορήγησης. Συχνές: κόπωση. Ψυχιατρικές διαταραχές. Συχνές: ανησυχία, αϋπνία, άγχος. Όχι συχνές: κατάθλιψη*. Εξωπυραμιδικά συμπτώματα (ΕΠΣ): Σχιζοφρένεια- σε μια μακράς διάρκειας 52-εβδομάδων ελεγχόμενη δοκιμή, οι ασθενείς που έλαβαν αριπιπραζόλη εμφάνισαν συνολικά μικρότερη συχνότητα (25,8%) ΕΠΣ, περιλαμβανομένων παρκινσονισμού, ακαθησίας, δυστονίας και δυσκινησίας σε σύγκριση με εκείνους που έλαβαν θεραπεία με αλοπεριδόλη (57,3%). Σε μια δοκιμή μακράς διάρκειας 26-εβδομάδων ελεγχόμενη με εικονικό φάρμακο, η συχνότητα εμφάνισης ΕΠΣ ήταν 19% για τους ασθενείς που έλαβαναν αριπιπραζόλη και 13,1% για τους ασθενείς που ελάμβαναν το εικονικό φάρμακο. Σε μια άλλη ελεγχόμενη δοκιμή μακράς διάρκειας 26-εβδομάδων, η συχνότητα εμφάνισης ΕΠΣ ήταν 14,8% για τους ασθενείς που ελάμβαναν αριπιπραζόλη και 15,1% για τους ασθενείς που ελάμβαναν ολανζαπίνη. Μανιακά επεισόδια στη Διπολική Διαταραχή τύπου Ι - σε μια ελεγχόμενη δοκιμή 12 εβδομάδων, η επίπτωση ΕΠΣ ήταν 23,5% για τους ασθενείς που έλαβαν αριπιπραζόλη και 53,3% για τους ασθενείς που έλαβαν αλοπεριδόλη. Σε μια άλλη δοκιμή 12 εβδομάδων, η επίπτωση ΕΠΣ ήταν 26,6% για τους ασθενείς που έλαβαν αριπιπραζόλη και 17,6% για αυτούς που έλαβαν λίθιο. Στη μακροχρόνια φάση συντήρησης 26 εβδομάδων μιας δοκιμής ελεγχόμενης με εικονικό φάρμακο, η επίπτωση ΕΠΣ ήταν 18,2% για τους ασθενείς που έλαβαν αριπιπραζόλη και 15,7% για τους ασθενείς που έλαβαν εικονικό φάρμακο. Σε ελεγχόμενες με εικονικό φάρμακο δοκιμές, η επίπτωση της ακαθησίας σε διπολικούς ασθενείς ήταν 12,1% με την αριπιπραζόλη και 3,2% με το εικονικό φάρμακο. Σε ασθενείς με σχιζοφρένεια η επίπτωση ακαθησίας ήταν 6,2% με την αριπιπραζόλη και 3,0% με το εικονικό φάρμακο. Από τη σύγκριση μεταξύ αριπιπραζόλης και εικονικού φαρμάκου, όσον αφορά το ποσοστό των ασθενών που εμφάνισαν δυνητικά κλινικώς σημαντικές αλλαγές στις συνήθεις εργαστηριακές παραμέτρους, δεν προέκυψαν ιατρικώς σημαντικές διαφορές. Παρατηρήθηκαν γενικά παροδικές και ασυμπτωματικές αυξήσεις της CPK (Κρεατινοφωσφοκινάση) στο 3,5% των ασθενών που ελάμβαναν αριπιπραζόλη σε σύγκριση με το 2,0% των ασθενών που έλαβαν εικονικό φάρμακο. Άλλα ευρήματα: Οι ανεπιθύμητες αντιδράσεις που είναι γνωστές ότι συσχετίζονται με την αντιψυχωσική θεραπεία και έχουν επίσης αναφερθεί κατά τη διάρκεια θεραπείας με αριπιπραζόλη, περιλαμβάνουν κακόηθες νευροληπτικό σύνδρομο, όψιμη δυσκινησία, σπασμούς, αγγειακά εγκεφαλικά ανεπιθύμητα συμβάματα και αυξημένη θνησιμότητα σε ηλικιωμένους ασθενείς με άνοια, υπεργλυκαιμία και σακχαρώδη διαβήτη (βλέπε παράγραφο 4.4). Μετά την κυκλοφορία: Τα παρακάτω ανεπιθύμητα συμβάματα έχουν αναφερθεί κατά τη διάρκεια της μετά την κυκλοφορία παρακολούθησης. Η συχνότητα αυτών των συμβαμάτων θεωρείται ως μη γνωστή (δεν μπορεί να υπολογισθεί από τα διαθέσιμα στοιχεία). Έρευνες: αυξημένη Κρεατινοφωσφοκινάση, αυξημένη γλυκόζη αίματος, διακύμανση γλυκόζης αίματος, αυξημένη γλυκοζυλιωμένη αιμοσφαιρίνη. Καρδιακές διαταραχές: παράταση QT, κοιλιακές αρρυθμίες, αιφνίδιος θάνατος άγνωστης αιτιολογίας, καρδιακή ανακοπή, κοιλιακή ταχυκαρδία δίκην ριπιδίου, βραδυκαρδία. Διαταραχές του αιμοποιητικού και του λεμφικού συστήματος: λευκοπενία, ουδετεροπενία, θρομβοπενία. Διαταραχές του νευρικού συστήματος: διαταραχή λόγου, Κακόηθες Νευροληπτικό Σύνδρομο (NMS), σπασμός γενικευμένης επιληψίας. Διαταραχές του αναπνευστικού συστήματος, του θώρακα και του μεσοθωράκιου: σπασμός στοματοφάρυγγα, λαρυγγόσπασμος, πνευμονία από εισρόφηση. Διαταραχές του γαστρεντερικού: παγκρεατίτιδα, δυσφαγία, κοιλιακή δυσφορία, δυσφορία του στομάχου, διάρροια. Διαταραχές των νεφρών και των ουροφόρων οδών: ακράτεια ούρων, κατακράτηση ούρων. Διαταραχές του δέρματος και του υποδόριου ιστού: εξάνθημα, αντίδραση από φωτοευαισθησία, αλωπεκία, υπερίδρωση. Διαταραχές του μυοσκελετικού συστήματος και του συνδετικού ιστού: ραβδομυόλυση, μυαλγία, δυσκαμψία. Διαταραχές του ενδοκρινικού συστήματος: υπεργλυκαιμία, σακχαρώδης διαβήτης, διαβητική κετοξέωση, διαβητικό υπερωσμωτικό κώμα. Διαταραχές του μεταβολισμού και της θρέψης: αύξηση βάρους, απώλεια βάρους, ανορεξία, υπονατριαιμία. Αγγειακές διαταραχές: συγκοπή, υπέρταση, θρομβοεμβολικά επεισόδια. Γενικές διαταραχές και καταστάσεις της οδού χορήγησης: διαταραχή ρύθμισης της θερμοκρασίας (π.χ. υποθερμία, πυρεξία), θωρακικό άλγος, περιφερικό οίδημα. Διαταραχές του ανοσοποιητικού συστήματος: αλλεργική αντίδραση (π.χ. αναφυλακτική αντίδραση, αγγειοοίδημα περιλαμβανομένης διογκωμένης γλώσσας, οίδημα γλώσσας, οίδημα προσώπου, κνησμός, ή κνίδωση). Διαταραχές του ήπατος και των χοληφόρων: ίκτερος, ηπατίτιδα, αυξημένη Αμινοτρανσφεράση της Αλανίνης (ALT), αυξημένη Ασπαρτική Αμινοτρανσφεράση (AST), αυξημένη Γάμμα Γλουταμυλτρανσφεράση (GGT), αυξημένη αλκαλική φωσφατάση. Διαταραχές του αναπαραγωγικού συστήματος και του μαστού: priαπισμός. Ψυχιατρικές διαταραχές: διέγερση, νευρικότητα, απόπειρα αυτοκτονίας, αυτοκτονικός ιδεασμός και «επιτυχής» αυτοκτονία (βλέπε παράγραφο 4.4). *4.9 Υπερδοσολογία:* Από τις κλινικές δοκιμές και την εμπειρία μετά την κυκλοφορία, διαπιστώθηκαν τυχαίες ή με πρόθεση οξείες υπερδοσολογίες μονοθεραπείας της αριπιπραζόλης σε ενήλικες ασθενείς με αναφερθείσες δόσεις που εκτιμώνται μέχρι και 1.260 mg χωρίς θανάτους. Τα πιθανά ιατρικά σημαντικά σημεία και συμπτώματα που παρατηρήθηκαν περιελάμβαναν λήθαργο, αυξημένη αρτηριακή πίεση, υπνηλία, ταχυκαρδία, ναυτία, έμετο και διάρροια. Επιπλέον, έχουν ληφθεί αναφορές τυχαίας υπερδοσολογίας σε μονοθεραπεία με αριπιπραζόλη (μέχρι 195 mg) σε παιδιά χωρίς θανάτους. Τα δυνητικά ιατρικώς σοβαρά σημεία και συμπτώματα που αναφέρθηκαν περιελάμβαναν υπνηλία, παροδική απώλεια συνείδησης και εξωπυραμιδικά συμπτώματα. Η αντιμετώπιση της υπερδοσολογίας πρέπει να επικεντρώνεται στην υποστηρικτική θεραπεία, με διατήρηση της επάρκειας των αεραγωγών οδών, της οξυγόνωσης και του καλού αερισμού και της συμπτωματικής αντιμετώπισης. Θα πρέπει να λαμβάνεται υπόψη η πιθανότητα εμπλοκής πολλών φαρμακευτικών προϊόντων. Γι' αυτό θα πρέπει να ξεκινάει αμέσως καρδιαγγειακή παρακολούθηση και θα πρέπει να περιλαμβάνει ηλεκτροκαρδιογραφική παρακολούθηση για την ανίχνευση πιθανών αρρυθμιών. Μετά από οποιαδήποτε διαπιστωμένη ή ύποπτη υπερδοσολογία με αριπιπραζόλη, ο ασθενής θα πρέπει να βρίσκεται σε στενή ιατρική επίβλεψη και παρακολούθηση μέχρις ότου ανακάμψει. Ενεργός άνθρακας (50 g) χορηγούμενος μια ώρα μετά την αριπιπραζόλη, ελάττωσε τη Cmax της αριπιπραζόλης κατά 41% περίπου και την AUC κατά 51% περίπου, υποδεικνύοντας ότι ο άνθρακας μπορεί να είναι αποτελεσματικός στη θεραπεία της υπερδοσολογίας. Αν και δεν υπάρχει πληροφόρηση για την επίδραση της αιμοκάθαρσης στην αντιμετώπιση της υπερδοσολογίας με αριπιπραζόλη, η αιμοκάθαρση είναι απίθανο να είναι χρήσιμη στην αντιμετώπιση της υπερδοσολογίας επειδή η αριπιπραζόλη είναι εκτετομένα συνδεδεμένη με τις πρωτεΐνες του πλάσματος. **6. ΦΑΡΜΑΚΕΥΤΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ:** *6.1 Κατάλογος εκδόχων:* ΔΙΣΚΙΑ 10 mg: Λακτόζη μονοϋδρική, Άμυλο αραβοσίτου, Μικροκρυσταλλική κυτταρίνη, Υδροξυπροπυλική κυτταρίνη, Στεατικό μαγνήσιο, Κόκκινο οξείδιο του σιδήρου (Ε172). ΔΙΣΚΙΑ 15 mg: Λακτόζη μονοϋδρική, Άμυλο αραβοσίτου, Μικροκρυσταλλική κυτταρίνη, Υδροξυπροπυλική κυτταρίνη, Στεατικό μαγνήσιο, Κίτρινο οξείδιο του σιδήρου (Ε172). ΔΙΣΚΙΑ 30 mg: Λακτόζη μονοϋδρική, Άμυλο αραβοσίτου, Μικροκρυσταλλική κυτταρίνη, Υδροξυπροπυλική κυτταρίνη, Στεατικό μαγνήσιο, Κόκκινο οξείδιο του σιδήρου (Ε172). ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ 10 mg: Πυριτικό ασβέστιο, Καρμελλόζη νατριούχος διασταυρούμενη, Κροσποβιδόνη, Διοξείδιο του πυριτίου, Ξυλιτόλη, Μικροκρυσταλλική κυτταρίνη, Ασπαρτάμη (Ε951), Καλιούχος ακεσουλφάμη, Βελτιωτικό γεύσης βανιλλίνη (περιλαμβανομένων βανιλλίνης και αιθυλοβανιλλίνης), Τρυγικό οξύ, Στεατικό μαγνήσιο, Κόκκινο οξείδιο του σιδήρου (Ε172). ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ 15 mg: Πυριτικό ασβέστιο, Καρμελλόζη νατριούχος διασταυρούμενη, Κροσποβιδόνη, Διοξείδιο του πυριτίου, Ξυλιτόλη, Μικροκρυσταλλική κυτταρίνη, Ασπαρτάμη (Ε951), Καλιούχος ακεσουλφάμη, Βελτιωτικό γεύσης βανιλλίνη (περιλαμβανομένων βανιλλίνης και αιθυλοβανιλλίνης), Τρυγικό οξύ, Στεατικό μαγνήσιο, Κίτρινο οξείδιο του σιδήρου (Ε172). ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ: Αιθυλενοδιαμινοτετραοξικό νάτριο, Φρουκτόζη, Γλυκερίνη, Γαλακτικό οξύ, Παραϋδροξυβενζοϊκός μεθυλεστέρας (Ε218), Προπυλενογλυκόλη, Παραϋδροξυβενζοϊκός προπυλεστέρας (Ε216), Υδροξείδιο του νατρίου, Σακχαρόζη, Ύδωρ κεκαθαρμένο, Φυσικό βελτιωτικό γεύσης πορτοκάλι τύπου κρέμας με άλλα φυσικά βελτιωτικά γεύσης. *6.2 Ασυμβατότητες:* Το πόσιμο διάλυμα δεν πρέπει να αραιώνεται με άλλα υγρά ή να αναμιγνύεται με οποιαδήποτε τροφή πριν από τη χορήγηση. *6.3 Διάρκεια ζωής:* ΔΙΣΚΙΑ ΚΑΙ ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ: 3 χρόνια. ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ: 3 χρόνια. Μετά το πρώτο άνοιγμα: 6 μήνες. *6.4 Ιδιαίτερες προφυλάξεις κατά την φύλαξη του προϊόντος:* ΔΙΣΚΙΑ ΚΑΙ ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ: Φυλάσσετε στην αρχική συσκευασία για να προστατεύεται από την υγρασία. ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ: Δεν υπάρχουν ειδικές οδηγίες διατήρησης για το προϊόν αυτό. *6.5 Φύση και συστατικά του περιέκτη:* ΔΙΣΚΙΑ: Διάτρητες ανά μονάδα δόσης κυψέλες αλουμινίου σε κουτιά των 28 x 1 δισκίων. ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ: Διάτρητες κυψέλες μιας δόσης από αλουμίνιο ψυχρής διαμόρφωσης σε κουτιά των 28 x 1 δισκίων. ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ: Φιάλες PET με πώμα ασφαλείας για τα παιδιά από πολυπροπυλένιο, που περιέχουν 150 ml ανά φιάλη. Κάθε κουτί περιέχει μια φιάλη και ένα βαθμονομημένο κύπελλο μέτρησης από πολυπροπυλένιο. *6.6 Ιδιαίτερες προφυλάξεις απόρριψης και άλλος χειρισμός:* Κάθε προϊόν που δεν έχει χρησιμοποιηθεί ή υπόλειμμα πρέπει να απορριφθεί σύμφωνα με τις κατά τόπους ισχύουσες σχετικές διατάξεις. **7. ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** Otsuka Pharmaceutical Europe Ltd. Hunton House Highbridge Business Park, Oxford Road Uxbridge Middlesex UB8 1HU Ηνωμένο Βασίλειο. **8. ΑΡΙΘΜΟΣ(ΟΙ) ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** ΔΙΣΚΙΑ 28 x 10 mg: EU/1/04/276/007, ΔΙΣΚΙΑ 28 x 15 mg: EU/1/04/276/012, ΔΙΣΚΙΑ 28 x 30 mg: EU/1/04/276/017, ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ 28 x 10 mg: EU/1/04/276/025, ΔΙΑΣΠΕΙΡΟΜΕΝΑ ΣΤΟ ΣΤΟΜΑ ΔΙΣΚΙΑ 28 x 15 mg: EU/1/04/276/028, ΠΟΣΙΜΟ ΔΙΑΛΥΜΑ 1 mg/ml - 150 ml: EU/1/04/276/034. **9. ΗΜΕΡΟΜΗΝΙΑ ΠΡΩΤΗΣ ΕΓΚΡΙΣΗΣ/ΑΝΑΝΕΩΣΗΣ ΤΗΣ ΑΔΕΙΑΣ:** Ημερομηνία πρώτης έγκρισης: 4 Ιουνίου 2004. **10. ΗΜΕΡΟΜΗΝΙΑ ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ:** 08/2008. Λεπτομερή πληροφοριακά στοιχεία για το προϊόν είναι διαθέσιμα στην ιστοσελίδα του Ευρωπαϊκού Οργανισμού Φαρμάκων (EMEA) http://www.emea.europa.eu/. ΛΟΙΠΕΣ ΠΛΗΡΟΦΟΡΙΕΣ: Για οποιαδήποτε πληροφορία σχετικά με το ABILIFY, παρακαλείστε να απευθυνθείτε στον τοπικό αντιπρόσωπο του Κατόχου της Άδειας Κυκλοφορίας: Bristol-Myers Squibb A.E., Αττικής 49-53 & Προποντίδος 2, 152 35 Βριλήσσια, Αττική. Τηλ: +30 2 10 60 74 300. ΔΙΑΝΙΚΗ ΤΙΜΗ: Abilify Tabs bt 28 x 10mg: 141,73€, Abilify Tabs bt 28 x 15mg: 141,73€, Abilify Tabs bt 28 x 30mg: 245,52€, Abilify disp tabs bt 28 x 10mg: 155,51 €, Abilify disp. tabs bt 28 x 15mg: 161,79€ Abilify OS 1mg/ml-150 ml: 198,24€. ΝΟΣΟΚΟΜΕΙΑΚΗ ΤΙΜΗ: Abilify Tabs bt 28 x 10mg: 83,80€, Abilify Tabs bt 28 x 15mg: 83,80€, Abilify Tabs bt 28 x 30mg:145,16€. Abilify disp. tabs bt 28 x 10mg: 91,94 €, Abilify disp. tabs bt 28 x 15mg: 95,66 €. Abilify OS 1mg/ml-150 ml:117,21€ ΠΟΣΟΣΤΟ ΚΑΛΥΨΗΣ ΑΠΟ ΤΑ ΤΑΜΕΙΑ: 100%.

Βιβλιογραφία:

1. Potkin SG et al.Arch Gen Psychiatry 2003; 60: 681-690.
2. Kasper S et al.Int J Neuropsychopharmacology 2003: 6: 325-337.
3. Kern RS et al.Psychopharmacol 2006; 187: 312-320.
4. McQuade RD et al.J Clin Psychiatry 2004; 65(suppl 18): 47-56.
5. Kane JM et al.J Clin Psychiatry 2002; 63: 763-771.
6. Hanssens L et al.Poster presented at the American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 20-25. (NR361)
7. Hanssens L et al.American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 20-25. (Abs 361)
8. Pigott TA et al.J Clin Psychiatry 2003; 64: 1048-1056.
9. Kerwin R et al.American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 20-25. (Abs 929)
10. Hanssens L et al.Poster presented at the American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 20-25. (NR360)
11. Hanssens L et al.Poster presented at the AEP 14th European Congress of Psychiatry, Nice, France, March 4-8, 2006.

Η Γονιδιακή πολυμορφία...

...απαιτεί ποικιλία θεραπευτικών επιλογών

SAVE not only the BRAIN

zolotrin®
Sertraline 50mg & 100mg

300mg & 400mg/CAP bbx50
Pentin®
Gabapentin

Rispefar®
Risperidone 1,2,3,4,6 & 8 mg/TAB

20mg/tab & 40mg/tab bt x 28
Seror®
Citalopram

Parosat®
Paroxetine 20mg/tab bt x 30

Topiref®
Topiramate

Quepin®
Quetiapine

SPECIFAR PHARMACEUTICALS

SPECIFAR ABEE
28ης Οκτωβρίου 1, 123 51 Αγ. Βαρβάρα, Αθήνα
Τηλ.: 210 54 01 500, Fax: 210 54 01 600
email: info@specifar.gr - www.specifar.gr

GENERAL INFORMATION

Congress Venue
Makedonia Palace Hotel, Thessaloniki, Greece
2, Meg. Alexandrou Avenue, +30 2310 897197, www.classicalhotels.com

How to get to Makedonia Palace hotel
Makedonia Palace Hotel can be reached easily by public transport or by taxi. Please visit the official web site to see the city map for further information.
www.psychiatry.gr

Official Languages
English is the official language of the Congress. All printed material and poster presentations must be in English. There will be continuous translation from English to Greek.

CME Accreditation
The Congress is accredited with 20 CME credits for the main congress program, by the European Accreditation Council for Continuing Medical Education (EACCME) Institution of the UEMS, to provide CME activity for medical specialists, recognized by the American Medical Association (AMA).

Certificate of Attendance
Certificates of attendance will be distributed on Sunday November 22nd, 2009 from the registration counter.

Poster Exhibition
Posters are allocated to the Amphitrion Hall and will be on display for the entire duration of the Congress. The poster exhibition is open to all registered delegates. Posters will be placed in the evening of November 19th and dismantled on mid day November 22nd. Posters which have not been removed will be disposed.
Poster size is 85cm width x 120cm height (33.46 inches x 47.24 inches).

Poster Awards
The International Congress on Neurobiology and Psychopharmacology announces 5 awards of 300 Euro each for the 5 best posters which will be presented during the 2009 conference.
All submitted posters are considered candidates for the awards, unless otherwise stated by the author(s).

Posters Award Jury
Co-chairs: Prof. Maria Luisa Figueira and Athanasios Koukopoulos
Members: Christina Leotsakou, Stavros Samolis, Charis Bastas, Ioannis Pavlidis, Periklis Stoforos

Abstract Book
All abstracts will are published as a hard copy, as an online abstract book (pdf format) via the congress website www.psychiatry.gr and in a supplement of the International Journal Annals of General Psychiatry www.annals-general-psychiatry.com by early 2010.

Exhibition
Within the Congress area there will be an exhibition of medical equipment and pharmaceutical products.

Presentations
Available visual equipment for all presentations will be through Power Point presentation. For Power Point use, your presence to 'slide reception desk' one hour before the time of your presentation is required in order to check the compatibility of your cd and to copy the relevant files. Use of personal computers will not be feasible.

Registration Fees (classification of countries according to the World Bank)

GROUP A countries
Specialists: 350€
Residents: 200€
Other mental health professionals: 100€
Students: Free

GROUP B countries
Specialists: 200€
Residents: 100€
Other mental health professionals: 50€
Students: Free

GROUP C countries
Specialists: 100€
Residents: 50€
Other mental health professionals: Free
Students: Free

GROUP D countries
Specialists: Free
Residents: Free
Other mental health professionals: Free
Students: Free

Note: For countries' classification visit the official web site (www.psychiatry.gr).

For free registrations the congress material will be provided according to availability.

On-site Registration
Participants who wish to register on-site are advised to arrive early. On-site registration will be processed on a first-come, first-served basis. Priority will be given to pre-registered delegates. Depending on the number of onsite registered delegates, availability of congress bags may be limited.

Name Badges
All participants are requested to wear their name badge at all times during all Congress Events.

Hotel Accommodation

Hotel Name	Double for Single Room (City View)	Double for Single Room (Sea View)	Double Room (City View)	Double Room (Sea View)
Makedonia Palace Hotel	175€	195€	195€	215€
City Hotel	105€		120€	

The above rates are daily per room including continental breakfast and taxes in Euro.

First Aid
First aid can be provided through the reception desk of the Makedonia Palace Hotel.

Mobile Phones
Participants are kindly requested to keep their mobile phones turned off while attending the scientific sessions in the meeting rooms.

Currency
Greek currency is EURO. Credit cards are fitly accepted.

Visa
The entry formalities for Greece vary according to the country of origin. Please address enquiries about entry and other requirements to your travel agent or the local Greek consulate.

Car Park
There is an underground car park providing a number of spaces with direct access to the congress venue. The parking fee is not included in the registration fee. There will be space for free parking in the area around the hotel.

Taxis
Taxis are available in front of the airport as well as the hotel entrances.

Insurance
We can not accept responsibility for any personal loss, accidents or damages to participants and / or accompanying persons. Participants are strongly advised to obtain personal insurance to cover any evenduality that may occur during the Congress.

Climate
The climate in Thessaloniki is relatively mild and is typically Mediterranean. In late November the average temperature is 10-15 °C during the day. Fluctuation between day and night temperatures is about 10 °C. Rain is quite often during these months.

Travel to Thessaloniki
Thessaloniki has one international airport, the Makedonia Airport with international flights from major cities all over the world. It is linked to public transport and there is also a taxi station nearby.

For further information regarding the Congress visit the Congress's web site:
www.psychiatry.gr.

Congress Secretariat

Global Events
50A Stadiou Str., 55 535 Pilea, Thessaloniki, Greece
Tel: +302310 247743, 2310 247734, Fax: +302310 247746
E-mail: info@globalevents.gr • www.globalevents.gr

PROCEEDINGS

Thursday November 19th, 2009

14.00-15.30 Symposium
MOLECULAR PHARMACOLOGY OF PAIN
Chairperson: **B. Kokkas** (Greece)

Tissue injury and inflammation

Basileios Kokkas
Professor of Pharmacology, 1st Department of Pharmacology, School of Medicine,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S1

Inflammation is a very complicated phenomenon and consist a part of the immune response which is divided to a natural phase followed by an adaptive one. Tissue injury is followed by a cascade of events leading to the inflammatory response which is divided in three phases. The first phase of inflammation is manifested by the activation of the local tissue macrophagues which exert their phagocytic action and the mast cells which liberate cytokines and vasoactive substances. Cytokines are divided in proinflammatory, chemokines and immunoregulatory ones. Proinflammatory cytokines trigger the second phase of inflammation while chemokines create a chemotactic current. Immunoregulatory cytokines prepare the adaptive phase of the immune response. A certain number of vasoactive substances mediate an initial local vasoconstriction aiming to restrict the cause of tissue injury. This vasoconstriction is followed by a broader local vasodilatation and an increased permeability of the vascular wall. These last events permit to the inflammatory cells and macromolecules to reach the site of tissue injury. Many vasoactive substances like istamine, bradykinine, prospaglandins, leukotrienes and nitric oxide participate in these actions. During the second phase of inflammation, blood cells following the chemotactic current move to the site of injury and start their phagocytic activity. The third phase of inflammation is connected with the tissue restoration.

Inflammation and pain

Maria Mironidou-Tzouveleki
Associate Professor of Pharmacology, School of Medicine,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S2

Inflammatory pain is characterized by an increased response to mechanical or heat stimuli, which are normally only mildly painful (mechanical or thermal hyperalgesia). Inflammatory mediators may elicit pain by activating peripheral nociceptors, by promoting further release of inflammatory mediators and, most significantly, by sensitizing primary afferent neurons to any kind of stimuli. On the other hand, leukocytes may counteract the aforementioned effects of inflammation by releasing opioid peptides in peripheral inflammed tissue.

Neuropeptides and pain

Dimitra Molyva
Research Associate, 1st Department of Pharmacology, School of Medicine,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S3

Neuropeptides comprise a diverse group of chemically distinct molecules, contained in and released from a range of sensory nerves. They are involved in the formation, transmission, modulation and perception of all types of pain (physiological, neuropathic and inflammatory). This fact is reflected

on their wide distribution, from primary sensory neurons to the dorsal root ganglia of the spinal cord and the brain. With the recent advent of molecular cloning techniques, transgenic animal models and the development of non peptide agonists/antagonists, efforts to describe their roles in the nociceptive processes at the molecular level have revealed a complicated pattern in terms of their localization, function and receptor expression. They co-localize with other neuropeptides or with neurotransmitters (ie. GABA) within the same nerve-ending; when released, they either block or enhance the effect of these other neurotransmitters and/or neuropeptides. In addition, neuropeptides, such as calcitonin-gene-related peptide (CGRP) and neuropeptide tyrosine (NPY), have been found to be expressed and released from non-neuronal cells, acting via the same (or more distant) receptors as their neuronal counterparts. Peptide expression is also characterized by plasticity under normal and experimental conditions, a trait related to their pleiotropic function. On the other hand, it is probable that neuropeptide action is characterized by considerable redundancy, which may account for the poor performance of individual neuropeptide inhibitors in clinical trials. This situation may well change however, as more and more neuropeptide targets are being characterized and techniques for the specific ablation of entire neuropeptide-synthesizing neurones are being developed. Hopefully, novel pain treatments based on the targeting of neuropeptide action are going to replace – or, at least, complement - the current use of opiate drugs, leading to increased efficacy and reduced adverse effects, in the not-too-distant future.

Drugs against pain-New concepts

Paraskeyi Papaioannidou
Associate Professor of Pharmacology, 1st Department of Pharmacology, School of Medicine, Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S4

Non Steroid Anti-Inflammatory Drugs (NSAIDs) have been the treatment of choice for mild to moderate inflammatory pain for more than a century. NSAIDs block the formation of prostaglandins by inhibiting cyclooxygenase (COX). Their most common side-effect is ulceration of the upper gastrointestinal tract. The development of selective COX-2 inhibitors (coxibs) has reduced gastrointestinal toxicity significantly, but coxibs appear to have a significant cardiovascular risk and to be less effective in neuropathic pain.
Opioids have traditionally been used for severe acute and cancer chronic pain, while recently their use in the therapy of chronic non-cancer pain has increased substantially. Chronic opioid therapy can be an effective treatment for carefully selected and monitored patients with chronic non-cancer pain. However, opioids are also associated with potentially serious harm, including opioid-related adverse effects and outcomes related to the abuse potential of opioids.
Many drugs that are used to treat other illnesses can also be used for the treatment of chronic and neuropathic pain, either alone or in combination with other analgesics. These drugs include antidepressants, anticonvulsants, antimigraine medicines, local anesthetics, corticosteroids, muscle relaxants, benzodiazepines, neuroleptics, cannabinoids, antihistamines, α2 adrenergic agonists, stimulants, biphosphonates and calcitonin, as well as tramadol, which is a weak μ-opioid agonist that inhibits the reuptake of norepinephrine and serotonin, too.
Recently, novel targets against inflammatory pain with improved specificity and fewer side-effects are under investigation, like prostaglandin E synthases, prostaglandin receptors, COX-inhibiting nitric oxide donators (CINODs), downregulation of inflammatory transcription factors and cytokines, and downstream effectors of prostaglandins in the PNS and CNS. New targets against chronic inflammatory and neuropathic pain include modulators of nociception and pain transmission, like NMDA and other glutamate receptors, GBP and voltage-gated Ca2+ channels (VGCC), nicotinic acetylcholine receptors, transient receptor potential (TRP) channels, tetrodotoxin-resistant Na+ channels, inhibitory glycine and GABA receptors, monoamine receptors, adenosine receptors, neuropeptide Y receptors, neurotensin receptors, as well as regulators of inflammation, neuroinflammation and pain, like nerve growth factor (NGF), matrix metalloproteases, neuropeptide S, substance P, neuromedin U, somatostatin and other neuropeptides.

15.30-17.00 Symposium
TRANSLATIONAL MEDICINE INFORMS TREATMENT GUIDANCE IN DEPRESSION
Chairpersons: **D. Taylor** (UK), K. J. **Aitchison** (UK)

New guidelines on depression from NICE

Ruth I. Ohlsen
Institute of Psychiatry, London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S5

In September 2009, NICE will publish two new guidelines in the field of depression - depression in adults and depression in chronic physical health problems. The guideline on depression in adults includes major changes to current prescribing practice. The most important of these is the recommendation that antidepressants drugs are switched if there is no response after three to four weeks. This reflects the growing recognition that antidepressants have a prompt onset of action and that failure to respond early in treatment predicts ultimate failure to respond. Also included is a strengthened recommendation for the use of additive antipsychotics (olanzapine, quetiapine, risperidone and aripiprazole) as a first-line option in refractory depression. The guideline on depression in chronic physical health problems mirrors recommendations in the adult guideline and adds specific recommendations for the use of antidepressants in a variety of physical disorders. In this guideline, drug choice is based to some extent on drug interactions and contra-indications. The outcome of this is that less often used drugs (mianserin, mirtazapine, trazodone) are recommended in a number of situations.

Clinical lessons from GENDEP for the treatment of depression

Katherine J. Aitchison
Senior Lecturer in Adult Psychiatry, MRC SGDP Centre, Institute of Psychiatry at King's College London and Honorary Consultant Psychiatrist, South London & Maudsley NHS Foundation Trust, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S6

In GENDEP, a European multicentre pharmacogenomic study (http://gendep.iop.kcl.ac.uk/results.php), subjects with major depression were treated with escitalopram (ESC) or nortriptyline (NOR), in a part-randomised potential crossover design, and prospectively rated for response and ADRs with measures including the MADRS, HDRS, BDI, UKU, and ASEC (a self-report measure developed for GENDEP, Uher et al, in press). Factor analysis and Item Response Theory applied to the three measures of depression employed in the study generated three symptom dimensions. Mixed linear regression models showed no difference between ESC and NOR on the three original scales, but symptom dimensions revealed drug-specific advantages: observed mood and cognitive symptoms improved more with ESC than with NOR; neurovegetative symptoms improved more with NOR than with ESC. CYP2C19 genotypic category significantly predicted steady-state (week 8) ESC concentration. Analysis of baseline weight as a predictor revealed that lower BMI predicted better response to NOR. There was good agreement between the UKU and the ASEC, and urinary symptoms, dry mouth, blurred vision, and orthostatic hypotension predicted discontinuation of either drug.

Using a preclinical approach to reveal potential mechanisms of ADRs to antidepressants in adolescents

Evangelia M. Tsapakis
Visiting Research Associate, MRC SGDP Centre, Institute of Psychiatry at King's College London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S7

A recent meta-analysis of the efficacy of all types of antidepressants in juvenile major depressive disorder patients (Tsapakis et al., 2008) urged that additional research be undertaken to clarify the basis of limited responses in adolescents and children to antidepressant treatments considered standard in the treatment of adult major depressive disorder (MDD). Sprague-Dawley rats were treated chronically with fluoxetine, imipramine, tranylcypromine or vehicle control. Total RNA was extracted from brain cortices, cRNA was fragmented and hybridised to Affymetrix Rat Genome 230 2.0 microarrays. A total of 24 microarrays were analysed (ie, 6 biological replicates in 4 treatment groups) and information on the probesets of interest was obtained using different websites. Taqman real-time qPCR methodology was used to validate the transcripts identified from the microarray data-analysis as the most significantly differentially expressed in response to treatment with imipramine or fluoxetine compared to vehicle. The relative expression of each gene was also determined. In both the imipramine- and fluoxetine-treated animals, expression of several genes was altered. These function in signal transduction (e.g., angiopoietin-like 4 protein), protein metabolism (e.g., sulfotransferase family 1A, phenol-preferring, member 1), cell survival (e.g., response gene to complement 32, metallothionein 1a), and nuclear functions (e.g., similar to Cat eye syndrome critical region protein 2). Therefore, in the developing rodent cortex, antidepressants alter the expression of genes involved in signalling, cellular survival and protein metabolism, involved in critical functions including neuronal plasticity. These findings have implications for the mechanisms of ADRs to antidepressants in children and adolescents.

References

1. Tsapakis E, Soldani F, Tondo L & Baldessarini R (2008) Efficacy of antidepressants in juvenile depression: meta-analysis. Br J Psychiatry 193, 10-17.

Insights from pharmacogenetic studies of antidepressants

Laura Mandelli
Assistant Professor of Psychiatry, Institute of Psychiatry, University of Bologna, Italy
Annals of General Psychiatry, 2010;9(supplement 1):S8

Up to 60% of depressed patients do not respond completely to antidepressants and up to 30% do not respond at all. Among the many reasons leading to non-response, such as inadequate treatments and comorbid conditions, genetic factors as likely to contribute to up to 50% of variance in antidepressant response. Environmental factors, such as chronic stressors, psychosocial adjustment and personality traits may also influence response to treatment and interact with these. The investigation of both of these types of factors has been informative in genetic aetiological studies (e.g. Caspi et al., 2003) and is increasingly employed in pharmacogenetics.

A growing number of genetic variants have been replicated in terms of association with SSRI efficacy. They include polymorphisms in the serotonin transporter gene (5-HTTLPR), tryptophan hydroxylase gene (TPH), 5HT1A and 5HT2A receptors, the G-protein beta3-subunit (GNB3), Catechol-O-methyltransferase (COMT), the noradrenaline transporter (NAT), and dystrobrevin binding protein 1 (DTNBP1). Data indicating environmental stressors and temperamental traits as moderators of the effect of such genes on response to treatment will also be presented.

In conclusion, there are genetic and environmental factors that interact in a complex manner to impact on response to treatment with antidepressants. Increased understanding of these, including clinical characteristics such as "harm avoidance," may assist the clinician in deciding the best antidepressant to prescribe for a given patient.

References
1. Mandelli L, Mazza M, Martinotti G. et al. Harm avoidance moderates the influence of serotonin transporter gene variants on treatment outcome in bipolar patients. J Affect Disord (in press).
2. Mandelli L, Marino E, Pirovano A, Calati R, et al. Interaction between SERTPR and stressful life events on response to antidepressant treatment. Eur Neuropsychopharmacol. 2009
3. Mandelli L, Serretti A, Marino E et al. Interaction between serotonin transporter gene, catechol-O-methyltransferase gene and stressful life events in mood disorders. Int J Neuropsychopharmacol. 2007 Aug;10(4):437-47.
4. Müller DJ, Mandelli L, Serretti A et al. Serotonin transporter gene and adverse life events in adult ADHD. Am J Med Genet B Neuropsychiatr Genet. 2008 Dec 5;147B(8):1461-9.

17.00-17.30 Lecture
Chairperson: **J. K. Rybakowski** (Poland)

Is "freedom of the Will" neutrally possible?

Philip Kargopoulos
Associate Professor of Psychology, School of Psychology
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S9

In this paper we are attempting in the context of recent developments in cognitive science to examine the viability of the Libet solution to the problem of the freedom of the will. We will be showing that this solution is still possible if refraining acts can be considered not only as different kinds of actions from performing acts, but also peculiar actions that have causal consequences without having a result component. It requires a very strong commitment to an odd model of action, which makes more plausible the Wegner idea that freedom of the will is to be explained away as an illusion, albeit an illusion that is helpful in establishing the authorship of actions.

17.30-19.00 Symposium
NEW TECHNOLOGIES IN BIPOLAR DISORDER
Chairperson: **Y. Malliaris** (UK)

Kraepelin Digitised: New technologies for monitoring the course of bipolar disorder

Yanni Malliaris
Institute of Psychiatry, King's College London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S10

In this symposium we will present novel work on new technologies developed to facilitate the symptomatic monitoring of Bipolar disorder in the context of recent prospective studies (Judd et al. 2002, Post et al. 2003) that have investigated the subsyndromal and syndromal course of the disorder and have highlighted the chronicity, variability, and complex nature of Bipolar symptomatology. Emil Kraepelin's need to map his clinical observations and to gather data in order to carefully characterize the episodic course of manic depressive illness led him to develop the first graphical life-chart for Bipolar patients. Many decades later paper-based life charting systems were developed to monitor bipolar disorder, including the ChronoSheet by Peter Whybrow and the Life Chart Methodology (NIMH-LCM) by Robert Post. Over the last 10 years these paper methodologies have been computerized, and we now have a number of different systems to assist the electronic monitoring of Bipolar disorder. In this symposium two complementary electronic systems will be presented (Moodchart and iMonitor) along with a brief overview of the research they have generated. Finally, the symposium will conclude

with novel and still experimental research using actigraphic devices for monitoring the course as well as the activities of bipolar patients.

Enhancing adherence to mood charting with an online version of the NIMH life chart

Daniel Lieberman
George Washington University Medical Center, Psychiatry Dept., USA
Annals of General Psychiatry, 2010;9(supplement 1):S11

Longitudinal mood instability is the essential feature of bipolar disorder, however most rating scales are cross sectional in nature, and focus on acute symptoms. By contrast, the NIMH Life Chart Methodology (LCM) characterizes in detail the severity, duration, and frequency of mood episodes. Unfortunately, adherence to daily rating tends to be low. Compared to the traditional paper chart, an online adaptation of the LCM that used links embedded in a daily email as the primary form of data entry substantially increased the number of days rated by a sample of patients with bipolar disorder. An analysis of the ways in which users interacted with the application found that manipulation of the user interface affected the number of days that were rated. Features of video games and commercial web sites designed to reinforce repeated long-term use can be adapted to therapeutic applications to support adherence. These features include content delivery, point accumulation, personalization, discovery, and reward.

MyiMonitor.com v. 1.0: A user-friendly mobile electronic diary for bipolar patients

Yanni Malliaris
Institute of Psychiatry, King's College London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S12

Subsyndromal symptoms and daily symptom variability is a potential risk factor for bipolar relapse. iMonitor is a mobile palm based electronic diary that was developed to measure this variability and to assist bipolar patients to track the daily course of their illness. iMonitor was designed to measure day to day fluctuations in bipolar symptom states and to track core features of the bipolar illness, such as sleep duration, mood variability, function, activation, self-esteem variability, medication adherence, and life events using visual analogue scales (VAS) following the NIMH-LCM method. In addition, a special feature of iMonitor is its ability to customise itself to each patient's relapse signature and to allow the tracking of more individual signs of relapse. The current version of iMonitor was developed to run on the cheapest possible handheld devices (Palm OS) in order to facilitate the application of electronic monitoring in low income patients who do not have access to personal computers (PCs) and the internet. The design of iMonitor appears relatively simple but this was based on advanced usability principles that serve to ensure an effortless user experience. Preliminary validation data have been gathered in the Maudsley Bipolar eMonitoring Project, and will be briefly discussed.

Porcupines: Fine grained activity monitoring in psychiatry using accelerometer sensors

Kristof Van Laerhoven
Darmstadt University, Computer Science Department, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S13

With activity sensors becoming smaller and more power efficient by the day, wearable activity sensors that anyone could wear just as easily as a wristwatch have become a feasible concept. We present a small lightweight module, called Porcupine, which aims explicitly at continuously monitoring human activities as long as possible, and as fine-grained as possible. The main focus in this work is not so much the hardware, which uses omni-present and relatively cheap accelerometer technology,

but the algorithms that analyze the sensor data and predict what physical activity the wearer is performing. We present results from the latest experiments with our prototypes, and show some scenarios in which such a fine-grained actigraph can be put to use. We also discuss the important application of the porcupine technology in the clinical monitoring of patients with Bipolar disorder and other psychiatric disorders where activity monitoring is clinically important.

19.30-20.00 Lecture
Chairperson: **N. Degleris** (Greece)

Bipolar mood disorder and treatment-resistant depression

Janusz K. Rybakowski
Department of Adult Psychiatry, Poznan University of Medical Sciences, Poland
Annals of General Psychiatry, 2010;9(supplement 1):S14

Two lines of evidence point to the relationship between bipolar mood disorder and treatment-resistant depression. First, the frequency of suboptimal response to antidepressant drugs is significantly higher in bipolar than in unipolar mood disorder. Secondly, the first and the second generation mood stabilizing drugs are efficacious for augmentation of antidepressants in treatment-resistant depression.
Short-term non-response to antidepressant drugs has been significantly higher in bipolar and in unipolar mood disorder. A significant percentage of unipolar depressed patients resistant to antidepressant drugs reaches a diagnosis of bipolarity during a specific screening or during follow-up. In the Polish all-country DEP-BI study including 880 depressed outpatients treated with psychiatrists, it was found that the percentage of treatment-resistant depression was significantly higher in bipolar than in unipolar mood disorder, especially so, in bipolar spectrum disorder where the features of bipolarity are most easy to overlook. Recent Polish TRES-DEP study included 1051 depressed patients (569 with treatment-resistant and 482 with treatment non-resistant depression). Using Hypomania Check List-32 (HCL-32) scale, it has been found that the percentage of ≥ 14 score on HCL-32, indicating bipolarity, was significantly higher in patients with treatment resistant than in treatment-nonresistant depression (44% vs 30%, respectively).
Lithium, the prototypic mood stabilizer, has been the most frequent modality used for the augmentation of antidepressants in treatment-resistant depression, and the efficacy of lithium in this respect has been confirmed by a number of meta-analyses. Our study has shown that such effect of lithium is significantly better in bipolar than in unipolar depression. Out of the first generation antidepressant drugs, also some efficacy of carbamazepine, and to less extent, valproate, has been found for the augmentation of antidepressants. Lamotrigine, new generation anticonvulsant and mood-stabilizer, demonstrated its antidepressant efficacy both during acute episode and in prophylaxis of depression in bipolar illness. It has been also effective for augmentation of antidepressant drugs in treatment-resistant depression. In our study we found that the overall efficacy of lamotrigine was similar to that of lithium, however, both drugs were more efficacious for augmentation of venlafaxine than paroxetine.
In recent years, there have been numerous studies on the efficacy of second generation antipsychotic drugs (some of them can be qualified also as second generation mood stabilizers) for the augmentation of antidepressants in treatment-resistant depression. While the clear antidepressant effect of quetiapine as monotherapy has been demonstrated, the majority of second generation antipsychotics proved their efficacy in augmentation of antidepressants in treatment-resistant depression, and aripirazole, obtained an official approval for such indication.

20.00-21.30 Symposium
ADDICTION IS A PERSONAL CHOICE-TREATMENT OF ADDICTION IS A COLLECTIVE EFFORT
Chairperson: **P. Georgakas** (Greece)

The nature of addiction and drug rehabilitation

Phaedon Kaloterakis
Assistant Director of KETHEA, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S15

The current bibliography suggests that drug rehabilitation schemes that are based on psychological and social parameters are efficient. While most researchers consider dependency to substances as symptomatic, there is a lot of controversy concerning the nature and - consequently - the definition of addiction.
The presentation will try to discuss the various points of view, taking into consideration the most recent research in the fields of mental and social health, neuroscience and therapeutic practice.

Addiction and guilt

Nikolaos Paraskevopoulos
Professor of Criminal Law, Law Faculty, Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S16

Both the concepts of addiction (drug-addiction) and of responsibility are not universally crystallized and accepted. Even the terms in Greek language are disputable: Toxicomania or exartisis (dependence)? Enoche (guilt) or katalogismos (imputation)? Nosology and Criminal Law disciplines do not share necessarily common definitions about.
The question here is if addiction implies merely incapacity to stop drug use, or even incapacity to choose a legal way to act in general. Is this incapacity an excuse or a mitigation factor, in the field of criminal responsibility?
The answer presupposes some critical differentiations (kinds of crimes seriousness of crime e.t.c). In spite of the complexity, a guideline is simple: where addiction annulates or restricts free will to choose right or wrong doing, responsibility and consequently penalty are affected in favor of the accused actor of a crime. Where this is not the case, a regular punishment is fair.

Alternative approaches of addiction and dominant scientific perspectives

Sotiris Lainas
Psychologist, Coordinator of Self Help Promotion Program,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S17

The initiatives of the directly involved citizens like self help groups or organizations, throughout the years, have contributed decisively to the interpretation of the phenomenon of addiction and to the production of successful intervention paradigms. The dynamics of these approaches, their influence on the creation of successful alternative professional approaches and to behavioral sciences in general are discussed in this presentation. Additionally the influence the mainstream nosological approaches have on these alternative approaches nowadays are presented, along with the emerging danger of abolishment of their innovative characteristics.

The primary prevention in the service of addiction

Vasilios Koutras
Counseling Center for Combating Drug Abuse (S.S.K.N.N.I.) and University of Ioannina, Department of Preschool Education, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S18

Taking into consideration the aetiology of drug use, primary prevention programs should enhance protective factors and reverse or reduce risks factors, address all forms of drug abuse, and be tailored to address risks specific to population or audience characteristics.
There are three types of prevention approaches defined in terms of population and risk factors. Universal prevention strategies apply to the general population of youth, regardless of individual risk, and aim to deter the onset of substance abuse. Selective prevention strategies target youth who are at greater risk because of their environment. Indicated prevention strategies are directed toward youth who are already using drugs or exhibiting individual and personal risk factors of drug use, such as thrill seeking, aggression, or conduct disorders.
Universal, selective, and indicated preventive interventions are defined by their specific targets, however, all universal, selective, and indicative preventive efforts may be categorized as school-based, family or community-focused.

The family's attitude towards addiction

Vasileios Kalampalikis
Psychologist, Head of the KETHEA ITHAKI Therapeutic Program, Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S19

We already know that addiction is a complicated phenomenon. One of the most important factor is family conditions. Try to write in short way, we could say that in one hand family is an important factor on the creation of substratum for dependence. On the other hand don't underestimate other factors of life such as personality, society and quality of life that are also very important. Family could take a serious role in the solution of addiction problem. Shortly, I will describe the basic steps of the way of a family that has one or more drug – addicted members.

- It takes a long time until family recognize the problem. Usually, family gives to the problematic behavior a lot of excuses.
- When they realize the problem fear, panic, perplexity, anger and sense of guilt comes to their lives
- Then a member of family (usually the mother) try to find the solution alone with many ways (doctors, lawyers, priests or Psychologists e.t.c) or try to press the drug – addicted person by saying "stop using drugs otherwise I will die or I will stop working to stay with you". This kind of family reaction can be continued for a long time
- All the practices of the family concern its' drug – addicted member (s)
- Finally the last step, and of course the hard one, is when family focuses to the "real" meaning: they cannot help the addicted people rebuild their lives. But can avoid behaviors that encourage the drug –addicted to stay in the problem. Family can also take care of the needs of its other members
- Family recognizes that addiction is a human behavior and can happen to almost everyone, to every "kind" of family.

Truth and lies about the social rehabilitation of drug addiction

Panagiotis Georgakas
Scientific Director of Argo–Alternative Therapeutic Program for Addicted Individuals, Psychiatric Hospital of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S20

A drug addict, after his detoxification, except for his "therapy" (abstinence from any drug use, abstinence from any criminal activities), has also to deal with his difficulties to confront or accept the social rules. And that is what rehabilitation is all about. To become able to accept the social rules is a long-term attempt to succeed in the following "rehabilitation" steps: a) Changes in the "way of thinking" b) Change of "life style" c) Development of "social skills" d) Development of "job skills" e) Cooperation with peers f) Know how to organize "free time"

Friday November 20th, 2009

09.00-09.30 Lecture
Chairperson: **D. Vartzopoulos** (Greece)

Changes in the expenditure for psychopharmaca in the last 20 years in Greece

Sotiris Koupidis
Deputy CEO, Dromokaiteion Psychiatric Hospital of Athens, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S21

The increased cost of psychopharmacological treatment in combination with the need for the transformation of Mental Health care with closing of big mental asylums and expansion of community-oriented services makes the need to evaluate the whole process. The analysis of the economic data from the years 2000-2009 for the mental health hospital of Corfu in comparison with data from the National Statistical Agency and coding according to the International Classification of Health Accounts (ICHA) suggests that the cost increased in spite of the fact that the number of patients decreased dramatically. The concomitant increase in the psychotherapeutic and psychosocial interventions did not cause any reduction in pharmacological costs.
It seems important to include economic indices in the evaluation of psychiatric transformation and also to apply international systems for the registration and assessment of health accounts. Also, the issue of generic drugs arises as of prime importance.

09.30-11.00 Symposium
THE CLINICAL PSYCHOPHARMACOLOGY OF EICOSAPENTAENOIC ACID (EPA)
Chairpersons: **B.K. Puri** (UK), **M. Cocchi** (Switzerland)

The structure, biosynthesis and functions of EPA: Biomolecular neuropsychiatric aspects

Sofia Tsaluchidu
University of Bologna, Italy
Annals of General Psychiatry, 2010;9(supplement 1):S22

Biochemical, clinical and genetic evidence indicates that in neuropsychiatric disorders the alteration of membrane phospholipids metabolism can play a protogenetic role associated with that of the proportional balance of polyunsaturated fatty acids.
Various PUFA have been experimented with as therapeutic and helpful means of protection in the treatment of neuropsychiatric pathologies. Among these, treatments with pure ethyl-eicosapentaenoic acid (EPA) in double blind clinical studies compared with the placebo have been proved to be more effective. Its biosynthesis starts from alpha-linoleic acid and the activity of the delta-6 desaturated enzyme.
Ethyl EPA modifies the activity of PLA2, the alteration of which is accompanied by structural changes in neuronal membranes, observed in depressed patients as well as those with Alzheimer's disease. It is enormously important as both precursor to active eicosanoids, which is as capable of competing with AA for the incorporation of the membrane as it is for the substrate according to the so called "fatty acid paradox" for the production of the DHA organism when this is necessary. Such EPA activity, which is crucial for the transmission of interneuronal signals, it interferes of phosphatidyl inositol bisphosphate regulation, linked to the activity of the alpha subunit of the G protein. The hydrolysis derivates of PIP2 they are the second messenger associated with different neurotransmissional systems and metabolic process. EPA interferes in the process, inhibiting the protein kinase-C AMPc- dependent (PKC). In vitro inhibit the activity of PKC of the protein kinase II Ca2+/ calmodulina dependent and inhibit the activation, induced by 5HT, of the protein kinase

activated by mithogen (MAPK).The proposed mechanism of pure ethyl EPA as the calcium-antagonist, blocking Ca2+ channels, is confirmed in cardiovascular studies. Blocking calcium channels could reduce the hyperactive signal transduction process.
Finally, EPA inhibits the production of pro-inflammatory cytokines that they are the main responsible for the appearance of the so called " Sickness behaviour syndrome ". Such data is important in recognising that the integrity and functionality of biomolecules is closely connected to the functionality of pure eicosanoid acids (EPA), from both the perspective of nutritional habits and that of therapy for neuropsychiatric illnesses.

The pharmacotherapy of depression with EPA

Basant K. Puri
Imperial College London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S23

This lecture considers the pharmacotherapy of depression with EPA under the following headings:
- Epidemiological evidence
- Biochemical evidence
- First trial of pure EPA in severe treatment-resistant depression
- Subsequent randomized double-blind placebo-controlled trials
- Putative mechanisms.

Results obtained from our own group, including structural neuroimaging and 31-phosphorus neurospectroscopy findings, showing an association of EPA treatment of depression with a marked decrease in cerebral phosphodiesters, a marked increase in cerebral phosphomonoesters and reduced lateral ventricular volume, will also be presented.

EPA in schizophrenia and violence

Ian H. Treasaden
Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College London and Consultant in Forensic Psychiatry, Three Bridges Unit, West London Mental Health Trust, Middlesex, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S24

This lecture will describe the role of EPA in schizophrenia and violence by first considering fatty acid metabolism abnormalities in violence and in schizophrenia.
The results of the first 31-phosphorus magnetic resonance spectroscopy study of cerebral metabolism in patients with schizophrenia who have seriously and dangerously violently offended will then be described, which found a significantly lower beta-NTP and significantly higher gamma-NTP level in the patient group compared with age- and gender-matched control subjects. To explore these findings further, the relationship between these neurospectroscopy results and the volumetric niacin response (VNR) was studied. A significant negative correlation (Spearman r = -0.78, P <0.005) was found between the VNR and cerebral Pi. The implications of this finding will be discussed. The further findings of our group relating to motion-restricted membrane phospholipids in the brain, measures of oxidative stress and changes in brain structure in patients with schizophrenia who have seriously and dangerously violently offended will be detailed.
Finally, the implications of our results for the role of EPA in schizophrenia and violence will be described.

EPA and the Perrin Technique: A combined approach to treating myalgic encephalomyelitis

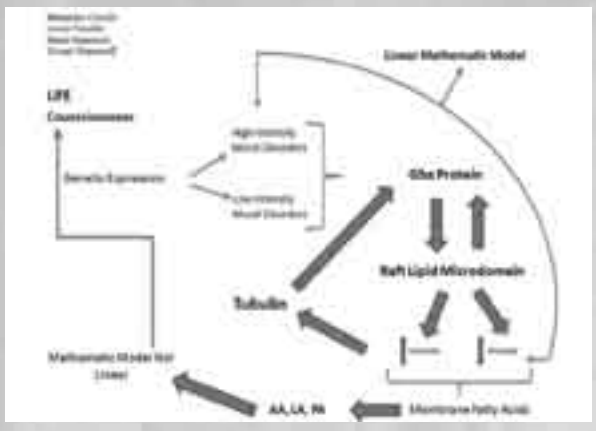
Raymond Perrin
Honorary Senior Lecturer at the School of Public Health and Clinical Sciences, UCLAN, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S25

Research over the past twenty years by the author into the bio-mechanical aspects of Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis has led to a hypothesis that a common aetiological pathway involves an insult to the lymphatic drainage of toxins from the central nervous system. Hypothalamic involvement in the pathogenesis of CFS/ME is discussed.
The ensuing neurotoxicity due to infection, pollution and emotional or physical trauma may lead to excess of neurotransmitters such as acetylcholine due to autonomic over-activity.
Indeed an increase of choline has been found in the occipital cortex of CFS/ME sufferers. (Excess breakdown in acetylcholine could lead to high levels of choline in the brain). Damage to the phospholipid bonds from neurotoxins is shown to be repaired by the additional supplementation of EPA. By combining the EPA with The Perrin Technique (a manual treatment combining lymphatic drainage, spinal and cranial osteopathy) it is argued that the neurotoxins are drained away from the central nervous system thus leading to a lasting improvement in the health of CFS/ME patients.

Running the hypothesis of a bio molecular approach to psychiatric disorder characterization and fatty acids therapeutical choices

Massimo Cocchi[1, 2] and **Lucio Tonello**[2]
[1] DIMORFIPA, University of Bologna, Italy
[2]Faculty of Human and Technological Sciences, LUdES University, Lugano, Switzerland
Annals of General Psychiatry, 2010;9(supplement 1):S26

Beyond the conviction that Major Depression can found its origin in genetics[1–3] a bio molecular mechanism could be hypothesized from what emerged from the studies on platelets fatty acid composition in human (normal and depressive subjects) which allowed classifying the depressive disorder[4] using an Artificial Neural Network (Self Organizing Map-SOM),[5] as mathematical tool, because of the complexity of the membrane dynamics.



Rapid changes in membrane lipid composition or in the cytoskeleton could modify neuronal signalling. In the knowledge to have found something that could have implications in the understanding of some aspects of psychiatric disorders and a very suggestive hypothesis was build as summarized in the figure. In figure is described the molecular depression hypothesis made according to Cocchi and collegues,[4] Donati and collegues,[6] Hameroff and Penrose.[7] The membrane viscosity can modify the Gsα protein status. The Gsα protein is connected with Tubulin. Tubulin, depending on local membrane lipid fase concentration, may serve as a positive or negative regulator of phosphatidylinositol bisphosphate (PIP2) hydrolysis, such as Gsα protein does. Tubulin is known to form high-affinity complexes with certain G proteins. The formation of such complexes allows tubulin to activate Gsα, which, in turn, can activate the Protein Kinase C and fosters a system whereby elements of the cytoskeleton can influence G-protein signalling. Rapid changes in membrane lipid composition or in the cytoskeleton might modify neuronal signalling. We have hypothesized that

through this mechanism is possible to modify the consciousness state and that it is mesurable through gamma syncrony EEG.
There are strong reasons to think that each fatty acid combination of Palmitic Acid (PA), Linoleic Acid (LA) and Arachidonic Acid (AA), in platelet, is responsible of the membrane viscosity and, therefore, of the molecular conditioning of the cellular stuctures (Gsα and Tubulin) and that the main therapeutic target is the reduction of the Arachidonic Acid.

References
1. Niculescu-H L. et al. (2008). Molecular Psychiatry. 1–19 1359-4184/08.
2. Poulter M.O. et al. (2008). Biol. Psychiat. 64:645-652.
3. Quilter C.L. et al. (2008). Am. J. Med. Genet. B 147:1126-1137.
4. Cocchi M.et al. (2008). BMC Psychiatry, 8(Suppl 1):S3.
5. Kohonen, T. Self-Organizing Maps. 3rd ed. Springer, 2001, Berlin, Germany.
6. Donati R.J. et al. (2008). J. Neurosci. 28:3042-3050.
7. Hameroff, S.R. Penrose, R. (1996) In: SR Hameroff, A Kaszniak and AC Scott (eds.) Toward a Science of Consciousness - The First Tucson Discussions and Debates. MIT Press, Cambridge, UK., 507-540.

EPA and Huntington's chorea: Treatment and associated cerebral changes

Basant K. Puri
Imperial College London, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S27

Huntington's disease (Huntington's chorea) is an autosomal dominant disease of the human brain caused by an unstable expansion of CAG trinucleotide triplet repeats in the huntingtin gene at 4p16.3; the CAG repeats are transcribed and translated into polyglutamine expansion (polyQ) stretches, and the length of the repeats correlates inversely with age of onset. Huntington's disease is characterized by motor dysfunction, with chorea and incoordination occurring relatively early and dystonia, rigidity and bradykinesia becoming more prominent with time; death usually occurs within 15-25 years of onset of motor symptomatology. The key neuropathological change is neuronal degeneration, particularly in the striatum. The scientific background is given for why fatty acids may play an important role in Huntington's disease. Evidence is then presented from a randomized double-blind placebo-controlled to show that ultra-pure ethyl-eicosapentaenoic acid (ethyl-EPA), a semi-synthetic, ethyl ester of eicosapentaenoic acid, is associated with clinical improvement in motor functioning in Huntington's disease. The likely mechanisms of this beneficial action are then described. Finally, the results are detailed of a further recent study to determine the extent to which ethyl-EPA might reduce the rate of progress of cerebral atrophy. High-resolution cerebral magnetic resonance imaging scans were acquired at baseline, six months and one year in up to 34 patients with stage I or II Huntington's disease who took part in the trial of ethyl-EPA. For each subject and each pair of structural images, the two-timepoint brain volume change was calculated in a double-blind manner.

11.00-12.30 Symposium
NEUROBIOLOGY OF TRAUMA
Chairperson: **L. Lykouras** (Greece)

Early neurobiological changes in childhood after traumatization

Apostolos Vourdas
Consultant in Child and Adolescent Psychiatry, Medical director of Hallowell Center, Athens, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S28

It is widely accepted that traumatic experiences during critical stages of child development can predispose in clinical conditions such as anxiety, depression, post traumatic stress disorder symptoms, personality disorder etc. The research about the developmental implications of trauma on the biological systems responsible for the modulation of stress is on its early stages. The involvement of endocrinological and neurochemical changes has long been described. Recently, neuroimmaging as well as molecular genetics findings have been reported. The exploration and understanding of the above biological mechanisms may lead to preventive strategies or more effective treatment for children who have fallen victims of abuse, neglect or trauma.

Pertinent changes in adult brain neurobiology due to trauma

Christos Tsopelas
Consultant Psychiatrist in Adult Psychiatry, Psychiatric Hospital of Attica, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S29

Introduction: Contrary to the general feeling of safety and stability in contemporary western societies traumatic events arise by nature unrepentantly due to natural disasters, terrorism or criminal acts. People affected in events alter brain development in early ages and differentiate the structure and function of several areas in the adult brain.
Methods: We perform thorough research of main medical databases, and web search engines for relevant studies with related key words and scrutinize them, before concluding about appropriateness.
Results: There are important and complex alterations in neurobiological networks that are responsible of triggering defensive reactions of autonomic, immune and endocrine systems forming different aspects of posttraumatic stress disorder. Brain areas involved are thalamus, amygdala, hippocampus, neocortex, corpus callosum and different neurotransmitter systems are accordingly implicated.
Conclusion: The symptomatology of mental disorder is the aftermath of the individual trying to face extraordinary events that fundamentally alter the vision and interpretation of its existence in an environment where the unexpected is the rule and not the exception. Traumatic events put our secluded way of living in danger and have as a consequence the development of different neurobiological responses on various brain circuits leading to the appearance and establishment of mental disorders.

Psychological treatments of trauma consequences in mental health

Ioanna Giannopoulou
Consultant Child and Adolescent Psychiatrist, 2nd Psychiatry Department Attikon University Hospital, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S30

Introduction: Survivors of different trauma events may present with different severity and length of symptoms. Various theoretical paradigms have been applied to understanding post-traumatic reactions but each model has its advantages and limitations to the extent it explains the post-trauma phenomenology.
Aim: This presentation will focus on the integrative model of adjustment following trauma events (i.e. stimulus, appraisal, emotional state, personality, socio-cultural factors and coping strategies) and its implication for clinical practice, with particular reference to various methods of psychological treatment, planning and implementing psychosocial interventions.
Conclusions: Psychological treatments based on CBT models are an integral part of delivering effective therapeutic interventions

Pharmacological treatment in mental health disorders after trauma

Athanasios Douzenis
Assistant Professor in Forensic Psychiatry, Athens University Medical School, 2nd Psychiatry Department, Attikon Hospital, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S31

Introduction: The treatment of psychological trauma depends partially on the type of emotional problem being presented, the time that has passed since the traumatic event(s), and the availability of means. However, it should be stressed that cognitive and behavioural treatment approaches work very well.
Aim: This presentation will focus on the pharmacological treatment of the psychological sequels of trauma, reviewing the literature on effective drug treatment. Results: Almost all types of psychiatric medication have been tried in order to alleviate the psychological symptoms associated with trauma. The most efficacious are considered to be the antidepressants.
Conclusions The best results are anticipated with a treatment combination of pharmacotherapy and psychotherapy, individual or in groups.

13.00-14.30 Symposium
HOW TO DEAL WITH THE HUGE COMORBIDITY OF SOMATIC DISORDERS IN PATIENTS WITH SEVERE MENTAL DISORDERS
Chairperson: **H.-J. Möller** (Germany)

The general problem of increased somatic comorbidity in bipolar patients

Julio Bobes
Professor and Chair of Psychiatry at the University of Oviedo, (Asturias) and Clinical Director of Psychiatric Services for the Oviedo Area, Spain
Annals of General Psychiatry, 2010;9(supplement 1):S32

There is an increasing recognition that bipolar disorder is associated with elevated mortality and morbidity rates. Although there are still some doubts whether schizophrenia impairs physical health more than other disorders, recent papers (1-2) have demonstrated that bipolar disorder impairs metabolic and cardiovascular systems as much as schizophrenia.

Reported prevalence of metabolic syndrome (MetS) in patients with bipolar disorder varies from 18% to 32% in the European Union (EU) and 40% to 49% in the United States of America (USA). These rates are substantially higher than that reported for the general population (15% EU, 27% USA) (3), and very similar to that reported for patients with schizophrenia (19.4% to 44.7%). Much less attention has been paid to cardiovascular risks in these patients. Two recently published studies (1, 4) demonstrated higher cardiovascular risk level than the general population. Furthermore, the Spanish study (4) demonstrated that Spanish patients with bipolar disorder were exposed to the same cardiovascular risk level as Spanish patients with schizophrenia.
Unpublished data from our comparative study on physical health in patients with bipolar disorder versus patients with schizophrenia shown that bipolar disorder impairs physical health even more than schizophrenia. There were not statistical significant differences according to diagnosis neither in MetS rates (21.4% of patients with bipolar disorder versus 28.7% of patients with schizophrenia, p 0.315), nor in the mean body mass index (bipolar= 30.3 versus schizophrenia= 30 kg/m2, p 0.723), or in the BMI categories (obesity: bipolar= 43.4% versus schizophrenia= 43%, p 0.964). However, patients with bipolar disorder reported greater proportion of hypertension than patients with schizophrenia (19.6% versus 6.2%, p 0.008) and met criterion 4 -elevated blood pressure- for MetS in a greater proportion too (35.7% versus 13.8%, p =.001).
Psychiatrists must be aware of these facts and carefully monitor and control patients with bipolar disorder for components of MetS and risk factors of cardiovascular diseases as part of the standard of care when treating these patients. Furthermore, specific programs should be implemented for patients with bipolar disorder aimed at reducing cigarette smoking, increasing exercise, and improving dietary habits.

References

1. Birkenaes AB, Opjordsmoen S, Brunborg C, Engh JA, Jonsdottir H, Ringen PA, Simonsen C, Vaskinn A, Birkeland KI, Friis S, Sundet K, Andreassen OA. The level of cardiovascular risk factors in bipolar disorder equals that of schizophrenia: a comparative study. J Clin Psychiatry 2007; 68: 917-23.
2. Correll CU, Frederickson AM, Kane JM, Manu P. Equally increased risk for metabolic syndrome in patients with bipolar disorder and schizophrenia treated with second-generation antipsychotics. Bipolar Disord 2008; 10: 1-10.
3. Garcia-Portilla MP, Saiz PA, Benabarre A, Sierra P, Perez J, Rodriguez A, Livianos L, Torres P, Bobes J. The prevalence of metabolic syndrome in patients with bipolar disorder. J Affect Disord 2008; 106: 197-201.
4. Garcia-Portilla MP, Saiz PA, Bascaran MT, Martínez S, Benabarre A, Sierra P, Torres P, Montes JM, Bousoño M, Bobes J, on behalf of the General Health Status in Bipolar Disorder Collaborative Group. Cardiovascular risk in patients with bipolar disorder. J Affect Disord 2009; 115: 302-308.

Increased metabolic and cardiovascular morbidity in patients with schizophrenia. Recommendation for diagnoses and treatment

Dan Cohen
Department of Clinical Epidemiology, University of Groningen, Netherlands
Annals of General Psychiatry, 2010;9(supplement 1):S33

Metabolic syndrome, diabetes and other cardiovascular risk factors are highly prevalent in people with schizophrenia. Patients are at risk for premature mortality and overall have limited access to physical health care. In part these cardio-metabolic risk factors are attributable to unhealthy lifestyle, including poor diet, high rates of smoking and sedentary behaviour. But over recent years it has become apparent that antipsychotic agents can have a negative impact on some of the modifiable risk factors. The psychiatrist needs to be aware of the potential metabolic side effects of antipsychotic medication and to include them in the risk/benefit assessment when choosing a specific antipsychotic. He should also be responsible for the implementation of the necessary screening assessments and referral for treatment of any physical illness. Multidisciplinary assessment of

psychiatric and medical conditions is needed. The somatic treatments offered to people with severe and enduring mental illness should be at par with general health care in the non-psychiatrically ill population.
The recently published joint recommendations of EPA, EASD and ESC on diabetes and cardiovascular risk in patients with severe mental disorders should be implemented in all mental health services.

Metabolic alterations in patients with depression and their relationship to the etiology of depressive disorders

Kail G. Kahl
Executive Director, Department of Psychiatry, Social Psychiatry and Psychotherapy, Hannover Medical School, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S34

Major depressive disorder (MDD) is an independent risk factor for the development of type 2 diabetes (T2DM) and cardiovascular disorders (CVD). Vice versa, patients suffering from T2DM or CVD bear an elevated risk of developing MDD. Recent epidemiologic studies suggest that MDD promotes the development of the metabolic syndrome (MetS), a well known risk factor for the development of T2DM and CVD. Furthermore, patients at risk for type 2 diabetes have a higher incidence of the MetS after a lifetime episode of MDD. These results point to an important role of MDD in the development of T2DM and CVD, and a bidirectional modulation between MDD and T2DM/ CVD. Several risk factors for the above mentioned associations have been described. Among these, a dysregulation of endocrine and immune systems, sedentary lifestyle and adverse health related behaviors have been found. Recently, a dysregulation of the central energy metabolism has been proposed as superordinated hypothesis to explain metabolic abnormalities in the context of depression. These findings expand our understanding of MDD as a complex, multi-etiological and multi-system disorder. As suggested by the joint recommendations of the EPA, EASD and ESC on diabetes and cardiovascular risk in patients with severe mental disorders, increased awareness of metabolic disorders is necessary in patients with depressive disorders.

No health without mental health-Towards a holistic approach

Meni Malliori
Assistant Professor of Psychiatry, Medical School, Eginition Hospital University of Athens, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S35

The importance of the promotion and the protection of physical and recently mental health is globally well recognized, but little attention has been given to the interrelationship between the two. Poor physical health can make individuals susceptible to poor mental health. Similarly, we know that people living with mental health problems often live with physical health problems as well. A growing body of evidence is now showing that, indeed, persons with an enduring mental illness are at much greater risk than the general population for developing certain physical health problems, most notably cardiovascular disease, diabetes, obesity. This is the reason why, compared with the general population, people with severe mental illness lose 25-30 years of normal life expectancy.
A holistic, but individualized, approach is proposed which involve, deep knowledge from health professionals about how to deal with co-morbidities, direct communication between doctors and families, careful monitoring of individuals receiving health care interventions and better collaboration among primary care physical and mental health specialists.

The EPA/EADS/ESC position statement on diabetes and cardiovascular risk in patients with severe mental disorders

Hans-Jürgen Möller
Professor of Psychiatry and Chairman of the Psychiatric Department, Ludwig-Maximilians University, Munich, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S36

People with severe mental illnesses, such as schizophrenia, depression or bipolar disorder, have worse physical health and reduced life expectancy compared to the general population. The excess cardiovascular mortality associated with schizophrenia and bipolar disorder is attributed to an increased risk of the modifiable coronary heart disease risk factors, obesity, smoking, diabetes, hypertension, and dyslipidaemia.
Antipsychotic medication and possibly other psychotropic medication like antidepressants can induce weight gain and further increase the risk of adverse metabolic effects which may result in further increased incidence of cardiovascular disease. Patients have limited access to general healthcare with less opportunity for cardiovascular risk screening and prevention than would be expected in a non-psychiatric population.
The European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC) published this statement aiming to improve the care of patients suffering from severe mental illness. The intention is to initiate co-operation and shared care between the different healthcare professionals and to increase the awareness of psychiatrists caring for patients suffering from severe mental illness to screen and treat increased cardiovascular risk factors and diabetes.

15.30-17.00 Symposium
NEUROBIOLOGY OF STRESS
Chairpersons: **J. Yesavage** (USA), **M. Sotiriou** (Greece)

Effects of sleep apnea and APOE ε4 status on follow-up of veterans with PTSD from the Vietnam conflict

Jerom Yesavage
Associate Chief of Staff for Mental Health, VA Palo Alto Heath Care System and Professor of Psychiatry, Stanford University School of Medicine, USA
Annals of General Psychiatry, 2010;9(supplement 1):S37

The purpose of this ongoing study is to examine the effects of sleep apnea in veterans of the Vietnam conflict who also have Post-traumatic Stress Disorder. At the point of the first analyses of the project, 142 subjects were fully screened and 114 were found eligible. Of the 114 eligible subjects, 97 have obtained baseline Rey Auditory Verbal Learning Test (RAVLT) results and 85 have data completely scored and ready for analysis. Of these 85 completed eligible subjects, 47 have completed a 1 year follow-up, 10 have not yet been scheduled for 1 year follow-up because there has not been sufficient time elapsed since they enrolled and 28 did not complete 1 year follow-up for one of several reasons described below. This resulted in an overall drop-out rate of 28/75, or 37%, which is substantially higher than the 20% rate predicted on the basis of prior sleep studies.
One of the most striking findings of the study to date is that the drop-out rate after one year for subjects who have neither SDB nor the APOE ε4 allele is only 17%, but is 73% in subjects having both risk factors. Using logistic regression analyses, this effect is statistically significant for the ε4-carrier status (Wald Chi-square = 4.45, p = 0.03), as well as for the effect of AHI > 20 status (Wald Chi-square = 5.76, p = 0.02) but not significant for the interaction of 4-carrier status and AHI > 20 status (Wald Chi-square = 0.003, p = 0.96). Thus, the effect of APOE ε4 status and AHI appears additive with drop-out rates of 40% and 44% respectively for each risk factor alone. In short, drop-out rates increase over 20% for each factor separately.

It would be extremely useful to understand why this disproportionate drop-out rate exists. Of the 85 subjects with complete data who were fully screened and entered into the study, 28 have not completed 1 year follow-up for reasons other than insufficient time elapsed since enrollment. Of these 28: 7 have been completely lost to follow-up (no telephone numbers, no recent CPRS records and no response to letters) and 5 of these 7 are ε4-carriers (71%); 17 have appointments overdue more than 1 month (contact information for subjects is active and correct but there has been no responses to inquiries) and 7 of these 17 are ε4-carriers (41%); and 4 consented to phone follow-ups, but would not return to the clinic and none of these are ε4-carriers (0%). Further data will be presented at the time of the conference.

The mediating role of 5-HTTLPR in the background of stress vulnerability

Xenia Gonda
Department of Clinical and Theoretical Mental Health and Department of Pharmacology and Pharmacotherapy, Faculty of Medicine, Semmelweis University, Budapest, Hungary
Annals of General Psychiatry, 2010;9(supplement 1):S38

The serotonergic system has been found to play a crucial role in the development of affective disorders, and more recently a functional polymorphism in the serotonin transporter gene, the 5-HTTLPR has been found to be associated with different manifestations of depressive illness. Stress has also been implicated in the background of these disorders. Research increasingly implicates that the s allele of the 5-HTTLPR leads to an increased vulnerability towards the development of depression, and this vulnerability can be manifested in several different forms. It seems from the evidence accumulating so far that the common pathway through which the s allele of the 5-HTTLPR mediates the development of affective sympotmatology is influencing vulnerability towards stress and stressful life events. Our research has shown that the presence of the s allele leads to the emergence of such psychological traits which are associated with increased neuroticism and lead to less efficient coping mechanisms and less adaptive reaction in the face of adverse life events. Neuroimaging data also supports that the s allele plays a role in influencing the reaction to stressful environmental stimuli, and animal data also indicate that the 5-HTTLPR genotype interacts with adverse environmental events in influencing the emergence of behavioural and neurochemical markers of stress reaction and affective disorders. Taken together this mounting evidence increasingly points to the conclusion that the 5-HTTLPR polymorphism plays a profound role in mediating the effects of stress and stressful life events.

Stress in medical patients

Stavros Samolis
Psychiatrist NHS, Psychiatric Department General Hospital of Thessaloniki "Ippokratio", Greece
Annals of General Psychiatry, 2010;9(supplement 1):S39

It has been observed that the majority of medical patients demonstrate psychological distress (64%).A lot of studies have examined the prevalence of anxiety and depression among several categories of medical patients such as: cardiovascular, general surgery, infectious and neurovascular patients.
Another finding is that the prevalence of anxiety and depression in hospitalized medical patients is high, occurs mainly in women, and no relation to illness severity is observed. Anxiety and depression are associated with both illness perception of greater severity and less improvement
Several studies indicate a relationship among depression, anxiety, pain and hospitalization. Depression has a bidirectional relationship with cardiovascular disease, and it is observed in HIV-positive individuals, in cancer patients and it often complicates chronic pain.
Other findings suggest that there is consistently high prevalence rates of depression associated with negative medical, functional, and psychosocial outcomes in hospitalized, medically ill, older adults
Screening for anxiety and depression should be included in the clinical interview carried out by the nurse or the doctor at the moment of admission to the ward.

Stress in special groups

Michael Sotiriou
Director, Psychiatric Adult Unit, Kavala General Hospital, NHS
Kavala, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S40

Stress occurs when homeostasis is threatened or perceived to be so. The stress system with its central and peripheral effectors regulate the brain's cognitive, reward and fear systems, wake–sleep centers as well as the growth, reproductive and thyroid hormone axes, and influence the gastrointestinal, cardiorespiratory, metabolic and immune systems. Malfunction of the stress system might impair growth, development, behavior and metabolism, which potentially lead to various acute and chronic disorders.
The speech will be focused: a) On linguistics, where stress is the relative emphasis that may be given to certain syllables in a word and stress manifests itself in the speech stream are highly language dependent. b) Gender is an important biological determinant of vulnerability to psychosocial stress. Research studies focused on the sex differences in stress responses revealed individual differences in stress reactivity in addition to genetic, socio-cultural, hormonal and developmental factors. Women appear more physiologically reactive to social rejection challenges, but men react more to achievement challenges. Women's greater reactivity to rejection stress may contribute to the increased rates of affective disorders in women. Another study specifically indicates that women with the BDNF Val/Met genotype and men with the Val/Val may be particularly vulnerable to social stress mediated by brain stress system activity (Psychoneuroendocrinology, 2009). c) Poor self-concept, impatience, poor consequential thinking, inability to set realistic goals and to prioritize, poor resource management, poor health habits, over-dependence, inflexibility are some of personality-related stressors. d) Stress responses associated with possible implications for psychopathology during childhood, adolescents and older adults. Prenatal stress and maternal exposure to exogenous glucocorticoids can lead to permanent modification of hypothalamo-pituitary-adrenal function and stress-related behaviour. Childhood stress and trauma have been related to adult psychopathology in different psychiatric disorders. e) Some transitions and dynamics can lead families to excessive stress. There are many stresses in healthy and dysfunctional families. Research revealed that secure-base interactions between parents and adolescents facilitate physiological regulation of stress, especially for adolescents with externalising symptomatology. f) Finally, the effects of stress reactivity may lead to physical symptoms and disorders (e.g. hypertension, appetite and gastrointestinal problems, skeletal muscles increased tension, smooth muscles increased contraction, visceral obesity, hyperlipidemia, hyperglycemia, cardiovascular disease, type II diabetes, suppression of immune system). There is also a link between stress and fertility. Women with infertility report equivalent levels of anxiety and depression as women with cancer, HIV status, and heart disease. Men also suffer fertility related stress, though they frequently keep their anxiety to themselves for fear of adding to their partner's burden.

17.00-17.30 Lecture
Chairperson: **K.N. Fountoulakis** (Greece)

Stigma by health and mental health professionals in comorbid states

Levent Küey
Associate Professor of Psychiatry, Secretary General, World Psychiatric Association Istanbul Bilgi University, Istanbul, Turkey
Annals of General Psychiatry, 2010;9(supplement 1):S41

People with mental disorders are facing the double pressure of undertreatment both for their mental and physical diseases. The dimensions and burden of these problems associated with the high

rates of medical comorbidity, disability, and mortality among people with mental disorders have been revealed in many recent reviews. This issue constitutes a major public health/mental health challenge and has serious consequences, including the stigma by health professionals. Efforts tackling the stigmatization attached to mental disorders have a history of almost couple decades. On the contrary, the stigma on the management of the somatic illnesses of patients with mental disorders is an issue that has only recently raised concern. Health/Mental health professionals can simultaneously be stigmatizers, stigma recipients and agents of de-stigmatization. The stigmatizing practices and approaches of the physicians, psychiatrists and the mental health workers on somatic illnesses and somatic treatments of patients with mental disorders is a serious aspect of the problem, and can be conceptualized as a reconstructed specific form of general stigma. The stigma by the health and mental health professionals especially on the treatment of medical comorbidities of people with mental disorders is the focus of this presentation. Hence, current researches on the relations of stigma and mental health professionals, general medical professionals, medical education, the care givers, and the cultural dimensions are reviewed. The conclusions warn us on reviewing the undergraduate and graduate training programmes in the context of current stigma theories and emphasize the need to improve our means of reducing the stigma among the mental health workers and the physicians.

17.30-19.00 Symposium
RECOMMENDED GUIDANCE ON SCHIZOPHRENIA
Chairpersons: **W. Gaebel** (Germany), **C. Höschl** (Czech Rep)

European treatment guidelines for schizophrenia

Wolfgang Gaebel
Medical Director, Department of Psychiatry and Psychotherapy
Heinrich-Heine-University Düsseldorf, Rhineland State Clinics Düsseldorf, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S42

One of the concrete projects resolved by the EPA European Platform of Psychiatrists concerns the development and implementation of evidence-based treatment recommendations in psychiatry with an European dimension named 'Recommended Guidance'. The major objective is to improve quality of mental health care in Europe by providing evidence-based information and advice and to identify and minimize health care gaps. To provide such guidance for schizophrenia, one of the most serious and disabling disease in psychiatry and in general, an overview will be given of existing treatment guidelines in Europe. This overview will focus on the one hand on methodological quality, since an international survey in 2005 stated (Gaebel et al. 2005), that the methodological quality of the most guidelines was at best moderate. Major objective however will be discussing treatment recommendations regarding core clinical questions like early recognition and intervention, acute and long-term treatment. Participants hopefully from all over Europe are encouraged to engage in the discussion and to provide information from their national / regional treatment guidelines, mostly not available in English (or German) language.

References

Gaebel et al. (2005): Schizophrenia practice guidelines: international survey and comparison. BJP, 248-55

WFSBP treatment guidelines and the problem of evidence grading

Hans-Jürgen Möller
Professor of Psychiatry and Chairman of the Psychiatric Department,
Ludwig-Maximilians University, Munich, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S43

The World Federation of Societies of Biological Psychiatry (WFSBP) has developed several drug treatment guidelines. The following guidelines have either been published already or will be published soon:

1. Acute and continuation treatment of major depressive disorder: BAUER M, WHYBROW PC, ANGST J, VERSIANI M, MÖLLER HJ, WFSBP TASK FORCE ON TREATMENT GUIDELINES FOR UNIPOLAR DEPRESSIVE DISORDERS (2002). World J Biol Psychiatry 3:5-43. World J Biol Psychiatry 3: 69-86.
2. Treatment of unipolar depressive disorders in primary care: BAUER M, BSCHOR T, PFENNIG A, WHYBROW PC, ANGST J, ERSIANI M, MÖLLERHJ (2007): WFSBP Task Force on Unipolar Depressive Disorders. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Unipolar Depressive Disorders in Primary Care. World J Biol Psychiatry 8(2): 67_104.
3. Acute and long-term treatment of schizophrenia: FALKAI P, WOBROCK T, LIEBERMAN J,GLENTHOJ B, GATTAZ WF, MÖLLER HJ, WFSBP Task Force on Treatment Guidelines for Schizophrenia (2005): World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Acute treatment of schizophrenia World J Biol Psychiatry 6(3): 132-191.
4. FALKAI P, WOBROCK T, LIEBERMAN J,GLENTHOJ B, GATTAZ WF, MÖLLER HJ WFSBP Task Force on Treatment Guidelines for Schizophrenia+ 2006: World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Long-term treatment of schizophrenia World J Biol Psychiatry 7(1): 5-/40.
5. Treatment of Anxiety, Obsessive-Compul¬sive and Post-Traumatic Stress Disorders: Bandelow B, ZOHAR J, HOLLANDER E, KASPER S, MÖLLER HJ & WFSBP TASK FORCE ON TREATMENT GUIDELINES FOR ANXIETY OBSESSIVE-COMPULSIVE POST-TRAUMATIC STRESS DISORDERS (2008): World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Pharmacological Treatment of Anxiety, Obsessive-Compulsive and Post-Traumatic Stress Disorders. World J Biol Psychiatry 9(4): 248_312.
6. Treatment of bipolar depression, treatment of mania and maintenance treatment of bipolar disorder: GRUNZE H, KASPER S, GOODWIN G, BOWDEN C, BALDWIN D, LICHT RW, VIETA E, MOLLER HJ (2003): The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders, Part II: Treatment of Mania. World J Biol Psychiatry 4: 5-13. GRUNZE H, KASPER S, GOODWIN G, BOWDEN C, MOLLER HJ (2004): The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of bipolar disorders, part III: maintenance treatment. World J Biol Psychiatry 5: 120-135. GRUNZE H, KASPER S, GOODWIN G, BOWDEN C, BALDWIN D, LICHT R, VIETA E, MÖLLER HJ (2002): World Federation of Societies of Biological Psychiary (WFSBP) guidelines for biological treatment of bipolar diorders, Part I: Treatment of bipolar depression. World J Biol Psychiatry 3: 115-124.
7. Treatment of personality disorders: HERPERTZ SC, ZANARINI M, SCHULZ CS, SIEVER L , LIEB K, MÖLLER HJ & WFSBP Task Force on Personality Disorders (2007): World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Personality Disorders. World J Biol Psychiatry 8(4): 212-244.
8. Treatment of acute bipolar depression: Grunze H, Vieta E, Goodwin G, Bowden C, Licht RW, MöllerHJ, Kasper S, (2009): The World Federation of Societies of Biological Psychiatry (WFSBP) Task Force on Treatment Guidelines for Bipolar Disorders. World J Biol Psychiatry 10: in preparation.

WFSBP guidelines are developed by special WFSBP task forces which include members of the WFSBP as well as non-WFSBP colleagues seen as international experts in the relevant field. The task forces are composed with the aim to include knowledge and experience in the guidelines from every part of the world, not only the western hemisphere. The core characteristic of the evidence criteria is that meta-analyses are not seen as the most important factors for a high grade of evidence, but the results of well-designed studies. This approach is closer to the decision process of the most important regulatory authorities such as the FDA or the EMEA/CPMP. Recently the evidence criteria have been optimised (Bandelow B, Zohar J, Kasper S, Möller HJ (2008): World J Biol Psychiatry 9(4): 242-247.).

Recommended guidance beyond guidelines

Cyril Höschl
Professor of Psychiatry and Chairman, Prague Psychiatric Centre, Czech Republic
Annals of General Psychiatry, 2010;9(supplement 1):S44

Hand in hand with an inflation of treatment guidelines across Europe, the gap between recommendations based on evidence and clinical practice paradoxically increases. There are several reasons for which guidelines use to be disregarded in everyday practice. First, there are always stakeholders staying out of consensus and therefore reluctant to support the implementation of its outcome. Second, most of guidelines are predominantly focused on pharmacotherapy to the detriment of other treatment modalities. Third, in contrast to the practical life guidelines often lack the recommendations for physical health monitoring and treatment as well as the management of co-morbidities, drug abuse etc.. Clinical experience, on the other hand, can answer questions (and has to solve problems), which are not covered by evidence, e.g., individual responsiveness to a drug and to other treatment modalities, individual sensitivity to side effects, individual psycho-social situation, individual defence and copying mechanisms etc. Too extensive and rigid application of guidelines can decrease the clinical motivation of doctors, can slow down the process of therapeutic innovations and can even lead to malpractice. Psychiatry as a medical discipline is now challenged in terms of the classification (categorical vs dimensional), in terms of diagnostic validity, and in terms of optimizing the proportion of "science" and "art" in the world where professional decision making process is more and more driven by payers, by reimbursement policies, and by business administration.

Guidance in the ages of neuroscience

Lefteris Lykouras
Professor of Psychiatry, Director of the 2nd Department of Psychiatry, Attikon Hospital, School of Medicine, Athens University, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S45

Over the past two decades important progress has been made in the area of intervention in psychiatric disorders, mainly with the introduction of novel antidepressant and antipsychotic drugs. Despite these advances, the interindividual differences in the psychotropic drug response and the development of drug-induced adverse effects remain a serious problem in clinical practice. On the other hand, more information about the mechanisms of action of psychotropic drugs may help the way they should be prescribed. In this regard application of technological advances in the field of neurosciences, namely modern neuroimaging methods and the enormously developed molecular genetics acquires paramount importance. PET and SPECT studies have indicated that antipsychotic response is associated with blockade of dopamine D2 receptors and antidepressant response has been linked to blockade of serotonin transporter receptors. According to Zipurski et al (2007), these findings have the following clinical implications: a) antipsychotic dosing for most patients with schizophrenia can be expected to occur within a narrow range of D2 receptor blockade, (b)

Antidepressant response for must patients can be expected to occur with blockade of 80% or more of the serotonin transporter. Pharmacogenetics and pharmacogenomics signal the beginning of a new era in the treatment psychiatric disorders. They provide a novel method in the search of informative correlates of psychotropic drug response. Polymorphisms of dopamine and serotonin receptor subtypes, transporter proteins and metabolic enzymes may contribute to variability in response to psychotropic drugs and the occurrence of their adverse reactions. In the field of molecular biology, it has been demonstrated that psychotropic drugs used to treat mood disorders, target molecules and signaling cascades implicated in the control of neuroplasticity. Our expanding knowledge of psychopharmacology will help lead to specific targeting for more predictable and safer medications in the near future. It is believed that perspectives are outstanding to achieve benefits previously unattainable.

1. AA Bolonna, MJ Arranz, D Mancama, RW Kerwin. Pharmacogenomics – can genetics keep in the care of psychiatric patients? Intern Rev Psychiatry 2004; 16: 311-319
2. RJ Schloesser, J Huang, PS Klein , HK Manji . Cellular plasticity cascades in the pathophysiology and treatment of bipolar disorders. Neuropsychopharmacology Rev 2008; 33:110-133
3. RB Zipurski, JH Meyer, NP Verhoeff. PET and SPECT imaging in psychiatric disorders. Can J Psychiatry 2007; 52: 146- 157

19.30-20.00 Lecture
Chairperson: **C. Höschl** (Czech Republic)

The American Psychiatric Association Treatment Guideline for major depressive disorder: Process and content

Alan J. Gelenberg
Clinical Professor of Psychiatry, University of Wisconsin and Professor Emeritus of Psychiatry, University of Arizona, USA
Annals of General Psychiatry, 2010;9(supplement 1):S46

Dr. Gelenberg has been a member of the American Psychiatric Association's Workgroup on the Treatment Guideline for Major Depressive Disorder since its inception in the 1980s. For the past several years, he has chaired the workgroup writing the 3rd edition, which should be published in late 2009. This talk will review the history of this work, discuss guidelines broadly in the current era of evidence-based medicine, define epistemology and its relevance, and describe the process of developing a treatment guideline—the scientific and the political. The talk will then outline recent changes in the treatment of depression-medications, stimulation approaches, psychotherapy, and others. It will conclude with a preview of the future in this area.

20.00-21.30 SERVIER SATELITE SYMPOSIUM
AGOMELATINE: A NEW ERA IN THE TREATMENT OF DEPRESSION
Chairpersons: **H.-J. Möller** (Germany), **K.N. Fountoulakis** (Greece)

Biological theory of depression in the light of new evidence

George Papageorgiou
Psychiatrist, NHS Director, Department of Psychiatry, Evangelismos Hospital, Athens Greece
Annals of General Psychiatry, 2010;9(supplement 1):S47

The finding of various structural and chemical abnormalities in the brain through neuroimaging ha sbeen the mainstay in depression research the last few years. Research isn't necessarily

focused in a specific area of the brain, bur rather combines the pathophysiology of neurochemical communication of various brain areas to specific symptoms. The functionality of various brain areas, such as the prefrontal cortex or the amygdale or nucleus accumbens is theoretically linked with diverse symptom constellations. This might lead to more sophisticated treatment methods. New data on the function of the HPA axis and the role of CRF in stress response, contribute to the further understanding to the neurobiology of depression. As for the present therapeutic implications, the monoaminergic theory of depression is paralleled with the chronobiolgy theory and mainly with the theory of circadian rhythm dysregulation. All of the above lead to the rationale of the correct choice of antidepressants.

References

1. DrevetsWC(2000): Neuroimaging studies of mood disorders. Biol Psychiatry 48:813– 829
2. Nestler EJ, Barrot M, DiLeone RJ, Eisch AJ, Gold SJ, Monteggia LM (2002): Neurobiology of depression. Neuron 34:13–25.
3. Stahl SM. Stahl's Essential Psychopharmacology. Neuroscientific Basis and Practical Applications, 3rd ed. Cambridge Univ. Press, New York, NY 2008.

Circadian rhythms: Strong evidence on how to approach depression

Konstantinos N. Fountoulakis
Assistant Professor of Psychiatry, 3rd Department of Psychiatry, School of Medicine, Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S48

It is widely accepted that mood disorders are related to biological rhythm abnormalities. It has been proved that this happens at least in a significant proportion of patients which profit from chronotherapeutic interventions. Rhythm abnormalities in mood disorders include among others diurnal mood variation, elevated nocturnal body temperature, lower nocturnal TSH, overall increased cortisol secretion, phase advance of cortisol and melatonin secration and sleep architecture abnormalities. The exact relationship of these abnormalities to the etiopathogenesis of depression remains unclear; it is however evident that at least some treatment modalities worsen rhythms, leave residual symptoms and therefore do not lead to full remission, which sould be the ultimate goal of any treatment approach. It seems important for an informed approach and understanding of mood disorders and their treatment to take into consideration the normalization and stabilization of endogenous rhythms.

Agomelatine: Relief ensured at each and every stage of depression

Hans-Jürgen Möller
Professor of Psychiatry and Chairman of the Psychiatric Department, Ludwig-Maximilians University, Munich, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S49

In the recent years the aim of drug therapy in depression was redefined and specified. According to this, the main goal of antidepressant treatment goes beyond achieving some degree of response, or full response in the sense of 50% reduction of a depression score, but to remission in the global sense as well as on a more differentiated level, which means almost complete relief of depressive symptoms or at least almost complete relief of the core or most relevant symptoms of depression. This redefinition of the major therapeutic goal of antidepressive treatment was necessary, because several long-term studies demonstrated, that only remission and in this context the relief of the core or most relevant symptoms of depression can guarantee with a reasonably high probability a positive outcome under long-term aspects. The presentation will focus especially on the issue of relief of the core or the most relevant symptoms of depression and the respective efficacy of drug treatment with the recently licensed antidepressant agomelatine. Traditionally, especially depressed

mood and lack of interest were seen as the core symptoms of depression. This is also mirrored in the current diagnostic manuals. However, considering the frequency and clinical relevance of sleep disturbances, and interpreting this in the context of the aetiopathogenetic hypothesis of disturbed circadian rhythm, sleep disorders can be interpreted as a core symptom in another sense. The same might be true for anxious symptoms, given the high neurogenetic association of depressive and anxious symptoms.

Agomelatine has demonstrated powerful antidepressive efficacy, amongst others in terms of improvement of depressive mood and in terms of remission. According to its neurobiological mood of action, agomelatine has a special efficacy focus on disturbances of circadian rhythms and demonstrates clinical efficacy in this respect. Given the high frequency of anxious symptoms in depression and the comorbidity between depression and anxiety disorder, the efficacy of agomelatine in anxious symptoms also seems to be a beneficial aspect of the efficacy profile.

Taken together, these findings show that agomelatine qualifies as an efficient option in the treatment of depression based on its broad efficacy on the full spectrum of depressive symptoms, including those occurring early as well as those that tend to persist late over the course of the disorder.

Saturday November 21st, 2009

09.00-09.30 Lecture
Chairperson: **G. Simos** (Greece)

Suicide among untreated and treated depressives: The role of compliance, drug-resistance and underlying bipolarity

Zoltan Rihmer
Department of Clinical and Theoretical Mental Health, Semmelweis University, Faculty of Medicine, Budapest, Hungary
Annals of General Psychiatry, 2010;9(supplement 1):S50

Suicide, this very complex and multicausal human behaviour, is related to several psychiatric-medical, psycho-social and demographic suicide risk factors. Psychological autopsy studies consistently show that over 90 percent of suicide victims have at least one (mostly untreated) current major mental disorder, most frequently major depressive episode (56-87%) substance-related disorders (26-55%) and schizophrenia (6-13%). As suicidal behaviour in patients with mood disorders seems to be state-dependent phenomenon (i.e., it decreases or vanishes after the clinical recovery), the succesful acute and long-term treatment of mood disorders is crutial for suicide prevention (Rihmer, 2007). However, depression is freuently underreferred, underdiagnosed and undertreated (and in the case of unrecognized bipolarity mistreated), and the rate of adequate antidepressant pharmacotherapy among depressed suicide victims is less than 20%, which is disturbingly low (Henriksson et al, 2001). The marked decrease in antidepressant utilization among children and adolescents most recently in the United States, The Netherlands and Canada coincided with a sharp increase in the rates of completed suicide in this subpopulation (Katz et al, 2008).
The most important pharmacotherapy-related factors of suicide in depression are: 1/ lack of treatment, 2/ inadequate treatment, 3/ the first 10-14 days of the treatment, particularly in the case of insufficient care and/or lack of co-medication with anxiolytics, 4/ early termination of the therapy either by the patient or by the doctor, 5/ lack of the long-term treatment in chronic or recurrent cases, and 6/ nonresponse and treament resistance. Most recent findings strongly suggest that antidepressant monotherapy (unprotected by mood stabilizers or atypical antipsychotics) can worsen the short-and long-term course of bipolar depression and increases the risk of suicidal behaviour (Rihmer and Akiskal, 2006).
References
1. Henriksson S, Boethius G, Isacsson G. Acta Psychiat Scand, 2001; 103; 301-306.
2. Katz LY, et al, CMAJ, 2008; 178: 1005-1011.
3. Rihmer Z, Suicide risk in mood disorders. Curr Opin Psychiat, 2007; 20: 17-22.
4. Rihmer Z, Akiskal HS, J Affect Disord, 2006; 94: 3-13.

09.30-11.00 Symposium
TREATMENT GUIDANCE/GUIDELINES: HISTORY, CONCEPT, NEED, THEORETICAL SUPPORT
Chairpersons: **N. Sartorius** (Switzerland), **W. Gaebel** (Germany)

Introduction to treatment guidance

Norman Sartorius
Professor, President of the Association for the Improvement of Mental Health Programmes, Geneva, Switzerland
Annals of General Psychiatry, 2010;9(supplement 1):S51

This symposium will address the requirements that have to be satisfied if guidelines produced in the

field of psychiatry are to be useful. One of the presentations will address this topic in general and another focus on guidelines that are being produced for research. A third presentation will exemplify the problems that might arise in the production of guidelines as well as the use to which they can be put by describing the experience gained by the National Institute of Clinical Excellence in the UK. It is expected that the symposium will lead to a full interaction between the speakers and the audience. Ethical issues that arise in connection with the application of guidelines will be highlighted in the introduction and in the concluding presentation by the chairpersons.

What makes good guidelines?

Wolfgang Gaebel
Medical Director, Department of Psychiatry and Psychotherapy
Heinrich-Heine-University Düsseldorf, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S52

In the last two decades, a large number of national and international treatment guidelines have been developed, to assist practioners in making decisions based on available evidence. However, according to a survey of schizophrenia practice guidelines for example (Gaebel et al. 2005), the methodological quality of the most guidelines was at best moderate. Hence, national and international institutions attempted great efforts to enhance guideline quality by describing and establishing characteristics for structure and process of their development. Beyond that, a 'good' guideline is expected to be effective, and thus to enhance outcome. Accordingly, an overview regarding methodological criteria for guideline development will be given. In addition, the results of empirical studies focusing the impact of treatment guidelines on health outcome will be summarized. As to the conclusions, developing guidelines based on highest methodological criteria is mandatory, however expectations regarding enhanced outcome in health care should be scaled down.

References

Gaebel et al. (2005): Schizophrenia practice guidelines: international survey and comparison. BJP, 248-55

NICE guidelines

Stephen Pilling
Director, Centre for Outcomes Research and Effectiveness, Research Department of Clinical Educational and Health Psychology, University College London United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S53

This presentation will outline the programme of clinical practice guidelines developed by the National Institute for Health and Clinical Excellence (NICE) in the UK. This programme consists of over 20 clinical guidelines and covers all the major mental disorders. The methodological challenges in its development will be described, including the limitations of the evidence base and some commonly made criticisms of the NICE approach to clinical guideline development. The major successes of the programme will be described including work on schizophrenia, substance misuse and more generally on psychological therapies. The importance of a broad approach to supporting guideline implementation will be emphasised and illustrated by the development of the UK Department of Health Improving Access to Psychological Therapies (IAPT) programme and related work on therapist training and competence.

Guidelines for research: Requirements and challenges

Silvana Galderisi
Department of Psychiatry, University of Naples SUN, Naples, Italy
Annals of General Psychiatry, 2010;9(supplement 1):S54

Research aimed to foster the understanding of causes and consequences of mental disorders and to improve their outcome should be a priority in the agenda of clinicians, researchers and health policy makers. Published guidelines for research in Psychiatry have highlighted main requirements, which will be summarized and discussed in the presentation. Research in Psychiatry has to conform to ethical principles and rigorous scientific standards. Openness and transparency should characterize the management of eventual conflicts of interests; professional integrity and independence from external pressure and influence must represent an obligation. In addition to human research ethical principles, research in Psychiatry involves unique aspects relevant to the nature of mental disorders. Awareness of general and disorder specific ethical aspects has to be promoted among trainees and researchers and adequate procedures to deal with these aspects must be implemented. Studies should address clinically relevant questions, select the least vulnerable individuals to adequately answer the study questions; the design and methods should minimize risks and threats for patients and be adequate to address the study questions. Care must be taken to ensure privacy and patients' freedom to leave the experimental protocol at any time without negative consequences for their clinical care. Translating these principles into everyday research activities is the present challenge for researchers in Psychiatry and for all those caring for the progress of the discipline. National and international educational programmes for trainees in Psychiatry, for investigators conducting research involving people with mental disorders, and for members of institutional review boards should be developed.

11.00-12.30 Symposium
FUTURE TRENDS IN SOCIAL PSYCHIATRY
Chairpersons: **J. Arboleda Florez** (Canada), D**. Moussaoui** (Morocco)

Impact of globalisation on social psychiatry

Marianne Kastrup
Head, Centre for Transcultural Psychiatry, Psychiatric. Dept. Rigshospitalet, Copenhagen University Hospital, Denmark
Annals of General Psychiatry, 2010;9(supplement 1):S55

We are living in a world of rapid change with the most drastic transformations taking place in developing countries. With increasing globalisation billions are forced to face a future so different from life when they grew up that few of their skills are able to assist them with new challenges. Change may result in insecurity, and unpredictability that many people may cope with difficulty. The process of globalisation is not uniform; and some claim that a result hereof is that differences between nations may decrease, but differences between individuals increase. Certain population groups run particular risks during this transformation. Such vulnerable groups may experience the consequences of globalisation as a negative influence on their mental health. From a social psychiatric point of view an important impact of globalisation is the risk of having inadequate access to health care including mental health care. Incentives should be encouraged that result in reducing inequalities among and within groups and nations.
Globalisation is welcoming labor market flexibility, which leads to huge groups of unskilled labourers migrate in search for work. Such populations rarely receive social benefits or protection in case of illness despite the fact that they may have an increased risk of developing mental illness. The process of globalisation is not uniform. In most societies large gender gaps exist regarding access to e.g. education, economic development or adequate health care. Particular attention should be

paid to that developmental initiatives are directed towards women thereby closing the gap with men regarding health and education. War and strife are prevalent, and displacement and refugee status are phenomena hitting millions worldwide. Again the distribution is skewed and the poorest parts of the world carry the heaviest burden. The mental health problems of these groups need increased attention from a global perspective.
Many ways may be taken to move forward. But psychiatrists globally need to recognize their responsibility in creating awareness and fighting for minimizing the existing disparities

Social Darvinism and psychopathology

Andreas Erfurth
Head of Clin Psychopharmacology and the Bipolar Spectrum Disorders Program, Division of General Psychiatry, Medical University of Vienna, Austria
Annals of General Psychiatry, 2010;9(supplement 1):S56

In recent years, aspects of Darwinism have been widely discussed in psychiatry to explain the origins of mood disorders (1-3). Authors were particularly focusing on the psychopathology of depression, while other considerations in the field of affective disorders have more broadly included the phenomena of mania (4) and temperament (5). This paper will review aspects of Darwinism in the psychopathology of mood and its social consequences.
References
1. Nesse RM. Evolution is the scientific foundation for diagnosis: psychiatry should use it. World Psychiatry. 2007, 6: 160-1.
2. Nesse RM, Ellsworth PC. Evolution, emotions, and emotional disorders. Am Psychol. 2009, 64(2): 129-39.
3. Allen NB, Badcock PB. Darwinian models of depression: a review of evolutionary accounts of mood and mood disorders. Prog Neuropsychopharmacol Biol Psychiatry. 2006, 30(5): 815-26.
4. Koukopoulos A, Ghaemi SN. The primacy of mania: a reconsideration of mood disorders. Eur Psychiatry. 2009, 24(2):125-34.
5. Akiskal KK, Akiskal HS. The theoretical underpinnings of affective temperaments: implications for evolutionary foundations of bipolar disorder and human nature. J Affect Disord. 2005, 85(1-2): 231-9.

What research is needed in social psychiatry?

Driss Moussaoui
Professor of Psychiatry and Psychological Medicine and Chairman of the Ibn Rushd University Psychiatric Centre in Casablanca, Morocco
Annals of General Psychiatry, 2010;9(supplement 1):S57

There is no such a thing as psychiatry without a social component. If the XIXth Century has been mostly dedicated to clinical descriptions and classification, if the XXth Century has been mostly therapeutic (psychotherapies, psychopharmacology and biological psychiatry), it is highly probable that the XXIst Century will be mostly oriented towards psycho-social psychiatry and mental health. Research will be an essential part of this evolution.
There is also an urgent need of education of young promising psychiatrists, learning the complexity of interactions between the psycho-social aspect and the biological one in psychiatry, but also the necessity using of a rigorous methodology.
There are plenty of topics which need to be investigated in social psychiatry. Some of the most important are:
- Migration and mental health, especially on the seemingly higher prevalence of schizophrenia among some groups of migrants;
- Religion, spirituality and mental health; as a matter of fact, they will play an increasing role in the future in the expression of psychopathology, and in psycho-social phenomena such as violence, substance abuse...

- Women's mental health, especially peri-natal mental health and psychiatry;
- Ethics and its relative relativity from one culture to another in psychiatric daily practice.

Social rituals and onset of mental disorders

Aleksandar Janca
Head of School of Psychiatry and Clinical Neurosciences, University of Western Australia, Perth, Australia
Annals of General Psychiatry, 2010;9(supplement 1):S58

The concept of a prodrome, or the very earliest signs of the onset of a mental disorder, is well known in clinical psychiatry, and refers to disturbances of ordinary behaviour that may precede the behaviour and experiences that constitute recognised psychiatric symptoms and signs. In the literature, however, prodromes are described simply by means of lists of behaviours, such as avoidance of meeting other people, irritability, polite greetings absent or minimal, poor table manners, conversation avoided or kept to a minimum, and lowering of standards of personal appearance and hygiene.
To examine a relationship between social rituals and onset of mental disorders, we decided to develop an instrument to measure changes in ritualistic behaviour during the prediagnostic stages of mental illness, and explore whether it could be used as a tool for early detection of individuals who are in, or at risk of soon developing poor mental health. The result is the Social Ritual Interview which consists of ten distinct domains which are based upon universal social rituals identified via extensive cross-cultural investigation.
Once the draft instrument was finalised, mental health professionals administered it upon 30 patients with a variety of mental disorders. The interview was then conducted with a close relative or other carer nominated by the patient, and the questions were asked in relation to the patient's appearance and behaviour. Data analysis found moderate to severe changes in most of the ten social ritual domains, meaning there is often an observable disrespect of such rituals during the prediagnostic stages of mental illness.
References
1. Janca A, Cooper JE. Measurement of some novel concepts in psychiatry. World Psychiatry 2002; 1(2):107-108.
2. Janca A, Isaac M. Psychiatric assessment instruments: a review of recent developments. In: Christodoulou GN, editor. Advances in Psychiatry. Athens: Beta Medical Publishers; 2002. p. 99-106.

13.00-14.30 BRISTOL-MYERS SQUIBB SATELLITE SYMPOSIUM
BIPOLAR DISORDER: FROM CLINICAL DATA TO REAL LIFE

Chairperson: **K.N. Fountoulakis** (Greece)

The global effect of aripiprazole monotherapy in the spectrum of symptoms in bipolar disorder: A meta-analysis

Konstantinos N. Fountoulakis
Assistant Professor of Psychiatry, 3rd Department of Psychiatry,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S59

Background: The current article is a systematic registration and meta-analysis of the available clinical trials concerning the usefulness of aripiprazole in the treatment of bipolar disorder in affective as well as in psychotic symptoms Material and methods: A systematic MEDLINE and repositories search concerning treatment guidelines and clinical trials for aripiprazole in bipolar disorder. Results: The pooled effect size for acute manic symptoms was equal to 0.34. The NNT was 6 for aripiprazole vs placebo concerning response at week 3 and equal to 14 concerning remission. The

average day response started was day 3. The suicide rates were negligible for all groups. In contrast to the individual isolated trials, the meta-analysis for acute bipolar depression suggests a significant difference at week 8 with an effect size 0.17. The meta-analysis of the 4 trials which reported the efficacy of aripiprazole on psychotic symptoms during an acute manic/mixed episodes suggests that the effect size vs. placebo was equal to 0.14 but a more reliable and accurate estimation is 0.18 for the total PANSS score. The effect was higher for the PANSS positive subscale (0.28), PANSS hostility subscale (0.24) and PANSS cognitive subscale (0.20), and lower for the PANSS negative (0.12). No data on the psychotic symptoms during the depressive phase of bipolar illness exist. The maintenance data suggest that the median survival time for the emergence of a manic episode for the aripiprazole group was not evaluable, while the median survival time for placebo was 118-203 days depending on the clinical subpopulation. Concerning psychotic symptoms, at week 26 all except the total PANSS score showed a significant superiority of aripiprazole over placebo (d=0.28 for positive, d=0.38 for the cognitive and d=0.71 for the hostility subscales) and at week 100 the results were similar (d=0.42, 0.63 and 0.48 respectively). Conclusion: The data analysed for the current study support the usefulness of aripiprazole during all phases of bipolar illness, inspite of the rather weak effect on depression and that the efficacy during the maintenance period is proven against new manic episodes and in patients with an index manic episode who responded to aripiprazole during the acute phase.

Aripiprazole in Bipolar Disorder: Clinical strategies to maximize efficacy and tolerability

Andrea Fagiolini
Chairman and Residency Training Director, Division of Psychiatry, University of Siena, School of Medicine, Siena, Italy
Annals of General Psychiatry, 2010;9(supplement 1):S60

A number of double-blind, randomized, controlled trials have confirmed the clinical efficacy of aripiprazole in bipolar disorder and schizophrenia. Aripiprazole is the prototype of the 'third generation' atypical antipsychotics, or dopamine-serotonin- stabilizers and is characterized by a relatively low risk of inducing metabolic adverse effects, causing sedation and other side effects such as hyperprolactinemia. As a partial agonist at dopamine D2 receptors, aripiprazole acts as a functional antagonist in the mesolimbic dopamine pathway, where excessive dopamine activity is thought to cause positive symptoms, but acts as a functional agonist activity in the mesocortical pathway, where reduced dopamine activity is thought to be associated with negative symptoms and cognitive impairment. This presentation will review the available research data on the efficacy of aripiprazole in bipolar disorder and discuss how this data translate in the real world clinical practice and what the best strategies are to maximize the efficacy and tolerability of this medication

17.00-17.30 Lecture
Chairperson: **L. Lykouras** (Greece)

The neurobiology of subjective tolerability to antipsychotic medications in schizophrenia Is it also relevant to the genesis of comorbid addiction?

George Awad
Professor Emeritus, University of Toronto, Chief of Psychiatry, Humber River Regional Hospital – Toronto, Canada
Annals of General Psychiatry, 2010;9(supplement 1):S61

One of the frequent but unrecognized side-effects of antipsychotic medications is the subtle alterations in subjective tolerability to these medications, including feelings of anxiety, distress and lack of pleasure, and which often lead to dislike and aversion to medications, with known serious

clinical consequences. Yet, those very patients take to frequent abuse of illicit drugs.
One popular and frequently accepted explanation for such a high association has been the self-medication hypothesis, which proved inadequate to explain all aspects of this phenomenon. Until recently, the neurobiological basis for alteration in subjective tolerability and the negative dysphoric responses to antipsychotic medications has not been clear, though it was generally understood that somehow it relates to dopamine, since all antipsychotic medications have antidopaminergic properties. In a series of studies, including our recent experimental dopamine depletion SPECT study, we demonstrated for the first time the relationship between negative subjective tolerability and dopamine-binding ratio in the nigro-striatal area. Our findings explain to a large part why only some patients, not all receiving antipsychotic medications, experience dysphoric responses, since only those who have low baseline dopamine function are more susceptible to further dopamine-blocking effects.
Meanwhile, emerging evidence from research in the addiction field has implicated dopamine in the same neural circuitry in motivational and reinforcement behaviour, which is central to initiation and continuation of dependency states. It's plausible, then, that what links vulnerability to addictions and negative subjective tolerability lies in a dysregulated dopamine signaling in the nucleus acumbens, resulting from frontal cortical and hippocampal dysfunction. Such a proposal, though many aspects of it have not yet been worked out clearly, and if confirmed represents a new rethinking of the concept of schizophrenia and its varied domains and manifestations and also has clinical implications in management.

17.30-19.00 Symposium
TREATMENT GUIDANCE ON BIPOLAR DISORDER
Chairperson: **S. Kasper** (Austria)

Treatment guidelines for acute mania

Jose Goigolea and **Eduard Vieta**
Psychiatrist, Bipolar Disorders Program of the Hospital Clinic, Barcelona, Spain
Annals of General Psychiatry, 2010;9(supplement 1):S62

Nowadays, psychiatrists have a wide range of treatment choices to treat acute mania. Introduction of atypical antipsychotics in the last decade has increased the range of available treatments. A good number of double-blind randomized clinical trials have supported the efficacy of several atypicals, (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) both as monotherapy and in combination with lithium or valproate. I.m. formulations of aripiprazole and olanzapine have also shown efficacy in agitated patients suffering acute mania. More recently, asenapine (both as monotherapy or combination) and paliperidone (only monotherapy so far) have shown positive results and may deserve a second-line option according to the most recent clinical guidelines. Atypicals are recommended over typical antipsychotics due to a better short-term side-effect profile. Although not yet proved in meta-analysis, several trials show that atypicals also have a lower risk of switch to depression.
More "classical" mood-stabilizers, such as lithium, valproate, and carbamazepine also share evidence-based antimanic properties. However, some data show lithium being slightly slower in his action, and carbamazepine not being advisable in combination (negative results with risperidone and olanzapine, and not tested with other atypicals). Clinical guidelines usually recommend monotherapy with an antimanic agent to treat mild or moderate mania, and combination treatment (usually with lithium or valproate plus an atypical antipsychotic) for more severe mania. However, combination treatment is usually the rule in clinical practice, especially when the patient is already taking a mood-stabilizer with antimanic action, taking for granted adherence has been demonstrated. Pros and cons of these different approaches will be discussed, as well as differences among antimanic treatment combinations. The use of benzodiazepines in the short-term, for managament of insomnia

and psychomotor agitation is also a recommended strategy in most guidelines. For treatment resistant mania, there is some evidence supporting the use of clozapine, and ECT may also be a good option. Novel treatments, such as tamoxifen, with four small positive randomized clinical trials, suggest new mechanisms of action that could be further understood in next years.

References

1. Yatham LN, Kennedy SH, Schaffer A, Parikh SV, Beaulieu S, O'Donovan C, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2009. Bipolar Disord 2009;11:225-55.
2: Grunze H, Vieta E, Goodwin GM, Bowden C, Licht RW, Moller HJ, Kasper S. The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Update 2009 on the Treatment of Acute Mania. World J Biol Psychiatry 2009;10:85-116.
3: Goodwin G; Consensus Group of the British Association for Psychopharmacology.: Evidence-based guidelines for treating bipolar disorder: revised second edition--recommendations from the British Association for Psychopharmacology. J Psychopharmacol 2009;23:346-88.
4: Fountoulakis KN, Vieta E.: Treatment of bipolar disorder: a systematic review of available data and clinical perspectives. Int J Neuropsychopharmacol 2008;11:999-1029

Treatment guidelines for acute bipolar depression

Konstantinos N. Fountoulakis
Assistant Professor of Psychiatry, 3rd Department of Psychiatry,
Aristotle University of Thessaloniki, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S63

Bipolar depression is the facet of bipolar disorder most difficult to treat and responsible for most of the disability related to bipolar disorder. Despite supposedly being evidence-based, guidelines for the treatment of bipolar disorder vary significantly across committees or working groups. While the usefulness quetiapine, the olanzapine-fluoxetine combination, lithium, valproic and carbamazepine is widely accepted, it is clearly stated that in bipolar depression antidepressants should be used only in combination with antimanic agents in order to avoid switching of phases. However there is still controversy over the usefulness of the various agents and modalities mainly due to little and poor evidence and conflicting opinions.

Long-term treatment of bipolar disorder

John Cookson
Consultant and Honorary Senior Lecturer in Psychiatry, The Royal London Hospital, London, England, United Kingdom
Annals of General Psychiatry, 2010;9(supplement 1):S64

Lithium was one of the first effective drugs to be introduced to psychotherapeutics, and it remains an important treatment both for mania and for the prophylaxis of bipolar disorder. Its action in preventing recurrences appears greater against mania than against depression. A major trend in recent years has been the recognition that antipsychotic drugs are useful not only in mania and hypomania, but in preventing both mania and depression in patients with bipolar I disorder. The antiepileptic agent lamotrigine is useful in preventing depression and to a lesser extent in preventing mania in bipolar I disorder and in bipolar II rapid cycling. The place of valproate or carbamazepine in long-term treatment has not been firmly established. The effectiveness of lithium is limited by side effects and poor compliance. There is growing evidence that certain antipsychotic agents are associated with better compliance and greater effectiveness than lithium, although their metabolic and endocrine side effects can be problematic. Recent Guidelines recognise the role of antipsychotics in the long-term management of bipolar disorder, alongside lithium, lamotrigine and sometimes antidepressants.

How can guidelines help us in daily practice

Siegfried Kasper
Professor and Chair, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria
Annals of General Psychiatry, 2010;9(supplement 1):S65

There are a number of national as well as international guidelines on the treatment of major psychiatric disorders available. The World Federation of Societies of Biological Psychiatry (WFSBP) publishes guidelines on unipolar depression, bipolar disorder, anxiety disorders, addiction, eating disorders, dementia, just to name a few of them. Whereas national guidelines can limitate themselves to the different kinds of medication that are available, a global perspective on guidelines needs to consider that there are different cultural beliefs and attitudes towards the disease, different legal and regulatory perspectives. Moreover, practice patterns change among countries and there are unique drug availabilities. Furthermore, the healthcare pay system might limitate one or the other treatment option and specific treatments might not have support from professional bodies and opinion leaders. It is noteworthy to mention that treatment guidelines should not be viewed as rigorous algorithm which should be followed in everyday practice. However, the more summaries the more information is available in the literature to guide clinicians in their everyday clinical practice.

19.30-20.00 Lecture
Chairperson: **A. Gelenberg** (USA)

Integrating science and clinical practice in the understanding and treatment of mood disorders

Hagop Akiskal
Distinguished Professor of Psychiatry, Director of the International Mood Center,
University of California, San Diego, USA
Annals of General Psychiatry, 2010;9(supplement 1):S66

The Hippocratic humoral theory is upheld in modern neuropharmacologic investigations showing depressive relapse with catecholamine-depleting agents. Serotonin dysregulation is supported, especially in females, in reduced 5-HT2A receptors in PET
studies. Furthermore, the ancient concept of temperament and its role in depression is supported by current psychometric research. Despite increasing clinical and public health recognition, sophisticated research strategies and the broad availability of relatively safer agents for treatment, depression continues to be a prevalent group of illnesses which
often pursue a recurrent and chronically relapsing course with considerable morbidity and mortality. Etiology is multifactorial, involving, among others, familial-genetic, demographic, developmental, personality, seasonal-circadian, experiential, interpersonal, conjugal, cultural and economic factors. Grief, losses and other life events, emphasized in Freud's and Bowlby's writings, as well as current clinical research experience, together with Darwin's landmark work on evolution, place sadness and related emotions in an adaptive context. Current evidence indicates that experiencing life events depends on a familial diathesis for depression, and that temperament increases reactivity to the very life events that precipitate depression. Even social support, a factor that buffers the depressant effect of life events, appears to be dependent on familial factors. Finally, a positive family history of depression, seems to involve the amygdala. It is of great theoretical and clinical interest that the responsivity of the amygdala is mediated through such conditions as anxiety, bipolar II and related affective personality styles. Response of aversive stimuli, too, appears to be processed through the limbic structures. Many medically associated somatic complaints--fibromyalgia, irritable bowel syndrome
and migraine--appear to be part of the foregoing affective spectrum. Depression may precede, follow or complicate such common diseases as diabetes, myocardial infarction, stroke,and treatment of the associated depression often improves the prognosis of the underlying disease. Another provocative development is the continuity of unipolar and bipolarI II doisorders, which may in selected patients necessitate the use of antidepressant augmentation strategies.
Current treatment research involves complex methodologies in both the psychosocial and psychopharmacologic realms ,which each clinician must practice as an art. Medications are best administered in the context of of an ongoing therapeutic alliance. Prototypes of modern mood stabilizers [lithium, carbamazepine, divalproex, topiramate, gabapentin, lamotrigene] are efficaceous

via somewhat overlapping yet distinct mechanisms. Many antipsychotics [eg, perphenazine, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole] exercise prominent mood stabilizing effects. Finally, prototypes of antidepressants exert thymoleptic action via putative noradrenergic [desipramine], serotoninergic [fluoxetine], or dual chemical action[venlafaxine], possibly dopaminergic [bupropion?] , and in the case of MAOIs such as tranylcypromine appear to involve all three neurotransmitters. Glutaminergic action represents a new fascinating vista beyond the scope of this presentation. Given that mood disorders do occur in a distinct minority of eminent and creative individuals, the clinician can appropriately weigh the relative advantages and limitations of these agents as well as their different side-effect profiles for a given patient in these populations.

20.00-21.30 JANSSEN-CILAG SATELLITE SYMPOSIUM
CAN WE ACHIEVE EARLY AND LONG-TERM EFFECTIVE TREATMENT OF SCHIZOPHRENIA?
Chairpersons: **H.-J. Möller** (Germany), **K.N. Fountoulakis** (Greece)

Why treating early, treating well, and treating for life is important in schizophrenia

Rene Kahn
Professor and Chair of the Department of Psychiatry and Head of the Division of Neuroscience at the University Medical Center, Utrecht, The Netherlands
Annals of General Psychiatry, 2010;9(supplement 1):S67

Schizophrenia is a progressive illness, with many psychotic episodes. Brain imaging studies have consistently demonstrated brain abnormalities in patients with schizophrenia. These changes are largely confined to decreases in gray matter volumes and enlargement of the lateral and third ventricles. To date schizophrenia has been considered to result from abnormalities in neurodevelopment, with brain changes to be static. However, schizophrenia has long been thought to be a progressive or a degenerative, not a developmental, disorder. Indeed, Kraepelin considered the progressive clinical deterioration to be the hallmark of the disorder, naming it dementia praecox to reflect this particular aspect. Lately, others have re-emphasized the importance of the decline in functioning in schizophrenia as a clue to its pathogenesis, suggesting that the brain abnormalities in schizophrenia could be expected to reflect this clinical progression. Indeed, we and others have reported brain abnormalities to increase over time in schizophrenia. Interestingly, not all patients show changes in brain volumes over time: we demonstrated that the changes are particularly pronounced in those patients with a poor prognosis in the first years of illness. Moreover progressive changes are most pronounced in the frontal and temporal areas as postulated by Kraepelin over a hundred years ago. Interestingly, white matter did not change over time. Also we found that brain loss over time was most pronounced in patients who had been psychotic longest. Finally, the progression in these frontal brain changes appeared to be attenuated by treatment with atypical, but not by typical antipsychotics. Thus, not only are brain changes progressive in schizophrenia, they are clinically relevant since they are related to outcome and may be reversed by some of the atypical antipsychotics. With the evidence pointing to a link between progressive disease and patient outcomes, it is becoming increasingly clear that every effort should be made to prevent psychotic relapses. Using medications with maximal effect is therefore warranted.

The need for efficient long-term neuroleptic treatment in schizophrenic patients and the place of long acting injectable antipsychotics

Hans-Jürgen Möller
Professor of Psychiatry and Chairman of the Psychiatric Department, Ludwig-Maximilians University, Munich, Germany
Annals of General Psychiatry, 2010;9(supplement 1):S68

Schizophrenia is a chronic disorder with a high risk of poor outcome in terms of symptoms and social

functioning and possibly also progressive brain alterations. The relapse rate is high and each relapse can induce further aggravations. Thus, long-term treatment with the highest degree of effectiveness should be provided to the patients. Amongst others, the suitable drug for the individual patient has to be selected as well as the high risk of non-compliance to be carefully considered.
All the available evidence from randomised controlled studies indicates that antipsychotic medications substantially reduce the risk of relapse. The lowest dose should be chosen at which preferably no side effects occur, the risk of relapse seems to be optimally reduced and, if symptoms are still present, suppression of these is optimised. Side effects have to be assessed and, if necessary, pharmacotherapy has to be adjusted.
Despite several methodological design issues, second-generation antipsychotics have proven superior efficacy in preventing relapse to FGAs. Available studies of the specific agents supply evidence for periods of up to 2 years. Due to the decreased risk of EPS, especially tardive dyskinesia and the superior efficacy in improving negative, cognitive and depressive symptoms, second-generation antipsychotics should be preferred in long-term treatment.
Given all the known problems in compliance and discontinuation, which were underlined in recent years by the CATIE and the EUFEST study, depot preparations should be considered for optimum effectiveness in preventing relapse. Altogether, randomised, control-group studies to determine the long-term advantages of depot preparations of atypical neuroleptics compared to depots of typical neuroleptics are still lacking. However, the huge database for long acting injectable risperidone is so convincing in terms of efficacy, tolerability and effectiveness that its special place in the long-term treatment of schizophrenia becomes obvious.
The target strategy in long-term treatment of schizophrenia should be a combination of long-term antipsychotic treatment and psycho- and sociotherapeutic procedures, so that the relapse rate is further reduced and the course of disease can be further improved.

References

1. Möller HJ: Course and long-term treatment of schizophrenic psychoses. Pharmacopsychiatry. 2004 Nov;37 Suppl 2:126-35
2. Möller HJ: Long-acting risperidone: focus on safety. Clin Ther. 2006 May;28(5):633-51.
3. Möller HJ: Long-acting injectable risperidone for the treatment of schizophrenia: clinical perspectives. Drugs. 2007;67(11):1541-66.
4. Möller HJ: Systematic of psychiatric disorders between categorical and dimensional approaches: Kraepelin's dichotomy and beyond. Eur Arch Psychiatry Clin Neurosci. 2008 Jun;258 Suppl 2:48-73.

The role of RLAI in early schizophrenia treatment: Critical aspects regarding efficacy and safety

George Papageorgiou
NHS Director, Department of Psychiatry, Evangelismos General Hospital, Athens, Greece
Annals of General Psychiatry, 2010;9(supplement 1):S69

It is well known that there are high levels of response to treatment topatients with a first episode and early schizophrenia. This outcome is hampered by inadequate treatment adherence , which leads to relapse, and high sensitivity to side-effects. Risperidone Long Acting Injectable (RLAI) treatment has proven to be advantageous compared to oral treatment to these early patients, both clinically and pharmacoeconomically. RLAI has proven to improve treatment adherence, prolong time to relapse vs. more chronically ill patients , to improve patient functioning and also to achieve better symptom control in comparison to oral haloperidol, risperidone and also to patients switched from oral olanzapine. Therefore , treatment with atypicals and especially with RLAI to first episode and early patients can alter favorably the course of the schizophrenic disorder.

References

1. Olivares J-M et al. Long-Term Outcomes in Patients with treat with Risperidone Long Acting Injection or oral antipsychotics in Spain:Results from the electronic Schizophrenia Treatment Adherence Registry (e_STAR) Europ Psychiatry ,2009: E pub Ahead of print
2. Lambert T Et al Risperidone Long Acting Injection in the Treatment of Recently vs. Longer Diagnosed Patients with Schizophrenia . Poster Presented at the 21st Congress of the European College of Neuropsychopharmacology, August 30 –September 3 , 2008 , Barcelona, Spain

Sunday November 22nd, 2009

09.00-09.30 Lecture
Chairperson: **Ch. Touloumis** (Greece)

Polypharmacy in schizophrenia – therapeutic option or a sign of despair?

Anastasios Konstantinidis
University Hospital for Psychiatry and Psychotherapy, Clinical Division for Biological Psychiatry, Vienna, Austria
Annals of General Psychiatry, 2010;9(supplement 1):S70

International guidelines on schizophrenia and worldwide experts in psychiatry recommend and insist on monotherapy with an antipsychotic medication for schizophrenic patients. Studies about the clinical practice of these guidelines show that all over the world most schizophrenia patients receive two or more antipsychotics. Further more combinations with antidepressants, mood stabilizers or benzodiazepines is also common. Regarding to local national differences polypharmacy rates are increasing and achieve rates between 50 and 90% of schizophrenic patients, exhibiting therefore a major international trend towards polypharmacy. Although in some cases combination therapy brings advantages, such as "enhancing" or "speeding up" the antipsychotic effect, there are still a lot of disadvantages in a polypharmacy treatment regiment, such as interactions of the drugs being involved, the greater risk of adverse reactions and the lack of compliance to treatment regiment. Small, randomised controlled studies with regard to antipsychotic combination therapy exist. In summary they exhibit a positive outcome for combinations of antipsychotics with different receptor profile. Altogether according to the study results combinations can be divided in irrational (e.g. clozapine and quetiapine), and rational ones, which provide a greater efficacy (e.g. clozapine and amisulpirid). Augmentation with antidepressant agents in case of persisting negative symptoms and with mood stabilizers in patients with additional affective symptoms can be recommended. Further randomised controlled studies are necessary to recommend combination strategies on a higher level of evidence for treatment resistant schizophrenia patients. In the speech given, I would try to give you an overview and discuss current data and trends in combining antipsychotic or other psychotropic treatment in schizophrenia.

09.30-11.00 Symposium
ETHICS, AESTHETICS AND PSYCHOPHARMACOLOGY
Chairpersons: **L. Câmara Pestana** (Portugal), **M.L. Figueira** (Portugal)

New patients, new disorders, new drugs and the rise of prescriptions

Luis Camara Pestana
Psychiatrist, Clinical Pharmacologist President of the Portuguese Association of Biological Psychiatry and Consultant of the Portuguese Authority of Drugs and Pharmacy, Portugal
Annals of General Psychiatry, 2010;9(supplement 1):S71

The rise of prescription of psychotropic drugs is a major healthcare problem namely in Psychiatry. The reason of the rise is not clear and many questions remain unanswered. Furthermore, we have more patients, more drugs, more resistant and demanding patients and more polypharmacy. Inappropriate prescribing and lack of rational is not uncommon and prescribing education is also a main concern. Although, the use of guidelines for treatment could make clinical work easier they differ in their objectives and contents. We will discuss the doctor´s capacity to make more diagnosis, the problematic of out of label prescriptions and the potential of abuse of some medication and the implications in the rise of prescription. The continuous update and training in clinical psychopharmacology and joint decision-making process between clinicians will allow a rational approach to treatment.

Are depressive residual symptoms independent of treatments?

Maria Luisa Figueira
Professor of Psychiatry, Faculty of Medicine, University of Lisbon, and Head of the Psychiatric Department Hospital Santa Maria, University of Lisbon, Portugal
Annals of General Psychiatry, 2010;9(supplement 1):S72

Residual symptoms occur in many depressive patients after acute treatment (1). There is growing evidence that residual symptoms are also prevalent in bipolar disorder during the euthymic phase and in unipolar depression, they are predictors of early relapse (2) (3). In long-term outcome, patients remitting from depression with residual symptoms, have more depressive symptoms and impaired social functioning, thus needing more aggressive treatment (4). Residual symptoms might be conceived as the persistence of the original mood disorder, despite in a milder presentation, or still be in relation to the neurobiological disorder substrate. Residual symptoms include core mood and functional symptoms of depression. The most common residual symptoms are sleep disturbances, fatigue, and disinterest. The clinician should be aware that patients despite being in apparent remission should be questioned thoroughly in order to identify residual cognitive difficulties, impairment of work and activities, psychic anxiety, sleep disturbances or mild depressive mood (5). The consequences of low-quality remission impairing psychosocial functioning have to be emphasized. In this presentation we will review the available evidence of the role played by the pharmacological treatments in the residual depressive symptoms.

References

1. Fava GA, Fabbri S, Sonino N Residual symptoms in depression: an emerging therapeutic target. Prog Neuropsychopharmacol Biol Psychiatry. 2002 Oct;26(6):1019-27.
2. Paykel ES, Abbott R, Morriss R, Hayhurst H, Scott J Sub-syndromal and syndromal symptoms in the longitudinal course of bipolar disorder. Br J Psychiatry. 2006 Aug;189:118-23.
3. Paykel ES, Ramana R, Cooper Z, Hayhurst H, Kerr J, Barocka A Residual symptoms after partial remission: an important outcome in depression.Psychol Med. 1995 Nov;25(6):1171-80.
4. Kennedy N, Paykel ES Residual symptoms at remission from depression: impact on long-term outcome. J Affect Disord. 2004 Jun;80(2-3):135-44.
5. Paykel. E.S.. Partial remission, residual symptoms, and relapse in depression. Dialogues Clin Neurosci. 2008;10(4):431-7.

Psychopharmacology at the era of EMEA (European Medicines Agency)

Luis Camara Pestana[1], **Licinia Gananca**[2]
[1] Psychiatrist, Clinical Pharmacologist President of the Portuguese Association of Biological Psychiatry and Consultant of the Portuguese Authority of Drugs and Pharmacy, Portugal
[2] Psychiatry Resident, Psychiatric Department, Hospital Santa Maria, University of Lisbon and Consultant of the Portuguese Authority of Drugs and Pharmacy, Portugal
Annals of General Psychiatry, 2010;9(supplement 1):S73

In the last decade the European Medicines Agency has been attempting to harmonize the work of the existing national medicines regulatory authorities and the data regarding efficacy criteria and safety for the use of human medicines in specific pathologies (eg. Schizophrenia, Bipolar Disorder, Depression), thus creating guidance notes for clinical investigation. Medical prescription decisions are generally made upon data acquired through scientific information (treatise, studies, consensus, meetings, congresses), specialists experience and pharmaceutical industry information. While prescription rules are established for approved indications by large scale studies, off-label prescribing lacks the support of robust clinical trials and is at its best based on expert consensus. It brings with it increased responsibility for the prescriber if the patient suffered an adverse reaction, as liability would rest with the prescriber and/or their employers. Nuclear information for a rational plan, risk assessment, scientific evidence for add-on therapy and off-label prescription, will be discussed in this presentation.

Medical care and long-term treatment of patients with schizophrenia: Ethical concerns

Frederico Simões do Couto
Neuroscience Department of the Institute of Molecular Medicine, Lisbon, and Department of Psychiatry, Hospital de Santa Maria and Faculty of Medicine of Lisbon, Portugal
Annals of General Psychiatry, 2010;9(supplement 1):S74

Despite the improvement in mental health care that has occurred in the last decades, the mortality risk in patients with schizophrenia has not been changed, and there was even an increase in the mortality of these patients when compared to the general population. The main causes for this increased mortality are somatic diseases, especially diabetes, hypercholesterolemia, hypertrygliceridemia, cardiovascular diseases (including arterial hypertension), obesity, HIV infection/AIDS, hepatitis C and osteoporosis (Saha et al, 2007). The link between second generation antipsychotics and cardiovascular risk factors has raised questions on their overall safety, and these concerns are even more important if patients are on compulsory treatment. Furthermore, at least half of patients suffering from schizophrenia have one co-morbidity not diagnosed or wrongly diagnosed (Muir-Cochrane, 2006). In a sample of 476 community patients suffering from schizophrenia, we found rates of diagnosed hypertension of 6,9%, hypercholesterolemia of 9,0%, hypertrigliceridemia of 6,3%, and diabetes of 4,2%. Not only these figures are lower than in other large studies, but also apparently only 12 to 30% of the patients presenting these disorders were being treated for these conditions (Simões do Couto et al, 2009). Barriers to recognition and management of physical diseases in patients with schizophrenia are related both to health care providers and to patient/disease. Acute admission could be a target for the screening and treatment of these disorders, and we tried to find a screening protocol for this situation. Acutely ill patients have higher rates of infections and liver abnormalities, but lower rates of hypercholesterolemia (Teixeira et al, 2009). In our sample more than 80% of patients with schizophrenia are retired or unemployed. Resources are scarce, and their allocation to these patients can prevent the access of people suffering from other disorders to the care they need.

References

1. Muir-Cochrane E. Medical co-morbidity risk factors and barriers to care for people with schizophrenia. Journal of psychiatric and mental health nursing. 2006;13(4):447-52.
2. Saha S, et al. A systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? Arch Gen Psychiatry. 2007;64(10):1123-31.
3. Simões do Couto F, et al. The characterization of a Portuguese population of outpatients with schizophrenia, and their therapeutical management, in the European context
4. Teixeira J, et al. Which blood analysis should be requested to patients with schizophrenia when hospitalized for acute psychosis? 17th EPA European Congress of Psychiatry, Lisbon, January 24-28, 2009.

11.00-12.30 Symposium
NEW INSIGHTS IN AFFECTIVE TEMPERAMENTS AND BIPOLAR SPECTRUM
Chairperson: **A. Koukopoulos** (Italy)

Temperament and major depressive disorder

Elie G. Karam [1,2,3], Mariana M. Salamoun[3], Joumana S. Yeretzia [3], Zeina Mneimneh[3,4], Aimee N Karam[1,2,3], John Fayyad[1,2,3]
[1]Department of Psychiatry and Clinical Psychology, St George Hospital University Medical Center, Beirut, Lebanon
[2]Department of Psychiatry and Clinical Psychology, Balamand University Medical School, Beirut, Lebanon
[3]Institute for Development Research Advocacy, and Applied Care (IDRAAC), Beirut, Lebanon
[4]Program in Survey Methodology, Institute for Social Research, University of Michigan, USA
Annals of General Psychiatry, 2010;9(supplement 1):S75

The Lebanese-Arabic TEMPS-A (Temperament Evaluation of the Memphis, Pisa, Paris and San Diego Autoquestionnaire) was used to assess the association between affective temperament and mental disorders in a nationally representative sample of the Lebanese Evaluation of the Burden of Ailments and Needs Of the Nation study(L.E.B.A.N.O.N). The five affective temperaments were associated with mental disorders with anxious temperament having a risk role while hyperthymic temperament having a protective role. This presentation will focus on the specific association between temperament and the age of onset of major depressive disorder.

Clinical approach of alcoholism through affective temperaments

Andreas Erfurth
Head of Clin Psychopharmacology and the Bipolar Spectrum Disorders Program, Division of General Psychiatry, Medical University of Vienna, Austria
Annals of General Psychiatry, 2010;9(supplement 1):S76

In the recent past multiple efforts have been made to subtype alcoholism beyond ICD-10, mainly in order to take in account the course of the disease and its neurochemistry. The typology of Otto Lesch (1,2) has received considerable attention due to its practical value and its relevance for the prediction of treatment response.
While the comorbidity of alcoholism and affective disorder has been thoroughly studied (3), the role of subthreshold affective disturbances and the role of temperament remain unclear.
At Vienna University Hospital he have studied consecutive admissions of patients with alcoholism by assessing temperament and subthreshold hypomania.
Our data show a clear link of the Lesch typology to the clinical burden of hypomanic and cyclothymic features. Implications for prevention and long-term treatment will be discussed.
References
1. Lesch OM et al. The course of alcoholism. Long-term prognosis in different types. Forensic Sci Int 1988; 36: 121-138
2. Pombo S, Lesch OM. The alcoholic phenotypes among different multidimensional typologies. Alcohol & Alcoholism 2009; 44: 46-54
3. Merikangas KR et al. Specificity of bipolar spectrum conditions in the comorbidity of mood and substance use disorders. Arch Gen Psychiatry 2008; 65: 47-52

Cyclothymic temperament and/or borderline personality disorder

Giulio Perugi
Professor of Clinical Psychiatry and Psychopharmacotherapy, University of Pisa, Italy
Annals of General Psychiatry, 2010;9(supplement 1):S77

Many patients within the Bipolar spectrum, especially when recurrence is high and the inter-episodic period is not free of affective manifestations, may meet criteria for personality disorders. This is particularly true for cyclothymic patients, who are often misclassified as borderline personality disorder because of their extreme mood instability and reactivity. In patients with cyclothymic temperament, lifetime comorbidity with anxiety disorders, in particular panic disorder-agoraphobia, bulimia nervosa, body dysmorphic disorder, alcohol and substance abuse disorder and both cluster C (anxious) and cluster B (dramatic) personality disorders, is the rule rather than the exception (Perugi and Akiskal, 2002). In particular, a large proportion of these patients meet DSM-IV criteria for borderline personality disorders. Cyclothymic-bipolar II-borderline patients display a long-lasting "stable" hyper-reactivity to many psychological (i.e, rejection, separation) and physical (i.e., food, light, drugs) stimuli. This marked reactivity of mood could also explain the frequent concomitance of impulse control disorder and substances and alcohol abuse. An analysis of the explanatory power of affective temperaments and personality disorders for each of the criteria of BPD (Perugi et al., in press) revealed that the presence of cyclothymic temperament explains much of the relationship between bipolar II disorder and BPD. The diagnosis of BPD in these patients was favored by the coexistence of an affective cyclothymic temperamental dysregulation coexisting with anxious-dependent traits. We find no reason to separate bipolar II with cyclothymic instability from the stable instability of the borderline type, because mood lability is a common characteristic of both sets of disorders. Further, correlational analyses (Perugi et al., 2003) indicate that in bipolar II atypical depressives mood reactivity and interpersonal sensitivity traits might be related constructs with a cyclothymic temperamental matrix.

References

1. Perugi G, Akiskal HS. Te soft bipolar spectrum redefined: focus on the cyclothymic-anxious-sensitive, impulse-dyscontrol, and binge-eating connection in bipolar II and related conditions. Psychiatr Clin North Am, 2002; 25:713-737.
2. Perugi G, Toni C, Travierso MC, Akiskal HS. The role of Cyclothymia in Atypical Depression: Toward a data-based reconceptualization of the Borderline-Bipolar II connection. J Affect Disord , 2003, 73: 87-98

Temperament and Schema-focused diagnosis in soft bipolarity

Elie Hantouche
Director of CTAH, Anxiety and Mood Center, France
Annals of General Psychiatry, 2010;9(supplement 1):S78

The current concept of Bipolar Spectrum is still evolving and much more interest is focused on the definition of Hypomania (BP-II Disorder) and especially Cyclothymic Disorder. In order to get the entire diagnosable range of bipolar conditions, the clinical approach must go beyond "polarity" of episodes: family history, age of onset, time course (circularity), level of recurrence, type of cyclicity (exogenous / endogenous), and especially affective temperaments. Clinical researches have been dedicated to explore affective temperaments and their role in psychopathology of mood disorders. Cyclothymia appears to be a likely precursor or a basic primary ingredient of the construct of soft bipolarity. The French studies directed by Hantouche and Akiskal showed that Cyclothymia is probably the most frequent expression of bipolar disorder, and represents a distinct entity with early onset, irritable ("dark") hypomania and high suicide risk. Despite these facts, there is a lot to learn about Cyclothymia. In the "psycho-education group therapy" model for Cyclothymia, elaborated in the CTAH, we recently addressed the following issues:

- Links between Cycothymic Temperament and Hypomania, dimensionally explored by the HCL-32

(Angst)
- Relationships between affective temperaments, especially Cyclothymic Temperament (assessed by TEMPS-A) and temperament (as measured by the Adult Temperament Questionnaire and the Affective Intensity Scale)
- Role of Cyclothymia in the "schema-focused approach" (J. Young)
- Expression of Cyclothymia through psychological vulnerabilities and interpersonal conflicts

Preliminary data will be presented.

References

1. E. Hantouche & B. Houyvet: « Cyclothymie : Troubles bipolaires des enfants et adolescents au quotidien », Josette Lyon, Janvier 2007
2. E. Hantouche, R. Blain: « Cyclothymie pour le pire et le meilleur : bipolarité et créativité », Robert Laffont, Avril 2008
3. E. Hantouche, V. Trybou: « Soigner sa cyclothymie : 7 clés pour retrouver l'équilibre de soi », Odile Jacob, Mars 2009

13.00-14.30 **Symposium**
TREATMENT OF ALCOHOL AND SUBSTANCE USE DISORDERS IN PEOPLE WITH HEPATITIS C
Chairperson: **P. Hauser** (USA)

Brief interventions for reducing drinking in veterans with Hepatitis C

Bret Fuller
Program Coordinator, NW Hepatitis C Resource Center and Staff Psychologist, Portland VA Medical Center, Portland, Oregon, USA.
Annals of General Psychiatry, 2010;9(supplement 1):S79

The prevalence of hepatitis C (HCV) infection among veterans treated within Veterans Affairs Medical Centers (VAMCs) is 3 to 4 times higher than the general population prevalence of 1.8%. Approximately 50 to 60% of patients with HCV are at risk for progression to end-stage liver disease. The risk for progression to end-stage liver disease is significantly increased in individuals with heavy alcohol consumption and veterans with HCV have a high rate of co-morbid alcohol use. Treatments that reduce or eliminate alcohol consumption among HCV-positive veterans may reduce the impact of the disease for the individual.

Motivational enhancement treatments (MET) have shown the greatest efficacy in treating alcohol use disorders in general. Further, medications that reduce alcohol craving and consumption, that are also not metabolized in the liver are equally beneficial. The objectives of this presentation are to detail two ongoing studies at the Veterans Affairs Medical Center that aim to reduce alcohol consumption for veterans with hepatitis C. The first study assesses the efficacy of MET to reduce number of drinking days over the period of six months. This study is being conducted in two VA Medical Centers and compares a four session MET intervention to a four session educational (control) intervention. The second study being conducted at three VA medical centers assesses the use baclofen, a generic medication approved for use in muscle spasm that has been shown in initial trials to reduce alcohol craving and consumption. Baclofen is not metabolized in the liver and is potentially ideal for patients with HCV. Both non-medication and medication interventions are crucial strategies for improving the health of veterans with HCV who have co-morbid alcohol use.

Medication treatment of alcohol use disorders in veterans with Hepatitis C

Peter Hauser
VISN 22 Mental Health Services Lead, Long Beach VA Medical Center, Long Beach, California, USA
Annals of General Psychiatry, 2010;9(supplement 1):S80

Hepatitis C viral infection (HCV) is the most common chronic blood borne viral infection in the world and in the United States affects approximately 1.8% of the general population. The prevalence of hepatitis C viral infection (HCV) is 3-4 times higher among veterans who use VA services than the general population rate of 1.8% and is estimated to be approximately 5 to 6%. A national VA study found that over 75% of veterans had some Substance Use Disorder. At the Portland VAMC, 57.6% (n=783) of veterans with HCV recently seen in the hepatology clinic reported consuming alcohol in the past year and approximately 25% reported heavy alcohol use (AUDIT C score of 4 or greater).
Alcohol use and HCV are thought to act synergistically to accelerate liver damage and cirrhosis. Several studies show heavy alcohol consumption increases the risk of fibrosis progression as well as the risk of end stage liver disease and cirrhosis in HCV patients. Among them Corrao and Arico (1998) found, among all patients who do not drink alcohol, HCV-infected patients are 9.2 times more likely to develop liver cirrhosis than non-HCV-infected patients. They also found that there is a dose-dependent relationship between lifetime daily alcohol intake, HCV infection, and risk of developing cirrhosis. Compared to HCV patients who do not drink, the risk of cirrhosis was three times higher in HCV patients who drank 75 to 100 grams per day, 16 times higher in HCV patients who drank ≥175 grams per day of alcohol than HCV patients who did not drink and over 140 times higher than people who did not have HCV or drink alcohol.
Effective treatments for alcohol use have not been studied in patients chronically infected with HCV and current FDA-approved medications for AUD can adversely affect the liver and are generally not well tolerated. The presentation will review current FDA –approved as well as off-label use medication studies for Alcohol Use Disorders and their utility for people who have hepatitis C and co-morbid Alcohol Use Disorders. The various treatment options will be discussed.

Chronic pain and substance use in patients with Hepatitis C

Ben Morasco
Staff Psychologist, Portland VA Medical Center, Portland, Oregon, USA
Annals of General Psychiatry, 2010;9(supplement 1):S81

The hepatitis C virus (HCV) is the most common blood-borne infection and affects approximately 2% of the U.S. population, with higher rates occurring in some segments of the population. Chronic pain affects approximately 35% of the general population, with 15% of individuals experiencing daily pain. In contrast, the prevalence of chronic pain among HCV patients may exceed 65%.
The reasons for the high rates of chronic pain among HCV patients are not clear. More than two-thirds of HCV patients have a history of substance use disorder (SUD), and history of SUD is associated with the development of pain. HCV patients also have high rates of co-morbid psychiatric disorders, which are also associated with chronic pain.
The purpose of this presentation will be to outline the issue of chronic pain and substance use among HCV patients and to describe factors that may lead to the high rate of chronic pain in this patient population. The results of ongoing studies that examined the role of biopsychosocial factors in the development and exacerbation of chronic pain in HCV patients will also be described.

14.30-15.00 Lecture
Chairperson: **P. Grigoriou** (Greece)

Cross-cultural psychopharmacology: A review

Edmond H. Pi, Weiguo Zhu
Department of Psychiatry and the Behavioral Sciences, University of Southern California, Keck School of Medicine, Los Angeles, California, USA
Annals of General Psychiatry, 2010;9(supplement 1):S82

Cross-cultural psychopharmacology seeks to determine whether there are differences in responses to psychopharmacologic agents among various ethnic groups and the reason for such variations. During the past four decades numerous clinical reports have addressed potential differences in therapeutic dosages and side effects of psychotropic medications between various ethnic groups. In addition, several rigorously designed studies have focused on ethnic differences in pharmacokinetics (including absorption, metabolism, distribution and excretion) and pharmacodynamics (including receptor-coupling activity). These ethnic variations are mainly influenced by genetic predisposition but are also influenced by other factors such as culture, environment, psychosocial supports, and attitudes towards pharmacology.
This presentation will provide a critical review of the existing information in regard to psychotropic medications including neuroleptics, antidepressants, lithium, and benzodiazepines among various ethnic groups. Also included will be data on neuroleptic-induced movement disorders, the clinical implications of genetic polymorphism of cytochrome P-450 isoenzymes, recommendations on how to better design a pharmacological approach in the treatment of psychiatric disorders among different ethnic groups, as well as recent advances and future directions regarding cross-cultural issues of psychopharmacology.
References
1. EH Pi, WG Zhu: New Research Advances in Ethnopsychopharmacology: An Asian Perspective. Journal of International Psychiatry, 2007, 4:57-58
2. EH Pi, GE Gray: A Cross-cultural Perspective on Psychopharmacology. Essential Psychopharmacology, 1998, 2:233-262

15.00-15.30 Lecture
Chairperson: **A. Soghoyan** (Armenia)

Specific inhibition of adenylyl-cyclase isoform 5 by mood stabilizers may be related to their mechanism of action

Liad Mann, Eliahu Heldman, Yuly Bersudsky, Orna Almog, RH Belmaker, **Galila Agam**
Psychiatry Research Unit and Department of Clinical Biochemistry, Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel
Annals of General Psychiatry, 2010;9(supplement 1):S83

Lithium, valproate and carbamazepine decrease brain cAMP. Adenylyl-cyclase (AC), which synthesizes cAMP has nine membrane-bound isoforms (AC1-AC9). In this study we used COS7 cells transfected with cDNA of each of the isoforms to study the effect of a therapeutic concentration of each of lithium, carbamazepine and valproate on ACs activity. AC5 was the most inhibitable isoform by lithium and carbamazepine either when stimulated by forskolin or by a D1 agonist. Ten mM Mg2+ reduced lithium-induced AC5 inhibition by 70% and in silico analysis suggested that carbamazepine preferentially affects AC1 and AC5 by interacting with two amino-acids at the catechol-estrogen binding site region. Valproate did not inhibit any AC isoform suggesting it decreases cAMP levels via a different mechanism. AC5 knockout mice behaved in the forced-swim-test similarly to antidepressant- or lithium-treated wildtypes implying that AC5 inhibition may be involved in the antidepressant effect of lithium and carbamazepine. Specific AC5 inhibitors may be mood-stabilizers or antidepressants.

CONTRIBUTING UNITS, SOCIETIES AND ORGANIZATIONS

- *1st Laboratory of Pharmacology, School of Medicine, Aristotle University of Thessaloniki, Greece*
- *Euro-Mediterranean Network on Migration and Mental Health*
- *European Bipolar Network*
- *European Psychiatric Association*
- *Forensic Mental Health Section of the Greek Psychiatric Association*
- *Hellenic Bipolar Organization*
- *International Society on Neurobiology and Psychopharmacology*
- *Network on Dialogue for Mental Health Care*
- *Portuguese Association of Biological Psychiatry*
- *Psychiatric Hospital of Thessaloniki, Greece*
- *The MRC SGDP Centre, Institute of Psychiatry at King's College London, UK*
- *World Psychiatric Association*
- *WPA Section on Private Practice Psychiatry*

POSTERS

P001

PREVALENCE OF PTSD IN THE KERMAN SCHOOLS STUDENTS WITNESSING THE BAM EARTHQUAKE SCENES ON TV

Khosropour F.[1], Farahmand M.[2], Yazdani R.[3]

[1]Psychology Department, Islamic Azad University, Zarand Branch, Kerman, Iran, [2]High Technology, Roshd Center, Kerman, Iran, [3]Medical Science University Kerman, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S84

Background: Observing horrible scenes may lead to PTSD, also it is possible that observing these scenes on TV may lead to PTSD however it is controversial.
Materials and methods: Using a cluster sampling procedure 300 students from the Kerman schools were selected. A PTSD symptoms check list a long with the DSM-IV diagnostic criteria were used to detect the symptoms 3 months after the Bam quake .All of them witness the Bam earthquake scenes on TV at least for one hour.
Results: Result Indicated that 195 were without any symptoms, 40 had the re-experience of the events in the form of repetitive remembering, 20 had avoidant behaviors, 19 had showed irritability, and 16 had detachment , and 10 had the full picture of the PTSD.
Conclusions: Considering the prevalence of the PTSD across children, care should be taken regarding observation of the horrible scenes by children.

References

M. Aulagnier, P. Verger, F. Rouillon: Efficacy of psychological debriefing in oreventing PTSD. Rev Epidemiol Sante Publique 2004, 52(1):67-79
S.H. Bland, L. Valoroso, S. Stranges: long-term follow-up of psychological distress following earthquake experiences among working Italian males. J. Nerv Ment Dis 2005, 193(6):420-423
M. Taylor, K. Jenkins: The psychological impact of September 11 terroism on Australian inpatients. Australas psychiatry 2004, 12(3):253-265
H. Cao, A.C. Mcfarlane, S. Klimidus: Prevalence of psychiatric disorder following the 1988 Yun Nan (China) earthquake - the first 5-month period. Soc psychiatry Epidemiolo 2003, 38(4):204-212

P002

SEVERE TRAUMATIC BRAIN INJURIES IN THE ELDERLY

Syrmos N., Iliadis Ch., Valadakis V., Grigoriou K., Paltatzidou K., Marakaki Ch., Arvanitakis D.

Neurosurgery Department, Venizeleio General Hospital, Heraklion, Crete, Greece

Annals of General Psychiatry, 2010; 9(supplement 1):S85

Background: The elderly are forming an increasingly larger proportion of the population in developed countries with increasingly active life styles. The injured elderly patient has a combination of decreased physiologic reserve and a high incidence of preexisting medical conditions that cause comparably worse outcome, complications, longer hospital stay, and high costs
Materials and methods: The purpose of this study was to compare data obtained from a statewide data set for elderly patients (> 65 years) that presented with severe traumatic brain injury with data from nonelderly patients < 65 years) with similar injuries. MATERIAL-METHODS - During the last 6 years(2003,2004,2005,2006,2007,2008) 200 (130 men-65%- and 70 women-35%-) patients were examined. 110 of them were > 65 years ,55% and the rest 90 < 65 years, 45%.Head-injured patients were identified by Glasgow Coma Scale (GCS) score at admission and discharge and Injury Severity Score (ISS). Outcome was assessed by a Functional Independence Measure score in three major domains: expression, locomotion, and feeding.
Results: 1.There were more male subjects in the nonelderly population (82 male subjects, 91,1%) compared with the elderly population (61men,55,4%). 2.Mortality was 28,1% in the elderly population compared with 12.2% in the nonelderly population. 3.The elderly non survivors were statistically older, and mortality rate increased with age. 4.Stratified by GCS score, there was a higher percentage of nonsurvivors in the elderly population. 5.Functional outcome in all three domains was significantly

worse in the elderly survivors compared with the nonelderly survivors
Conclusions: 1.Elderly traumatic brain injury patients have a worse mortality and functional outcome than nonelderly patients who present with head injury even though their head injury and overall injuries are seemingly less severe.2. Although the management of specific neurosurgical injuries is similar in the elderly, many benefit from an overall more aggressive approach to early resuscitation and optimization of cardiopulmonary dynamics. 3. An awareness of the importance of preexisting medical conditions and a coordinated, directed approach to the management of the injuries and the concomitant diseases leads to the most effective care. Upon recovery from injury there is often a change of functional level that precipitates a change in social circumstance.

References
Zenilman M.E., Hardin R.E.: Surgery in the elderly: the evolving role of palliative care in general surgical practice. Adv Surg 2004, 38:55-65.
Syrmos Nikolaos, Grigoriou Konstantinos, Valadakis Vasilios, Charzinasiou Evangelia, Arvanitakis Dimitrios and Syrmos Christos: Neurosurgery and quality of life in elderly people. Annals of General Psychiatry 2008, 7(Suppl 1):S237
Severs M.P., Wilkins P.S.: A hospital palliative care ward for elderly people. Age Ageing 1991, 20(5):361-4.

P003

THE USE OF INTERSPINOUS PROCESS SPACERS IN ELDERLY PEOPLE. PRELIMINARY EXPERIENCE

Syrmos N., Iliadis Ch., Valadakis V., Grigoriou K., Arvanitakis D.

Neurosurgical Department, Venizeleio General Hospital, Heraklion, Crete, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S86

Background: The spinous processes are located in the very back of the spinal column near the skin surface. In fact, by passing the hand down the center of the low back one is usually able to feel several small prominences. These are the spinous processes. The near proximity of the spinous processes to the skin allows for the implantation of interspinous process spacers with minimal operative intervention and spinal morbidity.The interspinous process devices are designed to distract (open) the foramen, where the nerve endings pass away from the center of the spinal region and into the legs. It is thought that these devices may also unload the intervertebral disc. They may limit spinal extension (the position the spine takes on when bending backward). This backward bending position may be painful for patients with spinal stenosis because it reduces the space available for the nerve roots in the exiting foraminal openings.The interspinous devices may be implanted with the patient under a mild sedative and local anesthesia as a day surgery procedure (patient goes home the same day) or under light anesthesia. This may be particularly beneficial for elderly patients for whom more extensive open surgery may present too great of a surgical risk due to less favorable general health and fitness level
Materials and methods: Aim of our study was to investigate the clinical outcome of patients with symptomatic lumbar spinal stenosis before and at periodic intervals after interspinous process spacers implantation. MATERIAL-METHODS- 33 consecutive patients over 65 years old, were enrolled and surgically treated with interspinous process spacers implantation implantation. They were clinically evaluated at the preoperative 1 month, 3-month, 6-month, 9 month and 1-year stage with clinical questionnaires (VAS, Zurich Claudication Questionnaire, Oswestry Disability Index, SF-36, JOA, AO SPINE)
Results: 13 patients failed to complete all the questionnaires at all time intervals and hence were excluded, leaving 20 patients who had completed all questionnaire at all time interval. By 12 months, 80% of these 20 patients -16-reported clinically significant improvement in their symptoms, 2 reported clinically significant improvement in physical function, and 2 expressed no satisfaction with the procedure.
Conclusions: The advantages of the interspinous process spacers are:- Low Risk Operation- Shorter Surgical Time- Minimally Invasive Surgery- Preserve Flexibility and Mobility- Faster Rehabilitation

References
Miller J.D., Nader R.: Treatment of combined osteoporotic compression fractures and spinal stenosis: use of vertebral augumentation and interspinous process spacer. Spine. 2008 Sep 1; 33(19):E717-20
Bono C.M., Vaccaro A.R.: Interspinous process devices in the lumbar spine. J Spinal Disord Tech. 2007 May; 20(3):255-61.
Kim D.H., Albert T.J.: Interspinous process spacers. J. Am Acad Orthop Surg. 2007 Apr; 15(4):200-7.

P004

TOBACCO SMOKING IN EATING DISORDERED FEMALE PATIENTS

Eiber R., Bernin I.[2]

[1]Psychiatrist private exercice 16 chemin du Calquet 31100, Toulouse, France, [2]Department of Pharmacology, Pitié-Salpêtrière Hospital, Paris

Annals of General Psychiatry, 2010; 9(supplement 1):S87

Background: Some smokers use tobacco in order to control weight. It is conceivable that eating disordered women smoke for that reason. Aim: to describe smoking features in eating disordered women; to show differences according to types of eating disorder and to identify factors explaining tobacco use in this population.
Materials and methods: A retrospective study including two hundred women diagnosed for eating disorders according to ICD-10 criteria. We gathered socio-demographic features and evaluated tobacco dependence with the Fagerström questionnaire (FTND).
Results: The body mass index was the same in all smoking and no smoking eating disordered patients. FTND score and daily consumption of cigarettes in eating disordered smokers showed significant differences according to diagnostic groups of eating disorders. Age of smoking the first cigarette, age of beginning daily tobacco smoking and reasons of smoking did not display any significant differences between diagnostic groups. Daily smoking was much more frequent in bulimics.
Conclusions: Our study did not allow to reveal that tobacco is used to control weight in eating disordered women.

References

Neumark-Sztainer D., Story M., Dixon L.B., et al. Adolescents engaging in unhealthy weight control behaviors: are they at risk for other health-compromising behaviors? Am J Public Health 1998; 88 :952-5.
Wiseman C.V., Turco R.M., Sunday S.R., et al. Smoking and body image concerns in adolescent girls. Int J. Eat Disord 1998; 24 :429-33.
Stock S.L., Goldberg E, Corbett S, et al. Substance use in female adolescents with eating disorders. J. Adolesc Health 2002; 31 : 176-82.
Anzengruber D., Klump K.L., Thornton L., et al. Smoking in eating disorders. Eating Behaviors 2006; 7 : 291-99.

P005

PREFRONTAL CORTEX GLUTAMATE AFFERENTS ARE ESSENTIAL FOR ACUTE AND CHRONIC EFFECTS OF RITALIN

Wanchoo S. , Swann A., Dafny N.

Department of Neurobiology and Anatomy, University of Texas-Houston, Houston, USA

Annals of General Psychiatry, 2010;9(supplement 1):S88

Background: Progressive augmentation of behavioral response following repeated psychostimulant administrations is known as behavioral sensitization, and is an experimental indicator of a drug's liability for abuse (Robinson and Berridge, 1993; Dafny and Yang, 2006). It is known that Ritalin or methylphenidate (MPD), a drug used to treat Attention-Deficit Hyperactivity Disorder (ADHD), induces sensitization in animals following repeated injections (Askenasy et. al., 2007; Yang et. al., 2007). Given that many children suffer ADHD, and are treated with MPD, it is essential to know the neuronal circuitry of MPD action. It was recently reported that bilateral electric (non-specific) lesion of PFC prevented behavioral sensitization after chronic MPD administration (Lee et. al., 2008). Since the PFC sends glutamatergic afferents to both ventral tegmental area (VTA) and nucleus accumbens (NAc), sites that

are involved in induction and expression of behavioral sensitization to psychostimulants and as PFC glutamatergic afferents are known to modulate the NAc and VTA dopaminergic neurons (Kalivas et. al., 2000; Kalivas et. al., 1993), the objective of this study was to study the role of glutamate from PFC in behavioral sensitization to MPD.
Materials and methods: Locomotor activity of three groups of rats- control, sham operated and group with specific chemical lesion of glutamate neurons of PFC- was recorded using an open-field assay and analyzed. Daily MPD injections were given to all groups on days 9-14 and the animals were rechallenged on the last day after 4 days of washout.
Results: It was found that the acute and chronic effects of MPD were eliminated in the lesion group.
Conclusions: Therefore, PFC glutamatergic afferents are essential for the MPD-induced hyperactivity and are also involved in its chronic effects such as behavioral sensitization to multiple MPD administrations.

References

E. P. Askenasy, K.H. Taber, P.B.Yang, N. Dafny, Methylphenidate (Ritalin): behavioral studies in the rat, Int. J. Neurosci. 117 (2007) 757-794.
N. Dafny and P.B. Yang, The role of age, genotype, sex, and route of acute and chronic administration of methylphenidate: a review of its locomotor effects, Brain Res. Bul. 68 (2006), pp. 393-405.
P. W, Kalivas and J.E. Alesdatter, Involvement of NMDA receptor stimulation in the VTA and amygdale in behavioral sensitization to cocaine, J. Pharmacol. Exp. Ther. 267 (1993) 486-495.
P.W. Kalivas, A role of glutamate transmission in addiction to psychostimulants, Addiction Biology 5 (2000) 325 - 329.

P006

HISTORICAL BACK TRAINING IN MOST IMPORTANT POINTS OF NEUROSURGERY

Syrmos N.[1, 2], Ampatzidis G.[1, 2], Fachantidou A.[1, 2], Mouratidis I. [1, 2], Syrmos Ch.[1, 2]

[1]Department of Physical Education and Sports, Aristoteleion University of Thessaloniki, Greece, [2]Neurosurgical Department, University Hospital AHEPA, Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S89

Background: The History of Neurosurgery begins with the presence of human in the earth. Begins from the depths of History (reports in Bible, Greek Mythology), as a part with Surgery until the last half of the 20th Century. Archaeological discoveries of human skull's proved the affair that the first neurosurgical action is the trepanation of skull or trephination (Burr hole in the cranial capsule with hand working drill), from material proportional the epoch (stone - copper, iron, brass etc). Chronological probably before the presence of written proofs and the use of metals, perhaps and from this 10.000 b.C. This action perhaps presented as a cerebration (in dead), but also as therapeutic in alive. This is the first surgical technique that prepared the trepanation of skull or trephination and later the craniectomy.
Materials and methods: All of this came from discoveries of skulls and surgical instruments, and show that the first Neurosurgical interventions in Ancient Greece are reduced in the Minoan epoch (skull in the Aharnes), in the Mycenaean epoch (Mycenae's skull, Argos). The study of the History is under a methodology as follows: A) Prehistoric period B) Historic period C) Invention of typography D) Invention of photograph - cinema E) Modern period A more important steps in the History of Neurosurgery are the following: - Prehistoric period Prehistoric and primordial trephinations - Embrionic period Babylonian and Egyptian Medicine - Greek - Roman and first Byzantine Period The origins of Neurosurgery a) Greek period - Greek Ancient (5th b.C. Century) b) Roman Period c) Early Byzantine period - Arabic Period - Mediaeval Period a) Arabic Medical School (750 - 1200 a.C.) b) West-European Medieval (1000 - 1400 a.C.) - Neurosurgery in 16 - 19th Century a) 16th Century Anatomic exploration b) 17th CenturyOrigins of Neurology c) 18th Century Adventures Surgeons – Neurosurgeons d) 19th Century Anesthesia - Antisepsis - Cerebral localisation - Advances in Surgical - Neurosurgical Techniques - Historical Review in Anatomy - Physiology of Nervous System The development of Neurosurgery is under investigations for Nervous System with improvement in Anatomy and Physiology:- Brain - White- Gray matter - Cerebellum - Ventrical System of the Brain - Arterial - Venous system of the Brain - Cerebral sulcus - Gyrus- The creation of Speciality of Neurosurgery

Results: Neurosurgery as speciality it would have never become without progress in neuroanatomy, neurophysiology, neurology, radiology, angiography of C.N.S. and neuroimagine (CT, MRI etc), and the importation of technology in Medicine, with researchers to progress of Neuroscience. The Neurosurgery in 1900-1940 represented by William Harvey Cushing (1869-1939) (the father of Neurosurgery) and Walter Edward Dandy (1886-1946), leaders in the History. The History of Neuroimagine methods The brain and the spinal cord under anatomic nature and place, for a lot of centuries kept well their secrets. Because existed difficulty of approach, as well as in localisation of the place of damage. Surgery in C.N.S. is without probabilities and mistakes. The modern Neurosurgery began with the first imagine methods of X - rays in clinical practice. The progress of imaging methods are with surgery of C.N.S., walking together as the diagnostic methods increases also surgical approaches are with bigger safety. X-ray of brain Angiography of brain CT of brain MRI of brain The History of Neurosurgery in Greece Begins in the end of the 19th Century as a part of surgery and in the last decades of 20th Century as a new surgical speciality. A' Period (1900-1920) B' Period (1930-1950) The speciality of Neurosurgery was established by V. Griponisiotis (1910-1993),Neurosurgeon and the first Professor of Neurosurgery after his election from Medical School of the A.U.TH. and director of the First Neurosurgical Clinic in 1966 in A.H.E.P.A. Hospital of Thessaloniki. C' Period (The beginning of modern Neurosurgery)
Conclusions: The History of Microsurgery Microsurgery in the Neurosurgical practice constitutes the point (perhaps the biggest), because gives opportunities for successful development. The using of surgical microscope begins in 1960 and in 1965 by M. Gazi Yaşargil who came the first microsurgical intervention in the Brain (terminal by terminal anastomosis with superficial temporal cerebral artery with a rumus of medium cerebral artery). The microsurgery involves revolution in the Neurosurgery, because almost all the surgical operations can be performed by surgical microscope. Today Neurosurgery and modern technology constitute the ideally combination for helping patients.
Acknowledgements:
Cushing H.: The special Geld of neurological surgery. Bull Johns Hopkins Hosp; 16:77-87, 1905.
Σύρμος Χ.Ν., Σύρμου Ε.Χ., Σύρμος Ν.Χ.: Ο κύκλος του Willis (Circle of Willis). Ιστορική Ανασκόπηση. Ιατρικά Θέματα Τεύχος 30ο σελ. 80-81, 2003.
Σύρμος Ν., Βασιλάκης Δ.Δ.: Νευροαγγειακές Μικροχειρουργικές Ανατομικές Σχέσεις στον Αρτηριακό Κύκλο του Willis. Εκδόσεις Ζυγός Θεσσαλονίκη 2004.

References
Yaşargil M.G.: Microsurgery Applied to Neurosurgery. Stuttgart: Georg Thieme, 1969.
Castiglioni A.: Storia della Medicina

P007

ENDOPHENOTYPIC MARKERS OF BIPOLAR DISORDER (BD) IN PROBANDS AND THEIR FIRST DEGREE RELATIVES WITH MAJOR DEPRESSION (MD)

Christodoulou A. T.

Department of Psychological Medicine, Institute of Psychiatry, King's College London, UK

Annals of General Psychiatry, 2010;9(supplement 1):S90

Background: The aim was to investigate the cognitive profile among BD patients and their MD first degree relatives compared to controls.
Materials and methods: Participants were 48 BD, 21 BDMD and 70 controls. All participants underwent assessment of Full Scale IQ (WAIS-R), working memory (N-back), initiation and inhibition (HSCT), cognitive set shifting and mental flexibility (WCST), memory (WMS-III), decision making and judgement (IGT), sustained attention (CPT) and interference (SCWT). Confirmation of diagnosis was made using Structured Clinical Interview for DSM-IV (SCID-I/II) and symptomatology was assessed with the HDRS and YMRS.
Results: No difference was found in IQ and initiation times 1 and 2 (HSCT). Deficits were found for both BD patients and their MDBD compared to controls in inhibitory control. In the WCST controls achieved

more categories compared to both BD and BDMD in addition to perseverative errors for the former but not the later group. In terms of CPT no difference was found among the 3 groups. Working memory (N-back) was impaired in BD but BDMD compared to controls. Decision making (IGT) was impaired in both BD and BDMD. BD patients underperformed in the SCWT. Finally, BD were impaired on all aspects of memory (WMS-III) whereas BDMD shared deficits with their probands in visual immediate and delayed memory, auditory delayed and recognition.
Conclusions: Response inhibition may be associated with genetic predisposition to BD, irrespective of phenotype. Abnormalities in auditory and visual delayed memory and recognition in addition to decision making and judgement may relate to disease expression, irrespective of specific diagnosis.

References
B. Arts, N. Jabben, L. Krabbendam, J. van Os: Meta-analyses of cognitive functioning in euthymic bipolar patients and their first-degree relatives. Psychol Med. 2007 9 1-15.
L.J. Robinson, J.M. Thompson, P. Gallagher, U. Goswami, A.H. Young, I.N. Ferrier, P.B. Moore: A meta-analysis of cognitive deficits in euthymic patients with bipolar disorder. J. Affect Disord 2006; 93:105-15.

P008

EFFECTS OF RIVASTIGMIN TARTARAT IN THE THERAPY OF PATIENTS WITH SCHIZOPHRENIA

Djordjevic S., Japalak S., Vidojevic V.

Special Hospital for Psychiatric Disorders, Kovin, Kovin, Serbia

Annals of General Psychiatry, 2010;9 (supplement 1):S91

Background: Rivastigmin tartarat is a dual, reversible cholinesterase inhibitor (acetil and butril). Its chemical composition is (S)-N-ethyl-N-methyl-3-1-dimethylamin - ethyl-phenyl carbamat hydrogen-(2R, 3 R)-tartrat. FDA has approved its use in treatment of Alzheimer dementia and dementia in combination with Parkison disease. In addition to this, results based on small clinical studies and case reports showed positive efects of rivastigmin tartarat in therapy applied in numerous pyschiatric disorders.
Materials and methods: In this study 11 patients have been observed. According to ICD-10 they all satisfied criteria for diagnosis of residual schizophrenia and had a score of below 24 at MMSE and high scores at NPI 12 and BPRS. During the period of 60 days, apart from antipsychotics and anxiolitics or psychostabilisers, patients also received rivastigmin tartarat in their therapy.
Results: The study showed that rivastigmine therapy produced significant improvements when it comes to cognition and reduction of disorders in the sphere of afective-behavioristic functioning of patients with residual schizophrenia. However, this interpretation cannot be confirmed to be completely valid due to the size of treated group, the absence of the control group, and the length of the observing period.
Conclusions: Dual cholinesterase inhibitors (Ach and BuCh) may produce improvement in cognition and behavioural performances, as well as the general quality of life with patients diagnosede with residual schizophrenia. Future studies applied on this kind of patients should precisely explain the basic farmachological mechanisams of rivastigmin tartarat, and approve/disapprove the results of clinical studies and case reports that have been preformed so far.

References
Hussain M., Chaudry A., Hussain S. Rivastigmine tartrate in treatment of neurocognitive deficits in clozapine treated schizophrenics.Poster presented at the 51st Annual Meeting of the Canadian Psychiatric Association, Montreal, Canada, 15-19 November 2001
Stryjer R., Strous R.D., Bar F., et al. Beneficial effect of rivastigmin augmentation for the management of comorbid schizophrenia and dementia. Clin Neuropharmacol. 2003; 26:12-17.
Alessandro Lenzi et al. :Effects of Rivastigmine on Cognitive Function and Quality Of Life in Patients With

Schizophrenia, Clinical Neuropharmacology, Vol. 26, No. 6, pp. 317-321. Lippincott Williams & Wilkins, Inc., 2003
Enz A., Boddeke H., Gray J., et al. Pharmacologic and clinicopharmacologic properties of SDZ ENA 713, a centrally selective acetylacetylcholin esterase inhibitor. Ann N Y Acad Sci 1991; 640:272-5

P009

RESULTS OF A NEW COGNITIVE METHOD IN RATS ON THE MORRIS WATER MAZE USED IN MODELING EXPERIMENTAL ALZHEIMER'S DISEASE

Megyeri K.[1], Albert M.[2], Gacsályi I.[1]

[1]Department of Behavioral Pharmacology, Division of Preclinical Research, EGIS Pharmaceuticals Plc., Budapest, Hungary, [2]Department of Safety Pharmacology, Division of Preclinical Research, EGIS Pharmaceuticals Plc., Budapest, Hungary

Annals of General Psychiatry, 2010;9(supplement 1):S92

Background: In Alzheimer's disease (AD) the loss of neurons in the hippocampal CA3 regions is present. In rats treated by sodium azide (NaN3) via subcutaneously implanted osmotic minipumps number of CA3 cells were decreased [1]. We developed a new method to produce AD-like dementia using single intracerebrally (ic.) injected NaN3 in rats.
Materials and methods: The CA3 neurons were chemically lesioned by intracerebrally administration of NaN3 in doses of 8 and 16 mg/ml. To examine learning functions Morris maze was used. During acquisition trials animals had to find a black platform within 120 s. We measured the "escape latency"(msec). Detailed histopathology of brain was performed at the termination of the study. Learning function was measured after 7 days of ic. treatment.
Results: 8 and 16 mg/ml doses of NaN3 significantly decreased escape time in ic. NaN3 treated rats compared to control animals. Neuronal necrosis, shrunk neurons, neurofibrillary tangle-like structures were seen in hippocampal area, also.
Conclusions: Decreased learning capability was induced by the ic. injection of 8 mg/ml and 16 mg/ml NaN3 dose in rats. We proved that with the new method, acut ic. injection of NaN3 produces comparable level of dementia caused by 31 days infusion of NaN3 using implanted osmotic minipumps [2], and it seems to be suitable to produce dementia in rats.
Acknowledgements: We thank Éva Körmöczi and Zsuzsa Helter for contributing to the experiments.

References

1. Bennett, M.C. (1996). Chronic in vivo sodium azide infusion induces selective and stable inhibition of cytochrome c oxidase. J. Neurochem 66, 2606-2611.
2. Bennett, M.C. (1992). Chronic sodium azide treatment impairs learning of the Morris water maze task. Behav Neural Biol 58, 72-75.

P010

EVOLUTION OF SYMPTOMS WITH ANTIPSYCHOTIC TREATMENT IN SCHIZOPHRENIC OUTPATIENTS IN GREECE: THE GRACE STUDY

Karadima D.[1], Chatzimanolis I.[2], Tsebelikos E.[3], Mavreas V.[4], Fokas A.[5], Kalogeropoulos A.[6], Deres S.[7], Christodoulakis Th.[8]

[1]Bristol-Myers Squibb, Greece, [2]Department of Psychiatry, University Hospital "Eginition", Athens, Greece, [3]Department of Psychiatry, "Sismanogleion" Hospital, Athens, Greece, [4]Department of Psychiatry, University Hospital, Ioannina, Greece, [5]2nd Department of Psychiatry, Hospital "Papageorgiou", Thessaloniki, Greece, [6]Hospital "Agia Fotini", Larissa, Greece, [7]Hospital "Therapeutirio Asklipios ", Veria, Greece, [8]Hospital "Panagia Grigorousa", Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S93

Background: To describe positive, negative and other symptoms evolution following treatment change, in schizophrenic patients in Greece.
Materials and methods: The GRACE study was a non-interventional observational, multicentre national survey. It involved 104 centres, proportionally distributed over Greece and observed patients diagnosed and treated for schizophrenia in the outpatients setting over a period of 12 months spanning from June 2007 till June 2008. Demographic and other patient characteristics including family status, educational level, living status, employment status, and centres monitoring patient's condition were recorded. Positive (aggressive behaviour, disorganised speech/thinking, illusions, delusions), negative (affective flattening, blunted effect, avolition, social isolation) and other (affective symptoms, aggressiveness, sleep disorders, cognitive disorders) symptom changes were recorded and analysed prior and post treatment change. Statistical analysis was performed by McNemar's Chi square statistic.
Results: In total, 2013 patients, mean age 39.7±12.5, were included in the study, 54.4% of which were males and 45.6% females. Most of the patients were unmarried (64%), living with their family (64.4%) and unemployed (54.2%) at the time of screening. After treatment change to another antipsychotic agent positive symptoms significantly decreased by 23.6% ($p<0.005$), negative symptoms remained unchanged and other symptoms significantly decreased by 15.9% ($p<0.05$). Illusions, delusions and disorganised speech/thinking, were the positive symptoms with the most profound decrease (14% $p<0.001$, 13.1% $p<0.001$ and 5.4% $p<0.005$ respectively). No significant changes were observed in affective flattening, aggressiveness, sleep and cognitive disorders. All administered antipsychotic treatments were associated with significant decrease in positive symptoms, with ziprasidone, olanzapine, rispesridone, quetiapine, aripiprazole, and aminosulpride showing more than 20% decrease ($p<0.001$). Ziprasidone, aripiprazole, cloazapine, quetiapine and aminisulrpide were associated with decrease in negative treatments, however only ziprasidone and ariprazole decreases reached significance ($p<0.01$ and $p<0.02$ respectively. All agents, showed significant decrease in other symptoms ($p<0.001$).
Conclusions: Negative symptoms remain difficult to control showing inconsistent patterns of symptom responsiveness. Currently available second generation antipsychotic agents appear to have minor to modest benefits on negative symptoms. All administered antipsychotics seem to have equal effectiveness in suppressing positive symptoms presented by schizophrenic patients in Greece.

P011

ADVERSE EVENT OCCURRENCE AND TREATMENT CHANGE IN PATIENTS WITH SCHIZOPHRENIA; THE GRACE STUDY

Karadima D.[1], Chatzimanolis I.[2], Tsebelikos E.[3], Mavreas V.[4], Fokas A.[5], Kalogeropoulos A.[6], Deres S.[7], ChristodoulakisTh.[8]

[1]Bristol -Myers Squibb Greece, [2]Department of Psychiatry, University Hospital "Eginition", Athens, Greece, [3]Department of Psychiatry, "Sismanogleion" Hospital, Athens, Greece, [4]Department of Psychiatry, University Hospital, Ioannina, Greece, [5]2nd Department of Psychiatry, Hospital "Papageorgiou", Thessaloniki, Greece, [6]Hospital "Agia Fotini", Larissa, Greece, [7]Hospital "Therapeutirio Asklipios", Veria, Greece, [8]Hospital "Panagia Grigorousa", Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S94

Background: Currently available, second generation antipsychotics interact with dopamine and serotonin receptors presenting less extrapyramidal symptoms and better tolerability in the elderly. Safety data gathered until today show that adverse events is one of the major reasons leading to antipsychotic treatment change, while in the meantime there is substantial differentiation of adverse events experienced by patients under treatment for schizophrenia. The present analysis aims at assessing treatment changes made during the observation period of the study and record the frequencies of treatment change due to adverse event as well as other disease-related factors.
Materials and methods: The Grace study was a descriptive, cross-sectional, multicentre national survey conducted in the outpatient setting by 104 psychiatrists, proportionally distributed around Greece. Investigators registered one visit of each of the first 20 consecutive patients that presented at their consultation. Patient's demographics, living status, smoking status, alcohol consumption, blood laboratory values, and data on the reasons leading to treatment change during the past 6 months were recorded. Additionally, the reason and the antipsychotic drug selected to carry on with, after the last treatment change were also specified.
Results: The observational period was from June 2007 to June 2008 and led to the recruitment of 2013 patients with an ICD-10 primary diagnosis of schizophrenia. Out of them 523 were being administered with a pharmacological treatment against schizophrenia. This population subset consisted of 51.6% men and 48.4% women, aged 39.9±12.4 years. The mean number of treatment changes during the past 6 months was 1.85±1.58 times. According to the investigators, the major adverse events that lead to treatment change were extrapyramidal symptoms (44.7%), weight gain (43.6%) and suppression (25%). For the most recent treatment change, apart from adverse event occurrence (61%), other reasons that led to treatment change, concomitantly present or not with adverse events, were "no signs of improvement" (37%) and "clinical deterioration" (21%).
Conclusions: Adverse events occurrence remains an important reason for treatment change in schizophrenic patients treated with second generation antipsychotic agents. Extrapyramidal symptoms and weight gain are precarious adverse events that should alert physicians for their early recognition and management.

P012

REASONS AND PATTERNS OF HOSPITALIZATION AMONG SCHIZOPHRENIC PATIENTS IN GREECE; THE GRACE STUDY

Karadima D.[1], Chatzimanolis I.[2], Tsebelikos E.[3], Mavreas V.[4], Fokas A.[5], Kalogeropoulos A.[6], Deres S.[7], ChristodoulakisTh.[8]

[1]Bristol -Myers Squibb Greece, [2]Department of Psychiatry, University Hospital "Eginition", Athens, Greece, [3]Department of Psychiatry, "Sismanogleion" Hospital, Athens, Greece, [4]Department of Psychiatry, University Hospital, Ioannina, Greece, [5]2nd Department of Psychiatry, Hospital "Papageorgiou", Thessaloniki, Greece, [6]Hospital "Agia Fotini", Larissa, Greece, [7]Hospital "Therapeutirio Asklipios", Veria, Greece, [8]Hospital "Panagia Grigorousa", Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S95

Background: Schizophrenia is one of the most frequent mental diseases with 1% probability among the whole population. Frequent hospitalization of schizophrenic patients is both a challenge to any health care system and a parameter that decreases patient quality of life and interrupts social functionality. The present analysis aims at assessing the current hospitalization pattern and at recording the most frequent reasons for hospitalization of schizophrenic patients in Greece.
Materials and methods: The Grace study was a descriptive, cross-sectional, multicentre national survey conducted in the outpatient setting by 104 psychiatrists proportionally distributed over Greece. Investigators registered one visit of each of the first 20 consecutive patients that presented at their consultation. Patient's demographics, living status, attending monitoring centre for schizophrenia, data on current treatment administration, number of hospitalizations and reasons of hospitalization were recorded. The analysis presented here involved only the subset of patients that were hospitalized during the last 12 months from the patient's visit to the doctor. Statistical analysis was performed by chi squared statistic, whereas magnitude of association is illustrated by odds ratios.
Results: The observational period lasted three months, from June 2007 to June 2008 and led to the recruitment of 2013 patients (mean age 39.7±12.5 years old, 57.4% males and 42.6% females) with an ICD-10 primary diagnosis of schizophrenia. Out of the 2013 patients, 265 were hospitalized at least once during the past 12 months of the visit. The median number of prior hospitalizations was 3, one of which occurred during the past 12 months and lasting up to 27 days for the 50% of patients. Besides the attending doctor, 66.92% of the patients were not monitored by any other medical centre. The reasons for hospitalization were: clinical deterioration (62%), discontinuation of treatment (43%), family burden (17%), drug use (10%), adverse events (8%), suicide attempts (8%) or other (7%). Patients receiving aripiprazole were less likely to be hospitalized due to clinical deterioration (OR=0.68, 95%CI:[0.49-0.92], p=0.019), treatment discontinuation (OR=0.77, 95%CI:[0.62-095], p=0.024) and family burden (OR=0.89 95%CI:[0.80-0.99], p=0.026), while patients receiving haloperidol were more likely to be hospitalized due to family burden (OR=1.18, 95%CI:[1.01-1.36], p=0.013).
Conclusions: Clinical deterioration, discontinuation of treatment and family burden remain significant reasons of hospitalization in schizophrenic patients in Greece. Aripiprazol may lead to less frequent hospitalizations due to these reasons. Most schizophrenic patients in Greece are not monitored by other health care centers except form their attending doctor and future investigations are needed to investigate whether changes in these practice could lead to better management of the disease.

P013

STRESS AND LIFE SATISFACTION AMONG UNIVERSITY STUDENTS-A PILOT STUDY

Paschali A.[1], Tsitsas G.[2]

[1]National and Kapodistrian University of Athens, [2]Harokopio University, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S96

Background: Life satisfaction has been described as an overall cognitive assessment of one's quality of life. This assessment is based on how people believe their life should be in relation to how it is. Anxiety has a negative impact on well-being and life satisfaction seems to be highly related with life satisfaction among University students. Studies have supported that lower levels of life satisfaction have been related to high anxiety.
Materials and methods: The study involved 200 University students, sample taken from the National and Kapodistrian University of Athens and the Xarokopion University (100 1st year and 100 4th year). Subjects were asked to complete the STAI-State & Trait Inventory and Life Satisfaction Index. The questionnaires were given to students to complete during their Fall and Spring semester studies.
Results: The mean ± standard deviation of the "life satisfaction score" was 4.3 ± 0.5. Moreover, the majority of participants (63.4%) were found to have low "life satisfaction" without any differences between the two sexes. Analysis of STAI showed that students low scores in STATE anxiety scale have high scores in life satisfaction scale whereas high scores have low scores in life satisfaction (p=0.005). Furthermore Trait Anxiety score analysis revealed non significant results. Treating the life satisfaction score as a continuous variable, it was found that the mean score (4.2 ± 0.4) of students of the 1st year was statistically significantly lower compared to students of the 4th year (4.4 ± 0.6, p=0.005).Two-way ANOVA showed that the two-way interaction between the year and students' sex (p<0.001), state of anxiety (p=0.034), were statistically significant.
Conclusions: According to the results of this study it can be suggested that students who have low anxiety scores have more life satisfaction. The fact that significant differences were found for the State condition and not the Trait could be explained by the perception and evaluation of the individual. Determining the relationship between anxiety and life satisfaction inthe university students could assist psychological counseling and guidance.

References

Anderson, S. A. (1988). Parental stress and coping during the leaving home transition. Family Relations, 37, 160-165. Bourland, S. L., Stanley, M. A., Snyder, A. G., Novy, D. M., Beck, J. G., Averill, P. M., & Swann, A. C. (2000). Quality of life in older adults with generalized anxiety disorder. Aging and Mental Health, 4, 315-323. Cook, J. M., Black, B. S., Rabins, P. V., German, P. (2000). Life satisfaction and symptoms of mental disorder among older AfHcan American public housing residents. Journal of Clinical Geropsychology, 6, 1-14. Deniz, M. E. (2006). The relationships among coping with stress, life satisfaction, decision-making styles and decision self-esteem: An investigation with Turkish university students. Social Behavior and Personality, 34(9), 1161-1170.

P014

BITE WOUND RELATED INFECTIONS IN RURAL AREAS OF MACEDONIA-GREECE: CONSEQUENCES ON OVERALL HEALTH

Syrmos N., Televantos A., Patiakas S., Kapoutzis N.

Surgical Department, Goumenissa General, Hospital, Kilkis, Macedonia, Greece

Annals of General Psychiatry, 2010; 9(supplement 1):S97

Background: In this 20 year retrospective study (1989-2009) depicted injuries recorded as dog, cat, horse and human bites from one hospital (Goumenissa General Hospital, Kilkis, Macedonia, Greece).

Materials and methods: The injuries were 35 dog bite,5 cat bite,5 horse bite,4 human bite.The incidence was higher in aged people(over 65 yerars old) and in children,dominant in males and were higher in summer. The highest humidity and highest temperatures was determined for dog-bites.
Results: In all the cases with the routine therapy (antitetanus vaxine, local debridement, Antibiotics) we achieved good results
Conclusions: Bite infections can contain a mix of anaerobes and aerobes from the patient's skin and the animal's oral cavity, including species of Pasteurella, Streptococcus, Fusobacterium, and Capnocytophaga. The most common pathogens associated with bite wounds are Streptococcus species, Staphylococcus species, Pasteurella multocida, Capnocytophaga canimorsus and anaerobic bacteria. Sporadically other pathogens are isolated from bite wounds. Human bites differ from animal bites by higher prevalence of Staphylococcus aureus and Eikenella corrodens.The lifetime risk of experiencing a bite wound, human or animal, is approximately 40%, and bite wounds account for approximately 2%of all visits to emergency departments .The majority of bite wounds are inflicted by dogs. It is important to be aware of the possibility of complicating infections following bite wounds, particularly after cat bites. Phenoxymethyl penicillin should be the drug of choice in treatment of infections associated with cat and dog bites. However, in case of slow recovery or no improvement, simultaneous lymphadenopathy or pneumonia, S. aureus or Francisella tularensis should be suspected; ciprofloxacin is recommended. For human bite infections the recommend treatment is phenoxymethyl penicillin in combination with penicillinase-stable penicillin.

References

Yaqub S., Bjornholt JV, Hellum K.B., Steinbakk M., Enger A.E., Bite wound infections Tidsskr Nor Laegeforen. 2004 Dec 16; 124(24):3194-6.
Emet M., Beyhun N., Kosan Z., Aslan S., Uzkeser M., Cakir Z.Animal-related injuries: epidemiological and meteorological features Ann Agric Environ Med. 2009 Jun;16(1):87-92.
Oehler R.L., Velez A.P., Mizrachi M., Lamarche J., Gompf S.Bite-related and septic syndromes caused by cats and dogs.Lancet Infect Dis. 2009 Jul; 9(7):439-47. Review.
Griego R.D., Rosen T., Orengo I.F., Wolf J.E.Dog, cat, and human bites: a review. J. Am Acad Dermatol. 1995 Dec; 33(6):1019-29

P015

CRANIOTOMY INFECTIONS- THE VENIZELEIO HOSPITAL EXPERIENCE

Syrmos N., Patiakas S., Iliadis Ch., Grigoriou K., Valadakis V., Chatzinasiou F., Arvanitakis D.

Neurosurgical Department-Venizeleio General Hospital, Heraklion, Crete, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S98

Background: Surgical site infections (SSIs) are defined as infections occurring up to 30 days after surgery and affecting either the incision or deep tissue at the operation site. Despite improvements in prevention, SSIs remain a significant clinical problem as they are associated with substantial mortality and morbidity and impose severe demands on healthcare resources. The incidence of SSIs may be as high as 20%, depending on the surgical procedure, the surveillance criteria used, and the quality of data collection. In many SSIs, the responsible pathogens originate from the patient's endogenous flora. The causative pathogens depend on the type of surgery; the most commonly isolated organisms are Staphylococcus aureus, coagulase-negative staphylococci, Enterococcus spp. and Escherichia coli
Materials and methods: Aim of our study was to to determine the incidence and risk factors of surgical site infections (SSIs) after craniotomy.During a 36-month period(2006.2007,2008), every adult patient undergoing craniotomy in our neurosurgical unit was prospectively evaluated for development and risk factors of SSI. The follow-up period was at least 60 days.
Results: Of a total of 155 patients,33(14,8%) with SSIs were observed including those with wound infections-5-, with bone flap osteitis-4-, with meningitis-1-, and with brain abscesses-2. Independent risk factors for SSIs were postoperative cerebrospinal fluid leakage and subsequent operation.

Independent predictive risk factors were emergency surgery, clean-contaminated and dirty surgery, an operative time longer than 4 hours, and recent neurosurgery.
Conclusions: The incidence of craniotomy infections, usually less than 4%, is dependent on many factors, such as how the information is collected and how the percentage is calculated.It is difficult to prove that a given factor contributes to infection. Most routines are based more on personal convictions than on solid evidence. CSF leak is one factor known to have great impact; it should be avoided with painstaking technique and, if it occurs, it should be treated promptly. Solid evidence favoring prophylactic antibiotics for persistent CSF leak is not available; but, until a well-designed randomized study tells otherwise, the high risk of meningitis justifies prophylaxis. Penicillin is adequate for leaks through the nose or the ear. For leaks through the skin, the antibiotic should be effective against staphylococci. The infection register should provide information about prevailing bacteria. In many hospitals, the prophylaxis should cover gram-negative bacilli. CRP is a useful diagnostic aid for detecting postoperative infections. The operation, however, also causes a CRP rise. Daily CRP monitoring, at least for patients with elevated temperature, is recommended. The third-generation cephalosporins are a welcome contribution to the treatment of bacterial meningitis. To avoid side effects, and to keep them potent when they are really needed, they should be used with caution. Most postoperative cases of meningitis are in fact aseptic. If the patient is moderately ill, chloramphenicol is still eligible as the first choice antibiotic. When the bacterial culture is negative, the antibiotic should be stopped. The standard treatment for bone flap infection is removal of the bone flap. The bone flap is essentially devascularized and comparable to a foreign body.

References

Blomstedt G.C. Craniotomy infections Neurosurg Clin N. Am. 1992 Apr;3(2):375-85
Korinek A.M. Risk factors for neurosurgical site infections after craniotomy: a prospective multicenter study of 2944 patients. The French Study Group of Neurosurgical Infections, the SEHP, and the C-CLIN Paris-Nord. Service Epidémiologie Hygiène et Prévention Neurosurgery. 1997 Nov;41(5):1073-9; discussion 1079-81.
Owens C.D., Stoessel K. Surgical site infections: epidemiology, microbiology and prevention J. Hosp Infect. 2008 Nov;70 Suppl 2:3-10.

P016

LONG-TERM EFFICACY AND SAFETY OF GALANTAMINE IN OUTPATIENTS WITH MILD COGNITIVE DISORDER

Zarra J.[1], Schmidt L.[2]

[1]Servicio de Psiquiatría, Hospital Italiano de La Plata, Buenos Aires, Argentina, [2]Servicio de Salud Mental, Hospital Centenario, Gualeguaychú, Entre Ríos, Argentina

Annals of General Psychiatry, 2010;9(supplement 1):S99

Background: Galantamine is a reversible, competitive cholinesterasa inhibitor that also allosterically modulates nicotine acetylcholine receptors. Inhibition of acetylcholinesterase, the enzyme responsible for hydrolisis of acetylcholine at the cholinergic cognitive impairment. To evaluate the efficacy, safety and tolerability of galantamine in long-term in Mild Cognitive Disorder.
Materials and methods: A multicenter, open label , prospective, observational study enrolled 800 patients, more 50 years old with Mild Neurocognitive Disorder (DSM IV criteria), during 24 months of treatment with galantamine 16 mg./day. Assessments included the Mini Mental State Examination (MMSE), Clinical Dementia Rating (CDR), Alzheimer's Disease Assessment Scale (ADAS-GOG), Seven minutes test, Wiscosin card sorting test, Boston naming test, Token test, Raven Test, Brow-Peterson test, Trail making test, Functional Activities Questionnaire (FAQ), GO-NO-GO test, Global Deterioration Scale, Global Clinical Impression (GCI) and UKU scale of Adverse Effects.
Results: A total 800 outpatients were treated with 16 mg./day galantamine during 24 months, the therapeutic response evaluated with CDR , MMSE and the tests and scales of function cognitive measuring , GCI and UKU scale of adverse effects, comparing the baseline to final scores .

Conclusions: Mild Cognitive Disorder is being examined , so there aren't enought treatment for this. A long-term treatment (24 months) galantamine improves cognition and global function, behavioural symptoms and the general state well being of patients with Mild cognitive Disorder. With incidence of adverse effects not significant and a very good profile of safety, the final results of the study suggest that galantamine may be particularly appropiate in the Mild Cognitive Disorder.

References

Blesa R.: Galantamine: therapeutics effects beyond cognition. Dement Geriatr Cogn Disord 2000; 11 (suppl 1):28-34.
Sramek J.J., Veroff A.E., et al: The status of ongoing trials for mild cognitive impairment. Expert Opin Inveting Drugs 2001; 10 (4):741-752.

P017

MILD COGNITIVE DISORDER AND DEPRESSION: TREATMENT WITH COMBINATION OF GALANTAMINE AND ESCITALOPRAM

Zarra J.[1], Schmidt L.[2]

[1]Servicio de Psiquiatría, Hospital Italiano de La Plata, Buenos Aires, Argentina, [2]Servicio de Salud Mental, Hospital Centenario, Gualeguaychú, Argentina

Annals of General Psychiatry, 2010;9(supplement 1):S100

Background: To evaluate the efficacy of galantamine-escitalopram combination in patients with Mild Cognitive Disorder and Depression. So there is a possible relation between the deficit of cerebral oxygenation and depression or relation between the serotonin system and cholinergic system in relation with disease comorbidity cognitive-depression
Objective: To evaluate the therapeutic response in patients with comorbility between Mild Cognitive Disorder and Depression in treatment with Galantamine, Escitalopram and the two drugs in combination.
Materials and methods: A group of 300 patients with symptoms of Mild Cognitive Disorder and Depression (DSM IV-R criteria) were separated in 3 groups of 100 patients. Each group received different treatment in an 8 months period:
Group 1: Galantamine 16 mg/day.
Group 2: Escitalopram 20 mg/day
Group 3: both drugs, same dose
Results: The therapeutic response evaluated in Hamilton Scale for Depression (HAM-D), Montgomery and Äsberg Depression Rating Scale (M.A.D.R.S.), Mini Mental State Examination (M.M.S.E.) and Global Clinical Impression (G.C.I.) scores during 8 months. In the third group who received the two drugs associated, had much better response than the others and "brain enhancer".
Conclusions: The group who received the combination of the nootropic agent Galantamine with antidepressant (SSRIs) Escitalopram had a relevant satisfactory therapeutic response (the best result), so there is a possible relation between the deficit in cholinergic systems and depression. Could be cerebral cholinergic systems deficit a generator of Depressive Disorder? Attention and memory functions are closely tied to the cholinergic neurotransmitter system. The cholinergic system is one of the neurotransmitter systems implicated in the pathophysiology of mood disorders. Evidence suggests that during major depressive episodes, the cholinergic system is hypersensitive to acetylcholine.

References

Blesa R.: Galantamine: Therapeutic effects beyond Cognition. Dement Geriatr Cogn Disord. 2000. 11 (suppl 1):28-34

P018

USING DAPTOMYCIN FOR THE TREATMENT OF SURGICAL SITE INFECTIONS IN A SINGLE NEUROSURGICAL UNIT-PRELIMINARY EXPERIENCE

Syrmos N., Iliadis Ch., Grigoriou K., Valadakis V., Arvanitakis D.

Neurosurgical Department, Venizeleio General Hospital, Herakleio, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S101

Background: The increasing frequency of methicillin-resistant Staphylococcus aureus as a cause of surgical site infections, and decreased susceptibility to vancomycin, highlight the need for alternative therapies. Daptomycin is a novel lipopeptide antibiotic used in the treatment of certain infections caused by Gram-positive organisms. It is a naturally-occurring compound found in the soil saprotroph Streptomyces roseosporus. Its distinct mechanism of action means that it may be useful in treating infections caused by multi-resistant bacteria Daptomycin is approved for the treatment of skin and skin-structure infections (4 mg/kg), and Staphylococcus aureus bacteremia, including right-sided endocarditis (6 mg/kg).
AIM- To evaluate the safety and efficacy of daptomycin when administered for a variety of gram-positive infections in a single neurosurgical unit.
Materials and methods: During the last three years we use damtomycin (2006-2007-2008) in 64 cases. For the purpose of this study, the safety and efficacy of daptomycin were evaluated in patients who received doses of 4 mg/kg or higher. Prior antibiotic therapy was given to 21,8% of patients(14)
RESULTS- The median final daptomycin dose was 5 mg/kg. The median duration of daptomycin therapy was 15 days. Daptomycin was well tolerated in patients with gram-positive infections.The most common infections were skin and skin-structure .The most common pathogens were S. aureus
Results: 1. A large number of novel antibacterial agents have been or are being developed for the treatment of complicated skin and soft tissue infections -cSSTIs -Daptomycin is one of them and it is available for clinical use.2.Daptomycin was well tolerated in patients with gram-positive infections. 3. Further prospective and comparative studies of daptomycin are warranted
Conclusions: We have always to rememder that the most mportant parameters that appear to determine the clinical effectiveness of an antibiotic for cSSTIs include the severity of the illness, patient co-morbidities, whether the patient receives appropriate antimicrobial therapy at the onset of illness and if this should be a combination or single-agent approach to cover a broad range of likely causative organisms.
Acknowledgements:
Special thanks to Mr Panagiotis Stratigakis

References

Chamberlain R.S., Culshaw D.L., Donovan B.J., Lamp K.C. Daptomycin for the treatment of surgical site infectionsSurgery. 2009 Aug;146(2):316-24. 2. Fenton C., Keating G.M., Curran MP.Daptomycin. Drugs. 2004;64(4):445-55; discussion 457-8.
Moise P.A., Hershberger E, Amodio-Groton M.I., Lamp K.C. Safety and clinical outcomes when utilizing daptomycin therapy in a neurosurgical department Ann Pharmacother. 2009 Jul;43(7):1211-9. 4. Nathwani D. New antibiotics for the management of complicated skin and soft tissue infections: are they any better? Int J .Antimicrob Agents. 2009 Jul;34 Suppl 1:S24-9
Quetglas E.G., San Julian M., Garcia Tutor E., Vazquez B., Lucena F., Landecho M., Azanza J.R. A long-term retrospective review of 5 cases using daptomycin for prosthetic device infections after surgery. Int J. Artif Organs. 2009 May;32(5):299-307. 6.. Sorlozano A, Gutiérrez J., Roman J., Liebana J., Piedrola G.. Activity of daptomycin against multiresistant clinical isolates of Staphylococcus aureus and Streptococcus agalactiae. Microb Drug Resist. 2009 Jun;15(2):125-7

P019

EVALUATION OF PHARMACOTHERAPY IN INPATIENTS WITH MANIA IN BIPOLAR DISORDER

Pirόg-Balcerzak A., Rzewuska M., Luks M., Skalska J., Kałwa A.

Independent Pharmacotherapy Unit, Institute of Psychiatry and Neurology, Warsaw, Poland

Annals of General Psychiatry, 2010;9(supplement 1):S102

Background: The studies concerning prophylactic treatment in bipolar disorder suggest it should be introduced after the first manic episode. [1] Also early polytherapy is promoted, mainly mood stabilizers and antipsychotics. Antipsychotics are recommended in short-term use [4], but they are also used after improvement. Typical antipsychotics are effective in monotherapy in 70% of patients, like mood stabilizers.[2]The combination of antipsychotics and mood stabilizers is superior to monotherapy in rapid control of agitation.
Materials and methods: We determined which drugs are chosen at Institute of Psychiatry and Neurology for treating and preventing manic episodes. 61 inpatients diagnosed with manic episodes were evaluated.At discharge, 28% of patient were ordered to take one drug. For 72% patients polytherapy was ordered.
Results: There was no difference in the number of disease or manic phases between the group of patients with a remission phase lasting for at least a year and less than a year. Recurrence within one year after discharge was twice as frequent in patients with polytherapy than with monotherapy. During polytherapy the probability of avoiding recurrnce was dropping quickly.No dependence was observed between the number of recurrences at patients with monotherapy or polytherapy and such parameters as the number of manic episodes, the number of depression episodes or education.
Conclusions: In most inpatients polytherapy was applied. For the maintenance phase of treatment the same drugs were recommended as used for active treatment. The way of treatment fully corresponds to bipolar disorder treatment standards.

References

Biel M.G., Peselow E., Mulcare L., Case B.G., Fieve R.Continuation versus discontinuation of lithum in reccurent bipolar illness:A naturalistic study. Bipolar Disorders 2007;9:435-442
Ertugrul A., Meltzer H.Y., Antipsychotic drugs in bipolar disorder. Int J Neuopsychopharmacology. 2003;6:277-284
Hirschfeld R., Calabrese J.R., Weissman M., Frye M., Keck P.E., Wagner K., Reed M. Prevalence of bipolar spectrum in US adults [abstract]. European Neuropsychopharmacology. 2002;12:218
Mendlewicz J., Souery D., Rivelli SK. Short-term and long-term treatment of bipolar patients: beyond the guidelines. J. Affect Dis. 1999;55:79-85

P020

PSYCHOMETRIC PROPERTIES OF THE METACOGNITIONS QUESTIONNAIRE-30 (MCQ-30) IN A GREEK SAMPLE

Typaldou M., Nidos A., Roxanis I., Dokianaki F., Vaidakis N., Papadimitriou G.

Department of Psychiatry, Athens University Medical School, Eginition Hospital, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S103

Background: The term Metacognition refers to the psychological processes that are involved in the way a person controls, modifies, and appraises his own thoughts [1]. Maladaptive metacognitions have been related to the development and maintenance of psychological disorder [2, 3]. The Metacognitions Questionnaire-30 (MCQ-30) is a multidimensional instrument for assessing metacognitions, composed of five factors: cognitive confidence, positive beliefs about worry, cognitive self consciousness, negative beliefs about worry and need to control thoughts [4]. Psychometric properties of the MCQ-30 have been well documented [4, 5] suggesting that it is a valid instrument that has already been used in clinical research with several psychiatric disorders [6].
Materials and methods: 223 undergraduate medical students from the Athens University Medical School (57.4 % females), aged 18-33, and 30 resident psychiatrists were administered the Greek versions of the following self-report instruments:
The MCQ-30, a 30-item questionnaire that measures a person's metacognitive processes.
The Trait Anxiety Inventory (STAI-T) [7], a 20-item measure used to assess anxiety proneness.
The Meta-worry Subscale of the "Anxious Thoughts Inventory" [8] , a 7-item scale that assesses a person's process worry dimension.
Results: Factor structure of the MCQ-305 factors were extracted using principal component analysis with equamax rotation, leading to a factor solution similar to the original non-clinical sample. Reliability the Greek version of the MCQ-30 had good internal consistency, split-half reliability and test-retest reliability (as measured on a sample of 30 resident psychiatrists). Convergent validity The MCQ-30 presented good convergent validity with adequate correlation coefficients with both the STAI-T and the Meta-worry subscale.
Conclusions: The Greek version of the MCQ-30 is a valid self-report instrument with good psychometric properties. Factor analysis of the MCQ-30 indicates an acceptable construct validity of the questionnaire in a Greek sample.

References

K. Corcoran, Z. Segal: Metacognition in depressive and anxiety disorders: current directions. International Journal of Cognitive Therapy 2008, 1: 33-44
A. Wells: Emotional disorders and metacognition: Innovative cognitive therapy. Chichester, 2000, UK: Wiley.
A. Wells, G. Matthews: Attention and emotion: A clinical perspective, 1994, Hove, UK: Erlbaum.
A. Wells, S. Cartwright-Hatton: A short form of the Metacognitions Questionnaire: Properties of the MCQ-30. Behaviour Research and Therapy 2004, 42: 385-396.

P021

CSF POTENTIAL BIOMARKERS AB42 AND TAU: ASSOCIATIONS OF APO E GENOTYPE

Ramesh K.[1], Gill K.D.[1], Prabhakar S.K.[2]

[1]Department of Biochemistry, PGIMER, Chandigarh, India, [2]Department of Neurology, PGIMER, Chandigarh, India

Annals of General Psychiatry, 2010;9(supplement 1):S104

Background: The most promising strategy to detect AD in preclinical or presymptomatic stage

need specific biomarkers. In this study we elucidated the relationship between Apo E genotype and CSF biomarkers Aß42 and Total tau in Alzheimer's Disease (AD) Patients, Non AD (NAD) patients, Neurological controls (NCs) and Healthy Controls (HCs).
Materials and methods: In this study we included 30 HC, 30 AD patients, 40 NAD, and 46 NC from Nehru Hospital, PGIMER, Chandigarh, India after obtaining informed consent from all the subjects. Apo E Genotyping was done according to the Wenham PR etal, 1991. The levels of Aß42 and total tau were determined by ELISA kits Innogenetics, Belgium.
Results: Our data of CSF Aß42 and tau levels in conjunction with ε4 allele had shown specificity and sensitivity of 100% and 42.8% respectively for the detection of AD. Aß42 and Apo E ε4 combination had shown specificity 80.8% and sensitivity 72.1 %. The ε4 allele distribution frequency was 40% and 2.5% in AD and NAD respectively, where as ε4/4 genotype and ε3/4 genotype distribution was 10 % and 50 % respectively. Our data has shown that ε4 allele in combination with Aß42 to have better sensitivity and specificity in the diagnosis of AD. AD patients with at least one ε4 allele had significantly lower CSF Aß42 levels than those without ε4 allele ($P < 0.001$). There was a positive correlation of Aß42 with low MMSE scores.
Conclusions: Observation from our study suggest that decreased Aß42 and increased tau level in CSF along with Apo E ε4 allele as risk factors for AD. Our study also shows ε4 allele incidence to be a risk factor for AD.
Acknowledgements: ICMR, New Delhi, India for funding this study and Senior Residents of department of neurology. Colleagues Nidhi, Deep raj and Aditya

References
Wenham P.R., Price W.H., Blandell G. Apolipoprotein E. genotyping by one-stage PCR. Lancet 1991; 337:1158-9
Tapiola T., Pirttila T., Mehta P.D., Alafuzofff I., Lehtovirta M., Soininen H. Relationship between apo E genotype and CSF beta-amyloid (1-42) and tau in patients with probable and definite Alzheimer's disease. Neurobiol Aging 2000;2:735-40.
Riemenschneider M., Schmolke M., Lautenschlager N., Vanderstichele H., Vanmechelen E., Guder W.G., et al. Association of CSF apolipoprotein E, Abeta42 and cognition in Alzheimer's disease. Neurobiol Aging 2002;23:205-11
Petersen R.C., Smith G.E., Ivnik R.J., Tangalos E.G., Schaid D.J., Thibodeau S.N., et al. Apolipoprotein E. status as a predictor of the development of Alzheimer's disease in memory-impaired individuals. JAMA 1995;273:1274-8.

P022

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 6 YEARS TILL 6 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Karagianni E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S105

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 6 years till 6 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f:50) recruited from Greek Schools at the region of Karditsa. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other

results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .777, & .768).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P023

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 7 YEARS TILL 7 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Kantakou F.P.[1], Tafiadis M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9 (supplement 1):S106

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 7 years till 7 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f:50) recruited from Greek Schools at the region of Ioannina. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .800, & .805).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P024

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 8 YEARS TILL 8 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Bergadi A.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9 (supplement 1):S107

Background: The present pilot study was the adaption and validation of receptive and expressive

language tests' for Greek children aged from 8 years till 8 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 105 participants (m:52, f: 53) recruited from Greek Schools at the region of Thessaloniki. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .800, & .805).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P025

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 9 YEARS TILL 9 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Zafeiropoulou G.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S108

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 9 years till 9 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 108 participants (m:55, f: 53) recruited from Greek Schools at the region of Drama. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .748, & .669).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P026

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 10 YEARS TILL 10 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Gkrekou X.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9 (supplement 1):S109

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 10 years till 10 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .813, & .801).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P027

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 11 YEARS TILL 11 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Paroutiadou I.[1], Papageorgiou K.[1], Tafiadis M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3] Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010; 9(supplement 1):S110

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 11 years till 11 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina. The sample was independent from origin

and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .638, & .599).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P028

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 12 YEARS TILL 12 YEARS AND 11 MONTHS)

Tafiadis D[1, 2], Mokas A.[1], Chorevas K. [1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9 (supplement 1):S111

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 12 years till 12 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Igoumenitsa. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .816, & .800).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P029

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 13 YEARS TILL 13 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Mokas A.[1], Chorevas K.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S112

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 13 years till 13 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Igoumenitsa. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .801, & .829).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P030

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 14 YEARS TILL 14 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Mokas A.[1], Chorevas K.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S113

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 14 years till 14 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Igoumenitsa. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.

Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .812, & .848).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P031

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 15 YEARS TILL 15 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Bogindrouka E.[1], Kentioglou K.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S114

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 15 years till 15 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Agrinio. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .659, & .663).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P032

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 16 YEARS TILL 16 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Bogindrouka E.[1], Kentioglou K.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Attika, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S115

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 16 years till 16 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Agrinio. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .693, & .716).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P033

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 17 YEARS TILL 17 YEARS AND 11 MONTHS)

Tafiadis D. [1,2], Pantazis E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S116

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 17 years till 17 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina and Agrinio. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.

Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .757, & .798).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P034

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY AND VALIDATION OF THE TESTS' IN NORMAL GREEK POPULATION - AGED FROM 18 YEARS TILL 18 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Zizika M.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S117

Background: The present pilot study was the adaption and validation of receptive and expressive language tests' for Greek children aged from 18 years till 18 years and 11 months. The 3rd edition (2000) - used in this research - of ROWPVT and EOWPVT was originally created by Rick Brownell in 1985.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek Schools at the region of Ioannina. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .757, & .798).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P035

THERAPY OF ADDITION FOR ALZHEIMER'S DISEASE: COMBINATION WITH GALANTAMINE AND MEMANTINE

Zarra J.[1], Schmidt L.[2]

[1]Servicio de Psiquiatría, Hospital Italiano de La Plata, La Plata, Buenos Aires. Argentina, [2]Servicio de Salud Mental, Hospital Centenario, Gualeguaychú, Entre Rios, Argentina

Annals of General Psychiatry, 2010;9(supplement 1):S118

Background: The efficacy, safety, and tolerability of nootropic cholinergic agent: GALANTAMINE (with a dual mechanism of action on the cholinergic a system) and moderate affinity NMDA- receptor antagonist: MEMANTINE, were assessed taking into account the profile of patients with neurocognitive disorder: Alzheimer's disease, from the clinical aspects and the different classifications.
Materials and methods: The experience included 380 patients who were enrolled in a prospective, observational, multicenter, and open-label study to receive 16 mg/day of galantamine and 30 mg/day of memantine for 12 months of treatment of addition.
Results: The therapeutic response was measured using the Mini Mental State Examination (MMSE), Clinical Dementia Rating (CDR), Alzheimer's Disease Assessment Scale (ADAS-GOG), Functional Activities Questionnaire (FAQ) the Clinical Global Impression Scale (CGI) and the UKU scale of adverse effects taking into account the efficacy, safety and adverse events of the treatment.
Conclusions: The final results of the study showed that galantamine with addition memantine improves cognition, behavioural symptoms, and the general well-being of patients with cognitive impairment: Alzheimer's disease. The incidence of adverse events was not significant and a very good profile of tolerability and safety was observed.

References

Blesa R.: Galantamine: therapeutics effects beyond cognition. Dement Geriatr Cogn Disord 2000; 11 (suppl 1):28-34.
Sramek J.J., Veroff A.E., et al: The status of ongoing trials for mild cognitive impairment. Expert Opin Inveting Drugs 2001; 10 (4):741-752.

P036

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY IN HIGH SCHOOL AGED CHILDREN & DATA FOR EXPRESSIVE AND RECEPTIVE LANGUAGE FOR THIS POPULATION)

Tafiadis D.[1, 2], Bogindrouka E.[1], Kentioglou K.[1], Pantazis E.[1], Zizika M.[1], Tafiadi M.[3], Papadopoulos A.[1], Koutsogianni P [1].

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S119

Background: The present pilot study was the adaption of receptive and expressive language tests' (ROWPVT and EOWPVT) for Greek children aged from 14 years till 18 years and 11 months, and to locate any differences between receptive and expressive language.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 400 participants (m: 200, f: 200) recruited from Greek High Schools. The sample was independent from origin and socio - economic situations. Children with medical problems (ENT, neurological or psychiatric) excluded, because it will

influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent to other results reported. No statistically significant differences were found according to sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .801, & .819).
Conclusions: The test appears to be sensitive for high school aged Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability, high content validity. The participants demonstrated clear patterns of responses and there were no differences between expressive and receptive language.

P037

THE APRAXIA BATTERY FOR ADULTS - 2 (ABA - 2). (A SECOND PILOT STUDY AND VALIDATION OF THE TEST IN APHASIC GREEK POPULATION)

Tafiadis D., Keloglou M., Zafeiri A., Tafiadi M.

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S120

Background: Purpose of present study was the second pilot validation and evaluation for Greek population of Apraxia Battery for Adults - 2 (ABA - 2). ABA was originally created by Brownell and Dabul, in 2000, and it is used as diagnostic scale for adult Apraxia of speech and measures the skills in the apraxic population.
Materials and methods: The commercial battery was administered to 37 participants 20 normal (as control group) and 17 with aphasic pathology, recruited from Greek health settings, aged from 38 - 70 years. The collection of sample became independent from socio-economic criteria, and they did not present any other pathology which probably influence the output in the particular scale.
Results: The analysis of the data revealed statistically significant difference to the results obtained is generally consistent with the results reported in the US. Also statistically significant differences were found between the results obtained between normal and pathological groups in all diagnostic categories. We also saw that the particular scale is not influenced by various parameters such as sex. The reliability of scale had a general cohesion Reliability Coefficients 6 items Alpha = .853 Standardized item alpha = .913.
Conclusions: The battery appears to be sensitive to Greek reality. From the control of validity and reliability in this sample we saw that the Greek version of ABA - 2 it is a valid and reliable scale, and presents satisfactory criterion and content validity as the participants assessed demonstrated clear patterns of answers and deficits.
Acknowledgements: We would like to thank the Neurological Department of Papageorgiou Hospital (Thesaloniki, Greece) for recruting aphasic subjects.

P038

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 4 YEARS TILL 4 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[0], Pagoni A.[0], Xatiefremidou E.[0], Tafiadi M.[0]
[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S121

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 4 years till 4 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.
Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m: 50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach ≥.80).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P039

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 5 YEARS TILL 5 YEARS AND 11 MONTHS)

Tafiadis D.[1, 2], Larentzaki S., Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[0], Pagoni A.[0], Tafiadi M.[0]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S122

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 5 years till 5 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.
Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach ≥.80).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents

satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P040

THE RELATIONSHIP BETWEEN VISUAL MEMORY AND THE P300 IN FAMILIES WITH SCHIZOPHRENIA

Pentaraki A.[1], Stahl D.[2], Bramon E.[1], Kravariti E.[1], Murray R.[1], Toulopoulou T.[1, 3]

[1]Division of Psychological Medicine, Institute of Psychiatry, King's College London, [2]Division of Biostatistics, Institute of Psychiatry, King's College London, [1]Harvard Medical School, Department of Psychiatry

Annals of General Psychiatry, 2010;9(supplement 1):S123

Background: Patients with schizophrenia and their unaffected relatives exhibit significant P300 amplitude and latency abnormalities in conjunction with neurocognitive deficits. Both the deficits in the P300 and neurocognition suggest that these indexes may be potential endophenotypes of the disorder. Few studies have examined the relationship between the P300 and neuropsychological measurements of sustained attention, visual memory and current intellectual ability in schizophrenia and these studies provide inconsistent results. The aim of the present study is (a) to examine which cognitive impairments the P300 reflects in schizophrenia and (b) to investigate the relationship between neurocognition and the P300 in families with schizophrenia in order to examine if these may be potential endophenotypes of the disorder.
Materials and methods: 95 patients with schizophrenia (35 females, 60 males), 149 of their non-psychotic unaffected first-degree relatives (91 females, 57 males) and 69 unrelated healthy controls with no personal family history of psychosis (39 females, 30 males) were assessed both in a P300 oddball paradigm and neuropsychological measurements such as the WAIS-R (Wechsler, 1981), response tendency of the Conner's Continuous Performance Test (Conners, 1995), immediate and delayed visual recall of The Wechsler Memory Scale-Russell's version (Russell, 1975). STATA 9.0 (STATA Corporation, College Station, TX) was used for the statistical analysis of data.
Results: Significant P300 amplitude reductions and prolonged latencies were found in patients and their unaffected relatives independent of current general intellectual ability, education and age. There was a significant effect of sustained attention (response tendency), on the P300 amplitude reductions of patients and their unaffected relatives. Immediate visual recall had a significant effect on the P300 amplitude reduction of patients and their unaffected relatives, while there was no effect of delayed visual recall. There was no significant effect of immediate and delayed visual recall on the P300 prolonged latencies of patients and their unaffected relatives. Sustained attention did not have a significant effect on the P300 latency, but after controlling for its effect the differences between the groups disappeared.
Conclusions: The findings of the present study suggest that the P300 amplitude reduction that patients and their unaffected relatives exhibited reflected impairments in effortful attention and in the use of short-memory processes (e.g. encoding) that involve the visual modality. The findings also suggest a dissociation between the P300 and delayed visual recall in patients and their unaffected relatives. Although it is less clear from the present findings, the prolonged P300 latency does not seem to reflect impairments in sustained attention and visual memory processes in either patients with schizophrenia or their unaffected relatives. The P300 amplitude reduction seems to be a potential endophenotype of schizophrenia

References

Wechsler, D. (1981). Wechsler Adult Intelligence Scale-Revised Manual. New York: Psychological Corporation.
Conners, C. K. (1995). Conners' continuous performance test computer program. Canada: Multi-Healthy Systems, Inc.
Russell, E. W. (1975). A multiple scoring method for the assessment of complex memory functions. Journal of Consulting and Clinical Psychology, 43, 800-809.
Stata Statistical Software. Release 9.2. College Station, T.X.: Stata Press.

P041

SYNTHESIS AND STUDY THE ANALGESIC AND ANTI-INFLAMMATORY EFFECTS OF RIGID BENZOFURANE 3, 4 DIHYDROXY CHALCON (DHC) IN MICE

Heidari M. R.[1], Heidari M.[1], Foroumadi A.[2], Asadipour A.[3], Noroozi H.[1]

[1]Department of Toxicology and Pharmacology, Faculty of Pharmacy, Pharmaceutics, Neuroscience and Physiology Research Centers, Kerman University of Medical Sciences, Kerman, Iran, [2]Department of Medicinal Chemistry, Faculty of Pharmacy, Pharmaceutics Research Centers, Tehran University of Medical Sciences, Tehran, Iran, [3]Department of Medicinal Chemistry, Faculty of Pharmacy, Pharmaceutics Research Centers, Kerman University of Medical Sciences, Kerman, Iran.

Annals of General Psychiatry, 2010;9(supplement 1):S124

Background: According to bibliography on the structure activity relationship it seems that the rigid Benzofuran dihydroxy chalcon (DHC) may be more effective on pain and inflammation. In this study the Rigid benzofuran DHC were synthesized and the analgesic and anti- inflammatory effect it, was evaluated.
Materials and methods: In this study the Rigid benzofuran DHC were synthesized and the analgesic and anti- inflammatory effect of different doses 12.5, 25 and 50 mg/kg of it, was evaluated by formalin Hot plate and caregeenan tests, in group of 7 mice.
Results: The result showed that, 3, 4- DHC with dose of 25mg/kg induced significant antinociception and anti- inflammation compared with control group. In additon the effect of DHC was higher in the chronic phase of formalin test, therefore it seems that DHC has better anti- inflammatory effect rather than analgesic effect. The dose of 25 mg/kg of DHC induces significant analgesia in hot plate test and antiu-inflammatory effect in carageenan test too. The doses of 25 and 50 mg/kg, induced lethargy in mice.
Conclusions: The result showed that with modification of structure of the DHC, this derivative has potential for more studies as a lead compound.

References

Hsieh H.K., T.H.. Lee, J.P. Wang, et al. 1998. synthesis and anti - inflammatory effect of chalcones and related compounds. Pharm Res 15(1): 39-46.
Sogawa, S., Y. Nihro, H. Ueda, et al. 1993. 3,4-Dihydroxychalcones as potent 5-lipoxygenase and cyclooxygenase inhibitors. J. Med Chem. 36: 3904-3909.

P042

RELATIONSHIP OF PARENTAL AGE WITH SET SHIFTING AND REVERSAL LEARNING IN SCHIZOPHRENIA

Kontis D.[1], Kleisas S.[1], Theochari E.[1], Kalogerakou S.[2], Andreopoulou A.[1], Psaras R.[1], Karouzos Ch.[1], Tsaltas e.[2]

[1]1st Psychiatric Department, Psychiatric Hospital of Attica, Athens, Greece, [2]Experimental Psychology Laboratory, Department of Psychiatry, Eginition Hospital, Athens University Medical School, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S125

Background: Advanced parental age at birth has been associated with the risk of schizophrenia and has been linked to cognitive deficits in children. However, the relationship of parental age with cognition and with attentional flexibility in schizophrenia remains unknown.
Materials and methods: 27 patients with schizophrenia, were tested on the intra-dimensional/extra-dimensional set-shifting task (IEDS) of the Cambridge Neuropsychological Test Automated Battery (CANTAB) in an acute psychiatric ward. The paternal (PAB) and maternal age at birth (MAB) were also registered. Statistical correlation analyses and the Mann-Whitney test were performed using the

SPSS
Results: PAB positively correlated with the intra-dimensional shifting errors in the IEDS (rho=0.7, p=0.005). MAB positively correlated with both intra- and extra-dimensional reversal errors (rho=0.572, p=0.026 and rho=0.9, p=0.037, respectively). When we divided our subjects into two groups according to their PAB (≥ and < 30 years), no differences were found in any cognitive measure. However, the group with a MAB≥30 years, showed increased intra-dimensional reversal errors compared with the group with a MAB<30 years (p=0.03 and 0.029 respectively).
Conclusions: Increasing parental PAB showed an inverse relationship with the intra-dimensional shifting ability, but did not affect rule reversal performance. MAB was associated with errors in both intra- and extra-dimensional reversal in schizophrenia.

References
Malaspina D., Harlap S., Fennig S., Heiman D., Nahon D., Feldman D., Susser E.S. Advancing paternal age and the risk of schizophrenia. Arch Gen Psychiatry. 2001;58(4):361-7.
Saha S., Barnett A.G., Foldi C., Burne T.H., Eyles D.W., Buka S.L., McGrath J.J. Advanced paternal age is associated with impaired neurocognitive outcomes during infancy and childhood. PLoS Med. 2009; 10,6(3):e40.

P043

THE EFFECT OF PSYCHOPATHOLOGY ON SET SHIFTING AND REVERSAL LEARNING IN SCHIZOPHRENIA

Theochari E.[1], Kontis D.[1], Kleisas S.[1], Kalogerakou S.[2], Andreopoulou A.[1], Karouzos Ch.[1], Tsaltas E. [2]

[1]1st Psychiatric Department, Psychiatric Hospital of Attica, Athens, Greece, [2]Experimental Psychology Laboratory, Department of Psychiatry, Eginition Hospital, Athens University Medical School, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S126

Background: Recent studies suggest that negative and disorganized symptoms of schizophrenia are modestly associated with cognitive deficits, whereas positive and depressive symptoms are not.
Materials and methods: 27 patients with schizophrenia were tested on an intra-dimensional/extra-dimensional set-shifting (IEDS) task of the Cambridge Neuropsychological Test Automated Battery (CANTAB) in an acute psychiatric ward. Their psychopathological state was assessed with PANSS and the Calgary Depression Scale. Correlation analysis was used to examine the association of psychopathology with set shifting and reversal learning performance.
Results: We found significant positive correlations of PANSS total (rho=0.53, p=0.016) and general (rho=0.590, p=0.006) scores with the intra-dimensional reversal errors in IEDS. No significant correlations of IEDS performance variables with the PANSS positive or negative symptoms scores were found. PANSS disorganization scores showed positive correlations with intra-dimensional reversal errors (rho=0.639, p=0.002), but a small negative correlation with the number of completed IEDS stages (rho=-0.392, p=0.043). No association was detected between depressive symptoms and IEDS task performance.
Conclusions: We found modest associations between symptomatology and the intra-dimensional reversal ability in schizophrenia. These associations are mainly driven by disorganization symptoms. Positive, negative and depressive symptoms are not associated with IEDS performance.

References
Dominguez Mde G., Viechtbauer W., Simons C.J., van Os J, Krabbendam L. Are psychotic psychopathology and neurocognition orthogonal? A systematic review of their associations. Psychol Bull. 2009;135(1):157-71
McKirdy J., Sussmann J.E., Hall J., Lawrie S.M., Johnstone E.C., McIntosh A.M.. Set shifting and reversal learning in patients with bipolar disorder or schizophrenia. Psychol Med. 2009;39(8):1289-93.

P044

PSYCHOLOGICAL STATUS AND BREATH AT CHILDREN WITH PSYCHOSOMATIC PATHOLOGY

Grishin O., Paramoshkina E., Leshinskaya V.

Laboratory for Respiratory Physiology, Research Institute of Physiology SB RAMS, Novosibirsk, Russia

Annals of General Psychiatry, 2010;9(supplement 1):S127

Background: Breath and emotions are closely connected and that is reflected in various symptomatology in children with psychosomatic pathology. The aim of study was to estimate the psychosomatic status and ventilation function of breath using of respiratory biofeedback in children with various psychosomatic diseases.
Materials and methods: To examine the relationship between respiration and psychological status in children with psychosomatic disorders, 20 children aged 8-12 were studied during the integrated treatment using respiratory BFB by capnography at day-care hospital. Rates of respiratory function, anxiety level and frustration reactivity were measured.
Results: The significant decreases of anxiety level, combined with an increase in frustration tolerance, were found. Moreover, these processes were accompanied by an increase in CO2 at the end of exhalation (FetCO2) and the structure changes of breathing pattern. An internal restructuring of the respiratory cycle was observed: expiration time increased while the respiration rate remained unchanged.
Conclusions: Whereas hyperventilation syndrome diagnosis in children should be focused mainly on FetCO2 and respiration rate indices, to identify other forms of functional respiratory disorders it is necessary to control the respiratory cycle data, among them the exhalation duration particularly.

P045

EVALUATING THE EFFECT OF TETRAHYDROCANNABINOL (Δ9-THC) EXTRACTED FROM CANNABIS SATIVA PLANT ON SPATIAL MEMORY CONSOLIDATION IN RATS

Ebrhimpour S.[1], Kafaee M.[1], Tehraniour M.[1], Behnamrasouli M.[2]

[1]Department of Biology, Faculty of Science, Islamic Azad University, Mashhad Branch,Mashhad,Iran,
[2]Department of Biology, Faculty of Science, Ferdowsi University of Mashhad, Mashhad, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S128

Background: As the point of physiology, memory form, from changes in the conducting message in the neural webs. These changes cause to formation of long-term potentiation. Δ9-THC is Psychotropic component of Cannabis sativa plant, studies show this matter can bind Cannabinoid receptor in CA1 area of Hippocamp.Thus the aim of this study is evaluation the effect of aqua extraction Cannabis sativa seed on spatial memory consolidation in Rats.
Materials and methods: Number of 40 male wistar Rats (3-4mounth, 320-260 g) wereCompletely divided into 4 experimental groups and control group.Cannabis sativa seed was extracted with Soxhlet apparatus. To test spatial memory, Morris water mazemaze (7 days,4 trails) was used. experimental groups with 50 mg.kg-1 ,100mg.kg-1 ,150mg.kg -1,210mg.kg-1 were injected in the peritoneal (IP) and after one hour of injection spatial memory was scaled
Results: The result show that experimental groups (50mg.kg-1,100mg.kg-1,150mg.kg -1 doses), for learning time have significant level eduction in the comparison of control group ($p<0.05$), but experimental group with 210mg.kg-1 dose has not significant level in the comparison of control group ($p<0.05$).
Conclusions: We demonstrate tetrahydrocannabinol can change brain function as earning and memory processes and probably was done with Depolarization-Induced Suppression of excitatory (DSE) mechanism in the CA1 area of Hippocamp that with neurotransmitter regulation cause to europlasticity.
Acknowledgements: The authors are grateful to Islamic azad university of mashhad, Iran for supports

References
Allyn C.Efficacy in CB1 receptor-mediated signal transduction. Br Pharmacol 2004, 142(8): 1209-1218.
Hooge R., DeDeyn, P.P.Applications of the Morris water maze in the study of learning and memory.Brain.Rev 2001.36:60-90
Sarne Y.,Keren O. Are cannabinoid drugs neurotoxic or neuroprotective.medical hypothesis 2004, 187-192.
Jonathan L.C.Memory reconsolidation mediates the strengthening of memories by additional learning.Nature neuroscience 2008, 11,1264-1266.

P046

EFFECTS OF EXPOSURE TO EXTREMELY LOW-FREQUENCY MAGNETIC FIELD OF 2μT INTENSITY ON SPATIAL MEMORY AND LEARNING IN MICE

Kafaee M.[1], Tehranipour M.[1], Haghpeima A.[2]

[1]Department of Biology, [2]Department of Physics
Faculty of Science, Islamic Azad University, Mashhad Branch, Mashhad, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S129

Background: Extremely low-frequency magnetic fields (ELFMF), have been reported to produce a variety of biological effects, interfere with the ctivity of the brain and may behavioral and cognitive disturbances disturbances. Some efforts have been to investigate the incidence of ELFMF on human health and animal physiology and behavior.thus In the present study, we examined the effects of chronic exposure (1 and 2 weeks) to an extremely low-frequency magnetic field (ELFMF) of 2μT intensity on memory in rats using an Morris water maze
Materials and methods: we examined the changes in spatial learning and memory by the Morris water maze test after 1 weeks of daily exposure of rats to a 10-Hz and30-Hz magnetic field of 2μT for either1 or 4 h.
Results: We found that chronic exposure to ELF MF reduced the latency to find the hidden platform and improved long-term memory of former location of platform without affecting motor activity
Conclusions: These findings for the first time indicate that chronic exposure to ELF MF exerts a positive effect on the acquisition and maintenance of spatial memory.
Acknowledgements: The authors are grateful to Islamic azad university of mashhad, Iran for supports.

References
Liu T., Wang S., He .L., Ye K.Chronic exposure to low-intensity magnetic field improves acquisition and maintenance of memory.neuroreport 2008,19(5):549-52.
Naomi M.S, Jennifer M.H., Shelly K., Kavaliers M., Frank S., Pratoa W.,.Analgesic and behavioral effects of a 100 μT specific pulsed extremely low frequency magnetic field on control and morphine treated CF-1 mice. Neuroscience Letters 2004,30-33.
Yu F., Cangkai W. , Jianhong W., Yanlin L. ,Yuanye M., Long-term exposure to extremely low-frequency magnetic fields impairs spatial recognition memory in mice.physiology and pharmacology 2008,797-800.
Hooge R.,Deyn P.Applications of the Morris water maze in the study of learning and memory.Brain.Rev 2001.36:60-90

P047

MEDICAL CONSULTATIONS IN PSYCHIATRIC INPATIENTS: A DESCRIPTIVE STUDY

Seyed Mehdi Samimi Ardestani [1], Abbas Rahmanimehr [2]

[1]Department of Psychiatry, Behavioral Science Research Center, Imam Hosein General Hospital, Shahid Beheshti University of Medical Science, Tehran, Iran, [2]Imam Hosein General Hospital, Shahid Beheshti University of Medical Science, Tehran, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S130

Background: According to previous studies medical illness is common in psychiatric patients but they are frequently treated without careful attention to medical problems[1]. Psychiatric symptoms can be manifestation of medical illness. Medical illness and psychiatric disorder can coexist and can affect on severity, course and prognosis of each other[2].
Materials and methods: this is a descriptive study (existing data). We studied the documentations 2500 admitted patients in Imam hossein hospital & those with medical consultations included in this study
Results: Total of consultations was 706 that for 490 patients. 61% of consultations were for women and 39% for men. 54% had diagnosis of bipolar disorder 14% depression, 7% schizophrenia, 8% schizoaffective and 17% other diagnosis. Emergent consultations were 29% and non emergent 71%. The most consultations were related to internal, neurology cardiologic wards (emergent and non emergent). In subspecialty services endocrinology consultations were the most common. The most common medical comorbidities were diabetes mellitus and cardiovascular diseases. CNS problems was the most frequent cause of psychiatric disorder due to general medical condition (in 4%) and the most psychiatric manifestation of them was mood disturbances (depression and bipolar). 28% of consultations were related to previously recognized medical disease (diabetes ,thyroid disease and epilepsy)
Conclusions: According to findings of this study medical problems among psychiatric inpatients are common. So psychiatrists should not ignore this probability to avoid the potential harm of these problems in any psychiatric settings. Availability of medical services for psychiatric inpatients (such as medical consultants or beings in a general hospital) seems to be considered as one of essentials in this line[3].

References

Hall R.C., Gardner E.R., Popkin M.K., Lecann A.F., Stickney S.K.:Unrecognized physical illness prompting psychiatric admission: a prospective study. Am J Psychiatry. 1981 May;138(5):629-35.
Koranyi EK:Morbidity and rate of undiagnosed physical illnesses in a psychiatric clinic population. Arch Gen Psychiatry. 1979 Apr;36(4):414-9.
Bunce D.F. 2nd, Jones L.R., Badger L.W., Jones S.E.: Medical illness in psychiatric patients: barriers to diagnosis and treatment.South Med J. 1982 Aug;75(8):941-4.

P048

GALANTAMINE IMPROVES COGNITION, BEHAVIORAL SYMPTOMS AND FUNCTIONING: A 6-MONTH NON-INTERVENTIONAL STUDY

Doskas T.[1], Giatas K.[2], Oikonomidis D.[3], Tsolaki M.[4], Politis A.[5], Fitsioris X.[6], Kontogianni V.[7], Makris N.[8], Papatriantafyllou I.[9], Rigopoulou S.[10], Sakka P.[11], Vagenas V.[12], Varelas G.[13], Gatos K.[14], Fortos A.[15], Taskos N.[16], Mestoussi A.[17] Vikelis M.[17]

[1]Naval Hospital of Athens, [2]251 General Airforce Hospital, Athens, [3]Ippokrateio General Hospital, Thessaloniki, [4]Private practice, Thessaloniki, [5]Eginition University Hospital, Athens, [6]Papageorgiou General Hospital, Thessaloniki, [7]Private practice, Athens, [8]Agios Andreas General Hospital, Patras, [9]Private practice, Athens, [10]Private practice, Thessaloniki, [11]Hygeia Diagnostic and Therapeutic Center, Athens, [12]Private practice, Athens, [13]General Hospital, Giannitsa, [14]Agios Georgios Clinic, Volos, [15]Dromokaitio Psychiatric Hospital of Attica, Athens, [16]AHEPA University Hospital, Thessaloniki, [17]Medical Department Janssen-Cilag Greece, Athens

Annals of General Psychiatry, 2010;9(supplement 1):S131

Background: Acetylcholinestarase inhibitors (AChEIs) are the treatment of choice for mild to moderate Alzheimer's disease (AD). Switches between AChEIs are usually performed when the current therapy is not effective or poorly tolerated.
Aim: To evaluate the effect of Galantamine treatment in cognition, behavioral symptoms and daily functioning of patients with mild-to-moderate AD.
Methods: 6-month, non-interventional, prospective study. Treatment-naïve patients or those who had failed on a previous AChEI therapy were enrolled. Naïve patients started treatment on 8mg daily. Patients switched from other AChEIs started at galantamine therapeutic levels -16mg- or 24mg if switched from max dose of rivastigmine. Efficacy was assessed using Mini Mental State Examination (MMSE), Neuropsychiatric Inventory (NPI), Disability Assessment for Dementia (DAD), and Cornell Scale. Caregivers also rated patient's condition using Clinical Global Impression (CGI) scale. Adverse events were closely monitored
Results: 333 patients were enrolled (58.6% female). The mean age was 73.5 (SD 6.7) and mean time since diagnosis was 64.2 months (SD 59.1). At the end of the study, the mean galantamine dose was 22.4 mg/day (SD 3.2). 95,2% of patients (317/333) had received another AChEI and inadequate response was the most frequent reason for switching (70.7%).
Efficacy results on all scales had a statistically significant improvement from baseline to month 6. MMSE was increased: 18.7 (SD 4.2) to 19.9 (SD 4.6), p<0.001; and DAD also increased:68.9 (21.0) to 73.7 (16.2), p=0.004. NPI, Cornell & CGI were decreased: NPI 12.6 (15.5) to 9.9 (13.2), p<0.001; Cornell 7.0 (7.7) to 4.6 (5.5), p=0.003; CGI-Caregivers 3.8 (1.1) to 3.6 (1.2), p<0.001. 9,9% of patients had at least one adverse event. Most were mild involving nausea (23.3%), vomiting (18.3%) and diarrhea (6.7%). 8 SAEs were recorded.
Conclusions: Discontinuation of a previous AChEI with subsequent treatment with galantamine at a therapeutic dose level may improve all clinical aspects of AD. The safety profile recorded in everyday clinical practice was similar to that reported in double-blind, controlled trials of galantamine.

P049

ASSOCIATION OF WEIGHT GAIN AND METABOLIC SYNDROME IN PATIENT TAKING CLOZAPINE: A 8-YEAR COHORT STUDY

Ya Mei Bai[1,2], Chao-Cheng Lin[3,4], Jen-Yeu Chen[5], Tzu Ting Chen[5], Tung-Pine Su[1,2]

[1]Department of Psychiatry, Taipei Veterans General Hospital, Taipei, Taiwan
[2]Department of Psychiatry, Collage of Medicine, National Yang-Ming University, Taipei
[3]Department of Psychiatry, National Taiwan University Hospital, Taipei, Taiwan
[4]Graduate Institute of Medical Informatics, Taipei Medical University, Taiwan
[5]Department of Psychiatry, Yu-Li Veterans Hospital, Taiwan

Annals of General Psychiatry, 2010;9(supplement 1):S132

Background: Metabolic syndrome is an important side effect associated with clozapine. It has been hypothesized that weight gain contributes to the development of metabolic syndrome, but a direct diabetogenetic effect has also been suggested. We conducted an 8-year cohort study to determine the association between weight gain and metabolic parameters among schizophrenic patients on clozapine.
Materials and methods: The subjects were hospitalized schizophrenic patients who began to receive clozapine and subsequently had monthly body weight monitoring during the entire study period. Chart reviews were conducted to obtain gender, age at initiation of clozapine treatment, baseline Body Mass Index (BMI), BMI changes after the initiation of clozapine treatment, treatment duration with clozapine and concomitant psychotropic medications. Anthropometric and biochemical measurements were performed to determine the presence of metabolic syndrome.
Results: Patients were maintained on clozapine for an average treatment duration of 56.0±27.8 (range 5 to 96) months. The prevalence of metabolic syndrome was 28.7%. The cohort regression models showed that baseline BMI ($p<0.0001$) and BMI change after clozapine treatment ($p<0.0001$) were significant factors for metabolic syndrome as were most metabolic parameters except hyperglycemia and diabetes mellitus, which were related to treatment duration ($p<0.05$).
Conclusions: For patients treated with clozapine, metabolic syndrome and most metabolic parameters were related to weight gain; however, glucose dysregulation was associated with treatment duration independent of weight gain. The results confirm that monitoring body weight is important, but periodic monitoring of blood sugar may also be required for clozapine patients who do not have significant weight gain.

References

Henderson D.C., Cagliero E., Copeland P.M., et al. Glucose metabolism in patients with schizophrenia treated with atypical antipsychotic agents: a frequently sampled intravenous glucose tolerance test and minimal model analysis. Arch Gen Psychiatry 2005;62: 19-28
Henderson D.C., Copeland P.M., Borba C.P., et al. Glucose metabolism in patients with schizophrenia treated with olanzapine or quetiapine: a frequently sampled intravenous glucose tolerance test and minimal model analysis. J. Clin Psychiatry 2006;67: 789-797
Howes O.D., Bhatnagar A., Gaughran F.P., et al. A. prospective study of impairment in glucose control caused by clozapine without changes in insulin resistance. Am J. Psychiatry 2004;161: 361-363
Lamberti J.S., Costea G.O., Olson D., et al. Diabetes mellitus among outpatients receiving clozapine: prevalence and clinical-demographic correlates. J. Clin Psychiatry 2005;66: 900-906

P050

FUGUE AND APHONIA AS FIRST AND FOREMOST PRESENTATIONS OF A CASE OF PSYCHOSIS

Leotsakou Ch.[1], Sardis A.[2], Robotis P.[1], Labiris Ch.[1], Giovanoglou M.[1], Paterakis P.[1]

[1]1st and 5th Department, Dromokaition Psychiatric Hospital, Athens, Greece
[2]5th Department, Psychiatric Hospital of Attica, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S133

Background: Hysteria has experienced many changes in diagnostic classification and clinical manifestations. It has become infrequent due to cultural but also diagnostic changes. A change in which people communicate their distress has taken place. In the past, bodily experiences used to express emotions whereas nowadays a shift from bodily experiences to emotional -or better to say psychological- experiences has been proposed. "Unable to speak but can whisper", "Cannot hold arm but can hold it in place", "Glove and stocking pain or numbing": all these represent the patient's idea of anatomy and physiology, and were seen more often in the past. On the other hand hysterical behavior has for long been described in cases of endogenous psychoses.
Materials and methods: Case Report: A 48-year-old woman, married, mother of three children, was admitted to our hospital for aphonia for the last year, severe anxiety and insomnia for the past week. Her first symptoms appeared three years ago when she had 4 episodes of fugue.
Results: One year ago, with no obvious precipitating factor, she fainted in her garden and couldn't talk after recovering of that. At hospital, high blood pressure and expressive aphasia, were diagnosed at first but after full neurological examination and a cranial computed tomography, revealing no infarct, the patient was discharged as having 'conversion disorder' and mirtazapine and diazepam were prescribed. For the next weeks she didn't speak but communicated through writing. During her hospitalization in our ward of a psychiatric hospital it became obvious, through her writings, that the patient was psychotic (paranoid type), having persecutory delusions and also auditory hallucinations especially in the evening preventing her from sleeping.The diagnosis of psychosis was confirmed by an MMPI. EEG, CT scan and MRI were negative. She was treated with aripiprazole 15 mg. At first she started to whisper but was incomprehensible most of the time and her sleep improved. Three weeks later we could understand her 'whispering' and she was discharged. Nine months later she is functional, has no hallucinations or organized persecutory ideas. She still has some suspiciousness and though communicating very well is most of the time whispering!
Conclusions: Symptoms do not fully determine diagnosis or better to say the same symptoms can be found in many diagnostic categories. The severity and insistence of her 'typical' hysterical symptoms should have guided clinicians to the diagnosis of psychosis.

References

J.L. Reed: The diagnosis of 'hysteria'. Psychol Med 1975, 5(1): 13-7.
L.M. Linett: A case of pure word mutism: don't be fooled. Ann Emerg Med 1989, 18(11): 1233-6.
W. Fisher, M. Gebhardt, H. Jahr: Hysteria and psychosis. Psychiatr Neurol Med Psychol (Leipz) 1986, 38(6): 324-30.

P051

TREATMENT OF BIPOLAR MANIA WITH PALIPERIDONE EXTENDED-RELEASE

Kotorki P.[1], Leotsakou Ch.[2], Pelka P.[2], Labiris Ch.[2], Mantzari E.[2], Messinezi A.[2], Fiste M.[2], Paterakis P.[2]

[1]Social Insurance Institue, Analipsi, Thessaloniki, Greece
[2]1st and 5th Department, Dromokaition Psychiatric Hospital, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S134

Background: Bipolar disorder is a life-long condition associated with frequent relapses of symptoms and clinicians often use combinations of psychotropic agents to treat their patients. Second generation antipsychotics are a frequent choice in antimanic pharmacologic treatment. The evidence suggests that for acute mania a combination of lithium or valproate and an atypical antipsychotic is the most effective approach. Paliperidone extended-release (ER) is approved for treatment of acute schizophrenia and for maintenance treatment of schizophrenia. It has -probably as a result of its pharmacokinetic profile- shown robust efficacy, and a favorable tolerability in multiple trials for the treatment of schizophrenia. Our goal was to assess its efficacy and tolerability as acute and maintenance of effect therapy in patients with bipolar I disorder experiencing manic or mixed episodes while on a mood stabilizer.
Materials and methods: Six hospitalized patients (2 men and 4 women) with average age 35.6 years and average duration of illness 7.2 years, with acute bipolar I mania (2 of them with a mixed episode) were put on paliperidone (3 patients on 6 mg and 3 patients on 9 mg). They were all receiving a mood stabilizer (3 were on valproate, 2 on lithium, and one on topiramate) although compliance was partial in at least 4 of the cases. The primary outcome measure was the mean change in the Young Mania Rating Scale (at baseline average: 40,3) and secondary measures included the 21-item Hamilton Rating Scale for Depression (HAM-D-21) and Clinical Global Impressions-Bipolar Version [(CGI-BP), at baseline average: 5,4] at Week 4 (average YMRS: 14 and CGI-BP: 3), 8 (average YMRS: 11 and CGI-BP: 2,4), and 16(average YMRS: 11 and CGI-BP: 2,2).
Results: Paliperidone ER provided improvement of acute mania within 4 days, continuing over 4 weeks and sustained over 16 weeks in 5 of our 6 patients. It was discontinued in one at day 8 due to worsening of her symptoms. Paliperidone was generally well tolerated and helped patients achieve and maintain remission without occurrence of depressive symptoms. In 2 of the patients on 9 mg, paliperidone was lowered to 6 mg after 8 weeks without recurrence of symptoms. No patient developed major depression.
Conclusions: Well tolerated and effective therapies for bipolar mania are required. It is well known that patients with bipolar disorder appear more sensitive to antipsychotics. Paliperidone provided in our small sample significant improvement of acute mania and maintained its effect for 4 months. Paliperidone ER may be a safe and effective treatment option for acute mania and provide additional benefit over monotherapy for the management of the manic phase but also for control of mood symptoms in the long run, particularly in preventing manic relapses. It should be noticed that our patients suffered moderate to severe manic episodes, 4 of them with psychotic features (Patients 1, 2, 4,6), and had to be hospitalized for them. This could partially explain why the addition of an antipsychotic improved rapidly their symptomatology. Studies with exclusively nonpsychotic acute or mixed episodes should be conducted.

References

J. Marino, J. Caballero J.: Paliperidone extended-release for the treatment of schizophrenia. Pharmacotherapy 2008, 28 (10): 1283-98.
R.H. Perlis, R.W. Baker, C.A. Zarate J.R., E.B. Brown, L.M. Schuh, H.H. Jamal, M. Tohen: Olanzapine versus risperidone in the treatment of manic or mixed states in bipolar I disorder: a randomized,double-blind trial. J. Clin Psychiatry 2006, 67 (11): 1747-53.
P. Corena-McLeod Mdel P., A. Oliveros, C. Charlesworth, B. Madden, Y.Q. Liang, M. Boules, A. Shaw, K. Williams, E. Richelson: Paliperidone as a mood stabilizer: a pre-frontal cortex synaptoneurosomal proteomics comparison with lithium and valproic acid after chronic treatment reveals similarities in protein expression. Brain Res 2008, 1233: 8-19.
A.H. Young A.H., D.A. Oren, A. Lowy, R.D. McQuade, R.N. Marcus, W.H. Carson, N.H. Spiller, A.F. Torbeyns, R. Sanchez: Aripiprazole monotherapy in acute mania: 12-week randomized placebo- and haloperidol-controlled study. Br J. Psychiatry 2009, 194 (1): 40-8.

P052

THE USE OF AMISULPRIDE IN SCHIZOPHRENIC PATIENTS WITH RESISTANT SYMPTOMATOLOGY

Kalfas D., Markou S., Gkletsos A., Parga M., Karras Th.

Psychiatric Clinic, Giannitsa General Hospital, Giannitsa

Annals of General Psychiatry, 2010;9(supplement 1):S135

Background: The purpose of this study was to evaluate the use of the pharmaceutical drug Amisulpride (Solian) in schizophrenic patients with resistant semiology
Materials and methods: The material of this study was 21 patients (17 men and 4 women) who were diagnosed with schizophrenic disorder paranoid type based on DSM-IV, and were recorded with durable symptomatology (delusions, paranoid ideas etc.) even though the continuous issuing of Amisulpride in normal doses (800-1200mg/daily). In these patients was given Amisulpride in larger doses than the proposed (1600-2000 mg/daily). The evaluation was done with the PANSS scale
Results: After a 30 day time interval and while the continuous issuing of Amisulpride in larger doses was observed considerably reprocess of the resistant symptoms, fact that recorded at the grade alleviation at PANSS scale
Conclusions: Is concluding that the continuous issuing of Amisulpride in larger doses than the normal ones help considerably in obliteration of the durable symptoms of schizophrenia.

P053

EVALUATION THE ANTINOCICEPTIVE AND ANTI-INFLAMMATORY EFFECT, OF NEW RIGID, PROPOXY BENZOPYRANE-3,4 DI-HYDROXYCHALCONE DERIVATIVE BY HOT-PLATE, FORMALINE AND PLETHYSMOGRAPHY

Payam Khazaeli[1], Mamoud Reza Heidari[2], Alireza Foroumadi[3], Mehdi Kalati[5]

[1]Department of Pharmaceutics, Faculty of Pharmacy, Pharmaceutics Research Center, Kerman University of Medical Sciences, Kerman, Iran,
[2]Department of Toxicology and Pharmacology, Faculty of Pharmacy, Pharmaceutics and Physiology Research Centers, Kerman University of Medical Sciences, Kerman, Iran,
[3]Department of Medicinal Chemistry, Faculty of Pharmacy and Pharmaceutical Sciences Research Center, Tehran University of Medical Sciences, Tehran, Iran,
[4]Department of Cardiology, Faculty of Medicine, Kerman University of Medical Sciences, Kerman, Iran,
[5]Kerman Neuroscience Research Center, Kerman University of Medical Sciences, Kerman, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S136

Background: There are many reports indicating the analgesic and anti inflammatory effects of 3,4-dihydroxy chalcones. In this study antinociceptive and anti-inflammator effects of rigid derivative 3-(3,4-dihydroxybenzylidene)-7-propoxy benzopyran-4-one, were evaluated by Formalin, Hot plate and Carageenan tests.
Materials and methods: Experimental doses of 50, 75 and 100 mg/kg of 3,4- DHC were injected to mice and the analgesic and anti inflammatory effects evaluated by Formalin, Hotplate and Carageenan tests. Effective dose compared with Morphine and Ibuprofen.
Results: The result showed that, propoxy chalcone with dose of 75mg/kg induced significant anti nociception and anti inflammation in Formalin and Carageenan tests.The results showed that the dose of 75 mg/kg of 3,4-DHC induces significant analgesia in 45 and 60 minutes in hot plate test .The analgesic effect of the most effective dose of 3,4- Dihydroxy chalcone 75mg/kg was lower than morphine (2.5 mg/kg) in all time in Formalin and Hot plate tests. The analgesic effect of DHC was higher than Ibuprofen (200mg/kg) in 0-5 minute in Formalin test and in 45 and 60 minutes in Hot plate test, but in chronic phase of Formalin test was nearly equal to Ibuprofen. In Carageenan test, the anti inflammatory effect of 3,4-DHC was higher than Ibuprofen (200mg/kg) and morphine (2.5 mg/kg) in the

first and third hours. Therefore it seems that 3,4-DHC has better anti-inflammatory effect rather than analgesic effect. The doses of 75 and 100 mg/kg, induced lethargy in mice.
Conclusions: The results showed that the modification of this structure of DHC, may lead to more effective derivative with significant analgesic effect and it could be used for more studies to access a clinical use of 3,4- DHC as a drug.

P054

SOCIAL ACTIVITY AND PARTICIPATION AS DETERMINANTS OF ANXIETY AND DEPRESSION AMONG ELDERLY IN PRIMARY CARE

Grammatikopoulos I.[1], Koutentakis C.[2]

[1]B' University Clinic, Psychiatric Hospital of Thessaloniki, Thessaloniki, Greece
[2]Department of Social Medicine, Faculty of Medicine, University of Crete, Heraclion, Crete, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S137

Background: Aim of this study was to investigate anxiety disorders and depression among members of one Open Care Centre for the Elderly (KAPI) in Crete-Greece, in correlation with their activity and participation levels.
Materials and methods: A cross-sectional study was designed and 132 aged (≥65) participated. All participants were members of the KAPI from a rural district in Crete, Greece. Data were collected with face-to-face interviews. Social activity and levels of participation in KAPI were examined. The Short Anxiety Screening Test (SAST) and the Geriatric Depression Scale (GDS-15) was used to assess anxiety disorders and depression respectively. Univariate and multivariate regression models used to determine the factors which correlate with these disorders.
Results: 132 aged (mean age 75.7 years) participated. 18,2% had minor depression (GDS≥7) and 8,3% moderate to severe depression (GDS≥11), while 17,4% (6,8% men vs 26,4% women) had an anxiety disorder according to SAST (≥24). According to univariate regression models, increasing age, female gender and the absence or minor participation in KAPI were associated with higher risk of depression; low levels of participation in KAPI and female gender were associated with higher risk of anxiety.
Conclusions: Our findings document the association of higher prevalence of anxiety and depression in elderly with limited social activity in primary care centres, and especially affect more women and aged in widowhood. These determinants of isolation should be factors of mental health prevention management in primary care.

References

Fountoulakis K., Tsolaki M., Iacovedes A., Yesavage J., O'Hara R., Kazis A., Ierodiakonou C. (1999). The validation of the short form of the Geriatric Depression Scale (GDS) in Greece. Aging (Milano) 11: 367-372.
Sinoff, G., Ore, L., Zlotogorsky, D. and Tamir, A. (1999) Short Anxiety Screening Test--a brief instrument for detecting anxiety in the elderly. Int J. Geriatr Psychiatry, 14(12): 1062-1071.
Wittchen H.U., Kessler R.C., Beesdo K., Krause P., Höfler M., Hoyer J. (2002) Generalized anxiety and depression in primary care: prevalence, recognition, and management. : J. Clin Psychiatry, 63(8): 24-34.
Papadopoulos F.C., Petridou E., Argyropoulou S., Kontaxakis V., Dessypris N., Anastasiou A., Katsiardani K.P., Trichopoulos D. & Lyketsos C. (2005) Prevalence and correlates of depression in late life: a population based study from a rural Greek town. Int J. Geriatr Psychiatry, 20: 350-357.

P055

PANIC DISORDER AS PRESENTING SYMPTOMS OF MULTIPLE SCLEROSIS

Algin D.İ.[1], Kilicoglu A.[2], Koplay M.[3]

[1]Department of Neurology, Dumlupinar University, Kutahya, Turkey, [2]Department of Psychiatry, Dumlupinar University, Kutahya, Turkey, [3]Department of Radiology, Dumlupinar University, Kutahya, Turkey

Annals of General Psychiatry, 2010;9(supplement 1):S138

Background: Multiple sclerosis (MS) is a chronic demyelinating disorder characterized by multiple neuropsychiatric symptoms Psychiatric disorders and symptoms may accompany the course of MS as primary or secondary reasons (1,2). We will present a case report with panic disorder as presenting symptoms of multiple sclerosis.
Materials and methods: A 47 years old female patient admitted to psychiatry clinic with attacs of palpitation, sweating, dispnea with a feeling of heart attack. These symptoms were present for 3 months,3-4 times a week and the patient started to have expectation anxiety. She was diagnosed as panic disorder and started paroxetine 20 mg/day . After one month her symptoms were not beter, and because of reference delusions as if people were looking at her, olanzapine 10 mg/day was added. After another month of medication, because she was not better, she was sent to neurology and she had a cerebral magnetic resonance imaging(MRI).In her neurologic examination her deep tendon reflexes were found to be increased. In her MRI a right frontal 10x5 mm periventricular deep white matter plaque and multiple subcorticle white matter hyperintense plaques were seen. In her serebrospinal oligoclonal band was positive . She was diagnosed as multiple sclerosis and after 5 day treatment of methylprednisolone 1000 mg/day, her psychiatric symptoms disappeared.
Results: Psychiatric symptoms may be primary symptoms of a new demyelinization epizode.
Conclusions: A MS patient may admit with psychiatric symptoms and there may be a misdiagnosis of psychiatric disorder.

References

Korostil M., Feinstein A. Anxiety disorders and their clinical correlates in multiple sclerosis patients. Mult Scler. 2007 Jan;13(1):67-72.
Minden S.L.Mood disorders in multiple sclerosis: diagnosis and treatment. J. Neurovirol. 2000 May;6 Suppl 2:S160-7.

P056

EVALUATING THE EFFECT OF AQUATIC EXTRACTION OF CANNABIS SATIVA SEED ON SPATIAL MEMORY CONSOLIDATION IN RATS

Saeedeh Ebrahimpour[1], Maryam Tehranipour[1], Morteza Behnam[2], Morteza Kafaee[1]

[1]Department of Biology, Faculty of Science, Islamic Azad University, Mashhad Branch, Mashhad, Iran, [2]Department of Biology, Faculty of Science, Ferdowsi University of Mashhad, Mashhad, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S139

Background: The existence of an endocannabinoid system in the central nervous system that consists of G protein-coupled CB1 cannabinoid receptors and endocannabinoids, including arachidonylethanolamide and 2-arachidonoylglycerol,has gained general acceptance. Recent reports suggest that this system may serve several physiological functions including learing and memory functions
Materials and methods: 40 male wistar Rats (3-4mounth, 320-260 g) were Completely divided into 4 experimental groups and control group.Cannabis sativa seed was extracted with Soxhlet apparatus. To test spatial memory,Morris water mazemaze(7 days,4 trails) was used.experimental groups with 50 mg.kg-1 ,100mg.kg-1 ,150mg.kg -1,210mg.kg-1 were injected in the peritoneal (IP) orderly and after one hour of injection spatial memory was done.
Results: The result show that experimental groups (50mg.kg-1,100mg.kg-1,150mg.kg -1 doses), for learning time have significant level deduction in the comparison of controlgroup ($p<0.05$),but experimental group with 210mg.kg-1 dose has not significant level in the comparison of control group($p<0.05$).
Conclusions: We demonstrate tetrahydrocannabinol can change brain function as learning and memory processes and probably was done with Depolarization-Induced Suppression of excitatory (DSE) mechanism in the CA1 area of Hippocamp that with neurotransmitter regulation cause to neuroplasticity.
Acknowledgements: We thank Dr Heravi and Mr Kazemi for money support and Azad university of Mashhad for prepare Lab for Test

References

L.C.Lee Jonathan.Memory reconsolidation mediates the strengthening of memories by additional learning. Nature Neuroscience 2008,11:1264-1266
Y. Kawamura,M.Fukaya,T.Maejima, T.Yoshida,E. Miura, M.Watanabe,T. Ohno-Shosaku,M.Kano.The CB1 Cannabinoid Receptor Is the Major Cannabinoid Receptor at Excitatory Presynaptic Sites in the Hippocampus and Cerebellum.Neuroscience 2006,26:2991-3001
M.Z.Kyari.Extraction and Charachterization of seed oils.Int Agrophysics 2008,22:139-142
S.A.Varvel,A.H.Litchman.Evaluation of CB1 receptor knockout mice in the Morris water maze.Pharmacol Exp Ther 2002,301:915-24

P057

CLUSTER 'A' IN PERSONALITY DISORDERS CATEGORY - DEVELOPMENT AND PERSPECTIVE

Donchev T.[2], Martinova H.[1]

[1]Military Medical Academy, Clinic of Psychiatry, Sofia, Bulgaria, [2]Medical University - Sofia, Sofia, Bulgaria

Annals of General Psychiatry, 2010;9(supplement 1):S140

Background: With the development of psychiatric science the group of Personality Disorders becomes clearly defined and within the various existing classifications a well-defined group stands out, characterized mainly by the cold affect and by the lack of empathy. The historical overview of the Paranoid and the Schizoid Personality Disorders reveals extremely high historical (temporal) stability of their diagnostic criteria. This stability and endurance of the Cluster A raises the question of its'

potential freedom from historical and/or cultural contextual effects.
Materials and methods: 42 male psychiatric patients, aged 18 to 25, diagnosed with Personality Disorder and Adjustment Disorder, were examined for this study. The participants were evaluated with psychiatric clinical interviews, as well as with semi-structured interview for assessment of personality disorders - International Personality Disorders Examination (IPDE).
Results: The current research confirmed the initial hypothesis that the reliability of the diagnostics criteria for the Cluster A is high, as is the validity of the diagnosis itself. Despite the fact that the sample group was ethnically diverse, the Bulgarian variation of the method did not reveal specific cross-cultural differences between participants from different backgrounds.
Conclusions: The criteria for Cluster A, unlike the criteria for the other types of Personality Disorders, were found to be cultural and historically insensitive.

References
Cloninger C. R., Surakic D. M., Pyzybeck T. R.: A psychobiological model of temperament and character. Archives of General Psychiatry 50: 975, 1993
Gunderson J. G.: Personality disorders, The New Harvard Guide to Psychiatry, A. M. Nicholi, editor, Belknap, Cambridge, MA, 1998, p.337
Trull T. J. & Durret C. A.: Categorical and dimensional models of Personality Disorders. Annual Review of Clinical Psychology, April 1: 355-380, 2005.

P058

ARE HEROIN ADDICTION MAKES TEMPERAMENTAL CHANGES?

Martinova H.[1], Donchev T.[3], Milanova V.[2], Akiskal H.[4]

[1]Medical University, Sofia, Bulgaria
[2]Military Medical Academy, Clinic of Psychiatry, Sofia, Bulgaria
[3]Medical University - Sofia, Department of Psychiatry, Sofia, Bulgaria
[4]International Mood Center, The San Diego Veterans Administration Medical Center, University of California at San Diego, California, USA

Annals of General Psychiatry, 2010;9(supplement 1):S141

Background: Investigation of specific personality traits is still in focus of modern psychiatry for years. The target usually pursues identification of those personality traits, described as a predisposition of addiction. But the question of fowl and egg is still open: are these traits are predispositions or they are consequences of Heroin personality change. Based on "mathematical" admission that temperamental traits describe an unchangeable basic concept we verify our hypothesis over addicted population.
Materials and methods: Heroin addicted and healthy group was assessed with TEMPS-A questionnaire to evaluate statistical significant differences between groups. 50 Heroin addicted and 50 healthy controls were engaged in this research. The target group includes in-patients hospitalized for heroin dependency treatment. Patients with concomitant psychiatric or organic mental disorder were excluded from enrolment. Healthy controls were randomly selected.
Results: The results demonstrate statistically significant differences between groups by "depressive" and "irritable" temperaments.
Conclusions: This study doesn't have ambition to give the right answer for the big question about predispositions or consequences, but it may be gives idea for the right questions.

References
Chang H.L., Chen S.H., Huang C.; Temperament of Juvenile Delinquents with History of Substance Abuse; Chang Gung Med J Vol. 30 No. 1 January-February 2007
Craig R.J.; The Personality Structure of Heroin Addicts; NIDA, "Neurobiology of Behavioral Control in Drug Abuse", Research Monograph, Series 74
Henderson M.J., Galen L.W., DeLuca J.W.; Temperament Style and Substance abuse Characteristics; Journal of Substance Abuse, Springer Netherland, Vol. 19, No 2, June 1998
Pompili M., Innamorati M., Lester D., Akiskal H.S., Rihmer Z., Del Casale A., Amore M., Girardi P., Tatarelli R.; Substance Abuse, Temperament and Suicide Risk: Evidence from a Case-Control Study; Journal of Addictive Diseases, Vol. 28, Issue 1, January 2009

P059

ASSOCIATION OF CYP2D6*4 GENETIC POLYMORPHISM ON THE METABOLISM OF DONEPEZIL WITH ALZHEIMER'S DISEASE IN INDIAN POPULATION

Vivekanandhan S.[1], Sonali N.[1], Manjari T.[2], Rajesh S.[3]

[1]Department of Neurobiochemistry, All India Institute of Medical Sciences, Delhi, India
[2]Department of Neurology, All India Institute of Medical Sciences, Delhi, India
[3]Department of Psychiatry, All India Institute of Medical Sciences, Delhi, India

Annals of General Psychiatry, 2010;9(supplement 1):S142

Background: Alzheimer's disease (AD) is the most common adult form of dementia.1 It is an age-associated neurodegenerative disorder pathologically characterized by the abnormal accumulation of intracellular neurofibrillary tangles and extra cellular amyloid plaques in selected brain regions. Donepezil is a cholinesterase inhibitor currently being used in the treatment of Alzheimer's disease is metabolized via CYP2D6 enzymes. The present study was undertaken to investigate CYP2D6*4 polymorphism on the serum concentration of Donepezil with responders and non-responders to Alzheimer's patients.
Materials and methods: 40 Alzheimer's patients with responders to Donezepil drug and 40 Alzheimer's patients with non-responders to donezepil drug were investigated for CYP2D6*4 polymorphism using polymerase chain reaction - restriction fragment polymorphisms (PCR-RFLP). Allele frequencies were derived from genotypic data. Drug responders - non-responders' comparisions were made using Chi-Square tests. Deviations from the Hardy -Weinberg equilibrium were also tested. Drug levels of Donezepil were determined using HPLC method.
Results: The CYP2D6*4 Polymorphism was seen to be in Hardy - Weinberg equilibrium and showed significant allelic association and genotypic association between responders and non-responders of donezepil. Genotypic: P = 0.05; OR = 0.39 (0.13-1.15), Allelic : P= 0.008; OR = 2.79(1.20-6.58).
Conclusions: N Our finding suggest that the CYP2D6 *4 genetic polymorphism may be associated with the individual differences in donezepil metabolism. An individualized dosage regimen design incorporating such genetic information would help to increase the clinical efficacy of donezepil in Alzheimer's patients.

References

Cacabelos. Pharmacogenomics and therapeutic prospects in Alzheimer's disease. Mol Diagn Ther. 2007; 11(6): 385-405.

P060

EVALUATING THE EFFECT OF AQUATIC EXTRACTION OF CANNABIS SATIVA SEED ON SPATIAL MEMORY CONSOLIDATION

Saeedeh Ebrahimpour[1], Maryam Tehranipour[1], Morteza Behnam[2]

[1]Department of Biology, Faculty of Science, Islamic Azad University, Mashhad Branch, Mashhad, Iran,
[2]Department of Biology, Faculty of Science, Ferdowsi University of Mashhad, Mashhad, Iran,

Annals of General Psychiatry, 2010;9(supplement 1):S143

Background: The existence of an endocannabinoid system in the central nervous system that consists of G protein-coupled CB1 cannabinoid receptor and endocannabinoids, including arachidonylethanolamide and anandamideand 2-rachidonoylglycerol, has gained general acceptance. Recent reports suggest that this system may serve several physiological functions.thus,this research has tried to examine the research is the role of Tetrahyrocannabinol on learning process and spatial memory consolidation.
Materials and methods: 40 male wistar Rats (3-4mounth, 320-260 g) were Completely divided into 4 experimental groups and control group.Cannabis sativa seed was extracted with Soxhlet apparatus. To test spatial memory,Morris water mazemaze(7 days,4 trails) was used.experimental groups with 50 mg.kg-1 ,100mg.kg-1 ,150mg.kg -1,210mg.kg-1 were injected in the peritoneal (IP) respectively and after one hour of injection spatial memory was done.
Results: The result show that experimental groups (50mg.kg-1,100mg.kg-1,150mg.kg -1 doses), for learning time have significant level deduction in the comparison of controlgroup ($p<0.05$), but experimental group with 210mg.kg-1 dose has not significant level in the comparison of control group ($p<0.05$).
Conclusions: The research findings show that, Cannabinoid components Injected dose dependent, can be effective on memory and learning processes in Morris water maze test.
Acknowledgements: We thank Dr Heravi and Mr Kazaemi form money support and Azad university of Mashhad,Department of PHysiology from prepare Maze and Materials.

References

M.Kyari.Extraction and characterization of seed oils.Agrophysics 2008,22:139-142
S. A. Varvel, A. H. Lichtman.Evaluation of CB1 Receptor Knockout Mice in the Morris Water Maze.Pharmacology and experimental Therapeutics 2002,30:915-924
R.Hooge.,P.DeDeyn.Applications of the Morris water maze in the study of learning and memory.Brain Rev2001,36:60-90
Y.Kawamura, M.Fukaya.The CB1 Cannabinoid receptor is the major Cannabinoid receptor at excitatory presynaptic sites in the Hippocampus and cerebellum.Eur neuroscience 2006.26(11):2991-3001

P061

EFFECTS OF EXPOSURE TO EXTREMELY LOW-FREQUENCY MAGNETIC FIELD OF 2MT INTENSITY ON SPATIAL MEMORY AND LEARNING IN RAT

Morteza Kafaee[1], Maryam Tehranipour[1], Alireza Haghpeima[2], Saeeedeh Ebrahimpour[1]

[1]Department of Biology, [2]Department of Physics
Faculty of Science, Islamic Azad University, Mashhad Branch, Mashhad, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S144

Background: Extremely low-frequency magnetic fields (ELFMF), have been reported to produce a variety of biological effects,interfere with the activity of the brain and may behavioral and cognitive isturbances disturbances. Some efforts have been to investigate the incidence of ELFMF on human health and animal physiology and behavior.
Materials and methods: 30 male Rat were completely divided into 3 groups(2 experimental,control).

Exp1, group that were exposed EMFs(50Hzferqency ,2mT intensity) for 20 minute .Exp2,group that were exposed EMFs(60Hz frequency, 2mT intensity) for 20minute.for similar conditions control group were situated into set of EMFs for 20 minute.Sapatial memory was done with Morris water maze(6days,4trails).
Results: the result show that exposed to EMFs(50Hz&60 Hz frequency,2mT intensity) are significantly better in practice related to spatial memory in comparison with control group.
Conclusions: Our results demonstrate that exposed ELFMF are significantly better in practice related to spatial memory in comparison with control group.
Acknowledgements: We thank Azad university of Mashhad for Support

References
Y.Kurokawa,H.Nitta,H.Imai, M.Kabuto.No influence of short-term exposure to 50-Hz magnetic fields on cognitive performance function in human. Int Arch Occup Environ Health 200376:437-442
A.A.Marino,E.Nilsen,J.A.L. Chesson,C.Frilot.Effect of low-frequency magnetic fields on brain electricalactivity in human subjects. Clinical Neurophysiology2004.115:1195-1201
M.Crasson.50-60 Hz electric and magnetic field effects on cognitive function in humans.Radiation Protection Dosimetry 2003,106:333-340
R.D'Hooge,P.P>DeDeyn.Applications of the Morris water maze in the study of learning and memory. BrainRev.2001;36:60-90

P062

REFERENCE DATA FOR DERIVED TRAIL MAKING TEST SCORES IN GREEK HEALTHY POPULATION

Zalonis I., Christidi F., Kararizou E., Triantafyllou N. I., Kapaki E., Paraskevas G., Sgouropoulos P., Vassilopoulos D.

1st Department of Neurology, Neuropsychological Lab., Aeginition Hospital, Medical School, National University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S145

Background: The Trail Making Test (TMT) via part B (TMT-B) has been widely used in the evaluation of the executive functions [1]. Apart from the direct scores (time to complete part A and B), derived TMT scores (B-A, B/A, B-A/A) are more and more used, as sensitive measures of prefrontal functioning [2-4]. The aim of the present study was to provide reference data from a large sample of Greek healthy participants in derived TMT scores.
Materials and methods: Six hundred and forty-three healthy participants (aged between 16-83 yrs and with an educational level between 6-18 yrs) were included, satisfying the exclusion criteria of medical, psychiatric and neurological disorders. From the TMT performance, we further calculated the following derived scores: the difference score (B-A), the ratio score (B/A) and the proportional score (B-A/A).
Results: For the entire sample (♂/♀: 382/261; age: 48.5±17yrs; education: 12±3.5yrs), derived mean scores for (B-A) was 61.7±43.6 seconds (range: 1-325 seconds), for (B/A) was 2.3±0.8 (range: 1-7.4), and for (B-A/A) was 1.3±0.8 (range: 0.01-6.4). At $p < .05$, age was significantly associated with (B-A) ($r = 0.53$), (B/A) ($r = 0.27$) and (B-A/A) ($r = 0.27$) scores. Significant correlations ($p < .05$) were also emerged between years of education and the three previous mentioned derived scores ($r = -0.20$, $r = -0.13$, $r = -0.13$, respectively). Gender was unrelated to derived TMT scores ($r < .05$, p n.s.). Based on post-hoc comparisons between age groups (per decade of age) and education groups (6-9yrs, 10-12yrs, 13-18yrs), we stratified our sample according to age and years of education and present reference data for the three derived TMT scores as mean (sd).
Conclusions: The Greek reference data for the derived TMT measures, stratified by age and education, are presented for application in clinical and experimental practice as useful indices in identification of probable executive dysfunction.

References
Lezak M.D., Howieson, D.B., Loring D.W.. Neuropsychological Assessment. NY Oxford University Press, 2004.
Lamberty GJP, Chatel SH, Bieliauskas D.M., et al. Derived Trail Making Test indices: A preliminary report.

Neuropsychiatry, Neuropsychology, & Behavioral Neurology 1994, 7: 230-234.
Stuss D.T., Bisschop S.M., Alexander M.P., et al. The Trail Making Test: A study in focal lesion patients. Psychological Assessment 2001, 13: 230-239.
Drane D.L., Yuspeh R.L., Huthwaite J.S., et al. Demographic characteristics and normative observations for derived-trail making test indices. Neuropsychiatry, Neuropsychology and Behavioral Neurology 2002, 15: 39-43.

P063

COGNITIVE DYSFUNCTION IN NON-DEMENTED PATIENTS WITH PARKINSON'S DISEASE

Zalonis I., Christidi F., Zournas C., Achilleas I., Kararizou E., Anagnostouli M., Andreadou E., Vassilopoulos D.

1st Department of Neurology, Neuropsychological Lab., Aeginition Hospital, Medical School, National University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S146

Background: Parkinson's disease (PD) is a common degenerative disorder, with clear evidence of cognitive impairment, mostly of executive and visuospatial functions [1-4]. The aim of the present study was to evaluate the neuropsychological (nps) profile in a sample of Greek non-demented PD patients.
Materials and methods: One hundred and thirty-nine non-demented PD patients (82♂/57♀; age:62.3±9.2, education:11.0±3.7, disease's duration:12.2±7.3), diagnosed between 1990-2000 according to explicit and generally accepted criteria based on neurological clinical examination, and 139 well-matched healthy controls (HC; 82♂/57♀; age:62.4±9.2, education:11.0±3.5) were included in the study. Both groups underwent a comprehensive series of neuropsychological tests, covered the cognitive domains of attention, learning and memory, language and academic skills, perceptual, constructional and visuomotor dexterities, verbal and visual reasoning, and executive functions. Patients did not show motor disabilities severe enough to interfere with nps performance.
Results: Statistical analysis was applied and the alpha level was set at 0.1% because of multiple comparisons. PD patients showed significantly worse performance ($p<.001$) compared to HC on most of the administered nps tests. When effect sizes (Cohen's d) were calculated, the magnitude of mean difference between HC and PD was small to medium ($0.5 \leqslant d \geqslant 0.1$) on tests of language and academic skills, verbal and visual reasoning, except for the large effect size in the Picture Completion WAIS subtest (d=0.8). On tests of attention, memory, perceptual, constructional and visuomotor dexterities, as well as executive functions, Cohen's d values corresponded to medium-large and large effect sizes ($1.2 \leqslant d \geqslant 0.8$). Disease's duration wasn't significantly associated (p n.s.) with patients' nps performance. Within PD group with less than 10 years of disease's duration, a substantial proportion of patients (>50%) still scored less than the 5th %ile of HC performance on some tests of memory and executive functions. Age at onset was significantly associated ($p<.001$) with specific measures of memory and executive functions, with patients developing the disease in older age revealing worse performance.
Conclusions: Neuropsychological dysfunction is present in patients with Parkinson's disease even in early stages and in absence of severe motor impairments. Most affected cognitive domains are emerged those of executive functions, visuoperceptual and constructional dexterities, verbal and visual memory, as well as attention.

References

Taylor A.E., Saint-Cyr J.A. The neuropsychology of Parkinson's disease. Brain 1995, 28: 281-296.
Dubois B., Pillon B. Cognitive deficits in Parkinson's disease. J. Neurol 1997, 244: 2- 8.
Janvin C., Aarsland D., Larsen J.P., et al. Neuropsychological profile of patients with Parkinson's disease without dementia. Dement Geriatr Cogn Disord 2003, 15: 126 -131.
Zgaljardic D.J., Borod J.C., Foldi N.S., et al. A review of the cognitive and behavioral sequelae of Parkinson's disease: relationship to frontostriatal circuity. Cogn Behav Neurol 2003, 16: 193-210.

P064

EXPRESSION OF NR1 SUBUNIT OF NMDA RECEPTOR AND PSD-93/95 IN RAT HIPPOCAMPUS AFFECTED BY NR1/NR2 ANTISENSE OLIGODEOXYNUCLEOTIDE

Vrajová M.[1], Bubeniková-Valešová V.[1], Klaschka J.[2]

[1]Prague Psychiatric Center, Prague, Czech Republic, [2]Institute of Computer Science, Academy of Sciences, Prague, Czech Republic

Annals of General Psychiatry, 2010;9(supplement 1):S147

Background: Abnormal protein expression of N-methyl-D-aspartate (NMDA) receptors essential subunits (NR1, NR2) and of associated post-synaptic density proteins (PSD-95, PSD-93) were observed in schizophrenic patients (post-mortem studies) [1, 2]. NMDA receptors containing NNR2A/B subunit associate in vivo at synapses with PSD-93 and PSD-95 [3]. In the present study, we have silenced the expression of NR1 and/or NR2 proteins in vivo with the goal of assessing the influence of that protein's alteration on the prepulse inhibition of acoustic startle reaction (PPI) and on the expression of related PSD-95/PSD-93 proteins.
Materials and methods: We used antisense oligodeoxynucleotide for NMDA-NR1 individually or in combination with NR2A or NR2B (aNR1, aNR2A, aNR2B) in the rat hippocampus and evaluated the PPI. Western blot was employed to assess the expression of affected proteins (NR1, NR2A and NR2B) and associated PSD-95/93 proteins.
Results: Changes in expression of NR1 were found. We observed a significant decrease in the hippocampi of rats affected by the combination aNR2A/aNR2B when compared with controls; yet we did not detect changes in other applications. In addition, we found significant changes in the expression of PSD-95, namely a decreased level of this protein in groups treated with NR2A or NR2B. There were no significant changes in NR2A/B and PSD-93 expression and in PPI.
Conclusions: Despite the fact, that the short term silencing of NR1/NR2 did not change PPI, there were changes in expression of PSD-95, which were connected with the NR2A/B subunit whose protein expression was not changed. This suggests that the association of PSD-95 with NR2A/B may occur in the early phase of biosynthesis.
Acknowledgements: This work was supported by grants GAČR 309/09/H072 and MŠMT ČR 1M0517.

References

L.V. Kristiansen, M. Beneyto, V. Haroutunian, J.H. Meador-Woodruff: Changes in NMDA receptor subunits and interacting PSD proteins in dorsolateral prefrontal and anterior cingulated cortex indicate abnormal regional expression in schizophrenia. Mol Psychiatry 2006, 11: 737-747

S.M. Clinton, V.H. Haroutunian, J.H. Meador-Woodruff: Up-regulation of NMDA receptor subunit and post-synaptic density protein expression in the thalamus of elderly patients with schizophrenia. J Neurochem 2006, 98: 1114-1125

N. Sans, R.S. Petralia, Y.X. Wang, J. Blahos, J.W. Hell, R.J. Wenthold: A developmental change in NMDA receptor-associated proteins at hippocampal synapses. J. Neurosci 2000, 20: 1260-1271

P065

RESULTS OF FIVE YEARS STUDY OF THE EPIDEMIOLOGICAL CHARACTERISTICS OF PSYCHOTIC PATIENTS PARTICIPATED IN THE PROGRAM OF DAY HOSPITAL, IN THE HELLENIC CENTER FOR MENTAL HEALTH AND RESEARCH, BRANCH OF HERAKLION, CRETE

Michelarakis E.[1,2], Bastas C.[1], Louloudi M.[1], Volikou C.[1], Gourniezaki A.[2], Micheli A.[3], Basta M.[3], Makaronas N.[1]

[1]Hellenic Mental Health & Research Center of Heraklion, Crete, [2]Technological University of Crete, Nursing Department, [3]Venizelio General Hospital of Heraklion

Annals of General Psychiatry, 2010;9(supplement 1):S148

Background: The purpose of this study was the description of the epidemiological characteristics and the results of the therapeutic interventions in the Day Hospital(DH) of Mental Health Center(MHC) of Heraklion, Crete, and more specifically for psychotic patients, over five years.
Materials and methods: Our sample consistent of 62 psychotic patients (44 men and 18 women) who participated in the DH of the MHC, in groups of 10 and for six months period, between the year 2003 and 2008.Data was analyzed with SPSS 15.
Results: The majority of the participants were between the age 26-35 years (41%) and 36-45 years (33,9%) old .71% were diagnosed with psychosis, 11,3% bipolar, while 14,5% had more than one diagnoses. Among the participants 79% came from the city of Heraklion and the rest from rural areas, 92% were non married or divorced, on the other hand 94% lived with some family members. Although, 72,6% had a high school or higher level education, 87,1% were either unemployed or disabled to work. A 56,5% of our participants had been hospitalized in closed psychiatric units and 49,4% reported a family history of mental disorder. Duration of participation in DH was> 6 months for 53,2% of our sample and 53,2% was compliant with treatment. Moreover, compliance to treatment was negatively correlated to recurrence (p= 0,036) and positively to the duration of participation in the DH(P=0,011). On the other hand pharmaceutical interventions included administration of antipsychotics (82,3% atypical, 9,7% typical), antidepressants (56,5%), mood stabilizers (22,8%) and benzodiazepines(25,8%). Medications were in tablets for 79%, while 16% were on intramuscular medications. Other therapeutic interventions included occupational therapy (66,1%), group therapy (85,5%) and crisis intervention (90,3%).
Conclusions: Our DH mainly applies to young and middle age psychotic patients, with severe impairment of their function improving compliance to their treatment and reducing the recurrence of the disorder.

P066

SELECTIVE EEG ANALYSIS FOR EMOTION RECOGNITION USING MULTIDIMENSIONAL DIRECTED INFORMATION CRITERIA

Petrantonakis P., Kaltsa V., Hadjileontiadis L.

Department of Electrical and Computer Engineering, Aristotle University of Thessaloniki, Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S149

Background: Brain waves captured by multiple electrodes during an electroencephalogram (EEG) recording, are derived as time series signals that represent the brain activity of various scalp sites. One important feature of these multiple time series is the information flow from one to another that under specific processing can reveal useful brain functionality.
Materials and methods: In this work, the Multidimensional Directed Information (MDI) [1] concept is adopted in order to examine the flow of information between EEG recordings from three different scalp sites with the objective to bring out and define the interconnections of different scalp sites of frontal and prefrontal cortex during an emotionally charged situation. In the line of these objectives, EEG signals were recorded from 16 healthy right-handed subjects during a specifically designed emotion elicitation experiment. Two monopole and one dipole EEG channels were placed at Fp1, Fp2 and F3/F4

positions respectively, according to the international 10/20 system [2].
Results: The EEG signals were analyzed using MDI as a parameter that could identify the EEG sections that contribute the most to the emotion recognition. In this way, an efficient emotion categorization could be achieved by keeping the effective parts of the EEG signal and further analyze it feeding a classifier towards the development of a robust and effective emotion recognition system from EEG recordings.
Conclusions: The encouraging preliminary results justify the feasibility of the proposed approach, stressing the importance of the targeted selection of the information source within the EEG recordings before any further categorization analysis.
Acknowledgements: The authors would like to thank all the 16 subjects participated in the experiment for their patience during the tedious EEG recording phase.

References

O. Sakata, T. Shiina, Y. Saito: Multidimensional directed information and its application. Electronics and Communication in Japan 2002, 85: 45-55
H. Jasper: The ten-twenty electrode system of the International Federation 1958. Electroencephalogr. Clin. Neurophysiol., 10:367-380

P067

INCREASED LEVELS OF ETHANE, A NON-INVASIVE, QUANTITATIVE, DIRECT MARKER OF N-3 LIPID PEROXIDATION, IN THE BREATH OF PATIENTS WITH SCHIZOPHRENIA

Puri B.K[1], Ross B.M.[2], Treasaden I.H.[3]

[1]Imaging Sciences Department, Hammersmith Hospital, Imperial College London, UK
[2]Division of Medical Sciences, Northern Ontario School of Medicine, Lakehead University, Ontario, Canada
[3]Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College London and Three Bridges Medium Secure Unit, West London Mental Health NHS Trust, Middlesex, UK
Annals of General Psychiatry, 2010;9(supplement 1):S150

Background: This study directly assessed whether there was a change in the level of exhaled ethane, which provides a non-invasive, quantitative, direct measure of n-3 lipid peroxidation, in the breath of patients with schizophrenia.
Materials and methods: Samples of alveolar air were obtained from 20 subjects with schizophrenia and 23 age- and sex-matched healthy control subjects. The air samples were analyzed for ethane using mass spectrometry.
Results: The mean level of ethane in the schizophrenia sample (5.15 (S.E. 0.56) ppb) was significantly higher than that of the healthy controls (2.63 (S.E. 0.31) ppb; $p < 0.0005$). A further sub-analysis showed that nicotine dependence was unlikely to be the cause of this difference.
Conclusions: These results suggest that the measurement of exhaled ethane levels may offer a non-invasive direct marker of increased n-3 lipid peroxidation in schizophrenia.

P068

STRUCTURAL BRAIN CHANGES IN PATIENTS WITH HUNTINGTON'S DISEASE PARTICIPATING IN A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF ETHYL-EICOSAPENTAENOIC ACID

Puri B.K[1], Bydder G.M.[2], Manku M.S.[3], Clarke A.[3], Beckmann C.F.[4]

[1]Imaging Sciences Department, Hammersmith Hospital, Imperial College London, UK
[2]Department of Radiology, University of California, San Diego, School of Medicine, San Diego CA, USA
[3]Amarin Neuroscience Limited, The Oxford Science Park, Oxford, UK
[4]Clinical Neuroscience Department, Imperial College London and FMRIB Centre University of Oxford, John Radcliffe Hospital, Oxford, UK

Annals of General Psychiatry, 2010;9(supplement 1):S151

Background: Ultra-pure ethyl-eicosapentaenoic acid (ethyl-EPA) is a semi-synthetic, ethyl ester of the long-chain fatty acid eicosapentaenoic acid which has been shown to be associated with clinical improvement in motor functioning in Huntington's disease. The aim was to determine the extent to which it might reduce the rate of progress of cerebral atrophy.
Materials and methods: High-resolution MRI cerebral scanning was carried out at baseline, six months and one year in 30 patients with stage I or II Huntington's disease who took part in a randomized, double-blind, placebo-controlled trial of 2 g daily ethyl-EPA or liquid paraffin, using a 1.0 T Picker HPQ scanner. For each subject and each pair of T1 images, the two-timepoint percentage brain volume change was estimated in a double-blind fashion using SIENA (Structural Image Evaluation, using Normalisation, of Atrophy), Version 2.5, part of the FSL (version 4.0) comprehensive library of analysis tools.
Results: Overall, patients treated with ethyl-EPA had a reduced mean rate of atrophy in all comparisons compared with the placebo group. There was no significant effect of age at the time of scanning on these results. Areas of significant group-level reduction in brain atrophy between patients receiving ethyl-EPA and those receiving placebo were found. Significant changes were observed at the head of the caudate nucleus and the posterior thalamus.
Conclusions: Treatment with ethyl-EPA is associated with significant reduction in brain atrophy in Huntington's disease, particularly in the head of the caudate and the posterior thalamus. No other drug tested in HD has shown this effect.
Acknowledgements: We thank the MRC and Amarin Neuroscience.

P069

PREVALENCE OF CATARACT IN ADULT DOWN'S SYNDROME PATIENTS

Puri B.K[1], Singh I.[2]

[1]Imaging Sciences Department, Hammersmith Hospital, Imperial College London, UK
[2]Mental Health Unit, Hillingdon Hospital, Uxbridge, Middlesex, UK

Annals of General Psychiatry, 2010;9(supplement 1):S152

Background: Age-related cataract is the major cause of blindness in humans throughout the world. The majority of previous studies of cataract in Down's syndrome have reported a prevalence that is higher for a given age range than in the general population. The aim was to study the prevalence of cataract in a well-defined population of adults with Down's syndrome.
Materials and methods: An in-patient population of 68 adults (35 males and 33 females) with Down's syndrome, aged between 28.9 and 83.3 years, underwent ophthalmological examination for the presence of cataracts.
Results: Overall, the prevalence of cataract was 16.2%, with no significant difference between males (17.1%) and females (15.2%). In those aged between 45 and 64 years, the prevalence was 16.7%, rising in those aged between 65 and 75 years to 28.6%.
Conclusions: Compared with the general population, the prevalence of cataract in Down's syndrome

was raised in those aged 45 to 64, but not in those aged 65 to 75 years; the latter might be a function of the relatively small number of patients in this age group. The increased prevalence of cataract found in those in the 45- to 64-year-old age group may be the result of increased levels of CuZnSOD, in turn resulting from the location of the associated five exons of SOD1 on chromosome 21. These elevated levels of superoxide dismutase may give rise to increased levels of reactive species, including hydrogen peroxide and hydroxyl radicals, which may increase the risk of cataractogenesis.

P070

BRAIN CELL MEMBRANE MOTION-RESTRICTED PHOSPHOLIPIDS IN PATIENTS WITH SCHIZOPHRENIA WHO HAVE SERIOUSLY AND DANGEROUSLY VIOLENTLY OFFENDED

Puri B.K[1], Counsell S.J.[1], Hamilton G.[2], Bustos M.G.[3], Treasaden I.H.[4]

[1]Imaging Sciences Department, Hammersmith Hospital, Imperial College London, UK
[2]Department of Radiology, University of California, San Diego, School of Medicine, San Diego CA,USA
[3]Three Bridges Medium Secure Unit, West London Mental Health NHS Trust, Middlesex, UK
[4]Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College London and Three Bridges Medium Secure Unit, West London Mental Health NHS Trust, Middlesex, UK

Annals of General Psychiatry, 2010;9(supplement 1):S153

Background: This study directly assessed, for the first time, whether, as expected under the membrane phospholipid hypothesis of schizophrenia, there was a change in brain cell motion-restricted membrane phospholipids in vivo in male forensic patients with schizophrenia who had seriously and violently offended (homicide, attempted murder, or wounding with intent to cause grievous bodily harm) while psychotic, by quantification of the broadband resonance signal from 31-phosphorus neurospectroscopy scans.
Materials and methods: Cerebral 31-phosphorus magnetic resonance spectroscopy was carried out in 15 male patients with schizophrenia who had seriously and violently offended (homicide, attempted murder, or wounding with intent to cause grievous bodily harm) while psychotic and in 12 age- and sex-matched normal control subjects. Data were obtained using a 1.5 T Marconi Eclipse system with a birdcage quadrature head coil dual-tuned to proton (64 MHz) and 31P (26 MHz). T1-weighted magnetic resonance images were acquired for spectral localization. Spectra were obtained using an image-selected in vivo spectroscopy sequence (TR = 10 s; 64 signal averages) localized on a 70 x 70 x 70 mm3 voxel.
Results: There was no significant difference in the broad resonances between the two groups, with the mean (standard error) percentage broadband signal for the patients being 57.8 (5.6) and that for the control subjects 57.7 (6.0). The phosphomonoesters and phosphodiesters narrow signals also did not differ between the groups.
Conclusions: Our data suggest that the membrane phospholipid hypothesis of schizophrenia may not apply to the subgroup of schizophrenia patients who have seriously and violently offended.
Acknowledgements: We thank the Three Bridges Medium Secure Unit and the MRC.

P071

REGIONAL GREY MATTER VOLUMETRIC CHANGES IN FORENSIC SCHIZOPHRENIA PATIENTS: A MAGNETIC RESONANCE IMAGING STUDY COMPARING THE BRAIN STRUCTURE OF PATIENTS WHO HAVE SERIOUSLY AND VIOLENTLY OFFENDED WITH THAT OF PATIENTS WHO HAVE NOT

Puri B.K[1], Counsell S.J.[1], Saeed N.[1], Bustos M.G[2], Bydder G.M. [3], Treasaden I.H.[4]

[1]Imaging Sciences Department, Hammersmith Hospital, Imperial College London, UK
[2]Three Bridges Medium Secure Unit, West London Mental Health NHS Trust, Middlesex, U
[3]Department of Radiology, University of California, San Diego, School of Medicine, San Diego, CA, USA
[4]Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College London and Three Bridges Medium Secure Unit, West London Mental Health NHS Trust, Middlesex, UK

Annals of General Psychiatry, 2010;9(supplement 1):S154

Background: The aim of this study was to carry out the first voxel-based morphometry study of grey matter changes in the whole brain in schizophrenia associated with a history of seriously and violently offending.
Materials and methods: Structural cerebral MRI scans of 26 patients with schizophrenia were analyzed using voxel-based morphometry: 13 of the patients had seriously and violently offended directly as a result of schizophrenia prior to admission, the offences consisting of homicide, attempted murder or wounding with intent to cause grievous bodily harm; the other 13 patients did not have a history of violence. There was no history of comorbid psychoactive substance misuse disorder in any of the patients. Voxelwise generalized linear modelling was applied to the processed magnetic resonance data using permutation-based non-parametric testing, forming clusters at $t > 2.3$ and testing clusters for significance at $p < 0.05$, corrected for multiple comparisons across space.
Results: The two groups were matched with respect to age, gender and illness duration, but the group with a history of serious violence was on average receiving a higher dose of antipsychotic medication than the other group. There were local regions of reduced grey matter volume in the group with a history of serious and violent offending, compared with the other group without such a history. Significant voxels ($p < 0.05$, corrected for multiple comparisons) were noted bilaterally in the cerebellum and in BA 39 and 40.
Conclusions: These regions are important in verbal working memory. The cerebellum may integrate inputs from ventrolateral prefrontal cortex and parietal regions, providing a corrective signal that refines the process of rehearing the contents of the phonological store. A strong connection has been hypothesized between the supramarginal region corresponding to BA 39/40 and Broca's area, which may correspond largely to the arcuate fasciculus, with the connectional pattern of the language regions of this model fitting the network of parietotemporal-prefrontal connections that participate in working memory. Therefore our results point to the possibility of an abnormality in neural circuits involved in verbal working memory in this group of patients.
Acknowledgements: We thank the Three Bridges Medium Secure Unit and the MRC.

P072

THE SPECTRUM CLOZARIL CLINIC MODEL: 12 YEARS OF POSTIVE OUTCOME FINDINGS

Nisbet B.[1], Dulmus C.[2], Greyber L.[2]

[1]Spectrum Human Services, Orchard Park, NY, USA
[2]School of Social Work, University at Buffalo, Buffalo, NY, USA

Annals of General Psychiatry, 2010;9(supplement 1):S155

Background: Clozaril (generic form Clozapine) is an atypical antipsychotic medication that is appropriate for use with a subset of individuals with psychotic disorders who have not benefited from conventional antipsychotic medications.
Materials and methods: This poster provides an overview of a unique agency-based integrated outpatient model for treating consumers with Clozaril and reports on 12 years of outcome findings (n=114). These are the outcomes for the first 12 years of the Spectrum Clozaril Clinic for the period of 1993-2005. The "Spectrum Clozaril Clinic" model is built on an interdisciplinary team approach that emphasizes the importance of regular peer interaction, at-site provision of ancillary services, and full coordination by the team of all other treatment, rehabilitation and support services, including specialized case management.
Results: Results indicate that Clozaril delivered within this model promotes an unusually high level of recovery from serious mental illness, including a dramatic level of relief from psychotic symptoms, shielding of suicidal impulses, and reducing inpatient hospitalizations.
Conclusions: The Spectrum Clozaril Clinic Model is a promising model to promote recovery from serious mental illness.

P073

PROLONGED BENZODIAZEPINE ELIMINATION IN ADDICTED PATIENTS AS A REASON OF EARLY POST-DETOXIFICATION RELAPSES

Basinska A., Jamrozy A., Habrat B.

Department of Substance Dependece Prevention and Treatment, Institute of Psychiatry and Neurology, Warsaw, Poland

Annals of General Psychiatry, 2010;9(supplement 1):S156

Background: Multiplicity of benzodiazepine dependency complications force the addicts into a radical detoxification. However, even motivated patients relapse right after leaving a hospital ward. This may be due to premature conclusion of detoxification.
Materials and methods: Presented data come from 200 cases. Detoxification followed through 4 stages: long-acting benzodiazepine substitution, dose reduction, elimination, post-withdrawal observation. Clinical state (CIWA-B, [1]) and the benzodiazepine serum level (standard immunoenzymatic assay) were monitored. Patient's dose reduction rate was adjusted according to current intensity of withdrawal symptoms. Continued clinical state monitoring followed the final dose until total serum benzodiazepines elimination.
Results: Uncorrelated of initial benzodiazepine levels and symptom-adjusted dose-reduction rate among patients, elimination of the serum benzodiazepines was commonly protracted, ranging 3 to 62 days after withdrawal. Within this period, intensity of the withdrawal syndrome peaked several times, in varying combinations of symptoms, until elimination completed (zero serum level). Intensity often culminated 3-4 weeks after withdrawal.
Conclusions: Underestimation of benzodiazepine elimination time and resulting premature termination of post-withdrawal observation may contribute to common post-detox relapses in benzodiazepine-

addicted patients. Peak-intensity of withdrawal symptoms often occurs only after the discharge from hospital ward. Monitoring of the serum level prevents untimely discharge of detoxified patients. Accordingly, a positive benzodiazepine serum level does not proove a recent benzodiazepine use.

References
U.E. Busto, K. Sykora, E. Sellers: A clinical scale to assess benzodiazepine withdrawal. Journal of Clinical Psychopharmacology, 1989, 9: 412-416.

P074

CUMULATIVE EFFECTS OF RISPERIDONE LONG ACTING INJECTION AND NARRATIVE THERAPY IN TREATING ETHANOL DEPENDENCY

Trandafir M.S.

Alexandru Obregia Hospital ,unit 7, Bucharest, Romania

Annals of General Psychiatry, 2010;9(supplement 1):S157

Background: Aims/objectives: Rationale: Ethanol dependency is among the most frequent psychiatric disorders regardless of age and sex and currently affecting an increasing number of women and children. Its treatment stands on the clinician's decision, family and/or social group support. Our aim is to assess the efficacy of using risperidone long-acting injection along with psychotherapy in gamma type alcohol dependency.
Materials and methods: Method: Case study. Gathering self-reported data, psychotherapy sessions for the patient and his/her family, data analysis. For relevance purposes we shall present below the case of a 30yo Caucasian male with a history of alcohol consumption since he was 12yo. During the past year his alcohol consumption started to follow a daily pattern. The patient's psychopathological presentation is dominated by psychomotor agitation, hypnic disorders, hetero-aggression, interpretative thoughts, depressive ideation, low self-esteem, social, professional and family desinsertion. Following the first four hospital admissions during which he received thymoregulatory, antidepressive and sedative agents his alcohol consumption increased and symptomatology intensified. During his fifth hospital admission the patient received risperidone 2mg per day, as a neuroleptic agent, followed by risperidone long-acting injection 25mg once every 2 weeks. After hospital discharge his condition improved incrementally. Two months after hospital release he relapses for two days but is able to cease consumption without external help. The patient is currently professionally and socially active and his family interactions are healthy. Along with risperidone long-acting injection therapy he was admitted to family therapy sessions every week during the first two months, every two weeks for the next two months followed by a monthly session during the next 6 months.
Conclusions: Conclusions: Using risperidone long-acting injections along with narrative therapy has protracted the abstinence period and has also contributed to social and family reinsertion.

References
Michael White, Maps of Narrative practice, Norton Professional Books, 2007 Alice Morgan, What is Narrative Therapy, Gecko, 2002

P075

IS AMISULPRIDE ASSOCIATED LESS WITH NEUROLEPTIC MALIGNANT SYNDROME? REVIEW AND HYPOTHESIS

Peritogiannis V.[1], Kalampokis G.[2], Lixouriotis Ch.[3]

[1]Private practice, Ioannina, Greece, [2]Department of Psychiatry, University Hospital of Ioannina, Ioannina, Greece, [3]General Hospital of Livadia, Livadia, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S158

Background: Atypical antipsychotics have been reported to induce neuroleptic malignant syndrome (NMS). The precise pathophysiologic mechanism is unknown but dopamine blockage is pivotal. The serotoninergic action of atypical antipsychotics may also been implicated because serotonin may inhibit dopamine release and worsen hypodopaminergic states. Amisulpride, which is a selective D2/D3 receptor antagonist and has no affinity for serotonin receptors may be less associated with the development of NMS.
Materials and methods: A Medline search was conducted for articles published till July 2009 relative to the induction of NMS by atypical antipsychotics in non-geriatric patients with schizophrenia or schizoaffective disorder. We used the key-words neuroleptic malignant syndrome and the names of all first-line atypical antipsychotics, with the exception of paliperidone, which has been recently marketed.
Results: The number of the reported cases of atypical antipsychotic-induced NMS in the defined population was 24 for risperidone, 18 for olanzapine, 7 for quetiapine, 9 for aripiprazole, and 5 for ziprasidone. Only two cases of amisulpride-induced NMS were revealed. In one case the patient was vulnerable to the induction of NMS which had been caused by three different atypical antipsychotics.
Conclusions: In the absence of large prospective studies regarding the induction of NMS by atypical antipsychotics, which are difficult to perform due to the rarity of the syndrome, definite conclusions cannot be reached. Amisulpride may be less than the other atypical antipsychotics associated with NMS, and this may be accounted for by its lack of serotoninergic action. Amisulpride may be a useful option for re-started antipsychotic medication in patients recovering from NMS.

P076

IMPAIRED COGNITIVE FUNCTION IN HEALTHY OFFSPRING OF BIPOLAR PATIENTS

Permoda-Osip A.[1], Borkowska A.[2], Rybakowski K.J.[1]

[1]Department of Adult Psychiatry, University of Medical Sciences, Poznan, Poland
[2]Clinical Neuropsychology Unit, Nicolaus Copernicus University Torun, Collegium Medicum, Bydgoszcz, Poland

Annals of General Psychiatry, 2010;9(supplement 1):S159

Background: Several recent papers report on impaired of cognitive functions in healthy offspring of patients with bipolar mood disorder (Gotlib et al, 2005; Clark et al, 2005; Bio et al, 2007). The aim of this study was an assessing of the performance on the Wisconsin Card Sorting Test (WCST), measuring executive functions, in the offspring of bipolar patients compared with gender- and age matched healthy subjects.
Materials and methods: Fifty persons (17 male, 33 female), aged 18-52 (30±7) years made the total adult offspring population of patients with bipolar mood disorder. Among them, two had a history of depressive episodes, and another eight scored positively on Mood Disorder Questionnaire (Hirschfeld et al, 2000). The head-to-head age- and gender-matched healthy subjects were used as a comparison group. The computer version of WCST designed by Heaton et al. (1993) adapted with instructions in Polish was used in all subjects. The following domains of WCST were measured: the percentage of perseverative errors (WCST-P), the percentage of non-perseverative errors (WCST-NP), the number of correctly completed categories (WCST-CC), the percentage of conceptual level responses (WCST-

%conc), and the set to the first category (WCST-1st cat).
Results: The results in the total offspring group were significantly inferior compared to matched control group in the categories of perseverative errors (WCST-P) and conceptual responses (WCST-%conc). These differences remained significant after Bonferroni correction. The offspring of patients with some affective morbidity (n=10) did not show differences with forty healthy patients.
Conclusions: The results of our study show the impairment of some aspects of executive functions, connected with prefrontal cortex activity, in healthy offspring of bipolar patients.

References

Bio, D.S., Rocca, C.C.A., Petresco, S., Kreling, R., Gutt, E., Moreno, R.A. (2007). Neuropsychological evaluation in the offspring of parents with bipolar disorder. World J. Biol. Psychiatry 8 (suppl.1), 100-101.
Clark, L., Sarna, A., Goodwin, G.M. (2005a) Impairment of executive function but not memory in first-degree relatives of patients with bipolar I disorder and in euthymic patients with unipolar depression. Am. J. Psychiatry 162, 1980-198
Gotlib, I.H., Traill, S.K., Montoya, R.L., Joorman, J., Chang, K. (2005) Attention and memory biases in the offspring of parents with bipolar disorder: Indications from a pilot 10 study. J. Child Psychol. Psychiatry 46, 84-93.
Heaton, R.K., Chelune, G.J., Talley, J.L., Kay, G.G., Curtis, G. (1993) Wisconsin Card Sorting Test Manual, Psychological Assessment Resources, Odessa, Florida.

P077

ASSOCIATION BETWEEN DEPRESSION AND BODY MASS INDEX IN PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Tselebis Ath.[1], Bratis D.[1], Harikiopoulou M.[2], Theodorakopoulou E.[2], Moussas G.[1], Karkanias Ath.[1], Kainis E.[2], Kosmas E.[2], Tzanakis N.[3], Siafakas N.[3]

[1]Psychiatric Department, Sotiria General Hospital of Chest Diseases, Athens, Greece
[2]Pulmonary Rehabilitation Centre, Sotiria General Hospital of Chest Diseases, Athens, Greece,
[3]Department of Thoracic Medicine, University of Crete Medical School, Heraklion, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S160

Background: It is well known that Chronic Obstructive Pulmonary Disease (COPD) is a disease with psychological comorbidities [1, 2]. Especially depression (which its prevalence ranging between 10% and 42%) affects physical functioning in these patients and may lead to increased risk of COPD exacerbations and rehospitalization [3]. Depression characterized, among other symptoms, by a significant weight loss or weight gain or decrease or increase in appetite nearly every day. Aim of the study is to investigate the association between depression and Body Mass Index (BMI) in patients with COPD.
Materials and methods: The study was performed in one of the largest hospitals in Greece and included 119 (95 male and 24 female) outpatient with COPD. The patients responded to the Beck Depression Inventory (BDI). BMI, age and education level were also recorded.
Results: Mean age and mean education level were 65.21(±7.99) and 11.05 (±4.22), respectively, with no statistical difference as to genders (T-test p>0.05). Mean BDI score was 11.69 (±7.54), while a percentage of 52% presented with moderate to severe depression. The percentage of women with positive BDI score was increased compared with that of men (x2 p=0.05). Mean BMI was 27.22(±4.71), while a percentage of 59.6% presented BMI>25 (with no differences between genders). Regarding the total sample, no correlation was observed between age, education level, BMI and BDI score (Pearson correlation p>0.05). However, separating the subjects as to gender, we observed a positive correlation between BMI and BDI score in women (spearman correlation p<0.05).
Conclusions: This study confirms the high prevalence of depression in COPD patients, and especially in women. Additionally, the association between depression and BMI seems to be clearer in female gender. However, further studies are required in order to clarify these findings.

References

Moussas G., Tselebis A., Karkanias A., Stamouli D., Ilias I., Bratis D., Vassila-Demi K: A comparative study of anxiety and depression in patients with bronchial asthma, chronic obstructive pulmonary disease and

tuberculosis in a general hospital of chest diseases. Ann Gen Psychiatry. 2008;7:7
Maurer J., Rebbapragada V., Borson S., Goldstein R., Kunik M., Yohannes A.M., Hanania N.A.: Anxiety and Depression in COPD. Chest 2008; 134; 43S-56S.
de Voogd J.N., Wempe J.B., Koëter G.H., Postema K., van Sonderen E., Ranchor A.V., Coyne J.C., Sanderman R. Depressive symptoms as predictors of mortality in patients with COPD. Chest. 2009; 135(3):619-25.

P078

FAMILY SUPPORT AND VITAL EXHAUSTION IN PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Tselebis A.[1], Bratis D.[1], Moussas G.[1], Karkanias A.[1], Dumitru S.[2], Kavoura P.[2], Lagou S.[2], Kosmas E.[2], Tzanakis N.[3], Siafakas N.[3]

[1]Psychiatric Department, Sotiria General Hospital of Chest Diseases, Athens, Greece
[2]Pulmonary Rehabilitation Centre, Sotiria General Hospital of Chest Diseases, Athens, Greece
[3]Department of Thoracic Medicine, University of Crete Medical School, Heraklion, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S161

Background: Many studies have attempted to delineate the relationship between the input in family support (FS) of patients with acute or chronic disease, as well as the effect of this support in the confrontation of illness. These studies showed a negative cross-correlation between the sense of family support and depressive or anxiety symptoms [1, 2]. On the other hand, it has been observed that the presence of vital exhaustion (VE), characterized by unusual tiredness, is an aggravating factor, especially in patients with cardiovascular diseases [3, 4]. Aim of the study is to investigate the association between the sense of family support and the degree of vital exhaustion in patients with chronic obstructive pulmonary disease (COPD).
Materials and methods: One hundred and four (87 males and 17 females) outpatients with COPD participated in the study. Family support and vital exhaustion were assessed by using the 13-item Julkunen Family Support Scale (FSS) and the Maastricht Questionnaire (MQ), respectively. Age and education level were also recorded.
Results: Mean age was 65.3 (±8.1) and mean education level was 10.97 (±4.2, in years). As to clinical measurements, mean FSS score was 54.87 (±7.1), whereas mean MQ score was 19.83 (±8.46), which is significant higher than the corresponding score (14.94) of the general population (sample t- test $p<0.01$). No correlation was observed between age, education level, FS and VE (Pearson correlation $p>0.05$). In contrary, a strong negative correlation was presented between FS and VE (Pearson correlation $p<0.05$).
Conclusions: Vital exhaustion seems to be present also in patients with COPD. However, further studies are required in order to clarify its associations with the comorbidities of depression and anxiety, which are common in these patients. Finally, our findings suggest the protective role of the sense of family support against vital exhaustion.

References

Bratis D., Tselebis A., Sikaras C., Moulou A., Giotakis K., Zoumakis E., Ilias I. Alexithymia and its association with burnout, depression and family support among Greek nursing staff. Hum Resour Health. 2009, 11; 7:72.
Ilias I., Tselebis A., Theotoka I., Hatzimichelakis E.. Association of perceived family support through glycemic control in native Greek patients managing diabetes with diet alone. Ethn Dis. 2004. 14 (1): 2
Appels A., Höppener P., Mulder P: A questionnaire to assess premonitory symptoms of myocardial infarction. International journal of cardiology, 17:15-24.
Anagnostopoulou T., Kioseoglou G.: The Greek adaptation of the Maastricht Questionnaire for the assessment of vital exhaustion. In: Sygkolitou E., Gonida-Bamniou E. (Eds): Scientific Yearbook of the Psychology Department, Aristotle University of Thessaloniki, Greece, 3, 137-152 (in Greek).

P079

PREVALENCE OF TRAIT AND STATE ANXIETY PRIOR A SURGERY

Sikaras C.[1], Maria A. [1], Voyagis G.[1], Anagnostopoulou M.[1], Bratis D.[1], Tselebis A.[1], Moulou A.[1], Toutouzas K.[2], Kiritsi E.[3], Stefanadis C.[2]

[1]Sotiria General Hospital of Chest Diseases, Athens, Greece
[2]Hippokration Hospital, Department of Cardiology, University of Athens, Greece
[3]Department of Nursing A', Technological Educational Institute of Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S162

Background: It is well known that an operation is undoubtedly a significant factor of anxiety symptoms development [1]. Aim of the study is to investigate the association between the trait and the state anxiety in patients prior a surgery, as well as the association of these psychological features with the ASA classification of the patient physical status, the age and the gender.
Materials and methods: One hundred and fifty two patients (99 males and 53 females), with ASA I-III and mean age 42.10±16.01 years, who were undergoing an operation included in the study. All participants filled out the Spielberger State-Trait Anxiety Inventory (STAI) [2, 3] 12 - 15 hours before the o
Results: Means of state and trait anxiety were 42.55±11.30 and 38.33±8.01, respectively, with significant difference (t-test, $p<0.001$). Furthermore, a strong correlation was observed between state and trait anxiety (Pearson Correlation, $p<0.001$, $r=0.61$). Regarding gender, females had significant higher state and trait anxiety scores (t-test, $p<0.05$). In particular, 25.3% of males had pathological state anxiety scores, whereas the corresponding percentage in females was 45.3% (x2 test, $p<0.05$). Younger patients (18-29 years old) presented significant higher levels of state and trait anxiety compared with the age groups over 50 years (Anova test, $p<0.05$). Considering the ASA physical status of the patient, no statistical difference was observed between stages, as to trait anxiety, although patients with ASA III presented higher scores compared to patients with ASA I and ASA II (Anova test, $p>0.05$). However, patients with ASA III presented significant higher state anxiety scores compared to patients with ASA I and ASA II (Anova test $p<0.05$).
Conclusions: Our findings suggest that younger patients, females and patients with ASA III are more vulnerable to anxiety. Therefore, these factors should be taken into account for the preoperative assessment in order to develop supportive psychological interventions.

References

Johnston M. Impending surgery. In Fisher S., Reason J. Handbook of life stress, Cognition and Health, 1988; 79-100
Tselebis A., Gournas G., Tzitzanidou G., Panaghiotou A., Ilias I. Anxiety and Depression in Greek nursing and medical personnel. Psychological Reports, 2006; 99, 93-96
Spielberger C.D., Goruch R.L., Lushene RE (1970). The state - trait Anxiety Inventory. Palo Alto C.A.: Consulting Psychologists Press.

P080

SLEEP DISTURBANCE SYMPTOMS AND THEIR ASSOCIATIONS WITH ALEXITHYMIA, DEPRESSION AND ANXIETY

Bratis D.[1], Spanopoulou A.[1], Dumitru S.[2], Lagou S.[2], Diamandi C.[2], Tselebis A.[1], Moussas G.[1], Karkanias A.[1], Gyftopoulos S.[2], Kosmas E.[2]
[1]Dept. of Psychiatry, Sotiria General Hospital of Chest Diseases, Athens, Greece
[2]Sleep-Disordered Breathing Laboratory of 3rd Dept. of Pulmonary Medicine, Sotiria General Hospital of Chest Diseases, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S163

Background: Several studies indicate that alexithymia and sleep disturbances (especially insomnia) coincide [1]. Aim of the present study is to record the levels of alexithymia, depression and anxiety in

a sample of patients with sleep disturbances and to investigate the associations between the above factors.
Materials and methods: The study included fifty (40 male and 10 female) outpatients who were attended a sleep laboratory of our hospital seeking medical support for symptoms of sleep disturbances. Levels of Alexithymia [2], depression and anxiety [3, 4] were assessed, by using the Toronto Alexithymia Scale (TAS-20), the Beck Depression Inventory (BDI) and the Spielberger Trait Anxiety Inventory (STAI). Age and education level were also recorded.
Results: Mean BDI score was 10.8 ± 6.0, mean STAI score was 45.0 ± 11.0 and mean TAS-20 score was 53.8 ± 14.3. Mean age and education level were 54.2±13 and 10.0±4.1, respectively. No correlation was observed between the demographic characteristics of the sample and the scores of the clinical measurements (Pearson correlation $p>0.05$). In contrary, a strong positive correlation was presented between TAS-20, BDI and STAI.
Conclusions: Our preliminary findings confirm the existence of the association between the sleep disturbance symptoms, alexithymia, depression and anxiety. However, some questions remains: are the associations between sleep disturbances and alexithymia caused by depression and/or anxiety or are independent of them? Further studies are required in order to clarify it.

References

Kronholm E, Partonen T, Salminen JK, Mattila AK, Joukamaa M: Alexithymia, Depression and Sleep Disturbance Symptoms. Psychother Psychosom 2008; 77: 63–65
Bratis D, Tselebis A, Sikaras C, Moulou A, Giotakis K, Zoumakis E, Ilias I. Alexithymia and its association with burnout, depression and family support among Greek nursing staff. Hum Resour Health. 2009. 11; 7:72
Tselebis A, Gournas G, Tzitzanidou G, Panagiotou A, Ilias I. Anxiety and depression in Greek nursing and medical personnel. Psychol Rep. 2006 Aug; 99(1): 93-6.

P081

REVERSAL OF SYMPTOMATIC ANTIPSYCHOTIC-INDUCED HYPERPROLACTINEMIA WITH ADDITION OF ARIPIPRAZOLE

Kotorki P.[2], Pelka P.[1], Leotsakou C.[1], Kalogeropoulou A.[1], Fiste M.[1], Vagionis G.[3], Roussi A. [1], Paterakis P.[1]

[1]Social Insurance Institute, Analipsi, Thessaloniki, Greece
[2]1st and 5th Department, Dromokaition Psychiatric Hospital, Athens, Greece
[3]Psychiatric Clinic, General Hospital of Chania, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S164

Background: Hyperprolactinemia is a well-recognized adverse effect of treatment with antipsychotic medication. From the second generation antipsychotics amisulpride, risperidone and paliperidone cause marked elevation in serum prolactin levels. Aripiprazole lowers serum prolactin below placebo when used as a single agent and as an adjunctive treatment has been shown, though not consistently, to improve antipsychotic-induced hyperprolactinemia. It may bind to the dopamine receptor more robustly and act as a dopamine receptor agonist in an antipsychotic-induced hypodopaminergic state. We report two cases of successful treatment of risperidone- and amisulpride-induced hyperprolactinemia and amenorrhea by addition of aripiprazole. This strategy was chosen over administration of an adjunctive dopamine agonist or discontinuation of treatment and a switch to a different antipsychotic agent to avoid clinical deterioration.
Materials and methods: Case 1: Ms M, a 35-year-old woman, had an eight-year history of DSM-IV paranoid schizophrenia with one previous compulsory admission. She was involuntarily admitted to our hospital for her third and very severe episode. She was successfully treated on our ward with 800 mg of amisulpride, which was the second trial of antipsychotic. She was discharged after almost 3 months. Amisulpride was gradually reduced to 400 mg after 6 months of treatment. The patient had developed amenorrhea which continued even after lowering the dose of amisulpride, something consistent with the existing data. It was the patient's decision not to discontinue amisulpride as it was very effective for her psychiatric symptoms, especially for her positive symptoms. She had gained insight and was scared about "voices and peculiar ideas coming back". Gradually, 10 mg of aripiprazole were added, and after 12 weeks she regained menstruation and prolactin

levels fell (from 81 ng/ml under amisulpride to 28 ng/ml). The patient remained clinically stable. Case 2: Ms E, a 30-year-old woman, had a four-year history of DSM-IV paranoid schizophrenia with no previous admission. She was involuntarily admitted to hospital for her third episode and was effectively treated with risperidone 6 mg. Risperidone was reduced to 4.5 mg two months after discharge. The patient had developed amenorrhea which continued 6 months after lowering the dose of risperidone. Aripiprazole 10 mg was gradually added. After 13 weeks she regained menstruation and prolactin levels fell (from 95 ng/ml under risperidone to 25 ng/ml65%). The patient remained clinically stable.
Results: Both subjects were clinically stable and there was a high potential risk for relapse due to their history. This led us to the addition of aripiprazole which successfully improved hyperprolactinemia. Treatment was safe and well-tolerated. Both patients regained their menstrual periods in more than 8 weeks, a time period that was previously reported. It appears that aripiprazole is effective in normalizing prolactin in some patients and this could become a treatment of choice.
Conclusions: When aripiprazole is co-administed with risperidone or sulpiride, it may bind to the dopamine receptor more robustly and act as a dopamine receptor agonist in an antipsychotic-induced hypodopaminergic state. It appears that aripiprazole is effective in normalizing (or partially normalizing) prolactin in some patients and reversing the clinical side effects without serious side effects or sacrificing psychopathology, and this could become a treatment of choice. Contrary to these findings, Paulzen and Gründer reported a lack of an expected decrease of serum prolactin levels by adding aripiprazole in patients treated with amisulpride. A possibility of partial, but not total restoration of symptomatic hyperprolactinemia might be due to the relatively low aripiprazole dose (10mg/day). Receiving aripiprazole 15-20 mg/day with risperidone has been reported to successfully reverse risperidone-induced hyperprolactinemia. The association between aripiprazole dose and prolactin level when used as adjunctive treatment needs to be more fully evaluated.

References

B-H Lee, Y-K Kim Y-K, S-H Park: Using aripiprazole to resolve antipsychotic-induced symptomatic hyperprolactinemia: a pilot study. Progress in Neuro-Psychopharmacology & Biological Psychiatry 2006, 30: 714-7.
M. Paulzen M., G. Gründer: Amisulpride-induced hyperprolactinemia is not reversed by addition of aripiprazole. Int J. Neuropsychopharmacol 2007, 10: 149-51.
J-C Shim, J-G K Shin, D.L. Kelly, D-U Jung, Y-S Seo, J-H Shon, R. Conley: Adjunctive treatment with a dopamine partial agonist, aripiprazole, for antipsychotic-induced hyperprolactinemia: a placebo-controlled trial. Am J. Psychiatry 2007, 164 (9): 1404-1410.

P082

DISCLOSURE OF CANCER DIAGNOSIS: WHAT IRANIAN PATIENTS DO PREFER?

Farhad Faridhosseini , Mehdi Samimi Ardestani , Fatemeh Shirkhani

Department of Psychiatry, Imam Hossein Horpital, Shahid Beheshty University of Medical Sciences, Tehran, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S165

Background: Doctors in Iran traditionally prefer to discuss the diagnosis of cancer with family members instead of patients. They are concerned about the psychological impacts of diagnostic disclosure. So it becomes an ethically controversial issue in doctor patient relationship which is practiced differently in various cultures and countries. The aim of this cross sectional descriptive study was to evaluate the amount of information that Iranian patients have and their preference for the disclosure of the cancer diagnosis.
Materials and methods: 126 patients admitted for chemotherapy in three different sites were questioned about their knowledge of the diagnosis. Two different structured questionnaires were designed for the people who know and who didn't know their diagnosis. For the former, the survey concerned their psychological reactions to their situations, whether they would prefer to know about their diagnosis .For the latter, the questionnaire included their preference whether and how to know the diagnosis.
Results: 60.31% of the patients knew their diagnosis and 39.68% didn't know. Among the subjects who didn't know their diagnosis, 88% preferred to be more informed about their diagnosis and 68% had

some psychological reaction to their situations in spite of their lack of knowledge. Among the subjects who knew their diagnosis, 73.68% preferred to know their diagnosis, 92.1 % preferred to be informed directly by their physicians.
Conclusions: The majority of Iranian patients with malignancy want to know the truth and they prefer to be informed directly by their doctors.

References
M. Janghorbani,M. Jianpour, H.R. Tabatabai: diagnostic disclosure and prognosis of adult patients with cancer (in persian).J ournal of Kerman Medical University 1993, 1(1): 12-17
F.L. Pimentel ,J.S. Ferreira ,M. Vila Real , M.N. Fesquita , J.P. Maia-Gonçalves: Quantity and quality of information desired by Portuguese cancer patients. Support Care Cancer 1999 7(6):407-12

P083

NEUROPSYCHIATRIC SYMPTOMS IN MILD COGNITIVE IMPAIRMENT

Algin D. İ.[1], Kilicoglu A.[2], Ozbabalık D.[3]

[1]Department of Neurology, Dumlupinar University, Kutahya,Turkey,
[2]Department of Psychiatry, Dumlupinar University, Kutahya,Turkey,
[3]Department of Neurology, Eskisehir Osmangazi University, Eskisehir, Turkey

Annals of General Psychiatry, 2010;9(supplement 1):S166

Background: Mild cognitive impairment (MCI) is an etiologically heterogeneous condition that is characterized by cognitive changes without impairment of activities of daily living and insufficient to represent dementia. MCI is an important risk state for Alzheimer dementia (1,2).
Materials and methods: A total of 30 subjects, aged more than 60 years old, with either MCI (n=¨16) or control group (n=14) were studied. Neuropsychiatric symptoms (NPS) were assessed using the Neuropsychiatric Inventory scale(NPI). Individual subscores of the 10 NPI symptoms and total NPI scores were compared between the MCI patients and control patients. We identified the prevalence of the symptoms in each group and differences between two groups.
Results: The most common symptoms in the MCI group were dysphoria (39%),apathy (39%), irritability (29%), anxiety (25%) and depression (%23). There were significant differences in apathy, dysphoria, irritability, anxiety, agitation, and aberrant motor behavior between the MCI and control groups. There was a significant difference between the MCI and control groups on total NPI scores ($p < 0.05$).
Conclusions: The significant differences between MCI and control groups according to NPI scores are important for drawing attention to both differentiating MSI and psychiatric symptoms and their comorbidity. For this reason it is important to diagnose MCI with detailed examination without ignoring psychiatric symptoms.

References
Apostolova L.G., Cummings J.L. Neuropsychiaric manifestations in mild cognitive impairment: a systematic review of the literature. Dement Geriatr Cogn Disord. 2008; 25(2):115-26
Hwang T.J., Masterman D.L., Ortiz F., Fairbanks L.A., Cummings J.L. Mild cognitive impairment is associaed with characteristic neuropsychiatric symptoms. Alzheimer Dis Assoc Disord. 2004 Jan-Mar; 18(1):17-21

P084

USE OF METHYLPHENIDATE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER IN AN OUTPATIENT MENTAL HEALTH CENTER

Lacueva C. G., Castaño J., Alvaro P., Sanchis R., Córcoles D., Portillo F., Diaz B., Martin L. M., Bulbena A.

Department of Psychiatry, Hospital del Mar, IAPS, Barcelona, Spain

Annals of General Psychiatry, 2010;9(supplement 1):S167

Background: According to the American Psychiatric Association practice guidelines, if a patient with Major Depressive Disorder (MDD) has not responded or achieved only a partial response after 4-8 weeks of therapy, a dose change, switch to a new drug, or augmentation therapy is recommended [1]. Combined use of standard antidepressants with dopaminergic agents and psychostimulants can lead to accelerate and enhance response if administered early in the course of treatment [2].
Materials and methods: Using a sample of 100 patients with diagnosis of MDD who have been visited in Barcelona´s Sant Martí Sud outpatient mental health center during the year 2008, Sociodemographical (gender, age) and clinical data (present toxic consume, presence of psychiatric background, use of antipsychotics) are analysed with SPSS 15.0 statistical package.
Results: Methylphenidate is used in 3% of the sample with an average dose of 20 mg/d. There is a predominancy in the female gender (66.7%), a global average age 66.33±7 years. The psychiatric background most frequently found is the presence of previous depressive disorder episodes (66.7%). None of these patients had toxic abuse nor had been hospitalised.
Conclusions: The use of metilphedinate is still not frequent in our sample as augmentation strategy of the antidepressive treatment. However initial results show that the combination with metilphenidate can be useful for patients in need of a rapid improvement in depression, particularly in those with chronic treatment-resistant depression but the tolerability of the combination may limit its use [2]. Further investigation using different treatment to achieve remission in patients with major depression is necessary.

References

American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder (revision). American Psychiatric Association. Am J Psychiatry. 2000: 157:1-45.
Helen Lavretsky,M.D., Susan Park,M.S., Prabha Siddarth,Ph.D., Anand Kumar,M.D., Charles F. Reynolds III, M.D. "Methylphenidate-enhanced antidepressant response to citalopram in the elderly: a double-blind, placebo-controlled pilot trial" Am J Geriatr Psychiatry 14:2, February 2006
Craig Nelson,J., Pikalov,A., Berman,R., 2008 San Francisco. "Augmentation treatment in major depressive disorder: focus on aripiprazole". Neuropsychiatri Dis Treat; 2008 October; 4 (5): 937-948

P085

USE OF MOOD STABILIZER DRUGS IN THE TREATMENT OF MAJOR DEPRESSIVE DISSORDER IN AN OUTPATIENT MENTAL HEALTH CENTER

Garnier C.[1], Castaño J.[1], Alvaro P.[1], Sanchis R.[1], Corcoles D.[1], Portillo F.[1], Diaz B.[1], Martin L.M.[1], Bulbena A.[1]

Department of Psychiatry, Hospital Del Mar, IAPS, Barcelona, Spain

Annals of General Psychiatry, 2010;9(supplement 1):S168

Background: Major depressive disorder (MDD) is a common and disabling psychiatric condition. Antidepressants are currently the mainstay of treatment for depression; however, almost two thirds of patients will fail to achieve remission with initial treatment, as a result, a range of augmentation and combination strategies have been used [1].
Materials and methods: Major depressive disorder (MDD) is a common and disabling psychiatric condition. Antidepressants are currently the mainstay of treatment for depression; however, almost two thirds of patients will fail to achieve remission with initial treatment, as a result, a range of

augmentation and combination strategies have been used [1].
Results: Mood stabilizers are used in 14% of the sample with a predominancy in the female gender (85.7%), a global average age 50.6±12.2 years. Regarding personal psychiatric background, there´s an absence of these in the first place (64.3%), followed by the presence of previous depressive episodes (21.4%) and dysthymic disorder (7.1%). In none of these cases there was toxic abuse. There is a predominancy in the absence of previous psychiatric hospitalisations (64.3%). The frequencies of use of mood stabilizers was: topiramate in the first place (50%) followed by lithium, carbamazepine and pregabaline (14.28% each of them), in the last place lamotrigine (7.1%). The average dose was 900 mg/d for carbamazepine, 600 mg/d for lithium, 300 mg/d for pregabaline, 128.5 mg/d for topiramate and 100 mg/d for lamotrigine.
Conclusions: In our sample the frequency of use of lithium is similar to the registered for the several antiepiletics (lithium, carbamazepine and pregabaline: 14.28% each one). However, lithium addition is recommended as a first choice for depressed patients who do not respond to therapy with conventional antidepressants [2].

References
Craig Nelson,J., Pikalov,A., Berman,R., 2008 San Francisco. "Augmentation treatment in major depressive disorder: focus on aripiprazole". Neuropsychiatri Dis Treat; 2008 October; 4 (5): 937-948
Baver,M., Döpfmer,S., "Lithium augmentation in treatment-resistant depresión: metaanalysis of placebo-controlled studies"

P086

USE OF ANTIPSYCHOTICS IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER IN AN OUTPATIENT MENTAL HEALTH CENTER

Garnier C., Castaño J., Alvaro P., Sanchis R., Corcoles D., Malagon A., Diaz B., Martin L. M., Bulbena A.

Department of Psychiatry, Hospital del Mar, IAPS; Barcelona, Spain

Annals of General Psychiatry, 2010;9(supplement 1):S169

Background: Antidepressants are currently the mainstay of treatment for depression; however, almost two thirds of patients will fail to achieve remission with initial treatment. Evidence has shown that adjunctive therapy with atypical antipsychotics has the potential for beneficial antidepressant effects in the absence of psychotic symptoms [1].
Materials and methods: Using a sample of 100 patients with MDD who have been visited in Barcelona´s Sant Martí Sud outpatient mental health center during the year 2008, sociodemographical (gender, age) and clinical data (toxic consume, psychiatric background, use of antipsychotics) are analysed with SPSS 15.0 statistical package
Results: Antipsychotics are used in 27% of the patients, with a predominancy in the female gender (77.8%), a global average age of 57.9±12.6 years. There is a predominancy of absence of psychiatric background (55.6%) and the absence of previous hospitalisations (66.7%). In 96.3% of the sample there was no toxic abuse.
It is observed the following distribution in the use of antipsychotics: quetiapine and olanzapine (29.6% each one), risperidone (26%), paliperidone (3%). Average dose was 5.7 mg/d for olanzapine, 2.3 mg/d for risperidone, 84.5mg/d for quetiapine and 6 mg/d for paliperidone.
Conclusions: It is observed an important frequency in the use of antipsychotic treatment for MDD, in relation with the fact that there is growing evidence for the efficacy of atypical antipsychotics for adjunctive treatment of depressive symptoms of MDD. There is scientific evidence that supports the use of the two antipsychotics predominantly used in our sample (olanzapine and quetiapine) [2], but more studies are needed to establish its place in management.

References
Craig Nelson,J., Pikalov,A., Berman,R., 2008 San Francisco. "Augmentation treatment in major depressive disorder: focus on aripiprazole"
Shelton R.C., Tollefson G.D., Tohen M., Stahl S., Gannon K.S., Jacobs T.G., Buras W.R., Bymaster F.P., Zhang W., Spencer K.A., Feldman P.D., Meltzer H.Y. "A novel augmentation strategy for treating resistant major depression" Am J. Psychiatry. 2001 Jan;158(1):131-4.

P087

USE OF BENZODIAZPINES IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER IN AN OUTPATIENT MENTAL HEALTH CENTER

Garnier C., Diaz B., Alvaro P., Sanchis R., Castaño J., Corcoles D., Portillo F., Martin L. M., Bulbena A.

Department of Psychiatry, Hospital del Mar, IAPS, Barcelona, Spain

Annals of General Psychiatry, 2010;9(supplement 1):S170

Background: The reviewers report that a combination of benzodiazepines (BZD) with antidepressants work in favour for the treatment of depression, because it decreases drop outs of treatment and it increases short-term response up to four weeks [1]. Early achievement of symptomatic remission is critical to the long-term success of treatment [2].
Materials and methods: Using a sample of 100 patients with MDD who have been visited in Barcelona´s Sant Martí Sud outpatient mental health center during the year 2008, sociodemographical (gender, age) and clinical data (toxic consume, psychiatric background, use of BZD) are analysed with SPSS 15.0 statistical package
Results: There is use of BZD in a 76% of the sample, with a predominancy of the female gender (72.4% vs 27.6%), a global average age of 56.55±12.4 years. In relation to personal psychiatric background it can be observed in 47.4% the absence of these, followed by 39.5% in which there is presence of previous depressive episodes. There is a predominancy in the absence of toxic abuse (97.4%) and the absence of previous hospitalisations (81%) It can be observed the following distribution by frequencies in the use of BZD: diazepam (25%), dipotassic clorazepate (23,7%), clonazepam (14.5%) and alprazolam (10.5%). The average dose was 10.2 mg/d for diazepam, 22.9 mg/d for dipotasic clorazepate, 2.7 mg/d for clonazepam and 1 mg/d for alprazolam.
Conclusions: The use of BZD in the DMM is large in our sample but the potential benefits of adding a BZD to an antidepressant must be balanced judiciously against possible harms including development of dependence and accident proneness, on the one hand, and against continued suffering following no response and drop out, on the other..

References

Furukawa, T.A., Streiner,D.L., Young,L.T., Kinoshita,Y. "Antidepressant plus benzodiazepine for major depression" Cochrane Database Syst Rev. 2001;(2):CD001026. Review.
Craig Nelson,J., Pikalov,A., Berman,R., 2008 San Francisco. "Augmentation treatment in major depressive disorder: focus on aripiprazole". Neuropsychiatri Dis Treat; 2008 October; 4 (5): 937-948

P088

THE PSYCHIATRIC PATIENT IN EMERGENCY ROOM AND Z ZONE

Lepri A.[1], Ponsillo N. G.[4], Spatuzzi V.[3], Veschi F.[2]

[1]Mental Health Departement North Umbria Italy EU, [2]Emergency Departement 118 North Umbria Italy EU, [3]Mental Health Departement ASL NA Naples Italy EU, [4]Italian Association Psychiatrist AIPSIMED

Annals of General Psychiatry, 2010;9(supplement 1):S171

Background: Public mental health in a smal area of 8 boroughs and 74.753 inhabitans in the centre of Italy.Mental Health Departement during 1 year:almost 3500 psychiatric patients: 2,8 % of the inhabitans of this small area. people presenting psychiatric desorders during the life, are estimated 25%; and then in this area possibly will be 28.000 persons who needed psychiatric help(OMS : 2001 Mental Health report). Bipolar desorders 33 % , anxiety and DAP 28 % , schizophreniza 12 % ,borderline desorders 7% , psychosomatic desorders compulsive behaviour 6% ,psychiatric symptoms in neurological desorders 5%, bhavioural desorder 4 % ,social problems 2,8 % , il 1,5% eating desorders, psychiatric symptoms abuse related 0,7 %
Materials and methods: File archives research.
Results: Standardized initial approach step by step in the emergency room or Z zone

Conclusions: The psychiatric patient in emergency room and Z zone. Drug Treatment parenterally administered. Conscious or unconscious patient.
Step 1 objective problems caused by the initial approach
Step 2 difficulties of gathering initial anamnesis information
Step 3 therapeutics start (usually not standardized attempts of limiting drugs or persuasion method) or treatment of an unconscious patient with suicidal mania
Step 4 finding a suitable hospitalization area in advance to deal with the patient.

P089

MANAGERIAL PERSPECTIVES ON EMPLOYEE ENGAGEMENT

Romanou N.[1], Soane E.[1], Truss K.[2], Alfes K.[2], Rees Ch.[3], Gatenby M.[4], Degleris E. N.[5], Mantelou E. [5], Solias A.[5], Karamberi M.[5]

[1]Department of Management, London School of Economics and Political Science, United Kingdom, [2]Kingston Business School, Kingston University, United Kingdom, [3]School of Management, Royal Holloway, United Kingdom, [4]School of Management, University of Surrey, United Kingdom, [5]Psychotherapeutic Center of Piraeus, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S172

Background: Senior management and leadership are believed to be responsible for the employment of such initiatives and their own level of engagement appears to have a strong impact on the levels of employees' engagement, theory suggests. This qualitative research explores the perceived levels, drivers and benefits, as well as the levels of managerial engagement at Organisation A, a leading support services company in the UK. This working paper means to contribute to previous studies of engagement conducted by the Kingston Business School Employee Engagement Consortium.
Materials and methods: In total, 25 managers were interviewed and semi-structured interviews took place in February and March 2009 at the company's headquarters. In this working paper, the research model consists of five thematic principles: drivers and counter-divers of engagement, methods of engagement, (perceived) levels of employee engagement, (perceived) benefits of employee engagement, and managers' levels of engagement. These five core principles entail all the information needed to test the engagement process in the present organisation. In order to assess the sustainability of the research model, the method of template analysis was chosen.
Results: Not surprisingly, the perceived levels of engagement are moderately high and managers seem to be engaged in their organisation driven by the challenging nature of the work, the recognition they receive and the feelings of accomplishment following a successful task. In line with these, what drives employee engagement is only slightly different: employees seem to be driven not only by the nature of their work but also by the career opportunities available at Organisation A and the collaborative and team-based organisational culture. In terms of benefits, employee engagement seems to lead to heightened organisational performance, improved customer satisfaction and low levels of absenteeism and turnover.
Conclusions: Managers were completely capable of identifying problematic areas in the engagement process and given the necessary resources might be in position to work on improving some critical elements of it.

References

A.B. Bakker, W.B. Schaufeli: 'Positive organizational behavior: Engaged employees in flourishing organizations'. Journal of Organizational Behavior, 2008, 29: 147-154
M. Gatenby, C. Rees, E. Soane, K. Truss: Employee engagement in context. (2008). London: CIPD.
N. King: 'Using templates in the thematic analysis of text' in Cassell, C., and Symon, G. (Eds.) Essential Guide to Qualitative Methods in Organizational Research. (2004). London: Sage
W. H. Macey and B. Schneider: 'The meaning of employee engagement'. Industrial and Organizational Psychology: Perspectives on Science and Practice, 2008, 1: 3-30.

P090

COGNITIVE RESTRUCTURING AND IMPROVEMENT OF SYMPTOMS WITH COGNITIVE-BEHAVIOURAL THERAPY AND PHARMACOTHERAPY IN PATIENTS WITH DEPRESSION

Mihai M. [1], Filimon L.[2]

[1]The Faculty of Social and Human Sciences, University of Oradea, Oradea, Romania, [2]D.P.P.P.D., University of Oradea, Oradea, Romania

Annals of General Psychiatry, 2010;9(supplement 1):S173

Background: Since 1960, psychological theories of maladaptive behavior began to change their focus from enviornment to expectation, control, decision and helplessness on the individual level. After 1965, M.E.P. Seligman introduces the concept of learned helplessness representing a giving up reaction determined by the belief that whatever you do it doesn't matter. According to theory (Abramson, Seligman & Teasdale, 1978) there are at least three types of inferences that people can make and this, changes the way people develop or not hopelessness followed by the simptoms of depressive lack of hope when confronted with negative life events (Peterson, Mayer & Seligman, 1993): 1) inference on the motive why certain events occur (inferated cause or causal attribution); 2) inference on the consequences which might result from events taking place (inferated consequences) and 3) inference on oneself given by events that have happened to oneself at some point (inference of personal characteristics). In this study we will investigate the efficiency of cognitive-behavioural and pharmaco-therapeutical interventions in changing depression symptoms and improving cognitive, emotional disfunctions and perception of social support. We investigate the relation between depression and disfuntional causal attributions, perception of social support, self esteem, emotions and reaction to daily life stress.
Materials and methods: Pharmacotherapeutical group (PT). The study included 13 patients diagnosed with depression and at the first hospitalization they got disthimia or major depressive episode diagnosis, beeing subsequently treated. Cognitive-behavioural therapy group (CBT) had 12 participants. Control group (C), 13 participants, was selected considering their scores on SCL-90, DEP scale. In diagnosis phase, subjects were given to fill in a set of scales similar to psychiatric patients, and it was applied again after 6-7 weeks and at the end of intervention. A group with high scores on BDI and SCL-90, indicating the presence of depression symptoms were tested only in pretest and posttest phases without beeing subjected to any therapeutical intervention. Participant admited into the study formed three groups: pharmacotherapeutical group (PT), psychotherapeutical group (CBT) and control group (C). Psychiatric patients were administrated with antidepressive medication. The psychotherapeutical group followed 18-20 sessions of therapy (onehour average session) over a period of 15 weeks; twice a week in the first two and once a week for the remaining. In this study we used the following scales: SCL-90; ASQ; SGC; SERV; POMS and SMSSP. Attributional Style Questionnaire (A.S.Q) is an instrument that measures the „explaning style" patterns representing the tendency of selecting certain causal explanations for favorable or unfavorable events. Symptom Check List 90-R (Derogatis, 1994) is an instrument which evaluates the gravity of the symptoms reported by patients. The internal consistency of its subscales is situated between .75 and .86 and for ISG it is .97. Test-retest trust quotient of the two testing phases (T1 and T2) is between .77 and .87. Multidimensional Scale of Perceived Social Support is an instrument projected to mesure the way people perceive social support from three sources: family, friends and significant others. Internal consistency is .91 (12 items). Test-retest trust quotient of the two testing phases (T1 and T2) is between .67 and .80. Kohn şi Macdonald (1992) proposed Survey of Recent Life Experiences which they validated starting from 92 items. The internal consistency of the total score was .90 (41 items). Test-retest trust quotient of the two testing phases is between .66 and .78. Current Thoughts Scale, as its name sugests, underlines the importance of current feelings. The internal consistency of the SGC total score was .84. Test-retest trust quotient of the two testing phases is between .64 and .81. In time, Profile of Mood States was accepted as an efficient way of measuring psychological stress. The internal consistency ranges between .90 (negative emotions) and .88 (positive emotions). Test-retest trust quotient is between .31 and .56.
Results: Atfer the first 6-7 sessions we can see an increase of self esteem as a state in

patients following CBT [t(11) = -2,684 , p<.02], an improvement in the perception of support from others in general [t(11) = -2,368 , p<.03] and fammily support in particular[t(11) = -2,534 , p<.02]. In PT group there is an unexpectedly increase of friends support [t(12) = -2,226 , p < .02]. Negative attributional style or depressogenic style is decreasing between T1 and T2 [t(11) = 4,568 , p<.001] proving the efficiency of CBT (compared to PT) in improvement of cognitive symptoms of depression. Yet, depressive attributional style in CBT3 is significantly decreasing compared to PT3 proving the efficiency of the cognitive level intervention. On the emotional level, the CBT and PT interventions are equally efficient, fact also sustained by the outcomes compared to C2. Therefore, CBT and PT can generate a decrease of negative emotions. Improvement of symptoms is obvious in CBT3 and PT3 compared to C sample. We consider CBT superior to PT in producing changes on the level of cognitive symptoms, indicating a better posttreatment prognosis and a lower rate of relapses. The significant statistic outcome for negative internal x group interaction showes that the two factors are not acting independentely but in a moderating relation. Both variables are statisticaly significant (group type and negative internal). That allows us to say that each factor is moderating the relation of the other with the dependent variable (the change of depression symptoms from T2 to T3).
Conclusions: This research paper subscribes to recent preoccupations for psycho-social implications of learned helplessness in explaining human behaviour (Beck, 1991; Seligman, Schulman, DeRubeis & Hollon, 1999). We analyse the cognitive modifications and symptoms decrease due to cognitive-behavioural therapy (CBT) and pharmacotherapy (PT) in depression. We evaluate the efficiency of CBT compared to PT in socio-cognitive and symptomathological changes as wel as the extent to which attributional changes in the first phase of CBT intervention are predictive for subsequent improvement of depression symptoms. We showed that learned helplessness gives an efficient explanation for psychological depression and less for endogenuous depression; this statement is sustained also by implementation of the study where we modified maladaptive attributions and the control perspective of the patients. Finally, we offer a comment about what to measure. In accordance with the hypothesis suggested, we propose that in future studies, in addition to measures such as the ASQ, the following constructs be examined as mediators: (a) the acquisition of problem solving and skills the patient can apply in response to events and (b) the frequency with which the patient applies those skills in daily encounters during the course of therapy. This research underlines, at a practise level, the implications of helplessness quantitative research in clinical psychology, and psychotherapy.

References

L.Y. Abramson, M.E.P. Seligman, J.D. Teasdale: Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology 1978, 87: 49-74
A.T Beck: Cognitive Therapy. A 30-Year Retrospective. American Psychologist 1991, 46: 368-375
L.R Derogatis: SCL-90-R: Administration, scoring, and procedures manual 1994, Minneapolis, MN: National Computer Systems
P.M Kohn, J.E Macdonald: The Survey of Life Experiences: A decontaminated hassles scale for adults. Journal of Behavioral Medicine 1992, 15: 221-236

P091

COGNITIVE PROFILE IN MIDDLE-AGED AND OLDER BIPOLAR PATIENTS

Elce C.[1], Falco M.[1], Ammendola S.[1], Orlando S.[1], Galletta D.[1], Fragassi N.[2], Casiello N.[1]

[1]Department of Neuroscience Section of Psychiatry, University Medical School Federico II, Naples, Italy, [2]Department of Neurology Section of Neuropsychology, University Medical School Federico II, Naples, Italy

Annals of General Psychiatry, 2010;9(supplement 1):S174

Background: Cognitive deficits are reported in euthymic and acute phases of bipolar disorder (BD)1. However, only few studies have previously evaluated the cognitive profile of middle-aged and older patients affected by BD.2,3. The main purpose of our study was to analyze the cognitive profile of bipolar patients aged between 45 and 70 years.
Materials and methods: 36 patients with BD (DSM IV-TR) (25 with BD-I and 11 with BD-II) who complained a recent onset of cognitive deficits, were recruited from 2004 to 2009 at the Psychiatric Day-

Hospital service of the University Medical School "Federico II". All patients underwent a comprehensive Neuropsychological assessment, focusing on short- and long-term mnesic and executive functions. A control group was composed by 37 outpatients (45-70 years), followed by the Neuropsychological service for recent outbreaks of cognitive disorders. Exclusion criteria for the control group were psychiatric or neurodegenerative disease as well as cranial trauma.
Results: No statistically significant differences were found between the study population and the control group with respect to the neuro-cognitive profile, even though patients affected by BD-I showed poorer performance in the executive functions, in the oral span and in the logical abstractive skills, when compared to the ones affected by BD-II and to the control-group patients.
Conclusions: Greater focus should be put on cognitive aspects of BD: in particular, in our sample, patients affected by BD-I seem to have a more severe cognitive profile compared with BD-II patients. Further investigations, hopefully with larger samples, are desirable to confirm these findings.

References
Goldberg J.F., Burdick K.E.: Cognitive dysfunction in bipolar disorder, a guide for clinicians. American Psychiatric Publishing, Inc. 2008.
Silva D., Santana I., Simoes do Couto F., Maroco J., Guerreiro M. and de Mendonça A.: Cognitive deficits in middle-aged and older adults with bipolar disorder and cognitive complaints: Comparison with mild cognitive impairment. Int J Geriatr Psychiatry, 2009; 24:624-631.
Delaloye C., Moy G., Baudois S., de Bilbao F., Dubois Remund C., Hofer F., Ragno Paquier C., Campos L., Weber K., Gold G., Moussa A., Meiler C.C., Giannakopoulos P. Cognitive features in euthimic bipolar patiets in old age. Bipolar Disord 2009. Epub ahead of print.

P092

EFFECTS OF ATYPICAL ANTIPSYCHOTICS ON NEUROCOGNITION IN EUTHYMIC BIPOLAR PATIENTS

Torrent C.[1], Martinez-Arán A.[1], Daban C.[2], Amann B.[3], Balanzá-Martinez V.[4], Del Mar Bonnin C.[1], Tabarés-Seisdedos R.[4], Vieta E.[1]

[1]Bipolar Disorders Program, Clinical Institute of Neuroscience, Hospital Clinic, IDIBAPS, CIBERSAM, University of Barcelona, Barcelona Spain, [2]INSERM, Pôle de Psychiatrie, Hôpital de Chenevier, Créteil, Paris, France, [3]Research Unit. CSAM. Psychiatric Hospital Benito Menni, CIBERSAM, St. Boi de Llobregat, Barcelona, Spain, [4]Department of Medicine, University of Valencia, CIBERSAM, Valencia, Spain

Annals of General Psychiatry, 2010;9(supplement 1):S175

Background: The effect of pharmacological treatment on cognition is still uncertain due to an insufficient number of studies examining this issue.
Materials and methods: A total of 114 subjects were included in the study. Of 79 DSM-IV euthymic bipolar patients, 63 were treated with one atypical antipsychotic, quetiapine (n=12), olanzapine (n=22), or risperidone (n=29). Sixteen patients were drug-free. The four groups were compared with a sample of drug-naïve patients and healthy control group (n=35) on several clinical and neuropsychological variables, especially on the domains of attention, verbal memory and executive functions.
Results: Bipolar patients taking one of the three antipsychotics presented with dose-independent significant deficits in most cognitive tasks compared to healthy controls. After several head-to-head group comparisons, the patients receiving quetiapine showed a better performance in learning task, short-term memory and recognition task assessed with the California Verbal Learning Test and verbal fluency ($p<0.05$).
Conclusions: Our results confirm previous studies of cognitive deficits in bipolar disorder. Untreated euthymic patients showed better cognitive performance than patients on atypical antipsychotics. Some iatrogenic-pharmacological effect, therefore, can not be excluded but quetiapine seemed to be less associated with impairment in measures of verbal memory than olanzapine or risperidone. We suggest to use drugs in bipolar disorder with a lower risk of cognitive side-effects. However, randomized controlled trials are urgently needed to give a definite answer to this critical problem.
Acknowledgements: This study was supported by grants from the Fundacio Marató de TV3 (2510/01),

FIS nº PI080180, and the CIBERSAM.

References

Martinez-Aran A., Vieta .E, Reinares M., et al. Cognitive function across manic or hypomanic, depressed, and euthymic states in bipolar disorder. Am J. Psychiatry 2004;161: 262-270

Torres I.J., Boudreau V.G., Yatham L.N. Neuropsychological functioning in euthymic bipolar disorder: a meta-analysis. Acta Psychiatr Scand Suppl 2007; 17-26

Balanza-Martinez V., Rubio C., Selva-Vera G., et al. Neurocognitive endophenotypes (endophenocognitypes) from studies of relatives of bipolar disorder subjects: a systematic review. Neurosci Biobehav Rev 2008;32: 1426-1438

Tabares-Seisdedos R., Balanza-Martinez V., Sanchez-Moreno J., et al. Neurocognitive and clinical predictors of functional outcome in patients with schizophrenia and bipolar I disorder at one-year follow-up. J. Affect Disord 2008;109:286-299

P093

SEXUAL DESIRE AND ORGASMIC DISORDERS IN FEMALE MEDICAL STUDENTS: PRELIMINARY RESULTS

Ferenidou F., Vaidakis N.

First Department of Psychiatry, National and Kapodistrian University of Athens,/Eginition Hospital, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S176

Background: Female sexual problems are age related, progressive and highly prevalent affecting up to 43% of women [1, 2]. Reduced sexual desire disorder and orgasmic disorders are amongst the most frequent female sexual disorders [1, 3].
Materials and methods: The study population included 129 female medical students of the University of Athens, during the academic year 2008-2009. The participants were asked to complete voluntarily and anonymously a self - administered questionnaire which included demographic data and a short questionnaire regarding reduced sexual desire and orgasmic difficulties.
Results: Mean women's age was 24 years. More than half of them (58.1%) were in a stable relationship, while the majority of them (84.4%) had sexual activity during the last year. Regarding sexual interest, 66.7% didn't have any difficulties during the last three months, while nearly one third of the women (27%) seem to face some orgasmic difficulties. Thirty nine percent of the participants believe that women should reach an orgasm in every sexual intercourse and 30.3% admit to sometimes pretend reaching an orgasm. Finally, the majority of women are very or quite satisfied with their sexual life (74.8%), their emotional closeness with their partner (78%) and more than half of them (78.2%) consider sex an important dimension of their total life satisfaction.
Conclusions: Low sexual desire doesn't seem to be a problem for this group of young women. Orgasmic disorders in this sample are similar to the percentages found by previous studies. Interestingly enough, one third of the participants admit to occasionally fake orgasm to their partner. This group of women presents high levels of sexual satisfaction and emotional bonding, which are important parameters of woman's sexuality. Any interpretations of the present study should be made with caution, because our results were based on a small, non-randomized, specific sample.

References

Laumann E.O., Paik A., Rosen R.C. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999;281:537-544.

Dunn K.M., Croft P.R., Hackett G.I. Sexual problems: a study of the prevalence and the need for health care in the general population. Fam Pract 1998;15:519-524.

Rosen R.C. Prevalence and risk factors of sexual dysfunction in men and women. Curr Psychiatry Rep 2000;2:189-195

P094

SEXUAL BEHAVIORS OF MEDICAL STUDENTS. PLELIMINARY RESULTS

Ferenidou F., Patera A., Vaidakis N.

First Department of Psychiatry, National and Kapodistrian University of Athens,/Eginition Hospital, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S177

Background: Sexual problems are quite prevalent affecting up to 20-30% of men and up to 43% of women [1- 4]. Information about sexual practices may help gain a better understanding of the occurrence of sexual problems and further improve their management.
Materials and methods: The study population included 231 medical students (99 men and 132 women) of the University of Athens, during the academic year 2008-2009. The participants were asked to complete a self - administered questionnaire which included demographic data and a questionnaire regarding sexual behaviors.
Results: Mean age of the participants was 24 years. More than half of them (67.1%) reported having a sexual partner and 75.8% of them reported having sexual intercourse more than once a week. The decision preceded the act by a few seconds or minutes in 82.6% of subjects. Foreplay was important, very important or essential for 97.4% of subjects, while most of them (73.5%) considered that foreplay was equally important for both partners. The majority of participants reported that they don't have a preferred timing (67.1%) or season (80.8%) for sexual intercourse. For most of the subjects it was very easy or quite easy to talk about sex with their sexual partner (95.2%) or with their friends (87.1%). The vast majority of the students reported informing themselves on sexual issues (83.8%) and information sources were primarily acquaintances (55%) and the internet (44.1%).
Conclusions: Sexuality seems to be important for this group of young adults. The decision to have sex is spontaneous, foreplay is an important component of sexual intercourse and the time of the day or the year doesn't really matter. Students talk about sex quite open and inform themselves on sexual issues. This study employed a small, specific sample, thus the results are not representative of the general population.

References

Lewis R.W., Fugl-Meyer K., Bosch R. et al. Epidemiology/Risk Factors of Sexual Dysfunction. Journal of Sexual Medicine 2004; 1: 35-39.
Laumann E.O., Paik A., Rosen R.C. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999; 281: 537-44.
Feldman H.A., Goldstein I., Hatzichristou D.G. et al. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. J. Urol 1994; 151: 54-61.
Dunn K.M., Croft P.R., Hackett G.I. Sexual problems: a study of the prevalence and need for health care in the general population. Fam Pract 1998;15: 519-24.

P095

EFFECT OF QUETIAPINE IN YOUNG SCHIZOPHRENIC PATIENTS WITH TARDIVE DYSKINESIA

Piyush Singh [1], Abu Qamar Siddiqui, Rakesh Gaur

[1]Department of Psychiatry, JN Medical College, Aligarh, India
Annals of General Psychiatry, 2010;9(supplement 1):S178

Background: One of the major challenges in long term psychopharmacological management of schizophrenia is development of side effects, most notably tardive dyskinesia. The problem of tardive dyskinesia (TD) was more prevalent with the use of first - generation anti psychotic medications; the second generation drugs are believed to have a lesser propensity to cause such movement disorder. However, once TD develops the treatment options are rather limited, with the possible exception of Clozapine - usually modestly effective in about half of the patients. Thus there exists a need for

searching alternative therapeutic methods for tackling this vexing problem.
Aim: The aim was to find out if use of quetiapine is associated with a decrease in tardive dyskinesia, in young patients of schizophrenia who developed TD on their first anti psychotic medication.
Materials and methods: This was an open label observation study involving six male patients diagnosed as suffering from acute schizophrenia for which they had been prescribed anti psychotic medications, namely haloperidol and Risperidone. The patients went on to develop tardive dyskinesias. The dyskinetic movements were predominantly involving facial and oral areas. The dyskinetic movements were rated with Abnormal Involuntary Movements Scale. Attempts to decrease or withdraw the drugs resulted in re-emergence of symptoms. A trial of quetiapine was carried out with a cross over and taper method of 2-3 weeks. The AIMS ratings were carried out at 0, 4 and 8 week intervals. A reduction in the scores on AIMS was observed.
Results: It was observed that young male patients (< 30 yrs.) who had received either haloperidol (5- 12.5 mgs. /day) or Risperidone (4- 8 mgs./day) in oral formulations as their first anti psychotic medication. They had these drugs for 4 - 9 month duration. All of them also had received oral trihexyphenidyl (2-6 mgs./day) concomitantly, but still developed involuntary movements. Their personal, family and medical history and physical examination, including neurological examination, were free of any neurological or movement disorder. They were not receiving any other concomitant medications. After cross-taper ,quetiapine was used at 300- 600 mgs. /day dose. AIMS ratings at 4 and 8 weeks after start of quetiapine therapy revealed a decrease in tongue, lips and perioral movements. Detailed ratings will be discussed at presentation.
Conclusions: Although Clozapine has been found to result in decrease of TD movements; its use is problematic due to side-effects and regular blood monitoring, which is very difficult in developing countries. Quetiapine, associated with least propensity for causing EPSEs, appears to be promising for decreasing TD. This case report supports the limited evidence base in support of the use of quetiapine for managing tardive dyskinesia, especially in a younger population who themselves have somewhat lesser propensity to develop TD.

References

Janicak P.G.,Davis J.M. , Preskorn S.H. ,Ayd F.J. Jr. , Marder S.:Principles and Practice of Psychopharmacothe rapy.4thEd;2006 .
Sadock B.J., Sadock V.A. , Ruiz P.: Comprehensive Textbook of Psychiatry ,9th Ed.;2009.
Soares-Weiser K. , Fernandez H.H.: Tardive dyskinesia. Semin Neurol.2007;27:159.

P096

EFFECT OF THE GREEK SOLUTIONS FOR WELLNESS WEIGHT MANAGEMENT PROGRAM ON QUALITY OF LIFE AND ASSOCIATED FACTORS IN PATIENTS WITH A PSYCHIATRIC DISORDER RECEIVING PSYCHOTROPIC MEDICATION

Psarra V., Drossinos V., Mantellou M.-V., Ntzamaras K., Beal C.

Medical Department of Clinical Research, Pharmaserve-Lilly, Athens, Greece, [2]Lilly UK, Erl Wood Manor, Windlesham, Surrey, United Kingdom

Annals of General Psychiatry, 2010;9(supplement 1):S179

Background: Weight gain is a major side effect of treatment with psychotropic agents (1). Besides its adverse metabolic effects, weight gain may also impair physical functioning and quality of life (QoL) (2). Clinical weight management programs are reported to improve quality of life in obese individuals not receiving psychotropic therapy (3), but this has not been sufficiently investigated in patients with psychiatric disorders. The primary objective of this study is to assess the impact of the Greek Solutions for Wellness (SfW) 3-month program, which focuses on nutrition and physical exercise, on QoL in patients with a psychiatric disorder who are taking psychotropic medication and have a weight problem. Secondarily it aims to investigate the impact of baseline patient variables (e.g. age, sex, diagnosis) on QoL at month 3.
Materials and methods: This 26-week prospective observational study enrolled 359 patients from outpatient settings routinely carrying out the Greek SfW, from 23/JAN/2007 to 27/FEB/2008. 297 of them entered the program while 62 others who declined, were used as a control group. The QoL instrument Subjective Well-Being under Neuroleptics (SWN), the Clinical Global Impression (CGI)

scale, weight (kg), body mass index (BMI, kg/m2) and waist circumference (WC) (cm) were collected at baseline, months 3 (program completion) and 6 (follow up visit). In addition, diagnosis, disorder duration, treatment regimen and demographic characteristics (age, sex) were recorded. The proportion of patients with a QoL improvement (any SWN increase) was estimated together with their 95% CI in both groups at month 3. Further, stepwise logistic regression models were fitted to adjust the SfW effect on QoL at month 3, controlling for baseline potential confounders and first-degree interactions. A sensitivity analysis was conducted after implausible WC values were found in the database.
Results: Patient characteristics were similar across both groups: Out of 359 patients, a total of 198 (55.2%) were female, the mean age (SD) was 40.6 years (10.9), mean weight (SD) 92.9 kg (17.9), mean BMI (SD) 32.2 kg/m2 (5.6). 52.4% of the patients presented with schizophrenia, 30.9% with bipolar disorder and 16.7% other. The mean illness duration was 10.6 years (SD=8.7). Out of 353 patients still in the study at month 3, 352 were assessable in terms of SWN increase: 206 patients out of 295 in the SfW group (69.8%) (95%CI = [64.2, 75.0]) showed QoL improvement and 33 out of 57 (57.9%) (95%CI = [44.1, 70.9]) in the control group. After controlling for baseline potential confounders the difference between the two groups was ORinitial = 1.43 [0.76; 2.67]; ORsensitivity = 1.44 [0.77; 2.71]. Covariates significantly associated with an improved QoL at month 3 included a low SWN score (ORinitial = ORsensitivity = 0.94 [0.92; 0.96] and a low CGI-S level (ORinitial = ORsensitivity = 0.62 [0.49; 0.79]).
Conclusions: QoL improvement at 3 months in patients with mental illness as well as weight problems and on psychotropics was associated with low baseline SWN and CGI-S scores, while the big majority of the patients following the Greek SfW program reported an improved QoL.
Acknowledgements: The Hellenic EY-ZHN Study Team.

References

Casey D.E., 2005 Metabolic issues and cardiovascular disease in patients with psychiatric disorders. Am J Med 118, Suppl 2, 15S-22S.
Kawachi I., 1999 Physical and psychological consequences of weight gain. J. Clin. Psychiatry 60, Suppl. 21, 5-9.
Blissmer B., Riebe D., Dye G., Ruggiero L., Greene G., Caldwell M., 2006 Health -related quality of life following a clinical weight loss intervention among overweight and obese adults: intervention and 24 month follow-up effects. Health and Quality of Life Outcomes, 4, 43.

P097

EFFECTS OF HARMFUL FACTORS AND ALCOHOL CONSUMPTION BY MOTHER CONCERNING THE PHYSICAL AND MENTAL HEALTH OF HER CHILD

Tomulescu I. M.

Department of Biology, Faculty of Sciences, University of Oradea, Oradea, Romania

Annals of General Psychiatry, 2010;9(supplement 1):S180

Background: Mental retardation is a developmental disability that first appears at children under the age of 18. About 5% of the mentally retarded population is affected by severe mental retardation. Approximately 20% of the population with mental deficience presents moderate mental retardation and about 75% have mild mental retardation. A very important factor that cause mental retardation of child is the alcohol consumption by mother on the pregnancy period. Fetal alcohol syndrome (FAS) is a group of birth defects occurring in an infant as a result of maternal alcohol abuse during pregnancy. This syndrome was first described in 1968. It is currently the leading cause of mental retardation in western civilisation, outranking Down syndrome.
Materials and methods: To realise this study, we investigated 596 children hospitalized on period of 1999-2001 in Neuropsychiatry Infantile Section of Neurology and Psychiatry Clinical Hospital from Oradea. Among these, 393 have different degree of mental retardation. We realised family investigation and followed the hereditary antecedents, the harmful factors, alcohol consumption by mother, smoking and social and economic situation of families with mentally retarded children.
Results: Among 393 children with mental retardation, 216 have mild mental retardation (63 of them have different harmful factors in their families), 87 have moderate mental retardation (40 of them have different harmful factors in their families) and 90 have severe mental retardation (33 have different harmful factors in their families).

Conclusions: This study shows that in general, when in a family exists one child with mental retardation there exist at least one toxic factor. So, the harmful factor can be added hereditary antecedents and particularly the advanced age of mother. Fetal alcohol syndrome is a group of birth defects occurring in an infant as a result of maternal alcohol abuse during pregnancy period. Fetal alcohol syndrome is completely preventable. Prognosis depends on the degree of mental and neurological development. The rate of this harmful factor is increased in population from rural environment. FAS is a public health issue.

References

Hanlin ,J.R., Heeding the alcohol beverage warning label during pregnancy: multiparae vs. Nulliparae; J. of the Study of Alcohol, march 1996, p.171-177.
Makela,P.; Valkonen,T.; Martelin,T., Contribution of deaths related to alcohol used to socioeconomic variation in mortality: register based follow up study; Br.Med.J., 315, 1997, p.211-216.
Tomulescu,I.M., Mental retardation and other associated genetic diseases with it in Bihor county, Romania; University of Oradea Publishing House, 2004.

P098

THE EFFECT OF MEMANTINE ON CEREBRAL CORTEX TUMOR NECROSIS FACTOR ALPHA EXRESSION IN A RAT MODEL OF ACUTE HYPERAMMONEMIA

Tsartsalis S.[1], Tomos C.[1], Karanikola Th.[2], Mironidou-Tzouveleki M.[1]

[1]A' Laboratory of Pharmacology, Medical School, Aristotle University of Thessaloniki, Greece, [2]Department of Alveolar Surgery, Implantology and Radiology, Dental School, Aristotle University of Thessaloniki, Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S181

Background: Literature suggests that proinflammatory mechanisms are implicated in the pathophysiology of hepatic encephalopathy. This is mainly caused by high circulating levels of ammonia (hyperammonemia-HA), due to liver failure [1, 2]. In addition, NMDA receptors are excessively activated during acute hyperammonemia and thus significally contribute to the brain damage [3]. In fact, blockage of this receptor type is beneficial in experimental models of acute hyperammonemia [3, 4]. The aim of this study is to assess the effect of memantine, a non-competitive NMDA receptor antagonist, on the expression of tumor necrosis factor alpha (TNF-α), a major proinflammatory cytokine, in the brain of a rat model of acute hyperammonemia.
Materials and methods: HA was induced in male Wistar rats by two consecutive ammonium acetate intraperitoneal (i.p.) injections of 12 and 8 mmol/kg respectively [2]. Another group of rats received memantine hydrochloride (20mg/kg) 30 minutes before the first ammonium acetate injection, while control group received saline i.p. Rats were decapitated 30 minutes after the last injection and cerebral cortex TNF-α expression was determined with reverse transcription quantitative PCR.
Results: TNF-α expression in rat cerebral cortex was significantly elevated while the administration of memantine hydrochloride diminished its expression.
Conclusions: Memantine manages to compensate the induction of TNF-α, a major proinflammatory cytokine, by acute HA, in the cerebral cortex of rats. Further research is needed in order to determine if the effect of memantine may be attributed to the blockage of NMDA receptors and if it has a similar impact on the expression of other proinflammatory cytokines.

References

Jiang W., Desjardins P., Butterworth R.F: Direct evidence for central proinflammatory mechanisms in rats with experimental acute liver failure: protective effect of hypothermia. J. Cereb Blood Flow Metab 2009, 29(5):944-952.
Singh S., Koiri R.K., Trigun S.K.: Acute and chronic hyperammonemia modulate antioxidant enzymes differently in cerebral cortex and cerebellum. Neurochem Res 2008, 33(1):103-113.
Rodrigo R., Cauli O., Boix J., ElMlili N., Agusti A., Felipo V.: Role of NMDA receptors in acute liver failure and ammonia toxicity: therapeutical implications. Neurochem Int 2009, 55(1-3):113-118.
Kosenko E., Kaminski Y., Lopata O., Muravyov N., Felipo V.: Blocking NMDA receptors prevents the oxidative stress induced by acute ammonia intoxication. Free Radic Biol Med 1999, 26(11-12):1369-1374.

P099

POSSIBLE CORRELATIONS BETWEEN THE PSYCHOLOGICAL STATE AND EXCESSIVE INNATE IMMUNITY RESPONSES IN ULCERATIVE COLITIS

Vlachos I.[1], Coccossis M.[2], Tsopanomichalou M.[3], Christoidoulou Ch.[4], Papadimitriou G.[2], Patsouris E.[1], Barbatis C.[3], Nicolopoulou-Stamati P.[1]
[1]Pathology Department, Medical School Athens University,Athens, Greece, [2]First Psychiatry Department, Medical School Athens University, Athens, Greece, [3]Pathology Department, Hellenic Red Cross Hospital, Athens, Greece, [4]Second Psychiatry Department, Medical School Athens University, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S182

Background: Inflammatory bowel diseases (IBD), including ulcerative colitis (UC) and Crohn's disease (CD), belong to the autoimmune disorders in the sense that an excessive response of the immune system(both innate and acquired) towards commensal microbial flora of the intestinal mucosa is involved in their pathogenesis. The progress of IBD is unknown, characterized by periods of exacerbation and quiescence. Depression and anxiety seem to coincide with relapse of IBD and further research is needed for the clarification of this correlation. Aim: To further investigate the relationship between the psychological state of UCpatients and the gravity of their biopsy during relapse.
Materials and methods: 29 UC patients, hospitalized in two general hospitals for the investigation of a possible relapse of their disease were examined. Methods: Four self- report inventories (Hospital Anxiety and Depression Scale-HADS, Zung Depression Scale, State Trait Anxiety Inventory Form1 and Form 2/ STAI1/STAI2) were administered to the patients and the scores were correlated with the severity of parameters of their corresponding biopsies
Results: Positive correlations were observed between the degree of anxiety and depression in the questionnaires and the activation of innate immunity (polymorphonuclear leucocytes and macrophages) in the biopsies of UC patients
Conclusions: Our findings suggest correlations between the psychological state of UC patients and the intensity of their innate immune response perpetuating inflammation.

References

Shih D.Q., Targan S.R., McGovern D.Recent advances in IBD pathogenesis: genetics and immunobiology.Curr Gastroenterol Rep. 2008;10(6):568-75.
Mikocka-Walus AA, Turnbull DA, Moulding N.T., Wilson I.G., Andrews J.M., Holtmann G.J.Controversies surrounding the comorbidity of depression and anxiety in inflammatory bowel disease patients: a literature review.Inflamm Bowel Dis. 2007;13(2):225-34.
Hisamatsu T., Ogata H., Hibi T.Innate immunity in inflammatory bowel disease: state of the art.Curr Opin Gastroenterol. 2008;24(4):448-454

P100

SIMPLE SCHIZOPHRENIA: CASE REPORT AND REVIEW OF THE LITERATURE

Efstratiou S.[1,2], Tzavaras N.[3]

[1]Department of Psychiatry General Hospital of Kilkis, NHS, Greece, [2]Doctor of Dimocritus University of Thrace, [3]Professor of Psychiatry, Chairman of the Hellenic Psychiatric Association

Annals of General Psychiatry, 2010;9(supplement 1):S183

Background: Simple schizophrenia remains controversial. In this study we illustrate the diagnostic complexities of the disorder by emphasizing the importance of the criterion "progressive development of odd behaviour".
Materials and methods: We report the case of a 35-year-old man with "organic mental disorder".His medical and psychiatric history notes were peer reviewed and, neuropsychological assessments (WISC and Rorschach), blood tests, EEG and Computed tomography were carried out. Several psychiatric

scales (SCID, BPRS, HDS-17, CAS and GAF and MMSE) were also used to establish diagnosis and to evaluate treatment changes. We reviewed the differential diagnosis of the case, the history of simple schizophrenia and its importance both to this case and to current thought about schizophrenia.
Results: The patient had followed a social skills training program in a community setting for two years. His current state indicates IQ: 97, attention and concentration deficits, blunting of affect, inability to meet the demands of society and decline in overall performance (GAF: 41-50, CAS: 25). Neuroimaging and laboratory tests are normal. Furthermore he meets research criteria for simple deteriorative disorder or simple schizophrenia. He is been treated with aripiprazole now, with good response.
Conclusions: The review of the literature (historical articles, case reports, epidemiological and trancultural surveys, studies on reliability and validity and review articles) demonstrates the heterogeneity of the simple schizophrenia diagnosis oven the years. However there is a lack of developmental and psychopathological approaches that could provide a better understanding on the disorder. More case reports may contribute to that.

References

Prefrontal abnormalities in patients with simple schizophrenia: structural and functional brain-imaging studies in five cases. Suzuki M., Nohara S., Hagino H., Takahashi T., Kawasaki Y., Yamashita I., Watanabe N., Seto H., Kurachi M. Psychiatry Res. 2005 Nov 30;140(2):157-71. Epub 2005 Oct 21.
Simple schizophrenia revisited: a clinical, neuropsychological, and neuroimaging analysis of nine cases. Serra-Mestres J., Gregory C.A., Tandon S., Stansfield A.J., Kemp P.M., McKenna P.J. Schizophr Bull. 2000;26(2):479-93.
Simple schizophrenia: past, present, and future Black D.W., Boffeli T.J. Am J. Psychiatry. 1989 Oct;146(10):1267-73
A case of "pfropfschizophrenia": Kraepelin's bridge between neurodegenerative and neurodevelopmental conceptions of schizophrenia. Mack A.H., Feldman J.J., Tsuang M.T. Am J. Psychiatry. 2002 Jul;159(7):1104-10.

P101

PSYCHOSOCIAL INTERVENTIONS IN A FORENSIC DEPARTMENT

Markopoulou M., Georgiadou O., Dini I., Tsiftsoglou K., Bobotas K.

[1]Forensic department, Psychiatric Hospital of Thessaloniki

Annals of General Psychiatry, 2010;9(supplement 1):S184

Background: Schizophrenia often entails difficulties in social and occupational functioning. Frequently the approach followed in the hospital wards is mainly pharmacological and different from that of the community-based service which is mainly psychosocial. The accumulating evidence on the active role of the person in his or her recovery has had a profound impact on our understanding and interventions in relation to that severe mental illness especially when is accompanied with violent behavior.
Materials and methods: At present there are 60 patients in our department. They have committed crimes and are under compulsory detention and treatment. Since 2000 a variety of psychosocial interventions began to be implemented in concert with medications to minimize symptoms and improve community adjustment in mentally disordered offenders hospitalized in the Forensic Unit of the Psychiatric Hospital of Thessaloniki.
Results: In order to motivate our patients and finally to strengthen their sense of purpose and self-confidence, a rehabilitation program including 20 patients started in 2000 co-sponsored by the European Union. Since 2005 only 12 patients participate in this program now funded from the Ministry of Health and Social Welfare. The program includes several working teams inside or outside the ward, still inside the hospital, leaving limited opportunities to use social skills.
Conclusions: It is the hope that these interventions, and in a larger scale, will allow people with mental illness and violent behavior to more speedily and effectively reintegrate into their families and community so that they may lead more satisfying lives. Although there is a lot that can be done towards rehabilitation, especially for this group of patients, it seems that regular work performance feedback and goal setting are especially important for reducing clinical and social morbidity.

P102

HIGH PREVALENCE OF BULIMIA NERVOSA IN LUPIC PATIENTS

Miranda L.[1], Costa L.[1], Asano N.[2], Costa M.[1]

[1]Department of Neuropsychiatry, UFPE, Hospital das Clinicas, Recife, Pernambuco, Brazil,
[2]Department of Rheumatology, UFPE, Hospital das Clinicas, Recife, Pernambuco, Brazil

Annals of General Psychiatry, 2010;9(supplement 1):S185

Background: Systemic erythematosus lupus is a chronic, inflammatory autoimmune disease and its common association with anxiety, depression and other psychiatric disorders is well known. Eating disorders in this particular population are not the center of attention. In this paper we describe the findings of our 9 months study with lupic patients at Hospital das Clinicas.
Materials and methods: We selected and interviewed 82 female patients (aged 18 to 40) suffering from lupus, using Mini International Neuropsychiatric Interview (MINI), as instrument of interview and diagnostic. Afterwards, patients diagnosed as bulimic were individually analysed.
Results: Twelve of the 82 patients had criteria for bulimia nervosa (14,63 per cent).Those patients had low self-steam, persistent preoccupation with weight gain related to medication. Many of them were also very preoccupied with other physical aspects, such as skin damage and hair loss.
Conclusions: An alarming high incidence of bulimia nervosa was found in this sample and this may indicate lupic patients are susceptible to eating disorders, considering their exposition to steroids and other medications related to weight gain. More studies are necessary in order to confirm such data.

References

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th ed.)
Comprehensive Textbook of Psychiatry (7th ed). Vol 2, 1663 - 1672.

P103

DOMINANT TEMPERAMENT TRAITS AMONG THE INMATE POPULATION: A COMPARATIVE STUDY

Donchev T.[1], Martinova H.[2], Milanova V.[3], Nakov V.[4], Akiskal H.[5, 6]

[1]Clinic of Psychiatry, Military Medical Academy, Sofia, Bulgaria, [2]Medical University - Sofia, Sofia Bulgaria, [3]Head of Department of Psychiatry, Medical University - Sofia, Sofia, Bulgaria, [4]National Center for Public Health Protection, Sofia, Bulgaria, [5]International Mood Center, University of California at San Diego, California, USA, [6]The San Diego Veterans Administration Medical Center

Annals of General Psychiatry, 2010;9(supplement 1):S186

Background: Multiple studies document specific personality traits, relatively homogeneous in the structural aspect. We attempt to extrapolate a purely psychological examination approach, applying the clinical conceptualizations of H. Akiskal. This study aims to asses the existence of statistically significant differences between the TEMPS-A scale ratings of subjects serving a prison sentence and a control group.
Materials and methods: We examined a total of 148 patients divided into 2 groups, balanced in quantity and gender: an experimental (prison inmates) (N=74) and a control group (N=74). The experimental group included subjects serving sentences in penitentiary institutions within the Republic of Bulgaria's territory. The control group was randomly selected. The TEMPS-A scale was applied to subjects in both groups.
Results: We found statistically significant differences between the average values in the two groups regarding all scales except for the Hyperthymic temperament.
Conclusions: The Hyperthimic temperament does not have a specific prognostic value regarding criminal behavior. This temperament can be expected to reflect the degree of adaptation. A question stands as to whether the TEMPS-A scales describe the temperament of premorbid personality or can

register changes in the structure of personality as a consequence of substance abuse.

References
Roberts A., Min Y., Tianqiang Z., Coid J.; Personality disorder, temperament, and childhood adversity: findings from a cohort of prisoners in England and Wales; Journal of Forensic Psychiatry & Psychology, Volume 19, Issue 4 December 2008
Engström G., Persson B., Levander S.; Temperament traits in male suicide attempters and violent offenders; European Psychiatry, Vol. 14, Issue 5, September 1999
Giotakos O., Vaidakis N., Markianos M., Spandoni P., Christodoulou G.N.; Temperament and character dimensions of sex offenders in relation to their parental rearing; Sexual and Relationship Therapy, Vol. 19, Issue 2, May 2004
Richter J., Krecklow B., Eisemann M.; Interrelations between temperament, character, and parental rearing among delinquent adolescents: A cross-validation; Comprehensive Psychiatry, Vol. 43, Issue 3, May 2002

P104

EXPERIENCES IN PSYCHOSOCIAL SUPPORT IN DISASTER SITUATIONS FROM DEVELOPING COUNTRIES: THE ICA - PERU EARTHQUAKES OF 2008

Tarev A. A.[1], Donchev T.[1], Escalante M.[2], Diaz M.[3]

[1]Psychiatry Clinic, Military Medical Academy, Sofia, Bulgaria, [2]Direction of Mental Health, Ministry of Health, Lima, Peru, [3]Ica Regional Health Direction, Ica, Peru

Annals of General Psychiatry, 2010;9(supplement 1):S187

Background: After a disaster event, little or no attention is paid to mental and psychosocial implications mainly due to the lack of guidelines and resources for work in the field of mental health in many countries. Advances have been made in developed countries with the capacity to afford research and logistic innovations. In developing countries there has been a constant effort to develop affordable, community-based practices, adjusted to financial and logistic scarcity, and in accordance with the existing cultural barriers.
Materials and methods: We compiled and analyzed a series of information materials regarding the implementation of mental health services after the 2008 Ica-Peru earthquake, focusing especially on the aspects related to organization of services and accesibilty.
Results: Although poorly-funded and short-staffed, local health authorities were able to establish mental health and psychosocial support after the disaster event. This response was based on the framework of the Community oriented primary care model (COPC) which enables the implementation of accessible emergency mental health programs. The IASC-Guidelines represent a substantial document because of its practical approach especially in economically challenged areas. COPC also has shown an advantage from a trans-cultural perspective, giving communities the ability to tackle challenges using available resources in a culturally aware manner.
Conclusions: Development of programs for mental health services in disaster situations cannot be based only on pure innovative spirit. Attention has to be pointed to the availability resources, as well as take in account cultural and ethnic barriers.

References
Bhugra, D., Psychiatry and disaster: paradoxical relationship. Int J Soc Psychiatry, 2005. 51(3): p. 195-7.
Bhui, K., et al., Cultural competence in mental health care: a review of model evaluations. BMC Health Serv Res, 2007. 7: p. 15.
Gofin, J. and R. Gofin, Atención primaria orientada a la comunidad: un modelo de salud pública en la atención primaria. Revista Panamericana de Salud Pública, 2007. 21: p. 177-185.
IASC, I.-A.S.C., IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007, Inter-Agency Standing Committee IASC: Geneva.

P105

INCREASED ATTENTION FOR NEGATIVE LIFE EVENTS IS ASSOCIATED WITH AN ELEVATED RISK FOR PREMENSTRUAL SYMPTOMS

Gonda X.[1,2], Fountoulakis K.N.[3], Csukly G.[4], Telek T.[2], Pap D.[2], Rihmer Z.[1], Bagdy G.[2]

[1]Department of Clinical and Theoretical Mental Health, Semmelweis University, Budapest, Hungary, [2]Department of Pharmacology and Pharmacotherapy, Semmelweis University, Budapest, Hungary, [3]3rd Department of Psychiatry, Aristotle University, Thessaloniki, Greece, [4]Department of Psychiatry and Psychotherapy, Semmelweis University, Budapest, Hungary

Annals of General Psychiatry, 2010;9(supplement 1):S188

Background: The majority of healthy women experience some degree of fluctuation of mood and physical phenomena parallelling their reproductive cycle. While in most women this doesnt significantly interfers with everyday functioning in a smaller portion of women it causes distress severe enough to seek medical help. Earlier it has been found that premenstrual syndromes show an association with perceived stress. However, we hypothesise that even in healthy women, the experience of more severe symptoms in the late luteal phase of the menstrual cycle is related to the perception of life events. The aim of our study was to investigate the association between severity of late luteal phase symptoms and perception of positive and negative life events in a sample of healthy women.
Materials and methods: 88 healthy women not meeting criteria for any DSM-IV premenstrual phase-associated disorders completed the PRISM calendar for three consecutive menstrual cycles. Subjects also completed the Objective and Subjective Event Checklist during the follicular phase of the first cycle. Association between PRISM score change from the follicular through the late luteal phase and life event variables were investigated using Generalized Linear Model Analysis (GENMOD).
Results: The PRISM score change showed a significant positive association with the ratio of positive subjective life events and a significant positive association with the ratio of negative subjective life events. We found no significant association in case of the objective life events.
Conclusions: The results of our study indicate that women manifesting a more marked increase of symptoms during the late luteal phase of the menstrual cycle are more likely to notice negative subjective life events and less likely to notice positive subjective life events. However, there was no difference in the number of positive and negative objective life events observed. This suggest a constant, trait-like negative bias in the perception of life events present throughout the whole reproductive cycle which may play an important role in the emergence of premenstrual symptoms.

P106

THE S ALLELE OF 5-HTTLPR: A POSSIBLE COMMON LINK IN THE BACKGROUND OF ENDOPHENOTYPES RELATED TO SUICIDAL BEHAVIOURS?

Gonda X.[1,2], Fountoulakis K.N.[3], Harro J.[4], Pompili M.[5], Bagdy G.[1], Akiskal K. K.[6], Akiskal S. H.[6], Rihmer Z.[2]

[1]Department of Pharmacology and Pharmacotherapy, Semmelweis University, Budapest, Hungary, [2]Department of Clinical and Theoretical Mental Health, Kutvolgyi Clinical Centre, Semmelweis University, Budapest, Hungary, [3]3rd Department of Psychiatry, Aristotle University of Thessaloniki, Thessaloniki, Greece, [4]Department of Psychology, Center of Behavioral and Health Sciences, University of Tartu, Tartu, Estonia, [5]Department of Psychiatry, Sant'Andrea Hospital, Sapienza University of Rome, Rome, Italy, [6]International Mood Center, La Jolla, USA

Annals of General Psychiatry, 2010;9(supplement 1):S189

Suicide is complex phenomenon with multiple causes and underlying processes which is an equally great challenge for contemporary science and our society in general. Several models have been proposed to explain suicide and several studies aimed at delineating the factors and processes playing a role in its background. The most well-known and widely accepted risk factors of suicidal behaviour deal mainly with psychological and socioeconomic factors, however, we know less about the biological,

neurochemical and genetic correlates and contributors of suicidality.
Suicidality has been associated with impulsive aggression, and the majority of suicides are committed by depressive patients. Recently an increasing number of studies point to an association between certain types of suicidal behaviour. The suggestion that conflicting results may be due to inhomogenous suicidal samples indicates that different phenotypes of suicides may have profoundly different underlying factors even on the biochemical and genetic level.
Research shows that the s allele of the 5-HTTLPR is associated with violent completed suicides. This polymorphism has also been related to affective disorders, however, evidence supports that the association between suicide and the s allele is independent of the association between the 5-HTTLPR and depression. The s allele is also associated with several traits, such as impulsive aggression, hopelessness and affective temperaments, which may serve as important endophenotypes in delineating the genetic background of different types of suicidal behaviour.
Expanding our knowledge and understanding of the role of the serotonergic system in suicidal behaviour may lead to better recognition of suicide and of the prodromal symptoms of suicidal behaviour and may also play an important role in developing drugs with a potential to reduce suicidality.

P107

A PRELIMINARY STUDY OF FUNCTIONAL IMAGING UPON PLACEBO ANALGESIA IN PROGRESSIVE MULTIPLE SCLEROSIS

Canellopoulou M.[1], Koumakis K.[2], Tsiloglou Ch.[3]

[1]Department of Psychology, The American College of Greece, Athens, Greece, [2]Department of Neurology, Athens Euroclinic, Athens, Greece, [3]Department of Psychology, The American College of Greece, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S190

Background: In light of solid data regarding the extent of the placebo response as well as the rigorous arguments in favor of the randomized, placebo-controlled clinical trial , placebo analgesia has widely been tested and documented as one of the most robust placebo effects. Newly developed brain imaging tools such as functional magnetic resonance imaging (fMRI) have provided systematic evidence for the neurophysiological substrates involved in placebo analgesia [1] [2]
Materials and methods: In the present study, the replication of a well-documented expectancy manipulation model combined with a placebo intervention via acupuncture [3] was conducted to determine neural mechanisms underlying placebo analgesia in a group of 12 patients (6 females; mean age, 38.4 +/- 4.5 SD) with progressive multiple sclerosis (MS) matched for age, sex, duration of disease, disability and subjective pain ratings. Procedures involved two behavioral testing sessions and one fMRI scanning session as well as the administration of expectancy and pain subjective rating scales.
Results: Subjective pain ratings indicated a significantly greater reduction in the placebo-control group as compared to the untreated condition (before/after treatment). The functional MRI signal difference between post-treatment and pre-treatment sessions was subtracted from the same difference in the non-treatment control group (post- and pre- placebo phases and post- and pre- control phases) indicating significant changes in mainly two of the so-called pain-sensitive brain regions such as the bilateral rostral anterior cingulated cortex (rACC) and the lateral prefrontal cortex.
Conclusions: Such findings are not consistent with research data from a wide range of neuropathies utilizing variant placebo treatments [4], suggesting that placebo analgesia as a result of expectancy can be detected in progressive multiple sclerosis yet, be subserved by the aforementioned brain regions. Future directions involve the study of brain activation patterns as a function of modality of placebo treatments with analgesic effects and identifying MS-specific forms of confounding as related to placebo analgesia.

References

D Levine, N C Gordon, H L Fields: The mechanism of placebo analgesia. Lancet 1978, 2: 654-657
F Benedetti, M Amanzio et al: The specific effects of prior opioid exposure on placebo analgesia and placebo respiratory depression. Pain 1998, 75: 313-319

J Kong, R L Gollub, I S Rosman, J Webb, M G Vangel, I Kirsch, T J Kaptchuk: Brain activity associated with expectancy-enhanced placebo analgesia as measured by functional magnetic resonance imaging. J Neurosci 2006, 26(2): 381-388
G A Hoffman, A Harrington, H L Fields: Pain and the placebo: what we have learned. Perspect Biol Med 2005, 48: 248-265

P108

JOB BURNOUT, SELF-EFFICACY THEORY AND JOB SATISFACTION IN A SAMPLE OF GREEK BANK CLERKS

Mantelou E., Tzioti M.-Ch., Degleris E. N., Solias A., Karamberi M.

Psychotherapeutic Center of Piraeus, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S191

Background: The aim of this study is the exploration of the job burnout syndrome in Greek bank clerks as well as the examination of the demographic factors that seem to have an impact on it. Based on Maslach and Jackson's (1986) theory, the job burnout syndrome has three components: emotional exhaustion, depersonalization and reduced professional efficacy within the workplace. In addition, we examined the correlation between job burnout and two other concepts, self-efficacy as described by Albert Bandura (1977b) and job satisfaction. Finally, we sought to examine whether the three components of the job burnout syndrome differentiate in relation to some demographic characteristics of the sample (i.e., age, educational level, working experience, gender and personal contact with customers).
Materials and methods: The following questionnaires were used: The Greek version of the general self-efficacy scale of Shwarzer, the Maslach Burnout Inventory - General Survey (MBI-GS), the Oldenburg Burnout Inventory (OLBI), the Job Satisfaction Questionnaire and a demographic characteristics questionnaire.
Results: The relationship between job burnout and self-efficacy was not found to be statistically significant, whereas job satisfaction was correlated with some MBI and OLBI dimensions.
Conclusions: All demographic factors, except for gender, were correlated to job burnout dimensions. Last but not least, it would be interesting to study the relationship between self-efficacy and job burnout in other professional groups as well.

References

A. Bandura: Self- efficacy: Toward a unifying theory of behavioral change. Psychological Review, (1977b), 84: 191-215.
E. Demerouti, A.B. Bakker, F. Nachreiner and W.B Schaufeli. 'The job demands-resources model of burnout'. Journal of Applied Psychology, 2001, 86: 499-512.
C. Maslach, & S. E. Jackson: Maslach Burnout Inventory. Manual. 2nd Edition, 1986, Palo Alto, C.A.: Consulting Psychologists Press.
R. Schwarzer: Measurement of perceived self-efficacy. Psychometric scales for cross-cultural research. Berlin, Germany: Freie Univesität Berlin, 1993.

P109

JOB BURNOUT AND SELF-EFFICACY SURVEY AMONG ELEMENTARY SCHOOL TEACHERS IN GREECE

Tzioti M.-Ch., Mantelou E., Degleris E. N., Solias A., Karamberi M., Romanou N.

Psychotherapeutic Center of Piraeus, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S192

Background: Emotional exhaustion, depersonalization and reduced professional efficacy within the workplace are the three dimensions of the job burnout syndrome. In this study, we examined the levels of job burnout in a sample of 100 teachers of elementary education. Also, we sought to identify the relationship between job burnout and general self-efficacy, teachers' self-efficacy and group self-efficacy. Moreover, we looked into the relationship between job burnout and the three types of self-efficacy with teachers' perceptions of particular work-related values. Job burnout dimensions and self-efficacy are also studied in relation to teachers' demographic characteristics.
Materials and methods: Job burnout was measured using the Maslach Burnout Inventory (Educators Survey) (Maslach, Jackson & Leiter, 1996). Self-efficacy was measured with the Shwarzer and Jerusalem's (1981) questionnaire. The work values questionnaire was makeshift and answers were given on a 6-point scale.
Results: Female teachers presented higher levels of job burnout, whereas teachers over 50 years old presented higher levels of self-efficacy than those between 31-40 years old. The three types of self-efficacy were negatively correlated with the three job burnout dimensions.
Conclusions: In particular, this research stresses the importance of the relationship between group self-efficacy and job burnout. What is more, job burnout seems to have an impact on people's perceptions about their occupation. Moreover, it would be interesting to study the relationship between self-efficacy and job burnout in other professional groups as well.

References

A. Bandura: Self- efficacy: Toward a unifying theory of behavioral change. Psychological Review, (1977b), 84: 191-215.
A. Bandura, D. Cervone: Self- evaluative and self-efficacy mechanisms governing the motivational effects of goal systems. Journal of Personality and Social Psychology, 1983, 45: 1017-1028.
C. Maslach, S. E. Jackson & M. P. Leiter: Maslach Burnout Inventory. Manual (3rd ed.), 1996, Palo Alto, C.A.: Consulting Psychologists Press.
R. Schwarzer: Measurement of perceived self-efficacy. Psychometric scales for cross-cultural research. 1993. Berlin,
Germany: Freie Univesität Berlin.

P110

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY IN GREEK SCHOOL AGED CHILDREN & DATA FOR EXPRESSIVE AND RECEPTIVE LANGUAGE FOR THIS POPULATION)

Tafiadis D.[1,2], Bergadi A.[1], Gkrekou X.[1], Karagianni E.[1], Kantakou F. – P.[1], Kentioglou K.[1], Paroutiadou I.[1], Papageorgiou K.[1], Tafiadi M.[3], Zafeiropoulou G.[1]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S193

Background: The present pilot study was the adaption of receptive and expressive language tests' (ROWPVT and EOWPVT) for Greek children aged from 6 years till 11 years and 11 months, and to locate

any differences between receptive and expressive language.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 615 participants (m: 310, f: 305) recruited from Greek Schools. The sample was independent from origin and socio - economic situations. Also an ENT, neurological and a psychological examination were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent to other results reported. No statistically significant differences were found according to sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .823, & .834).
Conclusions: The test appears to be sensitive for school aged Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability, high content validity. The participants demonstrated clear patterns of responses but in some ages differences were located between expressive and receptive language. Further research must be done, to exclude or include any adaptation, learning or developmental reasons.

P111

THE EXPRESSIVE AND THE RECEPTIVE ONE WORD PICTURE VOCABULARY TEST (EOWPVT & ROWPVT). (A COMBINE PILOT STUDY IN GREEK JUNIOR HIGH SCHOOL AGED CHILDREN & DATA FOR EXPRESSIVE AND RECEPTIVE LANGUAGE FOR THIS POPULATION)

Tafiadis D.[1,2], Mokas A.[1], Chorevas K.[1], Bogindrouka E.[1], Kentioglou K.[1], Pantazis E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S194

Background: The present pilot study was the adaption of receptive and expressive language tests' (ROWPVT and EOWPVT) for Greek children aged from 12 years till 14 years and 11 months, and to locate any differences between receptive and expressive language.
Materials and methods: The commercial versions of the tests were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 300 participants (m: 150, f: 150) recruited from Greek Junior High Schools at region of Epirus. The sample was independent from origin and socio - economic situations. Children with medical problems excluded, because it will influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent to other results reported. No statistically significant differences were found according to sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach = .848, & .812).
Conclusions: The test appears to be sensitive for junior high school aged Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability, high content validity. The participants demonstrated clear patterns of responses and there were no differences between expressive and receptive language.

P112

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 6 YEARS TILL 6 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[1], Pagoni A.[1], Xatiefremidou E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S195

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 6 years till 6 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.
Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach .796).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P113

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 7 YEARS TILL 7 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[1], Pagoni A.[1], Xatiefremidou E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S196

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 7 years till 7 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.
Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and

validity test were contacted and showed high criterion (a - Chronbach .766).
Conclusions:
The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P114

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 9 YEARS TILL 9 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[1], Pagoni A.[1], Xatiefremidou E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Ioanninon, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Ioanninon, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Attika, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S197

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 9 years till 9 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.
Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach .852).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P115

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION OF THE TEST IN NORMAL GREEK POPULATION AGED FROM 10 YEARS TILL 10 YEARS AND 11 MONTHS)

Tafiadis D.[1,2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[1], Pagoni A.[1], Xatiefremidou E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S198

Background: The present pilot study was the adaption and validation of word finding for Greek children aged from 10 years till 10 years and 11 months. The Test of Word Finding, (TWF - 2), 2nd edition (2000) - used in this research -was originally created by Diane German in 1985.

Materials and methods: The commercial version of the test were adapted in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 100 participants (m:50, f: 50) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent other results reported. No statistically significant differences were found according or sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach ≥.80).
Conclusions: The test appears to be sensitive to that age for the Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P116

THE TEST OF WORD FINDING (TWF - 2). (A PILOT STUDY AND VALIDATION IN GREEK PRE - SCHOOL AGED CHILDREN & DATA FOR WORD RETRIEVAL IN THIS POPULATION)

Tafiadis D.[1,2], Larentzaki S.[1], Magioglou D.[1], Mpourakis I.[1], Neofotistou M.[1], Pagoni A.[1], Xatiefremidou E.[1], Tafiadi M.[3]

[1]Department of Speech and Language Therapy, T.E.I. of Epirus, Ioannina, Greece, [2]Department of Neural Sciences and Sensory Organs (School of medicine), University of Ioannina, Ioannina, Greece, [3]Department of Mathematics, National and Kapodistrian University of Athens, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S199

Background: The present pilot study was the adaption of word finding test [(TWF - 2, 2nd edition (20000 originally created by Diane German in 1985] for Greek children aged from 4 years till 5 years and 11 months, and to locate the ability of word retrieval in pre - school age population.
Materials and methods: The commercial version of the test was translated in Greek language by a linguist, three speech language therapists and 2 native speakers of Greek language, having proficiency in English, and two native speakers of English having proficiency in Greek, and changes were contacted, for the best representation of the Greek version. In this research took part 200 participants (m: 50, f: 50/ per age) recruited from Greek pre - schools settings at the region of Agrinio. The sample was independent from origin and socio - economic situations. Medical examinations' were also requested, so no medical problems could probably influence the test results.
Results: Statistical analysis of the data revealed that the results obtained are generally consistent to other results reported. No statistically significant differences were found according to sex. Also reliability and validity test were contacted and showed high criterion (a - Chronbach .803).
Conclusions: The test appears to be sensitive to the pre - school aged Greek population and presents satisfactory criterion, internal consistency, temporal stability, interrater reliability. Also the test showed high content validity, as the participants assessed demonstrated clear patterns of responses, but further changes must be done for the Greek version in clinical and research settings.

P117

EVALUATION OF FUNCTIONALITY IN FAMILIES WITH A MEMBER DIAGNOSED WITH BIPOLAR DISORDER

Trandafir M.-S.

Alexandru Obregia Hospital ,unit 7, Bucharest, Romania

Annals of General Psychiatry, 2010;9(supplement 1):S200

Background: Affective disorders represent a pathology with cronic, recurent character, in a continuous growth which affect different categories of population causing serious socio- economical desinsertion and expensive costs The notion of "maniac-depressive psychosis" was used for the first time by Krepelin in 1913, in the German region. K.Leonhard and Scandinavic Psychiatry and later on Angst and Peris differentiate the notions of "mono-unipolar and bipolar psychosis" Duner (1976), divides the bipolar disorder into the first degree - major depression and mania, second degree bipolar disorder - major depression and hipomania. The family is an important support for the patients. Family therapy contribute to the increase of quality of the patient and his/her family life.
Aims: The study intends to focus on the functionality of a family with a patient diagnosed with biplolar disorder tip II. The results will be compared to a witness sample of families that do not have a member that suffers from a mental disease.
Materials and methods: A semple of 10 famlies that summed up a number of 30 persons have been included in the study. The gender repartition was 63,3% (19 males) and 36,6% (11 females). People aged 17 to 69 were included in the study, average: 42,2 years old, standard deviation 15,1, mode 26, mediana 44,5. We evaluated functionality of families using The Family Functioning Scale (FFS). As a comparison, we used the results obtained in "The clinical study on psychodinamics over a family's relationships in the psychiatrical clinic", published by Ph.D. Silvia Trandafir in 2005, from which we have taken the data regarding the so-called normal families in Romania. In the above-mentioned paper, a sample of 132 families were studied, sample that summed-up 323 persons.
Results: The following results were gathered: positive affect 32,23, communication 36,4, conflictuality 25,9, worries 41,23, and rituals 40,36. The results represent an average of the values obtained through the scale in the depression periods and those of hipomania.
Conclusions: The fifth components that come from the FFS measure the most important aspects of the functionality of the families. The study revealed significant differences between the component of the two types of families (with and without sick members). Families have a big adaptability to everyday problems, one may speak of a normality of the families with a Second Degree Bipolar Affective Disorder member (patient).

References

Marck Tavitian , Lawrance C Grebstein , Judith Lubiner , Dimension of family Functioning, Rhod Iland 1987, New-York
Michael P. Nichols, Richard C Schwartz , Family Therapy, Concepts and Methods VI th tr. Romana 2005 , Bucharest
Togliati Marisa Malagoli, Familie multiproblemetiche, nuova edizione, Carocci Editore, Roma, 2004
Akerman N., Psicodinamica della vita familiare, Ed. Bollati Boringheri, Torino, 1999

P118

SUBJECTIVE HEALTH DEFINITION AND HEALTH BEHAVIORS IN PERSONS SUFFERING FROM SCHIZOPHRENIA

Dutczak B., Bidzan L.

Department of Psychiatry, Medical Academy, Gdansk, Poland

Annals of General Psychiatry, 2010;9(supplement 1):S201

Background: Identification an importance of health as a value is considerable in preparing rehabilitation programs for patients suffering from mental disease, especially schizophrenia. Treatment should contains not only pharmacotherapy, but also social support and many changes in the environment to make their lifes more satisfying.
Materials and methods:
1. List of Health Criteria - LKZ (by Z. Juczyński) consist of 24 affirmations describing three heath variants: physical, psychical and social. This test is used to identify a health definition. 2. Health Behavior Inventory - IZZ (by Z. Juczyński) consist of 24 affirmations describing different types of health behaviors. 30 patients (men) suffering from schizophrenia, 25-35 years old
Results: Patients suffering from schizophrenia define health as ability to cooperate with other persons, to enjoy life and to control their feelings, emotions and vehemence. Persons suffering from schizophrenia as distinct from healthy persons declare more scrupulous behaviors related with control visit to psychiatries and listening their suggestions. Moreover they declare greater gwillingness to gain more medical informations about their disease (causes and treatment) and avoiding stress and strong emotions.
Conclusions: The most important result is that persons suffering from schizophrenia have very different kind of health definition, so if we want to construct rehabilitation programs, we have to try better to understand their perception of value.

References
Kępiński A. (2001) Schizofrenia. Wydawnictwo Literackie
Kępiński A. (2003) Poznanie chorego, Wydawnictwo Literackie.
Tsirigotis K., Gruszczyński W. (2001) Stan badań nad hierarchią wartości u osób z rozpoznaną schizofrenią paranoidalną, Badania nad Schizofrenią.

P119

ASSOCIATION OF MENSTRUAL CYCLE RELATED SYMPTOMS WITH MOOD CHANGES

Telek T.[1], Gonda X.[1,2], Csukly G.[3], Fountoulakis K.N.[4], Bagdy G.[1]

[1]Department of Pharmacology and Pharmacotherapy, Semmelweis University, Budapest, Hungary, [2]Department of Psychiatry Kutvolgyi Klinikai Tömb, Semmelweis University, Budapest, Hungary, [3]Department of Psychiatry and Psychotherapy, Semmelweis University, Budapest, Hungary, [3]3rd Department of Psychiatry, Section of Neurosciences,Faculty of Medicine, Aristotle University of THessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S202

Background: Nearly 80% of women experience some worsening of physiological and psychological symptoms a few days before the onset of menstruation, and these symptoms have an influence on well-being, and behaviour. Due to the premenstrual-period related symptoms relationship, family, and work-related conflicts may occur. Even economical loss has to be taken into consideration due to decrease in ability to work, and staying out of work. The aim of our study was to investigate the association between mood changes troughout the menstrual cycle phases of healthy women.
Materials and methods: 88 healthy women not meeting criteria for any DSM-IV premenstrual phase-associated disorders completed the STAI State Anxiety Scale (STAI-S), SCL-51 and the ZSDS during

first cycle on three predefined days (early follicular, late follicular and late luteal phase). Data were analysed using Generalized Linear Model Analysis (GENMOD).
Results: A significant effect of phase of the cycle was observable in case of the state anxiety scale (F= 6.27, p=0.0022), the SCL-51 total score (F=5.31, p=0.0055), the somatization subscale of the SCL51 (F=4.16, p=0.0167), the depression subscale of the SCL51 (F=4.58, p=0.0111), the obsessive-compulsive subscale of the SCL51 (F=3.63, p=0.0278) and the interpersonal sensitivity scale of the SCL51 (F=5.71, p=0.0038). Significant effect of phase also emerged on the ZSDS (F=3.14, p=0.0452).
Conclusions: In case of healthy women there is a significant fluctuation during the menstrual cycle in anxiety, somatisation, depression, obsessive compulsive symptoms and interpersonal sensitivity, so in the majority of women psychological well-being is significantly associated with the phase of the cycle. In case of psychological and psychiatric investigations, cycle phase thus should be taken into consideration since it may influence measurements even in case of healthy women.
Acknowledgements: These studies were supported by the Sixth Framework Programme of the EU, LSHM-CT-2004-503474 and the PhD Fellowship Program of the Semmelweis University, Ministry of Culture and Education, Hungary.

References
Gonda X., Telek T., Juhasz G., Lazáry J., Vargha A., Bagdy Gy. (2008) Patterns of mood changes throughout the reproductive cycle in healthy women without premenstrual dysphoric disorders. Progress in Neuro-Psychopharmacology&Biological Psychiatry, article in press
Gonda X., Lazáry J., Telek T., Pap D., Kátai Z., Bagdy Gy. (2008) Mood parameters and severe physical symptoms of the female reproductive cycle. Neuropsychopharmacologia Hungarica X/2; 83-88.
Telek T., Gonda X., Lazáry J., Benkő A., Bagdy Gy. (2006) A premenstruális szindróma pszichikai és fizikai változásainak vizsgálata. 5. Vajdasági Magyar Tudományos Diákköri Konferencia, Újvidék, Konferenciakiadvány, 59-60.

P120

AN ASSOCIATION STUDY BETWEEN VARIOUS MONOAMINE TRANSPORTER GENE POLYMORPHISMS AND TREATMENT RESPONSE TO MIRTAZAPINE IN MAJOR DEPRESSION

Hong Choi

Department of Psychiatry, St. Andrew's Neuropsychiatric Hospital, Icheon, Gyong-gi-do, Korea

Annals of General Psychiatry, 2010;9(supplement 1):S203

Background: Genetic differences may contribute to the inter-individual differences in treatment response to antidepressants among patients suffering from major depression. This study investigated a possible association of various monoamine transporter genetic polymorphisms with treatment response to mirtazapine in major depressive patients in elderly.
Materials and methods: In this study, three genetic polymorphisms were selected: serotonin transporter 5-HTTLPR, serotonin transporter 5-HTT intron 2 VNTR, and norepinephrine transporter NET(G1287A). The patients with major depression diagnosed by DSM-IV were recruited to a 6-week naturalistic mirtazapine treatment study in Samsung Medical Center. Treatment response to mirtazapine was defined as ≥50% decrease in HAMD-17 scores at 6 weeks, and the genotypes in the patients were determined using the polymerase chain reaction.
Results: Our results showed that ss allele carriers were included more in responder group (ss allele in responder vs. non responder group; 69.4% vs. 40.0%). In addition, l-allele (sl/ll) carriers were included less in responder group(sl/ll allele in responder vs. non responder group; 30.6% vs. 60.0%). Multiple logistic regression analyses showed the 5-HTTLPR polymorphism as an predictor of the mirtazapine response (5HTTLPR ss allele carrier vs. l-allele (sl/ll) carrier; odds ratio: 3.81; 95% confidence interval [CI], 1.32-11.0; P=0.013). However, 5-HTT intron 2 VNTR l/s (P=0.33 by multiple logistic regression; [OR], 0.53; 95% [CI], 0.15-1.88), and NET(G1287A) G/A (P=0.68 by multiple logistic regression; [OR], 1.25; 95% [CI], 0.44-3.53) showed no statistical significant influences on response rate.
Conclusions: In conclusion, 5HTTLPR polymorphism may predict treatment response to mirtazapine in major depressive patients in elderly.

P121

GUILLAIN-BARRE SYNDROME AND MOOD DISORDERS

Neroutsos E.[1], Vagionis G.[1], Fiste M.[2]

[1]General Hospital of Elefsina Thriasio, Athens, Greece, [2]Psychiatric Hospital of Athens Dromokaitio, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S204

Background: Guillain-Barre syndrome (GBS) is an acute, autoimmune polyradiculoneuropathy affecting the peripheral nervous system, usually triggered by an acute infectious process. It is included in the wider group of peripheral neuropathies. There are several types of GBS, but unless otherwise stated, GBS refers to the most common form, acute inflammatory demyelinating polyneuropathy (AIDP). Clinical hallmarks of this syndrome include symmetric progressive flaccid muscle paresis, areflexia, ataxia, dysautonomia, and respiratory insufficiency in the presence of an increased cerebrospinal fluid protein content, as well as electromyography studies demonstrating evolving demyelination.
Materials and methods: We report a 20 years old female that after the permanence in the ICU presented to us with a depressed mood. In the progress of the ill from the state of anxiety (especially evident at the initial phase of the disease during the dissemination and maximum intensity of paralysis) she went to a clear presentation of depressive symptoms during the phase of remission. After few days in the neurology clinic she met the criteria of a major depressive episode that was treated with mirtazapine 15mg daily
Results: There were mental status changes in 31 % of GBS patients and in 16% of controls [1]. Vivid dreams (19%), illusions (30%), hallucinations (60%, mainly visual) and delusions (70%, mostly paranoid) were included. They appeared a median 9 days after disease onset (range 1-40 days, during the progression or the plateau of the disease), and last a median 8 days. Seven (16%) patients experienced the symptoms before their admission to the ICU. Hallucinations were frequently hypnagogic, occurring as soon as the patients closed their eyes. In an older publication [2] anxiety (82%), acute stress disorder, depressive episodes (67%) and brief reactive psychosis (25%) were observed.
Conclusions: In GBS not only severe psychosis may occur, which may go unrecognised due to the severity of the neurological motor deficits, but also fatigue and depressive episodes as major restrictions of quality of life after the acute phase of GBS. Those are probably the major debilitating factors in chronic inflammatory neuropathies. Symptomatic treatment remains largely empirical and more studies are necessary.

References

Cochen V. et al. Vivid dreams, hallucinations, psychosis and REM sleep in Guillain-Barrı syndrome. Brain. 2005 Nov;128 (Pt 11):2535-45. Epub 2005 Jul 6
Weiss H., Rastan V., Mòllges W. Psychotic symptoms and emotional distress in patients with Guillain-Barrı syndrome. Eur Neurol. 2002;47(2):74-8.
Chan. A., Gold R. Neuropsychological/-psychiatric deficits in immune-mediated neuropathies.J Neurol. 2007 May;254 Suppl 2:II93-5

P122

ANTICONVULSANT TREATMENT AND MOOD DISORDERS. A VITAMINE B12 KEY ROLE?

Neroutsos E.[1], Vagionis G.[1], Fiste M.[2]

[1]General Hospital of Elefsina Thriasio, Athens, Greece, [2]Psychiatric Hospital of Athens Dromokaitio, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S205

Background: Clinical study of the correlation of plasma Vitamin B12 levels and mood disorders in a patient with history of long term treatment with antiepileptic drugs. A female patient with bipolar disorder II, treated in the near past with carbamazepine and sodium valproate, during her stay in our clinic ward mentioned weakness and loss of sensation in both arms, accompanied with a filling of unstable walking and hemodia. After the full neurological clinical evaluation and examination with structural neuroimaging procedures such a CT scan and MRI, our attention was moved to the possible relationship between the reported symptoms with the B12 serum levels. As the levels were 150 pg/ml and our patient's blood cell values do not reveal megaloblastic anaemia, we started substitute treatment, provided that she had been taking antiepileptic medicine for years and had low toxicity of B12. At following neurological examinations the patient's clinical icon had improved. Carbamazepine and sodium valproate are widely used as maintenance treatment of bipolar disorder. Although the alteration of accumulation of B12 in serum is not totally acceptable by scientists, there are indications for the relation between antiepileptic medicine and reduced levels of B12 at least at cerebrospinal fluid folate. Additionally, the combination of any inefficiency with the chronic alcoholism that is often present in this category of mental patients and the rise of life expectancy creates the need of a bigger demanded quantity of B12 in their diet.
Materials and methods: Clinical examination, laboratory tests, neuroimaging and bibliographic research.
Results: The full spectrum of relations between B12 and psychiatric illness is still not clear. Much of the evidence comes from case-control and cross-sectional studies. Cohort studies and definitive randomized-controlled trials to test the therapeutic benefit of B12 are required to confirm or refute any causal relationship. Evidence suggesting a causal relationship between the disturbed vitamin metabolism and the abnormal mental state.
Conclusions: The introduction in routine laboratory test of the determination of B12 serum levels under the evidence of the association of B12 deficiency and low serum B12 values in patients with mental disorders and atypical psychiatric symptoms may help. As the neuropsychiatric severity by vitamin B12 deficiency and the therapeutic efficacy depends on the duration of signs and symptoms, the B12 levels should be evaluated in every patient with history of treatment with antiepileptic drugs, resistant depressive disorders, dementia, psychosis or risk factors for malnutrition such as alcoholism or advancing age associated with neurological symptoms, anaemia, malabsorption, gastrointestinal surgery, parasite infestation or strict vegetarian diet.

References

Goggans F.C.A. case of mania secondary to vitamin B12 deficiency. Am J. Psychiatry. 1984 Feb;141(2):300-1.
Deda G., Caksen H., Içağasioğlu D., Effect of long-term carbamazepine therapy on serum lipids, vitamin B12 and folic acid levels in children. J. Pediatr Endocrinol Metab. 2003 Feb;16(2):193-6.
Frenkel E.P., McCall M.S., Sheehan R.G.. Cerebrospinal fluid folate, and vitamin B 12 in anticonvulsant-induced megaloblastosis. : J. Lab Clin Med. 1973 Jan;81(1):105-15.
E.H. Reynolds M.B., B.Ch., M.R.C.P. Schizophrenia-like Psychoses of Epilepsy and Disturbances of Folate and Vitamin B12 Metabolism Induced by Anticonvulsant Drugs. The British Journal of Psychiatry (1967) 113: 911-919.

P123

FACIAL EMOTION RECOGNITION IN SCHIZOPHRENIA: NEUROPSYCHOLOGICAL AND PSYCHOSOCIAL CORRELATES

Jaracz J., Grzechowiak M., Raczkowiak L., Rybakowski J.

Department of Adult Psychiatry, University of Medical Sciences Poznań, Poland

Annals of General Psychiatry, 2010;9(supplement 1):S206

Background: There is evidence that facial emotion recognition is disturbed in schizophrenic patient's (1) and is associate with other neurocognitive deficits. (2) Some evidence suggest that affect recognition is an important aspect of psychosocial functioning of patients with schizophrenia. (3) In this study we assessed recognition of facial emotional expression in schizophrenic patients and its relationship with selected clinical and neuropsychological variables as well as with social functioning.
Materials and methods: Twenty -three patients (mean age 32,3 SD 8,7; mean duration of illness 100 months SD 80) who met the DSM-IV criteria for schizophrenia -paranoid type, hospitalized at the Department of Adult Psychiatry University of Medical Sciences in Poznań, Poland were involved in the study. At time of testing the mean PANSS score was 86,6 (SD 17,7). To assess facial emotion recognition we applied the computerized Penn Emotional Facial Recognition (ER40) task. (4) Cognitive performance was studied using Wisconsin Card Sorting Test. Social functioning was measured with Social Functioning Scale. The control group of healthy volunteers matched for gender and age was included.
Results: Patients performed worse than control group on the total correct responses, particulary recognition of faces expressing fear (p=0.002) and sadness (p=0.02). The median time for correct response was significantly longer (p=0.004) in schizophrenic group. Patients gave more positive anger, happy and neutral responses, and need more time to identify correctly expression of fear (p=0.005), happy(p=0.03) neutral (0.03) and sad (p=0.005) faces. The number of correct responses correlated negatively with number of preservative errors. There was no association of facial emotion expression recognition and social functioning was found.
Conclusions: Schizophrenic patients performed worse on emotion recognition test than control group. Dysfunction of prefrontal cortex may negatively influence the recognition of emotions.

References

Kohler C.G., Turner T.H., Bilker W.B., Brensinger C.M., Siegel S.J., Kanes S.J., Gur R.E., Gur R.C.:Facial emotion recognition in schizophrenia: intensity effects and error pattern.Am J. Psychiatry. 2003;160:1768-74.
Sachs G., Steger-Wuchse D., Kryspin-Exner I., Gur R.C., Katschnig H. Facial recognition deficits and cognition in schizophrenia. Schizophr Res. 2004; 68:27-35.
Hofer A., Benecke C., Edlinger M., Huber R., Kemmler G., Rettenbacher M.A., Schleich G., Wolfgang Fleischhacker W. Facial emotion recognition and its relationship to symptomatic, subjective, and functional outcomes in outpatients with chronic schizophrenia. Eur Psychiatry. 2009;24:27-32.
Gur R.C., Erwin R.J., Gur R.E., Zwil A.S., Heimberg C., Kraemer H.C. Facial emotion discrimination: II. Behavioral findings in depression. Psychiatry Res. 1992;42:241-51.

P124

THE ROLE OF COMORBIDITY IN DELINEATING THE ETIOPATOMECHANISM OF DISEASE: THE CO-OCCURRENCE OF MIGRAINE WITH AURA AND RESTLESS LEG SYNDROME

Zsombok T.[1], Gonda X.[2, 3]

[1]Department of Clinical Psychology, Faculty of Medicine, Semmelweis University, Budapest, Hungary, [2]Department of Clinical and Theoretical Mental Health, Faculty of Medicine, Semmelweis University, Budapest, Hungary, [3]Department of Pharmacology and Pharmacotherapy, Faculty of Medicine, Semmelweis University, Budapest, Hungary

Annals of General Psychiatry, 2010;9(supplement 1):S207

The etiology and patomachanism of migraine is not yet fully understood. This may be related to the fact that the eitopathology of disorders comorbid with migraine (depression, restless leg syndrome) is also not fully known. The common well-known syndromes of migraine attack include nausea, vomiting, drowsiness, and its comorbidity with restless leg syndrome (RLS) and related neurogenetic and neurochemical research in the past years led to the proposal of the pathogenetic role of the dopaminergic system in the development of migraine. RLS affects about 10-15% of USA population and shows a 17% comorbidity with migraine. RLS is a sensomotor disorder showing a circadian pattern which worsens in a quiet awake state (especially around falling asleep). Often a permanent sleep-wake disorder develops with mental and affective disturbances. The origin of RLS is idiopathic in 30-40% of cases but it can also be familiar. In the background of secunder RLS there is often iron deficiency periferal neuropahty, uraemia, rheumatoid arthiritis, diabetes, etc is present. Pregnancy and hormonal symptoms may also enhance the symptoms. The treatment is complex: pharmacological and non-pharmacological therapy. We would like to present the case of a 57 year old woman who suffers from migraine with visual aura since her young adulthood and from restless leg syndrome since the age of 48, together with relevant literature data. She sought medical and psychological help for her sleep-wake disturbances, affective symptoms and deterioriating quality of life present in the last few years.

P125

EVALUATING THE EFFECT OF CANNABIS SATIVA SEED EXTRACTION ON MEMORY

Alireza Moghaddas Yazdi [2], Kafaee Razavi M.[1]

[1]Department of Biology, Azad University of Mashad, Mashhad, Iran, [2]Department of Statitics, Azad University of Mashad, Mashhad, Iran

Annals of General Psychiatry, 2010;9(supplement 1):S208

Background: Δ9-THC is Psychotropic component of Cannabis sativa plant, studies show this matter can bind Cannabinoid receptor in CA1 area of Hippocamp.Thus the aim of this study is evaluation the effect of aqua extraction Cannabis sativa seed on spatial memory consolidation in Rats
Materials and methods: Cannabis sativa seed was extracted with Soxhlet apparatus. To test spatial memory, Morris water mazemaze (7 days,4 trails) was used. experimental groups with 25 mg.kg-1,50mg.kg-1 ,150mg.kg -1 were injected in the peritoneal (IP) and after one hour of injection spatial memory was scaled.
Results: The result show that experimental groups (50mg.kg-1,100mg.kg-1,150mg.kg -1 doses), for learning time have significant level deduction in the comparison of control group ($p<0.05$).
Conclusions: we demonstrate Cannabis sativa seed in Low doses cause to Spatial memory improvement but in high dose has not significant level in comparison with control group.
Acknowledgements: We thans Azad university for supports

References
Belen G.Ramirez,Cristina Blazquez,Teresa Gomez del Pulgar,Manuel Guzman,Maria L.de Ceballos,2005.

Prevention of Alzheimer's disease pathology by Cannabinoid:Neuroprtection mediated by blockade of Microglial activation. j.neuroscience.25(8):1904-1913.
Bernard Le Foll ,Steven R . Goldberg, 2004. Cannabinoid CB1 receptor antagonist as Promising new Medication for drug Depence. j.pharmacology.312:875-883.
Castellano C., Rossi-Arnaud C., Cestari V., Costanzi M, 2003. Cannabinoids and memory Animal studies.bentham Science Publishers, 389-402
Hill MN, Gorzalka BB, 2009.Impairment in Endocannabinoid signaling and depressive illness. jama.301(11):1165-11676

P126

ELECTROPHYSIOLOGICAL CHANGES DURING EMDR TREATMENT IN PATEINTS WITH COMBAT-RELATED PTSD

Grbesa G., Simonovic M., Jankovic D.

Clinic for Mental Health, Clinical Centre, Nis, Serbia

Annals of General Psychiatry, 2010;9(supplement 1):S209

Background: Efficiency of the EMDR procedure is based on a presumption of neuropsychological changes in therapeutic process.The aim of the investigation is to scann and give evidence of electroactivity changes, during the process of EMDR procedure and after finishing it.
Materials and methods: We have recorded a continual polygraph EEG, before, during and after EMDR therapy, in patient with combat-related PTSD.
Results: Before the treatment, EEG recorded basic activity of low voltage (attenuation) of 20 μV, frequency of beta range (17-26 Hz), bioccipital, with no pathologic activity. Patient had prominent vegetative symptoms (anxiety,heart rate 100/min). Background activity immediately after the treatment records the amplitude values of around 50 μV, frequency of around 11-12 Hz. After the end of the treatment background activity possesses the amplitude value of about 37 μV, holding the persistence in frequency.
Conclusions: If the EMDR treatment is successful, sudden increase of amplityde activity is noted imensly. This sharp border line, which signifies normal activity, appears in 2-3 seconds affter the desensitize phase. The investigation suggest that from neurophysiological point of view, cortex (in EMDR procedure), works according to the principle "all or nothing". If there is processing of traumatic memory, the activity gets completly normal. If the therapy is not successful, there are numerous artefacts, because of increased muscle activity. This kind of activity, in our investigation is marked as "Artefact therapy". The results, indicate maintaining low level of amplitude values of electrocortical activities during the treatment, as well as increase after successful treatment. The increase of amlitude is corelated to decrease of anxiety after the successful treatment.
Acknowledgements: The results, indicate maintaining low level of amplitude values of electrocortical activities during the treatment, as well as increase after successful treatment. The increase of amlitude is corelated to decrease of anxiety after the successful treatment.

References

EEG Asymmetry and its Clinical Correlates in PTSD, Steven Silverstein, Stewart Shankman, Lea Williams, Patrick Hopkinson, Richard Bryant,

P127

PANDA QUESTIONNAIRE IN THE GREEK POPULATION: PRELIMINARY DATA

Theotoka I., Vagenas V., Kouremenos E., Kapaki E., Maltezou M., Liappas I.

Athens University Medical School, Department of Psychiatry and Neurology, Eginition Hospital, Department of Neurology 1st IKA Hospital of Athens, Department of Neurology, 251 GNA of Athens

Annals of General Psychiatry, 2010;9(supplement 1):S210

Background: The aim of this work is to validate in greek population the PANDA Questionnaire for the assessment of mild cognitive deficits and dementia in patients with Parkinson's disease.
Materials and methods: The study included two groups. The first consisted of 20 patients with Parkinson's disease, who were outpatients in the Movement Disorder Clinic and the Memory Clinic of the Neurological Clinic of two public health general hospitals and a university hospital. The second consisted of 20 healthy controls. The two groups were matched for age and education. Patients with Parkinson's disease were evaluated by an experienced clinical neuropsychologist with Mini Mental State Examination, Clock Test, Instrumental Activities of Daily Living. Healthy controls were evaluated only with Mini Mental State Examination, in order to ensure normal cognitive status. In the two groups, PANDA Questionnaire was also administered.
Results: PD patients performed statistically significantly worse than controls in all PANDA subtests, except the first subtest of immediate recall, where the two groups did not differ. PANDA is very well correlated with all neuropsychological tests. Healthy controls were intact cognitively with all instruments.
Conclusions: Greek version of PANDA can be an effective tool. PANDA has a good correlation with all tests used in this study and differentiates well PD patients from controls. Small sample size is a limitation of the study. In order to complete the validation study, we need a bigger sample.

P128

MAINTENANCE OF BLOOD GLUCOSE LEVEL UNDER INTENSIVE MENTAL ACTIVITIES: EPISODIC MODERATE DRINKERS VERSUS NON-DRINKERS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S211

Background: The benefits of alcohol, especially to the functioning of the hearth and circulatory system have always been recognized by many researchers world-wide (1). But besides, these positive effects, alcohol use, even in moderate amounts can be detrimental under certain conditions. Several studies have recognized the hypoglycemic effect of alcohol use in excessive doses. Centuries ago, Krebs and fellows admitted that acute alcohol intake in excessive doses results in hypoglycemia (2, 3). However, little is still known about the aftereffects of alcohol at low doses, even after a week's interval of moderate drinking.
Aim: We examine the efficiency of glucose homeostasis control of non-drinkers and episodic moderate drinkers, after approximately one week interval of moderate drinking and under intensive mental activities.
Materials and methods: The Ethics Committee approved the study protocol and informed consents were obtained from the volunteers after the aims and objectives of the study had been explained. The study took 6-hours (on fasting), involving male students (5 non-drinkers and 8 episodic moderate drinkers that have abstained from alcohol drinks of any composition for at least the last seven days before the study). Blood glucose concentration (BGC) was measured at 2 hours interval, including initial BGC. Various questionnaires - AUDIT, texts and questions, neuropsychological questionnaires, tests on visual, auditory, operative short-term memory and attention (using Anfimov geometric tables) were used as a measure. The Pearson and Student's t-tests were employed for statistical analysis of

results. The probability value for significance was set at p<0.05.
Results: Significant decrease in the effectiveness of active attention and a faster development of fatigue after 4-6 hours of mental activities in episodic moderate drinkers, compared to non-drinkers was statistically proven. Disorders in episodic moderate drinkers are retained within a period of 7-10 days after moderate alcohol use. The non-drinkers had increasing BGC in relation to their initial level in all phases of the experiment (ð<0.001). Increase in BGC of alcohol users was observed only within the first 2 hours (p<0.05). Thereafter, a significant fall in BGC was observed in the 4-6 hrs of the experiment in relation to the BGC of anon-drinkers and its level after 2 hours. Episodic moderate drinkers had 26 times higher errors on various tests than the abstainers (p<0.001). The errors made on various tests increased with decrease in BGC (r= -0.83; p<0.01).
Conclusions: This is the first study involving male volunteers to show that alcohol use, even episodic (1-2 times/month) in small doses (23±8 ml/person/session), after 7-10 days of alcohol intake, is accompanied by long-term glucose homeostasis disorders, leading to cognitive function disturbances and a decrease in the effectiveness of mental activities. Significant decrease in BGC in episodic moderate drinkers was detected in a condition of intensive mental activities and was apparent only after 4-6 hours decrease in BGC. Non-drinkers had an increase in blood glucose concentration under the same condition. Disorders in glucose homeostasis control might be the basis of cognitive function disorders in drinkers.

References

L.G.C .Catherine: Global status report on alcohol. Geneva. WHO, 2004: 1-200.
C.R. Goodlett, K.H. Horn: Mechanism of Alcohol Induced Damage to the Developing Nervous System. Alcohol Res Health 2001, 25 (3):175-184.
B.E. De Galan, B.J.W. Schouwenberg, C.J. Tack, P. Smits: Pathophysiology and management of recurrent hypoglycaemia and hypoglycaemia unawareness in diabetes. Neth J. Med 2006, 64 (8):269-279.

P129

ALCOHOL USE DISORDERS: A TRANS-CULTURAL STUDY AMONG THE SLAVIC AND ARABIAN UNDERGRADUATES IN BELARUS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S212

Background: The pattern of alcohol use might vary among people of different cultural backgrounds. Differences in alcohol use and related problems among undergraduates of various ethnic groups - Slavs, Arabians in Minsk, Belarus were analyzed.
Materials and methods: In a randomized anonymous study, we analyzed the results of 1345 Slavic, 120 Arabian undergraduates in Minsk, Belarus. All respondents were administered questionnaire containing the AUDIT, including other alcohol-related questions. The AUDIT cut-off point was set at 8.
Results: Overall, 91.1% Slavic, 63.3% Arabian undergraduates were alcohol users. A total of 16.3% Slavic, 32.5% Arabian problem drinkers were identified. Generally, beer was the most preferred alcoholic beverage among the undergraduates of both the Slavic and Arabian population.
Conclusions: Differences in the pattern of alcohol use and related problems exist among various ethnicities - Slavs and Arabs in Belarus. The Slavs had higher percentages of alcohol users, but relatively lower proportion of problem drinkers, compared to the results of the Arabs. Higher AUDIT scores were recorded for the Arabs. No significant differences were noted in the preference for alcoholic beverages among all ethnicities.

P130

ALCOHOL: USE AND RELATED PROBLEMS - PREVALENCE AMONG FOREIGNERS AND THE NATIVES IN BELARUS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian state medical university, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S213

Background: Alcohol use is a major public health problem. The problem of alcohol use might defer among the natives and foreigners in a given cultural milieu. Aim: To screen for the prevalence of alcohol use and related problems among the native Belarusians and foreigners in the general students population in Belarus.
Materials and methods: A total of 1517 respondents (172 foreigners and 1345 native Belarusians) from all major cities in Belarus enrolled for the survey. Standardized AUDIT, CAGE and MAST questionnaire including other alcohol-related questions were used as a measure. All three questionnaires were administered since it has been suggested that the CAGE might show less sensitivity, compared to the results of the MAST and AUDIT in some population (1, 2). The Student's t and Pearson, x2 tests were employed for analysis of results.
Results: Overall, 90% native Belarusians and 62% foreigners were alcohol users. Problem drinkers were 16% native Belarusians and 30% foreigners. A significant increase (in approximately 2 times) in the rate of alcohol use after a 2-4 years stay in Belarus was noted among the foreigners ($p<0.05$).
Conclusions: There is a significant difference in the pattern of alcohol use among the foreigners and native Belarusians. The rate of alcohol use and related problems is higher among foreigners, compared to the native Belarusians.

References

M.O. Welcome, Y.E. Razvodovsky, E.A. Dotsenko, V.A. Pereverzev: Prevalence of alcohol-linked problems among Nigerian students in Minsk, Belarus and their academic performance. Pîrt Harcourt Med J 2008, 3 (2): 120-129.
Catherine L.G.C.: Global status report on alcohol. Geneva. WHO; 2004.

P131

ALCOHOL-RELATED GLUCOSE-DEPENDENT FUNCTIONAL SYSTEM OF ERROR PROCESSING

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian state medical university, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S214

Background: Ridderinkhof and colleagues in 2002 (Science 2002; 298: 2209-2211) reported that moderate "acute" alcohol intake reduces the amplitude of the 'error-related negativity, a negative deflection in the electroencephalogram associated with error commission in speeded response time tasks. Their work is however, subject to a great deal of criticism. To consider arrow flank tasks responses generally, as cognitive functions as a whole is practically non-informative and to say that blood alcohol concentration of 1.0 per mile is a moderate alcohol dose, when legally it is already intoxication is not correct. Ridderinkhof and colleagues were rather careful in analyzing their results. Their study own our respect since it showed that error commission is related to the functions of the monitoring response system in the mediofrontal brain. The mechanisms for Ridderinkhof's and colleagues' work was defined by Holroyd et al (Trends in Neurosci 2003; 26 (8): 402 -404).
Materials and methods: Ridderinkhof et al/ Holroyd et al models, as well as the Peters et al. of blood-brain glucose metabolism were considered. Our data were critically analyzed: Wherefore, we have demonstrated that even episodic moderate intake of alcohol in insignificant doses (23ml of absolute ethanol) after a significant period of time (average of 8 days) leads to increase in error commission

under intensive mental activities, using a more complex and standard tests/tasks (Anfimov geometric tables - for active attention and visual productivity coefficient analyses; ten series of two-digit figures - for visual memory analysis; one-digit figure and letter on increasing row from 3-10 or any vowel letter - for auditory memory analysis and simple mathematical deduction - for operative memory analysis) as a measure of cognitive functions.
Results: The percentage of error committed was dependent on the blood glucose concentration. To explain the results of our study, we proposed a model - "alcohol related glucose-dependent functional system of error processing", in which not only the Ridderinkhof et al model is incorporated, but also the fishbone model of blood-brain glucose metabolism (Peters et al. Neurosci & Biobehav Rev 28; 2004: 143-180), and in which leptin and insulin - are the main regulators. Neuronal functions depend on the blood-brain glucose proportionality i.e. selective firing mechanisms of nervous impulses is dependent on the blood-brain glucose level. Lowering of the blood glucose level (e.g. inadequate energy reserve) leads to loss of impulses. The response-monitoring system in the basal ganglia is then activated.
Conclusions: The error processing capacity of these processes depends on the mesencephalic dopamine system, anterior cingulate cortex activities, and the blood-brain glucose level. The major concepts of the "alcohol-related glucose dependent functional system of error processing" unravel basic knowledge about the effect of drugs and other psychotic substances on the nervous system functions.

P132

THE EFFECT OF ALCOHOL USE ON ACADEMIC PERFORMANCE OF UNIVERSITY STUDENTS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S215

Background: Alcohol use by students is a major public health problem, leading to the Secondhand Effects - decrease in academic performance, injuries, blackouts, alcohol dependence etc.
Aim: To determine the extent of alcohol use on academic performance of university students.
Materials and methods: Students (n=46, mean age - 21 yrs) from three major universities (Belarusian State Medical University, Belarusian State Agro-Technical University and Belarusian State National Technical University) in Minsk, Belarus agreed to participate in the randomized anonymous study. All participants received questionnaire containing the AUDIT, MAST, CAGE and other alcohol related questions. Examination scores of each participant were filled into the questionnaire on "Academic Performance" from their examination booklets and were controlled by our researcher, Dr. MO Welcome. Academic performances (the Grade Point Average and the effectiveness to sit for examinations) of all participants from the 1st to 6th semesters of university education were used as objective criteria for problems related with alcohol use. The Pearson x2 and Student's t-tests were employed for analysis of results. The probability value for significance was set at $p<0.05$.
Results: Alcohol and non-alcohol users were 41.3% and 58.7% respectively. Among alcohol users, the average quantity of alcohol used by one person per month was 37ml of absolute ethanol. A 10.9 - 11.4% higher rate of academic performance was noted among the non-alcohol users only in the 3rd, 4th and 5th, 6th semesters. The cases of injuries and blackouts were higher among the alcohol users by approximately 35 times.
Conclusions: This study shows that alcohol use even in moderate doses leads to decrease in academic performance. The absence of any difference in academic performance among the non-alcohol and alcohol users on the 1st and 2nd semesters was probably conditioned by the large number of students (75% of all alcohol users) who reported alcohol use only in the university. This is because there is a time factor for alcohol effects to be manifested: dose-time response effect of alcohol use - negative effect of alcohol use on intellectual activities of students, using academic performance as a criterion, increases with increase in time and dose of alcoholic drinks.

P133

THE FIRST-LINE CAUSES OF ALCOHOL-RELATED PROBLEMS: A CASE STUDY AMONG UNIVERSITY STUDENTS IN BELARUS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian state medical university, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S216

Background: It has been reported that the causes of alcoholism are bio-socio-psycho-faceted. The present of psychological dysfunctions which are subsequently followed by alcohol-use can result in alcoholism (second line causes of alcohol-related problems) (1, 2). But many studies have failed to recognize the fact that psycho-behavioral patterns of people (without any psychological dysfunctions) can lead to alcohol use and maybe subsequently, alcohol related problems. Stacy and coauthors have noted that cognitive motivations of a person might be necessary for many behavioral patterns (drug or alcohol use etc). The expected consequences and perception determine whether the individual starts to use alcohol or not, regularly or misuse it, consequently leading to alcohol problems or not. Expectations and motives are the proximal factors in alcohol use (2-4). Many theories have been used to explain the pattern of alcohol use in the society. The self-effectiveness and motivational theories have been widely used to explain why people use alcohol. Alcohol users are mostly affected by the motives they prefer. For example, social factors are mostly associated with alcohol misuse. Alcohol use to reduce stress is associated with solitary drinking (3-5). As in many other countries, alcohol use is a major public health problem in Belarus. The aim of this survey was to unravel the psycho-behavioral patterns of young people towards alcohol-use and to identify the major first-line causes of alcohol related problems among young adults in Belarus.
Materials and methods: Minsk is the capital city of Belarus with the highest population of young adults (ages 19-25) from every part of the country. A total 1599 respondents (average age 20.5 years) were administered WHO recommended questionnaire (AUDIT) (5, 6), including other standardized questions. To determine the possible psycho-behavioral patterns necessary for the causes of alcohol-related problems, all respondents were divided into two major groups- the problem and non-problem groups. Some psycho-behavioral factors - celebrations, stress at home, days of wages, tradition, sweet properties of wine, to get drunk, use of alcohol to reduce bad mood were considered as potential factors related to alcohol problems. The probability value for significance was set at $p<0.05$. Statistical calculations were performed using SPSS 16.0 version of Windows and the criteria of Pearson and Student's t-test.
Results: All in all, 87.5% alcohol users, 17.7% problem drinkers were identified. Drinking to reduce bad mood (16.4%, $p<0.000001$); on days of wages (14.9%, $p<0.00001$); for the sweet qualities of alcohol (24.8%, $p<0.05$); to get drunk (26.7%, $p<0.0001$) were reported by 87.5% alcohol users (of which 17.7% were problem drinkers) as the first-line factors of alcohol related problems.
Conclusions: According to the present study, the problem of alcohol use in the general young adult population in Belarus is high. The first-line causes of alcohol related problems were drinking to reduce bad mood, day of wages, to get drunk, for the sweet qualities of alcohol (the first-line psycho-behavioral patterns related to alcohol problems). Psychological dysfunctions which are subsequently followed by alcohol-use and may result in alcoholism (second line causes of alcohol-related problems) and the first-line psycho-behavioral patterns related to alcohol problems in this study are proximal factors in alcohol use and related problems.

References

K. Emmanuel, K. Ronald, G. Gmel, R. Engels: Why do young people drink? A review of drinking motives. Clin Psych Rev 2005, 25: 841-861.
M.R. Frone. Work Stress and Alcohol Use. Alcohol Res Health 1999, 23 (4): 284-291.
A.W. Stacy, S. Ames, S. Sussman, C.W. Dent: Implicit cognition in adolescent drug use. Psychol Addict Behav 1996, 10: 190.
A.W. Stacy: Memory activation and expectancy as prospective predictors of alcohol and marijuana use. J. Abnorm Psychol 1997, 106 (1): 61-73.

P134

HE SAFE ETHANOL DOSE: A REVIEW OF EPIDEMIOLOGICAL DATA FOR THE LAST SIX DECADES

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian state medical university, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S217

Background: Alcohol use as a risk for health enormously contributes to the burden of disease world-wide. According to experts' estimation approximately 4% of global burden of disease is associated with alcohol misuse. Alcohol is involved in about 40% of motor vehicle accidents, 47-70% of homicides, 25-37% of suicides. Although 1-2 standard drinks/per day (with 1-2 free-alcohol days) has been recommended (especially for adults) as a prophylactic measure for ischemic heart disease, there is a paucity of data concerning the dose time dependent effect of alcohol use on psycho-physiological functions. Most of the problems related with alcohol use have been largely pronounced among the young adult population. Since in most cases, the effects of alcohol use are rather than harmful, there is need to determine a long-term "relatively" safe dose of alcoholic beverages.
Materials and methods: Our data (based on the psycho-physiological functions of university students for a 4 years period of study and follow-up), as well as current epidemiological and clinical data on the dose-time response effect of alcohol use for the last six decades were examined. All alcohol doses are given in values of pure ethanol.
Results: There is necessity of normalizing, not only the daily dose of alcoholic drinks, but also the monthly total dose.
Conclusions: We therefore, formulate the concept of relatively safe per session and monthly dose of alcoholic beverages, which must not exceed 27 ml and 40 ml for males respectively and not more than 24 ml and 31 ml respectively for females.

P135

PLASMA BRAIN-DERIVED-NEUROTROPHIC FACTOR LEVELS AND COGNITIVE FUNCTION IN EUTHYMIC BIPOLAR TYPE I PATIENTS

Videira Dias V.[1,5], Brissos S.[1,2], Frey N. B.[3], Andreazza A. C.[4], Kapczinski F.[5], Figueira M. L.[1]

[1]Bipolar Disorders Research Program, Hospital Santa Maria, Faculty of Medicine, University of Lisbon, (FMUL), Portugal., [2]Centro Hospitalar Psiquiátrico de Lisboa, Lisbon, Portugal, [3]Department of Psychiatry and Behavioral Neurosciences, McMaster University, Hamilton, ON, Canada, [4]Department of Psychiatry, University of British Columbia, Vancouver, Canada, [5]Bipolar Disorders Program and Laboratory of Molecular Psychiatry, Hospital de Clinicas de Porto Alegre, Brazil and INCT Translational Medicine

Annals of General Psychiatry, 2010;9(supplement 1):S218

Background: Brain-derived neurotrophic factor (BDNF) is an important contributor to the pathophysiology of bipolar disorder (BD), and abnormalities in the BDNF-signaling system may be implicated in the cognitive decline observed in BD patients. We aimed to investigate serum BDNF levels in BD patients, and its relation with neurocognitive function.
Materials and methods: We measured serum BDNF levels using an enzyme-linked immunosorbent assay method in 65 euthymic type I BD patients and 50 healthy controls, and administered a neuropsychological test battery to assess attention and mental control, perceptual-motor skills, executive functions, verbal fluency and abstraction, visuo-spatial attention, and memory.
Results: We found no significant differences regarding serum BDNF levels in BD patients and healthy controls. We found significant positive associations between serum BDNF levels and illness duration, and manic and depressive episodes in female BD patients only. Serum BDNF levels were lower in patients medicated with antipsychotics and/or lithium, whereas patients on valproate and/or

antidepressants showed higher serum BDNF levels. Patients performed significantly worse on 11 out of 16 neurocognitive tests as compared to controls. We found a significant positive association between serum BDNF levels and a test of verbal fluency in both BD patients and controls.
Conclusions: Present results support the hypothesis that BDNF normalizes with mood stabilization and pharmacological treatment. Our findings in young and physically healthy patients, with short illness duration and few mood episodes may explain the lack of association between serum BDNF levels and neurocognitive performance, even though cognitive performance in patients was overall significantly worse as compared to healthy controls.

References

Hasler G., Drevets W.C., Gould T.D., Gottesman I.I., Manji H.K. Toward Constructing an Endophenotype Strategy for Bipolar Disorders. Biol Psychiatry 2006;60(2):93-105.
Rybakowski J.K., Borkowska A., Skibinska M., Hauser J.: Illness-specific association of val66met BDNF polymorphism with performance on Wisconsin Card Sorting Test in bipolar mood disorder. Mol Psychiatry 2006;11(2):122-4.
Cunha A.B.M., Frey B.N., Andreazza A.C., et al. Serum brain-derived neurotrophic factor is decreased in bipolar disorder during depressive and manic episodes. Neurosc Lett 2006; 398: 215-9.
Martinez-Aran A., Vieta E., Colom F., et al. Cognitive impairment in euthymic bipolar patients: implications for clinical and functional outcome. Bipolar Disord 2004; 6(3):224-32.

P136

PSYCHOSOCIAL RISKS FOR DIABETIC CONTROL OF PREADOLESCENTS AND ADOLESCENTS WITH DIABETES MELLITUS TYPE I

Stankovic M.[1], Stankovic S.[2], Grbesa G.[1], Zivic S.[2], Milosavljevic L.[1]

[1]Clinic for Mental Health Protection, University Clinical Centre, Nis, Serbia, [2]Pediatric Clinic, University Clinical Centre, Nis, Serbia

Annals of General Psychiatry, 2010;9(supplement 1):S219

Background: The aim of the research is to mark psychosocial risks for diabetic preadolescents and adolescents and healthy control between 11 and 18 years old.
Materials and methods: Examinees completed questionnaires included FACES III, EPQ, Beck Depression Inventory (BDI), SCOFF and Overall Sociodemografic Inventory. Physicians completed patients' medical history and C-GAS scale of diabetic children. Subjects were asked to identify how they perceived themselves, their affective state, eating, sleeping, sexual behavior, family cohesion and adaptability. Physicians were asked to identify level of psychological, social, and school functioning of preadolescents and adolescents. Diabetic control was determinated by measuring glycosylated hemoglobin (GHgBA1c).
Results: Results revealed that patients almost uniformly had very low scores on BDI ($p<0.001$), low social skills, and both, patients and parents were in chaotically enmeshed family systems and tend to reach more chaotically enmeshed scores on ideal parent-child relationship ($p<0.0005$). Statistically, more patients, had tendency of not using professional and peer group support. Differences are more enhanced with worst diabetic control. Extraverted adolescents had worse diabetic control, and higher scores for eating disorders ($p<0.001$).
Conclusions: Perceiving family system as only supportive surrounding, denegation of psychological disturbances, with tendency of not using professional and peer group support and extravert personal traits are significant psychosocial risks for worst diabetic control within preadolescents and adolescents populations.

P137

A MODEL THAT MIGHT BETTER EXPLAIN THE EFFECTS OF ADDICTION SUBSTANCES ON THE NERVOUS SYSTEM: THE COBBGLUM MODEL

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S220

Background: The effect of addictive substances on brain's utilizing mechanisms of glucose for neuronal functions are poorly understood. To identify novel neurobiological mechanisms of addiction (precisely on brain glucose metabolism), we developed a model that incorporates the ß-cell and the fishbone models of glucose metabolism and examined the role of various psychostimulants (alcohol, cocaine, heroine) on the functions of the model. The abbreviation "CoBBGluM model" means Convergence (incorporation of the ß-cell and the fishbone models) model of Blood-Brain Glucose Metabolism.
Materials and methods: Peer reviewed literatures from Elsevier and Pubmed from the year 1940 to August, 2009 on the effect of various doses of alcohol on the blood glucose level and cognitive functions, including associated theories and hypotheses and models of glucose metabolism were also examined.
Results: The CoBBGlum model is based on the notion that the main regulators (leptin and insulin) of blood-brain glucose metabolism work synergistically, rather than individually. Addictive substances adversely affect the blood-brain glucose transport system both by their stimulating and toxic related action on the control mechanisms of leptin and insulin (by inhibiting its action and/or up and down regulatory mechanisms). The metabolic byproducts, including adducts of alcohol, for example might acquire the properties of transmitter of electrons across mitochondrial membranes. This is the etiopathogenetic basis of most addictive-diseases-associated neurodegenerative disorders. Pathogenic effects on the main glucose regulators might occur independently and/or dependently of each other, but subsequently leading to a total equilibrium disorder of the CoBBGluM model.
Conclusions: Adequate therapies for addictive diseases (that affect the nervous system) lie on the full understanding of the CoBBGluM model, since it serves as a classical tool for explaining the role of addictive substances in the nervous system.

References

Peters A., et al: The selfish brain: competition for energy resources. Neurosci Biobehav Rev 2004, 28: 143-180.
Kieffer T.J., Habener J.F.: The adipoinsular axis: effects of leptin on pancreatic beta-cells. Am J. Physiol Endocrinol Metab 2000, 278 (1): E1-E14.

P138

GENDER SPECIFIC ANALYSIS OF ALCOHOL USE

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S221

Background: Several studies all round the world have noted specific differences in the pattern of alcohol use among male and female genders (1-3). Aim: To examine specific gender differences in alcohol use among university students in Minsk, Belarus.
Materials and methods: Over 2000 students at random in four major universities in Minsk, Belarus were explained the study objectives. Approximately 75% of students in these universities are females. Only those who agreed to participate were considered for the study. A total of 465 males (mean age - 21yrs) and 1030 females (mean age - 20.5yrs) were administered anonymous AUDIT questionnaire and other alcohol related questions. Data analysis: statistical calculations were performed using SPSS (Statistical Package for the Social Sciences) 16.0 version for Windows; the criteria of Pearson (x2) and

Student's t-test. The value for significance was as $p<0.05$.
Results: Alcohol users were 85.7% males and 88.5% females. Problem drinkers were 33.7% males and 10.1% females. Approximately the same percentages of both males and females use only beer as alcoholic drinks. Significant percentage of males (16.8%) use spirits, wine and beer in their combination, compared to only 5.1% females. Bad mood as a deciding factor for alcohol use was reported by a higher percentage of males (8.1%), compared to the females - 1.9%. Alcohol use for celebrations was higher among the females than in the male population: a female to male ratio of 1.4.
Conclusions: This study reveals that the prevalence of alcohol problems is significantly higher among the males, compared to the females in the general Belarusian students' population, although no significant differences in the percentages of alcohol users among both genders exist. Differences in the preference for different alcoholic drinks and the causes for alcohol use were noted among the males and females.

References
Kauffman S.E., Silver P., Poulin J.: Gender differences in attitudes toward alcohol, tobacco, and other drugs. Soc Work 1997, 42 (3): 231-41.
O'Hare T., Tran T.V.: Predicting problem drinking in college students: Gender differences and the CAGE questionnaire. Addict Behav 1997, 22 (1): 13-21.
Wallace J.M. Jr, Bachman J.G., O'Malley P.M., Schlenberg J.E., Cooper S.M., Johnston L.D.: Gender and ethnic differences in smoking, drinking and illicit drug use among American 8th, 10th and 12th grade students, 1976-2000. Addiction 2003, 98 (2): 225-34.

P139

INTERCONFESSIONAL ANALYSIS OF USE AND RELATED PROBLEMS: THE CHRISTIANS AND MUSLIMS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S222

Background: The confession to which a person has been committed to will likely influence his/her attitude towards alcohol use. Many studies have suggested that the problem of alcohol use between people of different confession, although might differ, the gap is narrowing (1-2). We therefore examine the differences in the pattern of alcohol use among people of different confessions - the Christians and Muslims in Minsk, Belarus.
Materials and methods: The study was randomized and anonymous. Altogether, 214 (107 Christians and 107 Muslims) people were explained the study aims and objectives. A total 65 Christians and 70 Muslims agreed to participate in the study. All respondents were administered the AUDIT, CAGE and MAST questionnaire. Statistical analysis was performed using SPSS 16.0 version for Windows and the Pearson x2.
Results: The present study revealed that no differences in both the number of alcohol users and problem drinkers exist (according to the results of all three screening instruments) among the Christians and Muslims. Alcohol users were 67.69% (n=44) Christians and 57.14% (n=40) Muslims. Problem drinkers were 27.69 (n=18) Christians and Muslims - 34.29% (24).
Conclusions: This study is an exceptional case, where for both Christians and Muslims, the percentages (as well as the average scores in the various screening instruments) of alcohol users and problem drinkers were the same on the AUDIT, CAGE and MAST. According to the result of this study, no difference in the pattern of alcohol use exist among people of different confession in Minsk, Belarus

References
Heath D.B., ed: International Handbook on Alcohol and Culture. Westport, C.T.: Greenwood Press. 1995.
Bloomfield K., et al: Gender, Culture and Alcohol Problems: A Multi-national Study. Project Final Report. Berlin: Institute for Medical Informatics, Biometrics & Epidemiology, Charité Universitätsmedizin Berlin. 2005.

P140

PARKINSON DISEASE AND NEUROLEPTIC WITHDRAWAL

Jambunathan St., Gil J., Ong Hui Koh, Sulaiman H.

Department of Psychological Medicine, Faculty of Medicine, University Malaya, Kuala Lumpur, Malaysia

Annals of General Psychiatry, 2010;9(supplement 1):S223

Background: Abrupt cessation of most psychiatric drugs leads to varying withdrawal symptoms. Although Clozapine withdrawal symptoms are well documented, this case presentation addresses issues pertaining to the severity of the withdrawals and the similarities to Neuroleptic Malignant Syndrome (NMS). This patient who was only on 100mg of Clozapine required ventilation in Intensive care unit. Neurologist found no causative factor but treated the patient symptomatically to recovery. Family history however revealed that both the patient's parents suffered from severe Parkinson disease. This case presentation discusses the association between NMS like symptoms and neuroleptic withdrawal syndrome in patients with a family history of Parkinson disease.
Materials and methods: Case study
Results: Patient with a strong family history of Parkinson disease are at a greater risk of developing NMS like symptoms when Clozapine is abruptly withdrawn.
Conclusions: Clozapine and other medications with strong anticholinergic properties should never be abruptly stopped. This fact should be even more important if a patient has a family history of Parkinson disease.

P141

ARIPIPRAZOLE MONOTHERAPY IN THE TREATMENT OF BIPOLAR DISORDER: A META-ANALYSIS

Fountoulakis K.N.[1], Vieta E.[2], Schmidt F.[3]

[1]3rd Department of Psychiatry, Aristotle University of Thessaloniki, Greece, [2] Bipolar Disorders Program, Hospital Clinic, University of Barcelona, IDIBAPS, CIBERSAM, Barcelona, Spain, [3]Fethke Professor, Tippie College of Business, University of Iowa, USA

Annals of General Psychiatry, 2010;9(supplement 1):S224

Background: The current article is a systematic registration and meta-analysis of the available clinical trials concerning the usefulness of aripiprazole in the treatment of bipolar disorder.
Materials and methods: A systematic MEDLINE and repositories search concerning treatment guidelines and clinical trials for aripiprazole in bipolar disorder.
Results: The pooled effect size for acute mania was equal to 0.34. The NNT was 6 for aripiprazole vs placebo concerning response at week 3 and equal to 14 concerning remission. The average day response started was day 3. The switch rates were peculiarly in favour of haloperidol and against lithium. The suicide rates were negligible for all groups. The meta-analysis for acute bipolar depression suggests a significant difference at week 8 with an effect size 0.17. The maintenance data suggest that the median survival time for the aripiprazole group was not evaluable, while the median survival time for placebo was 118-203 days depending on the clinical subpopulation.
Conclusions: The data analysed for the current study support the usefulness of aripiprazole during all phases of bipolar illness, inpite of the rather weak effect on depression and that the efficacy during the maintenance period is proven only against new manic episodes and in patients with an index manic episode who responded to aripiprazole during the acute phase.

P142

TREATMENT OF PSYCHOTIC SYMPTOMS IN BIPOLAR DISORDER WITH ARIPIPRAZOLE MONOTHERAPY: A META-ANALYSIS

Fountoulakis K.N.[1], Gonda X.[2], Vieta E.[3], Schmidt F.[4]

[1]3rd Department of Psychiatry, Aristotle University of Thessaloniki, Greece, [2]Department of Pharmacology and Pharmacotherapy and Department of Psychiatry Kutvolgyi Klinikai Tömb, Semmelweis University, Budapest, Hungary, [3]Bipolar Disorders Program, Hospital Clinic, University of Barcelona, IDIBAPS, CIBERSAM, Barcelona, Spain, [4]Fethke Professor, Tippie College of Business, University of Iowa, USA

Annals of General Psychiatry, 2010;9(supplement 1):S225

Background: The current article is a systematic registration and meta-analysis of the available clinical trials concerning the usefulness of aripiprazole in the treatment of the psychotic symptoms in bipolar disorder.
Materials and methods: A systematic MEDLINE and repositories search concerning clinical trials for aripiprazole in bipolar disorder.
Results: The meta-analysis of 4 RCTs on acute mania suggests that the effect size of aripiprazole vs. placebo was equal to 0.14 but a more reliable and accurate estimation is 0.18 for the total PANSS score. The effect was higher for the PANSS positive subscale (0.28), PANSS hostility subscale (0.24) and PANSS cognitive subscale (0.20), and lower for the PANSS negative (0.12). No data on the depressive phase of bipolar illness exist, while there are some data in favour of aripiprazole concerning the maintenance phase, where at week 26 all except the total PANSS score showed a significant superiority of aripiprazole over placebo (d=0.28 for positive, d=0.38 for the cognitive and d=0.71 for the hostility subscales) and at week 100 the results were similar (d=0.42, 0.63 and 0.48 respectively).
Conclusions: The data analysed for the current study support the usefulness of aripiprazole against psychotic symptoms during the acute manic and maintenance phases of bipolar illness.

P143

DISRUPTION OF BIOLOGICAL RHYTHMS AS A CORE PROBLEM AND THERAPEUTIC TARGET IN MOOD DISORDERS: THE EMERGING CONCEPT OF "RHYTHM-REGULATORS"

Fountoulakis K.N.

3rd Department of Psychiatry, Aristotle University of Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S226

Biological rhythms was always considered to be disrupted in depression with the predominant theory being that of hyperarousal. However, recent data suggest that it might be more appropriate to suggest that depressed patients are incapable of achieving and maintaining that particular level of internal homeostasis which permits the organism to function smoothly, to lower enough the level of arousal during sleep, so that quality of sleep is good, and to increase this level enough during the day so as the person can function properly. Therefore the transition from one state to another is somewhat problematic, delayed, incomplete and de-synchronized. Thus agents with a 'rhythm stabilizing' effect could be beneficial in the treatment of mood disorders. Such an agent should have a beneficial effect on restoring and stabilizing the rhythm of a physiological function and not pushing it towards a specific pole, or inducing the opposite pole; it should also allow response to both internal and environmental stimuli and zeitgebers and restore synchronization of the various body rhythms and not inducing or worsening dysynchonization. Agomelatine could represent the first of a new class that is 'rhythm stabilizing antidepressant' but further research is necessary to support this.

P144

A STUDY OF COMBINED DRUG TREATMENT AND PREVENTION OF DELIRIUM TREMENS

Vainas Ch., Theofanidis P., Kakoulidis Ch., Skartsila G., Karatasiou-Ntokatzi E., Siotis Ch.

"Agia Aikaterini" Private Psychiatric Clinic, Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S227

Background: The preventive treatment of emergency situations and complications caused by chronic alcoholism presents psychiatrists and physicians with a great challenge. Delirium tremens is a potentially fatal form of alcohol withdrawal (mortality rate 5%-15%) that usually occurs in patients with heavy and chronic alcohol abuse.
Materials and methods: Our research took place in a private psychiatric clinic (2005-2009) and focused on the effectiveness of a certain pharmacological combination administered to a sample of 37 patients, in an attempt to control the alcohol withdrawal syndrome. The pharmacological combination comprised 30mg-60mg Chlordiazepoxide hydrochloride, 300mg-500mg Triapride hydrochloride, 300mg-500mg Hydroxyzine hydrochloride, 576mg Clometiazol, 600mg-1200mg Oxcarbazepine and B1+B2+B12 complex daily. Additionally, the patients received antidepressants and cardiovascular drugs.
Results: None of our sample patients developed any delirium tremens symptoms. The average duration of the drug combination administration was 11 days followed by a gradually decreasing dose until the maintenance dosage was reached.
Conclusions: When compared to other suggested drug treatments this method proved to be highly effective in delirium tremens prevention

P145

TESTING THE PYRAMIDAL HYPOTHESIS OF ALCOHOL USE DISTRIBUTION AMONG THE NIGERIANS, ARABS AND SLAVS IN BELARUS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S228

Background: According to the Ledermann Sully (1956) pyramidal hypothesis of alcohol use distribution, the increase in social drinkers in a given society leads to a disproportional increase in percentages of heavy users. In the same way, decrease in the number of social drinkers will have the greatest effect on heavy drinkers. In most western countries, where there are high percentages of heavy drinkers, the pyramid is broad. In Asian countries where there are fewer heavy drinkers the pyramid is a narrow one. The distribution of social drinkers compared to the heavy drinkers might differ among various ethnic groups even within a given country. We therefore, test the Ledermann hypothesis of alcohol use distribution among the Nigerians, Arabians and Slavs in Minsk, Belarus.
Materials and methods: The study was randomized and anonymous. Minsk was selected for the study since it inhabits over 22% (people from different parts of the country who have come to live in this city) of the country's total population. More so, it is the only city with highest number of foreigners (majority which are Nigerians, Arabs). Out of 56 Nigerians, 187 Arabs and 1988 Slavs that were explained the study aims and objectives, a total of 44 Nigerians, 120 Arabs and 1345 Slavs agreed to participate in the study. All respondents were administered questionnaire containing the AUDIT and other alcohol related questions. On the AUDIT, a score of 1-7 defines social alcohol use; 8-19 - heavy alcohol use; 20-40 - alcohol dependence.
Results: Social drinkers, heavy drinkers and people with alcohol dependence in the general Belarusian population were: Slavs - 74.8%, 13.8%, 2.5% respectively; Arabs - 29.2%, 20.8%, 10.8% respectively; Nigerians - 30.8%, 11.5%, 3.8% respectively.
Conclusions: According to the Ledermann hypothesis, this study shows that, in Belarus, the pattern of alcohol use by Arabs could be denoted with a narrow pyramid (pattern of alcohol use in most Asian

countries) and a broad pyramid (pattern of alcohol use in most western countries) for both Slavs and Nigerians.

P146

FROM JUNIORS TO SENIORS: PATTERN OF RISE OF ALCOHOL PROBLEMS AMONG UNIVERSITY STUDENTS IN BELARUS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S229

Background: The paucity of data concerning the problem of alcohol use among young adults (especially the students' population) in Belarus has contributed partly to the increase in the prevalence of alcohol use and related problems, as no intervention program is carried out. The cases of alcoholic liver cirrhosis, psychoses have been shown to increase in middle adulthood, and this is a major problem to public health. A screening that will address the rate of rise of alcohol use and related problems in relation to both the age and year of study in the university will be of great importance. Besides, the students' population is easily accessible, and since every data suggest that screening for the prevalence of alcohol use in the student's population, and subsequent intervention is of great benefit to public health (1-3), we therefore, screen for the prevalence of alcohol use and related problems in the general Belarusian students' population and trace the rate of rise of alcohol use and related problems in course of study in major universities in Minsk, Belarus.
Materials and methods: A total of 565 (first-second year, mean age - 18.9yrs), 537 (third-fourth year, mean age - 20.9yrs) and 397 (fifth-sixth year, mean age - 22.8 yrs) university students in Minsk, Belarus were administered the AUDIT questionnaire, including other alcohol related questions. The cut-off point on the AUDIT was set at 8. All statistical analyses were performed using SPSS 16.0 version for Windows; the criteria of Pearson, x2 and Student's t tests. The probability value for significance was set at $p<0.05$.
Results: Alcohol users in the first-second, third-fourth, fifth-sixth years of study were 83.6%, 85.6%, 94.2% respectively; the problem drinkers were 14.5%, 17.9%, 20.9% respectively. The use of strong strength alcoholic beverages was linked with a high risk of alcohol related problems, than the use of weak alcoholic beverages in the general students' population.
Conclusions: Statistically significant increase in alcohol use was noted only between students of first-second and fifth-sixth years of study ($p<0.05$). There was a gradual rise in the percentage of problem drinkers in relation to the increase in the year of study ($p<0.05$). The level of alcohol use and related problems in the general students' population in Belarus are high and show increase in order of increase both in the average age and in the year of study.

References

K. Kypri, J.B. Saunders, S.J. Gallagher: Acceptability of various brief intervention approaches for hazardous drinking among university students. Alcohol Alcohol 2003, 38 (6): 626-628.
M.B. do Amaral, L.l.M. Lourenco, T.M. Ronzani: Beliefs about alcohol use among university students. J. Subst Abuse Treat 2006, 31(2): 181-185.
S. O'Brien, H. Sinclair, S. Soni, T. O'Dowd, D. Thomas: Trends in alcohol consumption in undergraduate third level students: 1992-1999. Irish J. Med Sci 1999, 170 (4): 224-227.

P147

THE ALTRUISTIC HOMICIDES OF JEAN-CLAUDE ROMAND: AN AUTOPSY OF FAMILY SECRETES

Paraskevoulakou A.[1], Antonopoulou V.[2]

[1]Department of Psychology, University of Paris VIII, Paris, France, [2]Hospital of Paidon Agia Sophia, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S230

Background: The case of Romand concerns a man who pretended to be a medical doctor and killed his family while the fake identity he had cautiously impersonated for 18 years was about to be exposed. The purpose of this study is to determine the motive of Romand's following criminal act. In 1993, Romand smashed his wife's skull and shot his children while asleep. Afterwards, he joined his parents for a meal and shot them both. Later that night, he attacked his ex-mistress, but strangely enough, the few words she uttered, made him apologise and release her. He finally returned to his family home, which still contained the bodies of his dead wife and children, and set it on fire.
Materials and methods: After a bibliographic review of all reliable sources relative to this clinical case, we shall focus on the subversive events preceding the criminal act and examine three key aspects of Romand's life: 1) his enigmatic relationship with women, and especially with his wife and his mistress 2) the paternal role model he was for the local community, strongly suggesting that Romand assumed the exceptional role of a sacrificial figure 3) the criminal sequence.
Results: Romand's case extraordinarily contradicts the utilitarian motive allegation.
Conclusions: Romand's criminal gesture finds its own reason only if examined through the specificity of altruistic homicides. He tragically spared his family circle the shaking encounter with an intimate stranger who chose to invent the life he most certainly could have lived. This study represents a step toward understanding altruistic homicide risk.

P148

THE NECESSITY OF A STRUCTURED FRAMEWORK FOR CONSIDERING PATHOLOGICAL LYING IN THE FORENSIC CONTEXT

Paraskevoulakou A.[1], Antonopoulou V.[2]

[1]Department of Psychology, University of Paris VIII, Paris, France, [2]Hospital of Paidon Agia Sophia, Athens, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S231

Background: Although the psychiatric literature reveals no consensus over the concept of pathological lying, it systematically reflects the significance of this concept in forensic psychiatry. A growing number of case reports underline the implications of untruths in a legal context. This study aims to define these implications.
Materials and methods: Our bibliographic review of recent case reports strongly suggests that pathological liars share an extraordinary, yet paradoxical profile: individuals beyond suspicion, prominent men with social status (Judge Couwenberg and Professor Joseph Ellis) and women incarnating the graces of motherhood (later on to be diagnosed with Munchausen by Proxy) seeming particularly genuine and convincing, often driven by their lies to a clash with the judicial system or administrative structures (such as hospitals). This review also traces the historical development of pathological lying and its place in modern-day psychiatry.
Results: Pathological liars progressively merge into an apparent delusional establishment of a fictional self overwhelming the real one, state which is commonly described as a kind of "wish psychosis" in which the mastery of one's own lies is irremediably lost. Their ulterior engagement in criminal behaviour unfailingly underlines the lack of will in the act of lying as an end in itself.
Conclusions: Modern psychiatry fails to determine to which extent pathological lying reflects impairment

in reality testing, therefore can not define pathological lying as a wilful act. Even though pathological lying doesn't reach the threshold of insanity, it should be better placed in the DSM so that a structured framework in forensic context could be established in the future.

P149

CANNABINOIDS IN THE TREATMENT OF PAIN

Kara E., Tsanakalis F., Papaioannidou P.

Department of Pharmacology, Faculty of Medicine, Aristotle University of Thessaloniki, Thessaloniki, Greece

Annals of General Psychiatry, 2010;9(supplement 1):S232

Background: Cannabinoids and the endo-cannabinoid system play an important role in the sensation of pain. As conventional analgesics are often associated with serious side-effects, cannabinoids and agonists of their receptors offer a useful alternative or coanalgesic in the treatment of pain. The aim of this work is to summarize the role of cannabinoids and their receptors in nociception and pain treatment.
Materials and methods: Two main types of receptors for cannabinoids and endo-cannabinoids are implicated in nociception: the metabotropic cannabinoid receptors (mainly CB1 and CB2) and the ionotropic transient receptor potential channels TRP, which include the vanilloid receptors TRPV1, TRPV2, TRPV4 as well as TRPM8 and TRPA1.
Results: Antinociception related to CB1 receptor activation may be due to inhibition of GABA release in the brain, suppression of glutamate release in the spinal cord or due to induction of dopamine, noradrenaline and opioid peptide release. CB2 receptors are most likely implicated in antinociception of tonic inflammatory pain. Cannabinoid activation of TRP channels can result in desensitization of the TRPA1 and TRPV1 channel activities, inhibition of nociceptors, and antihyperalgesia and antinociception in certain pain models. There is also evidence for cooperation between metabotropic cannabinoid receptors and ionotropic TRP channels in nociceptive neurons.
Conclusions: Cannabinoids seem to be effective against neuropathic pain, inflammatory pain, post-operative pain and cancer pain. Their use as analgesics or coanalgesics may offer a useful alterative option for pain management in clinical practice.

P150

BINGING: A PREVALENCE STUDY IN BELARUSIAN UNIVERSITIES

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S233

Background: The extent of binging (≥5 drinks/session) largely contributes to the burden associated with alcohol use in most countries (1-3). Binging among undergraduate students in Belarus is a major public health problem, leading to violence, injury, unsafe sexual activities, as well as conduct problems. The high level of alcohol-related problems in this country is caused by combination of factors like high level of alcohol consumption per capita and hazardous drinking patterns. High level of alcoholism in the society calls for the necessity of carrying out preventive measures aimed at early diagnosis of alcohol related problems, with subsequent consultation and therapeutic intervention (2, 4). In particular, this concerns the students' population, inasmuch as recent epidemiological data show high level of alcohol related problems among students (1-4). This study was aimed at identifying the prevalence of binging and its associated harm among undergraduate students in Minsk, Belarus.
Materials and methods: Undergraduate students in the various institutions in Minsk, Belarus were explained the objectives of the study. One thousand six-hundred and fourteen (1614) reported for the

study. Standardized AUDIT, including other questions was used as a measure.
Results: Altogether, 17% of bingers were identified. Approximately 97% higher cases of alcohol problems (injuries, alcohol dependence, and psychiatric anamneses) were associated with binging ($p < 0.05$). The major reason for binging was reported to be the sweet qualities of alcohol and drinking to get drunk ($p < 0.05$). Also, use of vodka and other spirits was significantly higher than beer and wine among bingers, compared to non-bingers.
Conclusions: The extent of binging and associated harm among undergraduate students in Minsk, Belarus is a cause for concern.

References
H. Wechsler, J.E. Lee, J. Hall, A.C. Wagenaar, H. Lee: Secondhand effects of student alcohol use reported by neighbors of colleges: the role of alcohol outlets. Soc Sci Med 2002, 55: 425-435.
E.R. Weitzman, T.F. Nelson: College student binge drinking and the "Prevention Paradox": Implications for prevention and harm reduction. J Drug Educ 2004, 34 (3): 247-266
H. Wechsler, A. Davenport, G. Dowdall, B. Moeykens, S Castillo: Health and behavioral consequences of binge drinking in college:A national survey of students at 140 campuses. J. Am Med Assoc 1994, 272 (21): 1672-1677.
K. Kypri, J.B. Saunders, S.J. Gallagher: Rapid Communication: Acceptability of various brief intervention approaches for hazardous drinking among university students. Alcohol Alcohol 2003, 38 (6): 626-628.

P151

PATHOPSYCHOPHYSIOLOGICAL MECHANISM OF LOW ACADEMIC PERFORMANCE AMONG DRINKERS

Menizibeya Welcome O., Vladimir Pereverzev A.

Department of Human Physiology, Belarusian State Medical University, Minsk, Belarus

Annals of General Psychiatry, 2010;9(supplement 1):S234

Background: How alcohol use affect academic performance of students is not fully understood. It was recently shown that alcohol use reduces academic performance of university students by 6.6-12.1% (1). But, in spite of the enormous epidemiological data regarding students' problem drinking, the fact that alcohol use leads to a decrease in academic performance remains disputable. This study considers several data that have helped us unravel this disbelief.
Materials and methods: Peer reviewed publications from Elsevier, Medline and African Index Medicus from 1930 to June 30th, 2009 on the effect of alcohol use on academic performance, cognitive functions and metabolism were critically analyzed. Our data (based on the psychophysiological functions of university students for a three years period of study and follow-up) were examined. We produced a system of academic performance: the psychophysiological concept of academic performance, where the major components - motivational and demotivational factors are located in a center of cognition and metabolic balance.
Results: Distortment of the major elements of the system of academic performance like cognition and a negative shift in metabolic balance can result in low academic performance. A metabolic shift in important substrates (like glucose) for brain functions affects the equilibrium state of this system. This is because cognitive functions are dependent on the blood-brain glucose control systems (2-4). Alcohol use can affect the metabolic equilibrium state of the system in a drinker, subsequently leading to a distortment of cognition (a central component of the system). This distortment however, can be modulated by motivational or demotivational factors. The strength of the modulating factors (genetic, metabolic counter-regulatory systems, environmental factors) determines the level of academic performance.
Conclusions: This study solves the question: If alcohol use leads to low academic performance; can't poor academic performance result in alcohol use? A full understanding of the effect of alcohol use on academic performance lies on the psycho-physiological system of academic performance.

References
M.O. Welcome, Y.E. Razvodovsky, E.A. Dotsenko, V.A. Pereverzev: Prevalence of alcohol-linked problems among Nigerian students in Minsk, Belarus and their academic performance. Pîrt Harcourt Med J 2008, 3 (2): 120-129.

A. Peters, U. Schweiger, L. Pellerin, C. Hubold, K.M. Oltmanns, M. Conrad, B. Schultes, J. Born, H. Fehm: The selfish brain: competition for energy resources. Neurosci Biobehav Rev 2004, 28: 143-180.
E de Galan, B.J.J.W. Schouwenberg, C.J. Tack, P. Smits: Pathophysiology of management of recurrent hypoglycemia and hypoglycemia unawareness. Neth J. Med 2006, 64 (8): 269-279.
H.A .Krebs, R.A. Freedland, R. Hems, M. Stubbs: Inhibition of hepatic gluconeogenesis by ethanol. Biochem J. 1969, 112: 117-124.

P152

INTRODUCTION OF THE TERM "TRAUMA" IN PSYCHIATRY

Efstratiou S.[1,2]

[1]Doctor of Democritus University of Thrace, [2]Department of Psychiatry, General Hospital of Kilkis, NHS Greece

Annals of General Psychiatry, 2010;9(supplement 1):S235

Background: In 1889 Hermann Oppenheim transposed the surgical term "trauma" into psychology and psychiatry under the term of «traumatic neuroses». Related essays like Erichsen's Bernheim's , Strümpell's, Charcot's, Janet's, Kraft - Ebing's , Moebius's, Prince's, Breuer's and Freud's succeeded in arousing widespread interest in trauma.
Materials and methods: This study reviews the psychiatric literature in nineteen century when the term "trauma" was introduced in psychiatry. For methodological reasons the papers reviewed were divided into six categories: a) referring to shock and to "shell-shock", b) connecting memory with emotions like fear or terror, c) concerning hypnoses and memory disturbances, d) reviews of the hysterical phenomena, e) papers about traumatic paralysis and multiple personalities, and f) clinical studies where traumatic cures including psychoanalysis were described.
Results: Some clinical syndromes like the railway spine, the hysterical paralysis in man and the multiple personality were identified as traumatic syndromes. However the genealogy of trauma is similar to that of hysteria. There are many pairs (suggestion-hypnosis, functional neuroses-ideation, emotions-memory, fantasy-instincts, conscious- unconscious, mnemic symbol- hysterical repetition compulsion, abreaction- fixation, etc) that identified the existence of traumatic power and established the economic model of affect-trauma.
Conclusions: In the first dynamic psychiatry, trauma considered as the psychic process when the intrapsychic balance become unstable due to an affect linked to the traumatic memory.
Acknowledgements: Tihs paper is the introduction of the author's doctora thesis:"The meaning of trauma in the beginning of psychoanalysis", Democritus University of Thrace, 2008.

References

Ellenberger H.F. (1970): The Discovery of the Unconscious. Basic Books, New York: 53-569.
Charcot J.M. (1961): Clinical Lectures on certain diseases of the nervous system. Lecture VII. On six cases of hysteria in the male subject. In Shipley T.(ed). Classics in Psychology. Philosophical Library. New York: 370-416.
Leys R. (2000): Trauma. A genealogy. The University of Chicago Press. Chicago & London: 1-119,153-189.
Stewart W. A. (1967): Psychoanalysis: the first ten years 1888-1898, The Macmillan Company, N.Y.:1-115.

POSITION STATEMENT EUROMED NETWORK ON MENTAL HEALTH AND MIGRATION

Introduction/Context

Migration is one of the most important challenges of the XXIst century. Europe in particular has seen a dramatic rise in migration over the past decade, and all indications suggest that this increase will continue well into the future.

It is becoming increasingly clear that the mental health needs of migrants require specific attention. Recent reports indicate that migrants are underrepresented in mental health care centers, are subject to more diagnostic error, more coercive measures and involuntary treatment, less psychotherapy and less second generation medication [1, 2]. The specific relationship between migration and mental health remains unclear, although a number of protective and risk factors have been identified [3] . What would appear to be clear is that there is a robust relationship between migration and schizophrenia, with odds rations varying from 2 to 8 for individuals from the European community for the former and Afrocaribbean migrants for the latter [4]. In addition, research indicates that the children of immigrants—second generation citizens—also have higher odds ratios for the development of psychotic and affective disorders .

All of this has implications for psychology and psychiatry as a whole. The field of transcultural psychiatry overtly emphasizes the biopsychosocial model: that migration overwhelmingly impacts the incidence of schizophrenia emphasizes that experience itself, and not simply biological structure or genetics is involved. Difficulties with diagnosis demand reconsideration of existing nosological systems, as reflected, for example, in the pathway towards the DSM-V and the ICD-11, and treatment issues, be they psychotherapeutic or pharmacological indicate that treatments may need to be adapted given the cultural and/or ethnic background and migratory experience of the patient [5, 6].

A clear conclusion is that the mental health needs of immigrants are not being met [7]. This can be seen at the two levels identified above and are related to both prevention and treatment. To that end the Euromed network calls for the development of both clinical and institutional cultural competence by attending to research, training, and advocacy. This human rights issue which involves considerable suffering implicates all levels of stakeholders, from individuals to their families, from clinicians to the institutions they work for, to health care systems, professional associations, and professional training programs.

Research

Most all of what we know about migration and mental health comes from research. Although considerable strides have been made in this area, it is clear that there remains much to be done. We call for more research to be facilitated and carried out in this area. It is noteworthy that the vast bulk of psychological and psychiatric research uses a "gold standard" that is not representative of more than 80% of the world's population, which means that much of what we know may be of questionable applicability to the latter, which is particularly true of clinical trials.

Indeed, the field of ethnopsychopharmacology clearly demonstrates that pharmacokinetics and pharmacodynamics are not "universal" but rather vary with the genetic makeup [6]. Thus treatment, be it pharmacological or psychological, needs to be investigated at more population specific levels in order to ensure that all patients receive an optimal quality of care.

It is essential that research is carried out on all aspects related to the improvement of care of migrants, from pharmacological intervention to psychotherapy to the participation of intercultural mediators and medical interpreters. In addition, research needs to examine institutional and administrative characteristics to determine what maximizes access and quality of care. All of this is necessary to

improve the overall cultural competence of the mental health care system.

One of the big questions facing researchers has to do with the degree to which immigration in and of itself constitutes a risk factor for common mental disorders, on the one hand, and what best explains the relationship between immigration and schizophrenia [4]. In addition to requiring further exploration, these areas of research all thematize the complexity of applying research methodology and instrumentation developed in one particular cultural, social, and political context in another. Psychometrics are clearly influenced by cultural differences, to the extent that leading experts agree that there is no such thing as a "culture free" or even "culture fair" test [8]. This means that how research is carried out needs to be rethought, with, perhaps, more emphasis given to qualitative approaches.

The area of prevention also warrants attention. Clearly, the optimal way of improving the mental health of a population is to prevent mental health problems and promote mental health. How to do this, however, demands a better understanding of the risk and protective factors related to the migratory process. Research in this area is growing and needs to be further developed and then made relevant to mental health promotion and prevention and treatment on psychopathology.

Training and education

In today's increasingly diverse world, it is arguable that culture and difference play a role in most every sort of patient contact. To that end, it is, in our opinion, an ethical requirement that all mental health professionals receive training in cultural competence. The very notion of professional competence is predicated on a combination of practical experience along with theory and research [9]. Whereas many clinicians have ample experience working with migrants, they all too often lack a scientific basis on which to frame and further develop their work.

Training should be focused on promotion of mental health, prevention of psychopathology, and diagnosis and treatment, and should be provided not only to clinicians but also to administrators, researchers, as well as all clinical staff.

We need to have a better understanding of the effectiveness of training. Many models exist; however, there exists minimal research that evaluates the clinical impact. We need to know what sorts of training initiatives have a real world impact on the sort of care imparted by trainees.

Advocacy

As things stand, it is clear that migrants are not having their best interests attended to. It is essential that those with the means to do so advocate on behalf of this more vulnerable population ranging from advocacy at the community to that of the individual level.

In a related vein, we call upon national and international associations to organize or promote sections or special interest groups related to migration and mental health/transcultural psychiatry as a means of identifying and needs and developing appropriate responses. Such special interest groups can then network in order to further share ideas, experiences, and research findings, with an eye to improving the mental health of migrants.

The Euromed Network on Migration and Mental Health

One of the central objectives of the Euromed Network on Migration and Mental Health is the development of a forum in which local and relevant research, experiences, and initiatives can be shared, compared, and contrasted with the objective of contributing to an overall improvement in the mental health of migrants.

1. Nagayama Hall GC: **Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues**. *J Consulting Clin Psychol* 2001, **69**(5):502-510.
2. Lay B, Lauber C, ouml, ssler W: **Are immigrants at a disadvantage in psychiatric in-patient care?** *Acta Psychiatrica Scandinavica* 2005, **111**:358-366.
3. Bhugra D: **Migration and mental health**. *Acta Psychiatrica Scandinavica* 2004, **109**(4):243-258.
4. Cantor-Graae E, Selten JP: **Schizophrenia and migration: A metal-analysis and review**. *Am J Psychiatry* 2005, **162**(1):12-24.
5. Sue S: **In defense of cultural competency in psychotherapy and treaetment**. *Am Psychol* 2003, **58**(11):964-970.
6. Ruiz P: **Ethnicity and Psychopharmacology**. In *Ethnicity and Psychopharmacology. Volume 19*. Edited by Ruiz P. Washington, DC: American Psychiatric Press; 2000:91-113.
7. Department of Health: **Inside outside: improving mental health services for black and minority ethnic communities in England**. London: Department of Health; 2003.
8. van de Vijver F, Tanzer NK: **Bias and equivalence in cross-cultural assessment**. *Rev Eur Psychol Appl* 2004, **54**:119-135.
9. Qureshi A, Collazos F, Ramos M, Casas M: **Cultural competency training in psychiatry**. *Eur Psychiatry* 2008, **23 Suppl 1**:49-58.

MEDOCHEMIE
HELLAS A.E.
Ποιότητα στην υπηρεσία της **υγείας**

Στα εργαστήριά μας παράγονται
τα εξής φαρμακευτικά ιδιοσκευάσματα:

Προϊόντα σε κυκλοφορία:

Κ.Ν.Σ.

- **ADOVIA** *(Risperidone 1, 2, 3, 4, 6mg)*
- **VELPINE XR** *(Venlafaxine 37.5, 75, 150mg)*
- **TABERIL** *(Paroxetine 20mg)*
- **PAROXIA** *(Paroxetine 20, 30, 40mg)*
- **DAGRILAN** *(Fluoxetine 20mg)*
- **LAMOTRIX** *(Lamotrigine 50, 100, 150, 200mg)*

ΚΑΡΔΙΑΓΓΕΙΑΚΟ ΣΥΣΤΗΜΑ

- **PRIACIN** *(Simvastatin 10, 20, 40mg)*
- **ABESYL** *(Amlodipine 5, 10mg)*

ΟΥΡΟΛΟΓΙΑ

- **MAGURAN** *(Doxazocin 2, 4mg)*

Νέα Προϊόντα:

Κ.Ν.Σ.

(Olanzapine, Pramipexole, Oxcarbamazepine, Levetiracetam, Donepezil)

ΚΑΡΔΙΑΓΓΕΙΑΚΟ ΣΥΣΤΗΜΑ

(Atorvastatine, Valsartan, Irbesartan, Clopidogrel, Glimepiride)

ΟΓΚΟΛΟΓΙΑ

(Gemcitabine, Letrozole, Imatinib)

ΟΥΡΟΛΟΓΙΑ

(Alfuzosine, Finasteride)

✓Δραστηριότητα σε 95 χώρες

✓9 εργοστάσια παραγωγής

✓62,1% των πωλήσεων στην Ευρώπη

ADOVIA®

Risperidone 1-2-3-4-6 mg

ΤΕΚΜΗΡΙΩΜΕΝΗ ΕΠΙΛΟΓΗ

στην αντιμετώπιση της **σχιζοφρένειας**
& της **διπολικής διαταραχής**

Παστέρ 6, Αθήνα 115 21 • Τηλ: 210 6413160 • Fax: 210 6445375
Κων. Καραμανλή 145, Θεσσαλονίκη 542 49 • Τηλ: 2310 300869
e-mail: greece@medochemie.com • www.medochemie.com

MEDOCHEMIE HELLAS A.E.

ADOVIA®

Risperidone 1-2-3-4-6 mg

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΪΟΝΤΟΣ

ΟΝΟΜΑΣΙΑ: Adovia .**ΠΟΙΟΤΙΚΗ & ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ:**Κάθε δισκίο Adovia περιέχει 1mg, 2mg, 3mg, 4mg και 6mg ρισπεριδόνη. **ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ:**Δισκία επικαλυμμένα με υμένιο με χαραγή. **Θεραπευτικές ενδείξεις:**Η ρισπεριδόνη ενδείκνυται για τη θεραπεία: Σχιζοφρένειας – οξείες και χρόνιες σχιζοφρενικές ψυχώσεις και άλλες ψυχωσικές παθήσεις. Η ρισπεριδόνη είναι επίσης αποτελεσματική στη διατήρηση της κλινικής βελτίωσης κατά τη διάρκεια συνεχούς θεραπείας σε ασθενείς που έχουν δείξει ανταπόκριση στην αρχική θεραπεία. Μανιακά επεισόδια με διπολικές διαταραχές. Θεραπεία διαταραχών της συμπεριφοράς και άλλων παρορμητικών διαταραχών παιδιών, εφήβων και ενηλίκων με υπό του μέσου όρου νοητική λειτουργία, στους οποίους είναι έντονα τα καταστροφικά συμπτώματα και στους οποίους η μη ιατρικής φύσης ψυχο-κοινωνική θεραπεία δεν αποδείχθηκε αποτελεσματική. **Δοσολογία και τρόπος χορήγησης**: Ενήλικοι:Το Adovia μπορεί να χορηγείται 1-2 φορές την ημέρα.Η συνήθης αρχική δόση είναι 2 mg την ημέρα. Η βέλτιστη δόση είναι 4 mg/ημέρα – 6 mg/ημέρα. Ηλικιωμένοι:Συνιστάται αρχική δόση 0,5 mg δύο φορές την ημέρα, μέχρι τα 1-2 mg δύο φορές την ημέρα. Παιδιά:Δεν υπάρχει εμπειρία από τη χορήγηση σε παιδιά και εφήβους ηλικίας μικρότερης των 18 ετών.**Διαταραχές της συμπεριφοράς και παρορμητικές διαταραχές:** Η βέλτιστη δόση για τους περισσότερους ασθενείς είναι 1 mg μία φορά την ημέρα.Παιδιά και έφηβοι Η βέλτιστη δόση για τους περισσότερους ασθενείς είναι 0,5 mg μία φορά την ημέρα. Αντενδείξεις:Υπερευαισθησία στη ρισπεριδόνη ή σε κάποιο από τα έκδοχα.**Ειδικές προειδοποιήσεις και ιδιαίτερες προφυλάξεις** Ηλικιωμένοι ασθενείς με άνοια είχαν αυξημένη θνησιμότητα σε σύγκριση με εικονικό φάρμακο. Πρέπει να δίνεται ιδιαίτερη προσοχή και να εκτιμώνται οι κίνδυνοι και τα οφέλη του συνδυασμού ρισπεριδόνης και φουροσεμίδης ή της ταυτόχρονης χορήγησης με άλλα ισχυρά διουρητικά πριν ληφθεί απόφαση χρήσης. Η ρισπεριδόνη δεν συνιστάται για τη θεραπεία των συμπτωμάτων συμπεριφοράς της άνοιας εξαιτίας αυξημένου κινδύνου για εγκεφαλοαγγειακά ανεπιθύμητα Λόγω της δραστηριότητας άλφα αναστολής, μπορεί να προκύψει ορθοστατική υπόταση, ειδικά κατά την αρχική περίοδο τιτλοδότησης της δόσης. Η ρισπεριδόνη πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με γνωστές καρδιοαγγειακές διαταραχές, όπως ο συσχετισμός με μακρό διάστημα QT, για τους οποίους η δόση πρέπει να τιτλοδοτείται σταδιακά. Συμπτώματα όψιμης δυσκινησίας/εξωπυραμιδικά συμπτώματα (TD/EPS), Κακοήθες Νευροληπτικό Σύνδρομο (NMS). Σε ηλικιωμένα άτομα και σε ασθενείς με νεφρική ή ηπατική ανεπάρκεια, συνιστάται η μείωση κατά το ήμισυ της δοσολογίας. Υπεργλυκαιμία:Έχει αναφερθεί ή επιδείνωση προϋπάρχοντος διαβήτη σε πολύ σπάνιες περιπτώσεις. Προλακτίνη: υπάρχει πιθανότητα αυξημένων επιπέδων προλακτίνης. Συνιστάται προσοχή κατά τη θεραπεία ασθενών με επιληψία. Όπως ισχύει και με τα άλλα αντιψυχωσικά φάρμακα, οι ασθενείς πρέπει να ενημερώνονται σχετικά με το ενδεχόμενο αύξησης του σωματικού τους βάρους. **Αλληλεπιδράσεις:** πρέπει να χρησιμοποιείται με προσοχή σε συνδυασμό με άλλα φάρμακα που έχουν επίσης δράση στο κεντρικό νευρικό σύστημα, συμπεριλαμβανομένου του αλκοόλ. Η τροφή δεν επιδρά στην απορρόφηση της ρισπεριδόνης από το στομάχι. **Κύηση και γαλουχία** Η ρισπεριδόνη πρέπει να χρησιμοποιείται κατά τη διάρκεια της κύησης μόνο όταν το ενδεχόμενο όφελος είναι μεγαλύτερο από τον κίνδυνο. **Επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανών:**Η ρισπεριδόνη μπορεί να έχει επίδραση σε όσες δραστηριότητες απαιτούν νοητική εγρήγορση. **Ανεπιθύμητες ενέργειες:** Αύξηση του βάρους, Έχει αναφερθεί υπεργλυκαιμία ή επιδείνωση προϋπάρχοντος διαβήτη. Διαταραχές ύπνου, ανησυχία, άγχος, κεφαλαλγία. Έχει αναφερθεί καταστολή με μεγαλύτερη συχνότητα σε παιδιά και εφήβους από ότι σε ενήλικες, ελαφριά και μόνο παροδική. Υπνηλία, κόπωση, ζάλη, ελάττωση της συγκέντρωσης και όψιμη δυσκινησία. Σε υψηλότερες δόσεις, εξωπυραμιδικές ανεπιθύμητες ενέργειες.Ορθοστατική ζάλη, κακοήθες νευροληπτικό σύνδρομο, σπασμοί. Ορθοστατική υπόταση, ανακλαστική ταχυκαρδία. Δυσκοιλιότητα, δυσπεψία, ναυτία/έμετος, κοιλιακό άλγος. Αυξημένα ηπατικά ένζυμα. Εξαρτώμενη από τη δόση αύξηση της προλακτίνης στο πλάσμα, η οποία μπορεί να οδηγήσει σε γαλακτόρροια, γυναικομαστία, διαταραχές στην εμμηνορρυσία και αμηνόρροια.Πριαπισμός, διαταραχές στύσης, διαταραχές εκσπερμάτωσης και διαταραχές οργασμού. **Φαρμακοκινητικές ιδιότητες:** Cmax εντός 1 έως 2 ώρες. Η ρισπεριδόνη μεταβολίζεται εν μέρει σε 9-υδρόξυ-ρισπεριδόνη, η οποία έχει παρόμοια φαρμακολογική δράση με αυτήν της ρισπεριδόνης. Αποβάλλεται με χρόνο ημίσειας ζωής περίπου 3 ωρών και η 9-υδροξυ-ρισπεριδόνη με χρόνο ημίσειας ζωής περίπου 24 ωρών. Σταθερά επίπεδα της 9-υδροξυ-ρισπεριδόνης επιτυγχάνονται μετά από χορήγηση επί 4-5 ημέρες. Οι συγκεντρώσεις στο πλάσμα είναι ανάλογες με τη δόση εντός του πεδίου τιμών θεραπευτικών δοσολογιών Ο όγκος κατανομής είναι 1-2 l/kg. Η πρωτεϊνική δέσμευση στο πλάσμα της ρισπεριδόνης είναι 88% και της 9–υδροξυ-ρισπεριδόνης είναι 77%. Μία εβδομάδα μετά τη χορήγηση, το 70% της δόσης εκκρίνεται με τα ούρα και το 14% με τα κόπρανα. **ΑΡΙΘΜΟΣ (-ΟΙ) ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ** 1 mg:26932/06/9-2-2007, 2 mg: 26933/06/9-2-2007, 3 mg:26934/06/9-2-2007, 4 mg:26935/06/9-2-2007, 6 mg:26936/06/9-2-2007 **ΗΜΕΡΟΜΗΝΙΑ ΠΡΩΤΗΣ ΑΔΕΙΑΣ/ΑΝΑΝΕΩΣΗ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:**15. Νοέμβριος 2005 **ΤΙΜΕΣ:** 1mg x 20 ΧΤ: 9€, ΝΤ: 7.83€, ΛΤ: 13.24€, 2mg x 20 ΧΤ:16.90€, ΝΤ: 14.70€, ΛΤ: 24.87€, 3mg x 20 ΧΤ: 26.10€, ΝΤ: 22.71€, ΛΤ: 38.41€, 4mg x 20 ΧΤ: 34.28€, ΝΤ: 29.82€, ΛΤ: 50.44€, 6mg x 20 ΧΤ: 58.76€, ΝΤ:51.12€, ΛΤ: 86.47€, 3mg x 60 ΧΤ: 68.89€, ΝΤ: 59.93€, ΛΤ: 101.37€, 4mg x 60 ΧΤ: 90.50€, ΝΤ: 78.74€, ΛΤ: 133.17€, 6mg x 60 ΧΤ: 140.13€, ΝΤ:121.91€, ΛΤ: 206.2€ **ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ: MEDOCHEMIE HELLAS A.E., Παστέρ 6, Τ.Κ.: 115 21, Αθήνα, Τηλ.: 210-6413160, Fax: 210-6445375**

MEDOCHEMIE HELLAS A.E.

Isofredil®

AMISULPRIDE

Vocate

Γούναρη 150, 166 74 Γλυφάδα Αθήνα
τηλ. 210-962 4436, 210-962 4627, fax. 210-964 6582
e-mail: vocate@vocate.gr, web page: www.vocate.gr

Υποκατάστημα Βορείου Ελλάδος:
Ανδριανουπόλεως 33, Καλαμαριά 55133
τηλ./fax. 2310-488090

Zanipram®

Citalopram

Διώχνει το «Γκρίζο» από τη ζωή του ασθενούς

Vocate

Γούναρη 150, 166 74 Γλυφάδα Αθήνα
τηλ. 210-962 4436, 210-962 4627, fax. 210-964 6582
e-mail: vocate@vocate.gr, web page: www.vocate.gr

Υποκατάστημα Βορείου Ελλάδος:
Ανδριανουπόλεως 33, Καλαμαριά 55133
τηλ./fax. 2310-488090

ANNALS OF GENERAL PSYCHIATRY

BioMed Central
The Open Access Publisher

www.annals-general-psychiatry.com

Editorial Office
For all enquiries about content or submissions please contact the Editor-in-Chief at
AGP.Editorial@googlemail.com

Θεραπεύστε τα συμπτώματα της κατάθλιψης και του άγχους που αναφέρουν οι ασθενείς σας... αλλά και εκείνα που δεν αναφέρουν

Cymbalta®
duloxetine HCl

Θεραπεία και πέρα από το προφανές

ΦΑΡΜΑΣΕΡΒ - ΛΙΛΛΥ Α.Ε.Β.Ε.
15ο χλμ. ΕΘΝ. ΟΔΟΥ ΑΘΗΝΩΝ - ΛΑΜΙΑΣ 145 64 ΚΗΦΙΣΙΑ ΤΗΛ.: 210-6294600 FAX: 210-6294610 Τ.Θ. 51288
ΓΡΑΦΕΙΟ ΘΕΣ/ΝΙΚΗΣ: ΑΔΡΙΑΝΟΥΠΟΛΕΩΣ 24 - ΚΑΛΑΜΑΡΙΑ - Τ.Κ.: 551 33 ΘΕΣ/ΝΙΚΗ ΤΗΛ.: (2310) 480180
www.lilly.gr

Επειδή η αποτελεσματικότητα μετράει...

ZYPREXA® VELOTAB™

στη Σχιζοφρένεια

05-ZYP-05/09

@elilys

ΟΝΟΜΑΣΙΑ: ZYPREXA VELOTAB δισκία διασπειρόμενα στο στόμα. **ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ:** Κάθε δισκίο περιέχει 5/10/15/20mg ολανζαπίνη. **ΦΑΡΜΑΚΟΤΕΧΝΙΚΗ ΜΟΡΦΗ:** Δισκίο κίτρινου χρώματος, στρογγυλό, αποξηραμένο δια ψύξεως, ταχέως διασπειρόμενο για τοποθέτηση στη στοματική κοιλότητα ή εναλλακτικά, διασπειρόμενο σε νερό ή σε άλλο υγρό κατάλληλο για στοματική χορήγηση. **Θεραπευτικές ενδείξεις:** *Ενήλικες:* Θεραπεία σχιζοφρένειας. Διατήρηση κλινικής βελτίωσης, κατά τη διάρκεια της συνεχιζόμενης θεραπείας σε ασθενείς, οι οποίοι εμφάνισαν αρχικά ανταπόκριση στη θεραπεία. Θεραπεία μέτριου έως σοβαρού μανιακού επεισοδίου. Στους ασθενείς που το μανιακό επεισόδιο ανταποκρίθηκε στη χορήγηση ολανζαπίνης, η ολανζαπίνη ενδείκνυται για την πρόληψη των υποτροπών σε ασθενείς με διπολική διαταραχή. **Δοσολογία και τρόπος χορήγησης:** Σχιζοφρένεια: Η συνιστώμενη δοσολογία έναρξης της είναι 10 mg/ημερησίως. Μανιακό επεισόδιο: 15mg χορηγούμενη εφάπαξ ημερησίως ως μονοθεραπεία ή 10mg ημερησίως σε συνδυασμένη θεραπεία. Πρόληψη υποτροπών στη διπολική διαταραχή: 10mg/ημερησίως. Για ασθενείς που λαμβάνουν ολανζαπίνη για τη θεραπεία μανιακού επεισοδίου, να συνεχίζεται η θεραπεία για πρόληψη υποτροπών στην ίδια δοσολογία. Κατά τη διάρκεια της θεραπείας της σχιζοφρένειας, του μανιακού επεισοδίου και της πρόληψης των υποτροπών της διπολικής διαταραχής, η ημερήσια δοσολογία θα πρέπει να προσαρμόζεται ανάλογα με την κλινική κατάσταση του ασθενούς, στο εύρος των 5-20mg/ημερησίως. Σταδιακή μείωση της δόσης συνιστάται, πριν τη διακοπή της αγωγής με ολανζαπίνη. *Παιδιά και έφηβοι:* Δεν συστήνεται η χορήγηση της ολανζαπίνης σε παιδιά και εφήβους ηλικίας κάτω των 18 ετών. *Ηλικιωμένοι:* Μια μειωμένη αρχική δοσολογία 5mg αν και δεν αποτελεί τη συνήθη συνιστώμενη τακτική, μπορεί να χορηγηθεί σε ασθενείς 65 ετών και άνω, όπου οι κλινικές εκδηλώσεις το απαιτούν. *Νεφρική και/ή ηπατική ανεπάρκεια:* Μια μικρότερη αρχική δοσολογία 5mg, πρέπει να χορηγηθεί στους ασθενείς αυτούς. **Αντενδείξεις:** Υπερευαισθησία στη δραστική ουσία ή σε οποιοδήποτε από τα συστατικά του φαρμάκου. Ασθενείς με κίνδυνο εμφάνισης γλαυκώματος κλειστής γωνίας. **Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση:** *Ψύχωση σχετιζόμενη με άνοια και/ή διαταραχές συμπεριφοράς:* Η ολανζαπίνη δεν αποτελεί εγκεκριμένη θεραπεία ασθενών με ψύχωση και/ή διαταραχές συμπεριφοράς σχετιζόμενες με άνοια και δεν συνιστάται η χρήση της. *Νόσος του Parkinson:* Η χορήγηση της ολανζαπίνης σε ασθενείς με φαρμακο-επαγώμενη (ντοπαμινικού αγωνιστή) ψύχωση στο πλαίσιο νόσου Parkinson δεν συνιστάται. *Κακόηθες Σύνδρομο από Νευρολεπτικά (ΝΜS):* Σπάνιες περιπτώσεις χαρακτηρισθείσες σαν ΝΜS έχουν σχετισθεί με την ολανζαπίνη. *Υπεργλυκαιμία και διαβήτης:* Υπεργλυκαιμία και/ή εμφάνιση ή επιδείνωση σακχαρώδη διαβήτη έχει σπάνια αναφερθεί. Συνιστάται κατάλληλος κλινικός έλεγχος, σύμφωνα με τις ενδεδειγμένες αντιψυχωτικές κατευθυντήριες οδηγίες. Οι ασθενείς που λαμβάνουν θεραπεία με οποιουσδήποτε αντιψυχωτικούς παράγοντες, περιλαμβανομένου του ZYPREXA VELOTAB, θα πρέπει να παρακολουθούνται για σημεία και συμπτώματα υπεργλυκαιμίας και οι ασθενείς με σακχαρώδη διαβήτη ή εκείνοι με παράγοντες κινδύνου για την ανάπτυξη σακχαρώδη διαβήτη θα πρέπει να παρακολουθούνται τακτικά για επιδείνωση του ελέγχου της γλυκόζης. Το σωματικό βάρος πρέπει να παρακολουθείται τακτικά. *Λιπιδικές μεταβολές:* Ανεπιθύμητες μεταβολές στα επίπεδα των λιπιδίων έχουν παρατηρηθεί σε ασθενείς υπό θεραπεία με ολανζαπίνη σε κλινικές μελέτες ελεγχόμενες με εικονικό φάρμακο. Οι μεταβολές των λιπιδίων πρέπει να αντιμετωπίζονται καταλλήλως κλινικά. *Αντιχολινεργική δραστηριότητα:* Προσοχή συνιστάται όταν συνταγογραφείται σε ασθενείς με υπερτροφία προστάτη, ή παραλυτικό ειλεό και ανάλογες καταστάσεις. *Ηπατική λειτουργία:* Προσοχή απαιτείται σε ασθενείς με αυξημένες τιμές ALT και/ή AST, με σημεία και συμπτώματα ηπατικής βλάβης,με προϋπάρχουσα κατάσταση που συνοδεύεται από περιορισμό της ηπατικής λειτουργικής επάρκειας και σε ασθενείς οι οποίοι αντιμετωπίζονται με δυνητικά ηπατοτοξικά φάρμακα. *Διακοπή της θεραπείας:* Οξέα συμπτώματα όπως εφίδρωση, αϋπνία, τρόμος, άγχος, ναυτία, ή έμετος έχουν αναφερθεί πολύ σπάνια (<0,01%). *QT διάστημα:* Σε κλινικές μελέτες, κλινικά σημαντικές παρατάσεις στα διαστήματα του διορθωμένου QT (QTc) ήταν ασυνήθεις (0,1% - 1%) σε ασθενείς που έλαβαν ολανζαπίνη, χωρίς σημαντικές διαφορές στα σχετιζόμενα καρδιακά συμβάματα συγκριτικά με το εικονικό φάρμακο. *Γενική δραστηριότητα ΚΝΣ:* Θα πρέπει να δίδεται προσοχή στη συγχορήγηση της με άλλα φάρμακα που δρουν επίσης στο ΚΝΣ καθώς και με το αλκοόλ. *Επιληπτικές κρίσεις:* Έχουν αναφερθεί σπάνια σε ασθενείς με ολανζαπίνη. *Ψηφιμη Δυσκινησία:* Η ολανζαπίνη σχετίζθταν με στατιστικά σημαντικά χαμηλότερη επίπτωση φαρμακοεπαγώμενης δυσκινησίας. **Αλληλεπιδράσεις:** Η ολανζαπίνη μεταβολίζεται μέσω του CYP1A2. **Επιδράσεις στην ικανότητα οδήγησης και χειρισμού μηχανών:** Η ολανζαπίνη μπορεί να προκαλέσει υπνηλία και ζάλη, οι ασθενείς θα πρέπει να ενημερώνονται για τους πιθανούς κινδύνους κατά το χειρισμό μηχανημάτων, περιλαμβανομένων των οχημάτων. **Ανεπιθύμητες ενέργειες:** *Ενήλικοι:* Οι πιο συχνά αναφερόμενες (≥ 1%) ανεπιθύμητες ενέργειες,ήταν υπνηλία/αύξηση βάρους/ηωσινοφιλία/ αυξημένα επίπεδα προλακτίνης, χοληστερόλης, των επιπέδων γλυκόζης και τριγλυκεριδίων/ γλυκοζουρία/αυξημένη όρεξη/ζάλη/ακαθησία/παρκινσονισμός/δυσκινησία/ορθοστατική υπόταση/αντιχολινεργικές επιδράσεις/παροδικές ασυμπτωματικές αυξήσεις των ηπατικών τρανσαμινασών/εξάνθημα/εξασθένιση/κόπωση και αϊδημα. Μη-συχνές (≥ 0.1% και < 1%), λευκοπενία/ουδετεροπενία/βραδυκαρδία/ παράταση του διορθωμένου διαστήματος QTc/αντίδραση από φωτοευαισθησία /αλοπεκία /αυξημένα επίπεδα κρεατινικής φωσφοκινάσης/αυξημένη ολική χοληρυθρίνη. *Αντιμετώπιση υπερδοσολογίας:* Δεν υπάρχει ειδικό αντίδοτο για την ολανζαπίνη. Η συμπτωματική αντιμετώπιση και ο έλεγχος των λειτουργιών των ζωτικών οργάνων μπορούν να εφαρμόζονται ανάλογα με την κλινική κατάσταση του ασθενούς. Η καρδιαγγειακή παρακολούθηση είναι απαραίτητη για τον έλεγχο πιθανών αρρυθμιών. Στενή ιατρική επιβλεψη - παρακολούθηση είναι απαραίτητη μέχρι ο ασθενής να ανακάμψει πλήρως. **ΦΑΡΜΑΚΟΛΟΓΙΚΕΣ ΙΔΙΟΤΗΤΕΣ:** Κατηγορία: αντιψυχωτικό, ΑΤC κωδικός N05A H03. Η ολανζαπίνη είναι ένας αντιψυχωτικός, αντιμανιακός και σταθεροποιητικός της διάθεσης παράγοντας που εκδηλώνει ένα ευρύ φαρμακολογικό προφίλ επιδράσεων σε ένα αριθμό συστημάτων υποδοχέων. **Κατάλογος εκδόχων:** Ζελατίνη/Μαννιτόλη (E421)/Ασπαρτάμη (E951)/Μεθυλ-παραϋδρόξυ-βενζοϊκό νάτριο (E219)/ Προπυλ-παραϋδρόξυ-βενζοϊκό νάτριο (E217). **Διάρκεια ζωής:** 3έτη. **ΜΟΡΦΕΣ/ΤΙΜΕΣ:** Δισκία 2,5mgX28 Λ.Τ.: 36,08€, 5mgX28 Λ.Τ.: 74,59€, 7,5mgX56 Λ.Τ.: 156,01€, 15mgX28 Λ.Τ.: 242,27€, 20mgX28 Λ.Τ.: 323,02€. Διασπειρόμενα Δισκία: 5mgX28 Λ.Τ.: 72,18€, 10mgX28 Λ.Τ.: 144,37€, 15mgX28 Λ.Τ.: 233,88€, 20mgX28 Λ.Τ.: 306,72€. Ενέσιμο διάλυμα 10mg σκόνη Χ1 φιαλίδιο Λ.Τ.: 5,53€, **ΕΠΙΧΟΡΗΓΗΣΗ ΑΠΟ ΤΑ ΤΑΜΕΙΑ:** 100%. **ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** Eli Lilly Nederland B.V., Grootslag 1-5, NL-3991 RA Houten, Ολλανδία. **ΑΡΙΘΜΟΙ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** EU/1/99/125/001, 005, 009, 013. **ΗΜΕΡΟΜΗΝΙΑ ΠΡΩΤΗΣ ΕΓΚΡΙΣΗΣ/ ΑΝΑΝΕΩΣΗΣ ΤΗΣ ΑΔΕΙΑΣ:** Ημερομηνία πρώτης έγκρισης: 3 Φεβρουαρίου 2000. Ημερομηνία τελευταίας ανανέωσης της άδειας: 27 Σεπτεμβρίου 2006. **ΗΜΕΡΟΜΗΝΙΑ ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ:** Ιούλιος 2009.
Για περισσότερες πληροφορίες σχετικά με το προϊόν, απευθυνθείτε στην εταιρεία.

Lilly
ΦΑΡΜΑΣΕΡΒ - ΛΙΛΛΥ Α.Ε.Β.Ε.

ΦΑΡΜΑΣΕΡΒ - ΛΙΛΛΥ Α.Ε.Β.Ε.
15ο χλμ. ΕΘΝ. ΟΔΟΥ ΑΘΗΝΩΝ - ΛΑΜΙΑΣ 145 64 ΚΗΦΙΣΙΑ ΤΗΛ.: 210-6294600 FAX: 210-6294610 Τ.Θ. 51288
ΓΡΑΦΕΙΟ ΘΕΣ/ΝΙΚΗΣ: ΑΔΡΙΑΝΟΥΠΟΛΕΩΣ 24 - ΚΑΛΑΜΑΡΙΑ - Τ.Κ.: 551 33 ΘΕΣ/ΝΙΚΗ ΤΗΛ.: (2310) 480160
www.lilly.gr

Πριν τη συνταγογράφηση συμβουλευτείτε την ΠΧΠ.
Για περισσότερες πληροφορίες απευθυνθείτε στην εταιρεία.

Schering-Plough

ΑΘΗΝΑ: Αγ. Δημητρίου 63, 174 55 Άλιμος, Τηλ.: 210 989 7300. ΒΟΡΕΙΑ ΕΛΛΑΔΑ: Συγκρότημα Θερμοκοιτίδα - Θέρμη,
9ο χλμ. Εθν. Οδ. Θεσ/νίκης Θέρμης, Στ. Καζαντζίδη 47, 570 01 Πυλαία, Τηλ.: 2310 863 634, Fax: 2310 863 687, **www.schering-plough.com**

Call for Registrations

The Tenth International Review of Bipolar Disorders 2010

12 - 14 May 2010
Novotel Budapest Congress & World Trade Center, Budapest, Hungary

Conference chair:
Professor Zoltán Rihmer (Hu)

International Review of Bipolar Disorders
IRBD
www.irbd.org

www.irbd.org

For details of group booking benefits please contact info@irbd.org

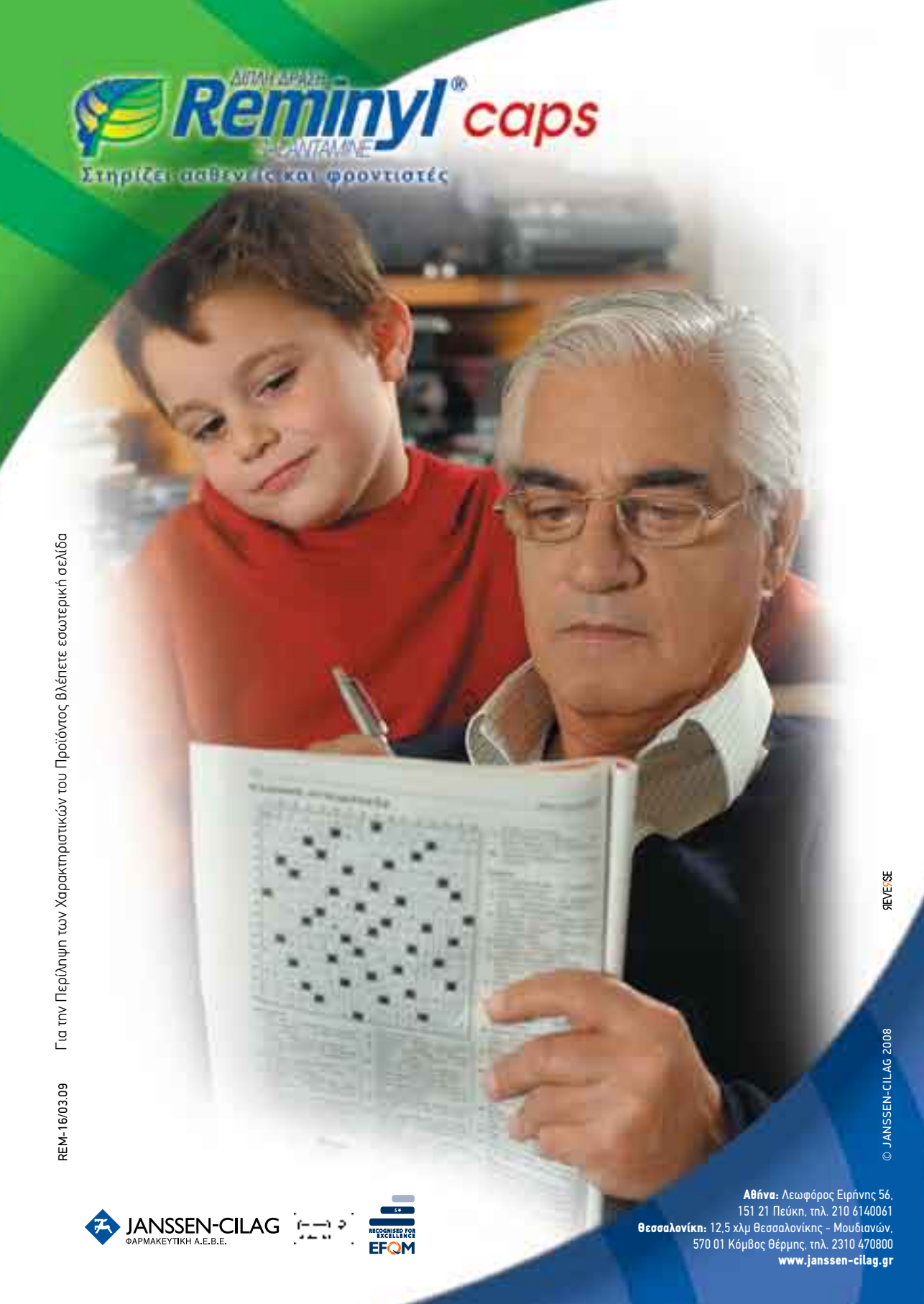
A Cortex Congress Conference
www.cortexcongress.com

Cortex

Reminyl® caps

Galantamine

Στηρίζει ασθενείς και φροντιστές



Για την Περίληψη των Χαρακτηριστικών του Προϊόντος βλέπετε εσωτερική σελίδα

REM-16/03.09

REVERSE

JANSSEN-CILAG
ΦΑΡΜΑΚΕΥΤΙΚΗ Α.Ε.Β.Ε.

RECOGNISED FOR EXCELLENCE EFQM

Αθήνα: Λεωφόρος Ειρήνης 56,
151 21 Πεύκη, τηλ. 210 6140061
Θεσσαλονίκη: 12,5 χλμ Θεσσαλονίκης - Μουδιανών,
570 01 Κόμβος Θέρμης, τηλ. 2310 470800
www.janssen-cilag.gr

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΙΟΝΤΟΣ (SPC)

REMINYL® (υδροβρωμική γκαλανταμίνη). ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ: REMINYL 8mg καψάκια παρατεταμένης αποδέσμευσης, σκληρά. REMINYL 16mg καψάκια παρατεταμένης αποδέσμευσης, σκληρά. REMINYL 24mg καψάκια παρατεταμένης αποδέσμευσης, σκληρά. REMINYL 8 mg + 16 mg καψάκια παρατεταμένης αποδέσμευσης, σκληρά (συσκευασία έναρξης θεραπείας). **ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ σε δραστικά συστατικά:** - Κάθε καψάκιο 8mg περιέχει 8mg γκαλανταμίνη (ως υδροβρωμικό άλας). Κάθε καψάκιο 16mg περιέχει 16mg γκαλανταμίνη (ως υδροβρωμικό άλας). Κάθε καψάκιο 24mg περιέχει 24mg γκαλανταμίνη (ως υδροβρωμικό άλας). Έκδοχα: 8 mg: σακχαρόζη 59 mg. 16 mg: σακχαρόζη 117 mg. 24 mg: σακχαρόζη 116 mg. **ΚΛΙΝΙΚΑ ΣΤΟΙΧΕΙΑ. Θεραπευτικές ενδείξεις.** Το Reminyl ενδείκνυται για τη συμπτωματική θεραπεία της ήπιας έως μετρίως σοβαρής άνοιας τύπου Alzheimer. **Αντενδείξεις.** Υπερευαισθησία στη δραστική ουσία ή σε οποιοδήποτε από τα έκδοχα. Λόγω έλλειψης διαθέσιμων στοιχείων για τη χρήση της γκαλανταμίνης σε ασθενείς με σοβαρή ηπατική (Βαθμολόγηση κατά Child-Pugh μεγαλύτερη από 9) και σοβαρή νεφρική (κάθαρση κρεατινίνης μικρότερη από 9ml/min) ανεπάρκεια, η χρήση της γκαλανταμίνης σε αυτούς τους ασθενείς αντενδείκνυται. Η γκαλανταμίνη αντενδείκνυται σε ασθενείς που έχουν σημαντική έκπτωση και της νεφρικής και της ηπατικής λειτουργίας. **Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση.** Το Reminyl ενδείκνυται σε ασθενείς με ήπια έως μετρίως σοβαρή άνοια του τύπου Alzheimer. Σε ασθενείς με άλλους τύπους άνοιας ή άλλους τύπους διαταραχών της μνήμης δεν έχει αποδειχθεί το όφελος της γκαλανταμίνης. Σε 2 κλινικές μελέτες διάρκειας 2 ετών σε άτομα με την επονομαζόμενη ήπια γνωσιακή διαταραχή (πιθανότεροι τύποι διαταραχών της μνήμης που δεν πληρούν τα κριτήρια της άνοιας τύπου Alzheimer) η θεραπεία με γκαλανταμίνη απέτυχε να αποδείξει κάποιο όφελος είτε στην επιβράδυνση της νοητικής εξασθένισης ή στην μείωση της κλινικής μετατροπής προς άνοια. Το ποσοστό θνησιμότητας στην ομάδα της γκαλανταμίνης ήταν σημαντικά μεγαλύτερο σε σχέση με την ομάδα εικονικού φαρμάκου (placebo), 14/1026 (1,4%) ασθενείς σε γκαλανταμίνη και 3/1022 (0,3%) ασθενείς σε placeba. Οι θάνατοι αφείλονταν σε διάφορα αίτια. Σχεδόν οι μισοί από τους θανάτους στην ομάδα της γκαλανταμίνης φαίνεται να προήλθαν από διάφορες αγγειακές αιτίες (έμφραγμα του μυοκαρδίου, αγγειακό εγκεφαλικό επεισόδιο και αιφνίδιος θάνατος). Δεν είναι γνωστή η σημασία του ευρήματος αυτού για τη θεραπεία των ασθενών με άνοια τύπου Alzheimer. Στη άνοια τύπου Alzheimer, διενεργήθηκαν κλινικές μελέτες ελεγχόμενες με εικονικό φάρμακο διάρκειας μόνο 6 μηνών. Σε αυτές τις μελέτες δεν εμφανίστηκε αυξημένη θνησιμότητα στις ομάδες της γκαλανταμίνης. Η διάγνωση της άνοιας Alzheimer πρέπει να γίνει με βάση τις πρόσφατες κατευθυντήριες οδηγίες από ένα έμπειρο γιατρό. Η θεραπεία με γκαλανταμίνη πρέπει να γίνει με την επίβλεψη του γιατρού και πρέπει να ξεκινήσει μόνο αν υπάρχει διαθέσιμα άτομο που μπορεί να παρακολουθεί τακτικά τη λήψη του φαρμακευτικού ιδιοσκευάσματος από τον ασθενή. Οι ασθενείς που πάσχουν από τη νόσο Alzheimer χάνουν βάρος. Η θεραπεία με αναστολείς της χολινεστεράσης, συμπεριλαμβανομένης της γκαλανταμίνης, έχει συσχετισθεί με ελάττωση βάρους σε αυτούς τους ασθενείς. Κατά τη διάρκεια της θεραπείας, το σωματικό βάρος του ασθενούς πρέπει να παρακολουθείται. Όπως συμβαίνει και με άλλα χολινεργικά, η γκαλανταμίνη πρέπει να χορηγείται με προσοχή στις ακόλουθες περιπτώσεις: ***Καρδιακές διαταραχές***. Λόγω της φαρμακολογικής τους δράσης, τα χολινεργικά μπορεί να έχουν παρασυμπαθητικοτονικές δράσεις στην καρδιακή συχνότητα (π.χ. βραδυκαρδία). Η πιθανότητα αυτής της δράσης μπορεί να είναι ιδιαίτερα σημαντική για ασθενείς με σύνδρομο νοσούντος φλεβόκομβου ή άλλες διαταραχές υπερκοιλιακής καρδιακής αγωγιμότητας ή σε αυτούς που κάνουν ταυτόχρονη χρήση φαρμακευτικών ιδιοσκευασμάτων που μειώνουν σημαντικά την καρδιακή συχνότητα, όπως διγοξίνη και β-αναστολείς ή σε ασθενείς με διαταραχή ηλεκτρολυτών που δε διορθώνεται (π.χ. υπερκαλιαιμία, υποκαλιαιμία). Για το λόγο αυτό χρειάζεται προσοχή κατά τη χορήγηση της γκαλανταμίνης σε ασθενείς με καρδιαγγειακές νόσους, π.χ. κατά την περίοδο αμέσως μετά από έμφραγμα του μυοκαρδίου, κατά την εμφάνιση κολπικής μαρμαρυγής, σε δευτέρου βαθμού καρδιακό αποκλεισμό ή μεγαλύτερου, ασταθής στηθάγχη ή σε συμφορητική καρδιακή ανεπάρκεια, ιδιαίτερο NYHA ομάδας III- IV. Σε μια συνοπτική ανάλυση όλων των ελεγχόμενων με εικονικά φάρμακο μελετών σε ασθενείς με άνοια τύπου Alzheimer που ακολούθησαν αγωγή με γκαλανταμίνη παρατηρήθηκε μια αυξημένη συχνότητα εμφάνισης συγκεκριμένων καρδιαγγειακών ανεπιθύμητων ενεργειών. (βλ. λήμμα Ανεπιθύμητες ενέργειες). ***Διαταραχές του γαστρεντερικού***. Ασθενείς που έχουν αυξημένο κίνδυνο να εμφανίσουν πεπτικά έλκη, π.χ. αυτοί που έχουν ιστορικό έλκους ή αυτοί που έχουν προδιάθεση σε αυτές τις καταστάσεις, συμπεριλαμβανομένων αυτών που λαμβάνουν ταυτόχρονα μη στεροειδή αντιφλεγμονώδη φάρμακα (ΜΣΑΦ), πρέπει να παρακολουθούνται για συμπτώματα. Η χρήση της γκαλανταμίνης δε συνιστάται σε ασθενείς με γαστρεντερική απόφραξη ή σε αυτούς που αναρρώνουν από χειρουργική επέμβαση γαστρεντερικού. ***Διαταραχές του νευρικού συστήματος***. Παρόλο που πιστεύεται ότι τα χολινεργικά υπάρχει πιθανότητα να προκαλέσουν σπασμούς, η εμφάνιση σπασμών μπορεί επίσης, να αποτελεί εκδήλωση της νόσου Alzheimer. Σε σπάνιες περιπτώσεις αύξηση του χολινεργικού τόνου μπορεί να επιδεινώσει τα παρκινσονικά συμπτώματα. Σε μια συνοπτική ανάλυση όλων των ελεγχόμενων με εικονικό φάρμακο μελετών σε ασθενείς με άνοια τύπου Alzheimer που ακολούθησαν αγωγή με γκαλανταμίνη παρατηρήθηκαν, όχι συχνά, αγγειακά εγκεφαλικά επεισόδια (βλέπε παράγραφο Ανεπιθύμητες Ενέργειες). Αυτό πρέπει να ληφθεί υπόψη κατά τη χορήγηση γκαλανταμίνης σε ασθενείς με αγγειακή εγκεφαλική νόσο. ***Διαταραχές του αναπνευστικού συστήματος, του θώρακα και του μεσοθωράκιου***. Τα χολινεργικά πρέπει να χορηγούνται με προσοχή σε ασθενείς με ιστορικό σοβαρού άσθματος ή αποφρακτικής πνευμονικής νόσου ή ενεργές πνευμονικές λοιμώξεις (π.χ. πνευμονία). ***Διαταραχές των νεφρών και των ουροφόρων οδών***. Η χρήση της γκαλανταμίνης δε συνιστάται σε ασθενείς με απόφραξη στην αποχετευτική μοίρα του ουροποιητικού ή μετά από χειρουργική επέμβαση ουροδόκου κύστης. ***Χειρουργικοί και άλλοι ιατρικοί χειρισμοί***. Η γκαλανταμίνη, σαν χολινεργικό, είναι πιθανό να προκαλέσει υπερβολική μυϊκή χάλαση σουκκινυλοχολινικού τύπου κατά τη διάρκεια αναισθησίας, ιδιαίτερα σε περιπτώσεις ανεπάρκειας ψευδοχολινεστεράσης. ***Άλλα***. Τα καψάκια παρατεταμένης αποδέσμευσης Reminyl περιέχουν σακχαρόζη. Οι ασθενείς με σπάνια κληρονομικά προβλήματα μη ανοχής της φρουκτάζης, δυσαπορρόφησης γλυκόζης-γαλακτόζης ή ανεπάρκειας σουκράσης-ισομαλτάσης, δε θα πρέπει να λαμβάνουν αυτό το φάρμακο. **Ανεπιθύμητες ενέργειες.** Οι πιο συχνές ανεπιθύμητες ενέργειες που παρατηρήθηκαν στις κλινικές μελέτες (συχνότητα > 5% και δύο φορές τη συχνότητα του εικονικού φαρμάκου-placebo) ήταν ναυτία, έμετος, διάρροια, επιγάστριο άλγος, δυσπεψία, αναορεξία, κόπωση, ζάλη, κεφαλαλγία, υπνηλία και ελάττωση βάρους. Η ναυτία, ο έμετος και η αναορεξία παρατηρήθηκαν συχνότερα στις γυναίκες. Άλλες συχνές ανεπιθύμητες ενέργειες που παρατηρήθηκαν στις κλινικές μελέτες (συχνότητα ≥5% και ≥εικονικού φαρμάκου-placebo) ήταν σύγχυση, κατάθλιψη, πτώσεις, κάκωση, αϋπνία, ρινίτιδα και λοίμωξη του ουροποιητικού συστήματος. Σε μια τυχαιοποιημένη, διπλή-τυφλή, ελεγχόμενη με εικονικό φάρμακο κλινική μελέτη, οι ανεπιθύμητες ενέργειες που εμφανίστηκαν με χορήγηση των καψάκιων παρατεταμένης αποδέσμευσης Reminyl μία φορά την ημέρα, ήταν παρόμοιες ως προς τη συχνότητα και τη φύση με αυτές που παρατηρήθηκαν με τα διακία. Η πλειονότητα αυτών των ανεπιθύμητων ενεργειών εμφανίστηκαν κατά τη διάρκεια της περιόδου εξατομίκευσης της δοσολογίας. Η ναυτία και ο έμετος, οι πιο συχνές ανεπιθύμητες ενέργειες, διήρκεσαν λιγότερο από μια εβδομάδα στις περισσότερες περιπτώσεις και οι πιο πολλοί ασθενείς είχαν μόνο ένα επεισόδιο. Χορήγηση αντιεμετικής αγωγής και εξασφάλιση πράσλητης επαρκούς ποσότητας υγρών μπορεί να αποβούν χρήσιμα σε αυτές τις περιπτώσεις.

Ανεπιθύμητες ενέργειες που παρατηρήθηκαν κατά την διάρκεια των κλινικών μελετών και από την εμπειρία μετά την κυκλοφορία του φαρμάκου.

Οργανικό σύστημα	Πολύ συχνές	Συχνές	Ασυνήθεις	Σπάνιες	Πολύ σπάνιες
Μολύνσεις και λοιμώξεις		Ρινίτιδα, Λοιμώξεις του ουροποιητικού σωλήνα			
Διαταραχές του μεταβολισμού και της θρέψης		Ανορεξία, Μείωση βάρους		Αφυδάτωση (που οδηγεί σε νεφρική διαταραχή και νεφρική ανεπάρκεια), Υποκαλιαιμία	
Ψυχιατρικές διαταραχές		Σύγχυση, Κατάθλιψη (πολύ σπάνια με τάσεις αυτοκτονίας), Αϋπνία		Επιθετικότητα, Διέγερση, Ψευδαισθήσεις	
Διαταραχές του νευρικού συστήματος		Ίλιγγος, Υπνηλία, Συγκοπή, Τράμος	Παραισθησία	Επιληπτικές κρίσεις	Επιδείνωση παρκινσονισμού
Διαταραχές του ωτός και του λαβυρίνθου			Εμβοή		
Καρδιακές διαταραχές			Κολπική αρρυθμία, Έμφραγμα του μυοκαρδίου, Ισχαιμία του μυοκαρδίου, Αίσθημα παλμών	Βραδυκαρδία (σοβαρή)	Κολποκοιλιακός αποκλεισμός
Αγγειακές διαταραχές		Υπέρταση	Αγγειακή εγκεφαλική νόσος, Παροδικό ισχαιμικό επεισόδιο		Υπόταση
Γαστρεντερικές διαταραχές	Έμετος, Ναυτία	Επιγάστριο άλγος, Διάρροια, Δυσπεψία			Δυσφαγία, Αιμορραγία γαστρεντερικού
Διαταραχές του ήπατος και των χοληφόρων					Αυξημένα ηπατικά ένζυμα. Ηπατίτιδα
Διαταραχές του δέρματος και του υποδόριου ιστού				Εξάνθημα	Αυξημένη εφίδρωση
Διαταραχές του μυοσκελετικού συστήματος και του συνδετικού ιστού			Κράμπες του κάτω άκρου		
Γενικές διαταραχές και ενοχλήσεις στη θέση χορήγησης		Αδυναμία, Κόπωση, Πυρετός, Κεφαλαλγία, Αίσθημα κακουχίας			
Κακώσεις, δηλητηριάσεις και επιπλοκές θεραπευτικών χειρισμών		Πτώση, Τραύμα			

Οι συχνότητες καθορίζονται ως εξής: πολύ συχνές (≥1/10), συχνές (≥1/100 έως <1/10), ασυνήθεις (≥1/1000 έως <1/100), σπάνιες (≥1/10000 έως <1/1000) και πολύ σπάνιες (<1/10000). Ορισμένες από αυτές τις ανεπιθύμητες ενέργειες μπορεί να οφείλονται στις χολινεργικές ιδιότητες της γκαλανταμίνης ή σε ορισμένες περιπτώσεις μπορεί να αποτελούν εκδηλώσεις ή επιδεινώσεις των προϋπαρχόντων παθολογικών καταστάσεων γεγονός αύνηβες στα ηλικιωμένα άτομα. **ΥΠΕΥΘΥΝΟΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** JANSSEN-CILAG Φαρμακευτική ΑΕΒΕ, Λ. Ειρήνης 56, 151 21 Πεύκη, Αθήνα, Τηλ: 210 61 40 061.

ΗΜΕΡΟΜΗΝΙΑ ΤΗΣ (ΜΕΡΙΚΗΣ) ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ: 23.7.2008. **ΣΥΣΚΕΥΑΣΙΕΣ / ΤΙΜΕΣ:**
Reminyl PR.CAP 8 mg/CAP, BT x 28 Λ.Τ. 69,18 €
Reminyl PR.CAP 16 mg/CAP,BT x 28 Λ.Τ. 103,49 €
Reminyl PR.CAP 24 mg/CAP, BT x 28 Λ.Τ. 122,13 €
Συσκευασία έναρξης θεραπείας: Reminyl PR.CAP BT x 28x 8mg + BT x 28x16mg Λ.Τ. 172,77 €

Για το πλήρες κείμενο της Περίληψης των Χαρακτηριστικών του Προϊόντος Reminyl απευθυνθείτε στην εταιρεία Janssen-Cilag

JANSSEN-CILAG
ΦΑΡΜΑΚΕΥΤΙΚΗ Α.Ε.Β.Ε.

Αθήνα: Λεωφόρος Ειρήνης 56, 151 21 Πεύκη, τηλ. 210 6140061
Θεσσαλονίκη: 12,5 χλμ Θεσσαλονίκης - Μουδανιών, 570 01 Κόμβος Θέρμης, τηλ. 2310 470800
www.janssen-cilag.gr

CONTRIBUTORS

Agam Galila
J. Dreyfus Professor of Biochemistry in Psychiatry, Psychiatry Research Unit and Department of Clinical Biochemistry, Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, ISRAEL

Dr AGAM is a member of the Scientific Advisory Committee of the National Institute for Psychobiology in Israel. Is B.Sc., Chemistry, Biochemistry, Hebrew University, Jerusalem, M.Sc., Medical Sciences/Biochemistry - *with distinction;* Hebrew University, Jerusalem, Israel and Ph.D., *Summa Cum Laude*, Ben Gurion University of the Negev, Beersheva, Israel.
She has received grants from the Israel Institute for Psychobiology, the Harry Stern Psychobiology Foundation, the Stanley Foundation, the Israel Ministry of Health, the US National Alliance for Research on Schizophrenia and Depression (NARSAD), the Bi-National USA-Israel Science Foundation, the Dreyfus Health Foundation, the Chief Scientist of the Israel Ministry of Industry, Commerce and Labor. She has co-authored 115 Papers and 37 book chapters, edited one book and two journal special issues

Aitchison Katherine
Senior Lecturer in Adult Psychiatry, MRC SGDP Centre, Institute of Psychiatry at King's College London and Honorary Consultant Psychiatrist, South London & Maudsley NHS Foundation Trust, UNITED KINGDOM

Dr Aitchison received a First Class BA (Hons) in Physiological Sciences from Oxford University in 1987, with a top University Prize, her MRCPsych in 1996, and a PhD in the role of genetic variation in cytochrome P450 enzymes in antidepressant and antipsychotic treatment response from UCL in 2003 (funded by a Wellcome Trust Fellowship). This included work at NIH and the University of Colorado (USA) on a Lilly Travelling Fellowship awarded by the Royal College of Psychiatrists. She was appointed as a Senior Lecturer and Honorary Consultant Psychiatrist in 2001, and joined the MRC SGDP Centre as an Executive Member in 2003. She has been the Deputy Coordinator of a multicentre integrated programme of research funded by the European Commission under the Framework 6 Programme (GENDEP, http://gendep.iop.kcl.ac.uk/results.php), and has run and contributed to other translational medicine projects. Her awards include a Junior Investigator Award at the World Congress of Psychiatric Genetics (1995), a Young Investigator Award for the International Congress in Schizophrenia Research (ICOSR 1997), a Young Scientist Award at the 10th Biennial Winter Workshop on Schizophrenia (2000), and a Scholarship to present at the 2008 Meeting on Pharmacogenomics, held at Cold Spring Harbor Laboratory, NY. She has served on international Committees including the Annual Pharmacogenetics in Psychiatry Meeting Faculty, the Translating Advances in Biological Psychiatry into Therapeutics Conference Organising Committee, on Editorial Boards including the Journal of Psychopharmacology, and co-leads the Psychopharmacology Special Interest Group of the Royal College of Psychiatrists.

Akiskal Hagop
Distinguished Professor of Psychiatry and Director of the International Mood Center at the University of California at San Diego, USA

Dr. Akiskal obtained his medical degree (Alpha Omega Alpha) from the American University of Beirut in 1969. Thereafter he settled in the United States and obtained his psychiatric training at the Universities of Tennessee, Memphis and Wisconsin, Madison. He was appointed Professor of Psychiatry and Pharmacology at the University of Tennessee (1972-1990), and subsequently recruited as the Senior Science Advisor to the Director of the National Institute of Mental Health (1990-1994). He is presently Professor of Psychiatry and Director of the International Mood Center at the University of California at San Diego. He holds honorary doctorate degrees from the University of Lisbon and Aristotle University at Thessaloniki. Since 1996, he is the Editor-in-Chief of the Journal of Affective Disorders.
Professor Akiskal rose to prominence with his integrative theory of depression (Science, 1973). Subsequently he established chronic depressions as treatable mood disorders. His research on cyclothymia paved the way for understanding the childhood antecedents of bipolarity, and helped in the worldwide renaissance of the temperament field. With Kareen Akiskal he has studied the temperament and creativity of parisian artists and southern blues musicians His focus on subthreshold mood disorders enlarged the boundaries of bipolar disorders. He has received the Aristotle Gold Medal of the Brain and Behavior Society, the Gold Medal for Pioneer Research (Society of Biological Psychiatry), the German Anna Monika Prize for Depression, the NARSAD Prize for Affective Disorders, the Jean Delay Prize for international collaborative research (World Psychiatric Association), as well as the French Jules Baillarger and the Italian Aretaeus Prizes for his research on the bipolar spectrum. He has served as honorary president of the Hungarian suicide prevention society. He has been elected into the French and Armenian National Academies.
Professor Akiskal has pioneered in the study of outpatient mood disorders. At the University of Tennessee, he established mood clinics which have had worldwide appeal because of his philosophy of conducting clinical training and research while delivering high quality care. His clinical expertise ranges from dysthymia to bipolar spectrum disorders, as well as comorbidity, resistant depression, interface of personality with mood disorders, mixed states, anxious bipolarity, and PTSD. He is listed in Thomson's most ten cited researchers in psychiatry and psychology. He has received the lifetime achievement award from the society of international review of bipolar disorders (IRBD). In 2003, he received the US Ellis Island Medal of Honor "for exceptional national humanitarian service."

Arboleda-Florez Julio
Professor Emeritus and immediate past Head, Department of Psychiatry, Queen's University, CANADA

Dr Arboleda-Flórez, MD, FRCPC, DABFP, PhD, DLFAPA, FCPA, FRSM, Forensic Psychiatrist, Epidemiologist is Professor Emeritus and immediate past Head, Department of Psychiatry, Queen's University, Canada; immediate past Chief-of Psychiatry Queen's Affiliated Hospitals. He is Honorary Professor, Universidad de Chile; Adjunct and Visiting Professor at several international universities; researcher (mental health systems, stigma, psychiatric epidemiology, mental illness and violence), author, international lecturer; versed in several European languages. Professor Arboleda-Flórez is Distinguished Life Fellow American Psychiatric Association; Inaugural Fellow of the Canadian Psychiatric Association and Fellow of the American College of Forensic Psychiatry and American Board of Forensic Examiners; Fellow Royal Society of Medicine; Honorary Member World Psychiatric Association and Asociación Ecuatoriana de Psiquiatría; Member Emeritus, Forensic Department, Associaõ Brasileira de Psiquiatria; past-President International Academy of Law and Mental Health; immediate past President Canadian Academy of Psychiatric Epidemiology; immediate past Chairman Forensic Section World Psychiatric Association. He is also Honorary Life President of the Forensic Section, World Psychiatric Association and President World Association for Social Psychiatry.

Awad George
Professor emeritus in the Department of Psychiatry, and Faculty of the School of Graduate Studies in the Institute of Medical Science, University of Toronto, CANADA

Dr. Awad is a professor emeritus in the Department of Psychiatry, and on the Faculty of the School of Graduate Studies in the Institute of Medical Science, University of Toronto. He also serves as the Psychiatrist in Chief of the Department of Psychiatry and Mental Health at Humber River Regional Hospital in Toronto. Dr. Awad continues to serve as a national and international reviewer and consultant for academic and service programs. He also serves in several national and international organizations, including recently being elected as the first Founding President of the newly developed International Society for CNS Clinical Trails and Methodology (ISCTM). He also served as the eleventh president of the Canadian College of Neuropsychopharmacology. He chaired and served on a number of NIH, NIMH, CINP committees. He continues to serve as a member of the International Advisory Board to the German federal government, which oversees the network of Schizophrenia Centres of Excellence in Germany. Dr. Awad made significant contributions to the Canadian Psychiatric Research Foundation, having chaired its Professional Advisory Board for a number of years and was instrumental with support from the Tanenbaum family to establish the Tanenbaum Distinguished Scientist Award in Schizophrenia. Dr. Awad was honoured to receive such an award in 1998. In 2000, he was also awarded the Canadian College of Neuropsychopharmacology medal for meritorious contributions in psychopharmacology research, teaching and services. Dr. Awad is recognized for his national and international contributions that has led to significant research development in such areas as quality of life, subjective tolerability to medications and patient reported outcomes, and outcomes research in general.

Bobes Julio
Professor and Chair of Psychiatry at the University of Oviedo (Asturias) and Clinical Director of Psychiatric Services for the Oviedo Area, SPAIN

Dr Bobes is Principal Investigator of the Oviedo node of the National Network of Mental Health Biomedical Research centres (Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM)), funded by Instituto de Salud Carlos III of the Spanish Ministry of Science and Innovation. He has a longstanding track record of attaining research funding at national and European level. His primary research interests are the evaluation, management, treatment and assessment of the impact of various psychiatric disorders, including addiction, psychosis, affective, anxiety and psychophysiology disorders. He also pursues a research interest relating to the prevention of suicidal behaviour. He has lectured extensively at national and international conferences. He has published more than 100 peer-reviewed papers and has contributed to many academic textbooks as author and editor. He is a member of many academic and professional societies and is currently President of the Spanish Society of Biological Psychiatry and a member of the Board of the European Psychiatric Association.

Câmara-Pestana Luis
Psychiatrist, Clinical Pharmacologist, President of the Portuguese Association of Biological Psychiatry and consultant of the Portuguese Authority of Drugs and Pharmacy, PORTUGAL

Dr Câmara Pestana's main area of scientific research is clinical psychiatry and psychiatric disorders in association with Epilepsy. He has been involved in the organisation of various national and international meetings namely the 1997 European College of Neuropsychopharmacology (ECNP) regional meeting and the 17th European Congress of Psychiatry. In the past he had participated in several psychopharmacological clinical trials. He has published 35 papers and over 160 scientific presentations in national and international meetings.

Massimo Cocchi
Professor of Nutrition Biochemistry, Faculty of Human and Technological Sciences, LUdeS University, Lugano, SWITZERLAND

Professor Massimo Cocchi was born in Bologna on 8th, October 1945. He attended the University of Bologna where he graduated in Medicine in 1971. He studied Nutrition and Biochemistry at an advanced level, throughout the first five years of the Medical Degree Course at the Institute of Biochemistry of the University of Bologna.
The major scientific research has always been connected with aspects of lipid metabolism in both, experimental animals and man.
Summary of original scientific work in: Biochemistry of Nutrition and lipid metabolism
1) Ethanol and lipid 2) Dietary lipids, tissue lipids and unusual fatty acids 3) Studies about Essential Fatty Acids (EFA) 4) Fatty Acids of the n-6 and n-3 series 5) Cellular nutrition 6) Lipid metabolism during development and growth 7) Platelet fatty acids in Major Depression and Ischemic Cardiovascular Disease.
In 1995 he has been appointed as Professor of Nutrition Biochemistry (Scottish Agricultural College). In 2005 he has been appointed as Contract Professor of Food and Human Nutrition at the Faculty of Veterinary Medicine of the University of Bologna. In 2005 he started to study the platelet fatty acids in groups of patients (Depressive and Ischemic) realizing a combination between Biochemistry and Artificial Neural Network which has allowed to characterize the depressive and the ischemic population versus the apparently normal people.
In 2009 he has been appointed as Full Professor of Nutrition Biochemistry at the Faculty of Human and Technological Sciences, LUdeS University, Lugano, Switzerland

Cohen Dan
Department of Clinical Epidemiology, University of Groningen, NETHERLANDS

Dan Cohen wrote his thesis on 'Diabetes mellitus in schizophrenia or schizoaffective disorder: an endogenic or iatrogenic problem?'(2006). He has steadily been working on diabetes mellitus and the metabolic syndrome in schizophrenia.
Apart from his scientific work at the Department of Clinical Epidemiology, University of Groningen (Netherlands) he heads the Outpatient facility for Metabolic Disturbances in North- Holland North, He is currently implementing standard metabolic screening for all outpatient SMI patients who are in ACT-care in North Holland North.

Cookson John
Consultant and Honorary Senior Lecturer in Psychiatry at The Royal London Hospital in London, England, UNITED KINGDOM.

John Cookson obtained a doctorate in pharmacology at Oxford, and studied clinical medicine at University College Hospital in London. His higher training in Medicine was in London and in Psychiatry was at St. Bartholomew's and the Maudsley Hospitals.
He is responsible for a catchment area service comprising a community mental health team and a general psychiatric ward, with access to a Home Treatment Team, an Early Intervention Service and an Assertive Outreach Team. He was consultant for a Psychiatric Intensive Care Unit from 1988-2007, and for a Specialist Addictions Unit from 1981-1996.
Dr. Cookson's research interests are in psychopharmacology and the use of drugs in psychiatry, particularly in relation to the treatment of bipolar disorder.
He has participated in the development of new drugs for bipolar disorder, schizophrenia, depression, social phobia, and panic disorder. He serves on the editorial boards of *The British Journal of Psychiatry*, *International Clinical Psychopharmacology*, and *Advances in Psychiatric Treatment*. He coauthored the fourth and fifth editions (2002) of *Use of Drugs in Psychiatry: The Evidence from Psychopharmacology,* published by the Royal College of Psychiatrists. He participated in the British Association for Psychopharmacology Guidelines for Bipolar Disorder.

Degleris Nickolaos
Neuropsychiatrist, former-Senior Lecturer of Social Medicine and Mental Health, Assistant Etr. Universite PARIS V, Director of the Psychotherapeutic Center of Piraeus, GREECE

He was born in 1952 in Piraeus. He graduated in 1976 from medicine of the university of Athens. In 1979-1980, he got a scholarship from the Onassis Foundation for his dissertation on historico-Medical documentation.
As a neuropsychiatrist (Aeginitio Hospital of Athens)- Prof. C. Stefanis, he was further educated at the University Paris V , where he was specialized on the field of Behavioural and Cognitive Psychotherapy (Psychiatric Hospital ste Anne Paris/ CNRS)-Prof. P. Pichot, where he continues to collaborate as a visiting researcher (Prof. B. S. Lajeunesse).
He worked as a senior lecture at the University of Ioannina (Section of Social Medicine and Mental Health). At the same time he has been President of the Greek Institute on the Research of Human Behaviour as well as scientific assistant director , at the Centre of Mental Health , responsible on educational ant staff management issues.
He collaborates with Mass Media and he has participated in debates on T.V where he spokes several times about issues on couple counselling and human relationships.
He also collaborated with the Court of Appeal in Piraeus as an expert on psychiatric-judicial issues. He has been activated as a Scientific Counsellor of the publishing firm "ELLINIKA GRAMMATA" and at the public and private organisations on issues of human resources development. He runs the Psychotherapeutic Centre of Piraeus and at the same time he animates the annual seminar of EMOTIONAL INTELLIGENCE and PSYCHOEDUCATION.
Since February 1997 he coordinates the Dementia's Medical Care Unit at the Piraeus Centre of Mental Health on clinical, educational and research fields.

Douzenis Athanasios
Assistant Professor in Forensic Psychiatry, 2nd Psychiatry Department at Attikon University General Hospital, Athens University Medical School, GREECE

Dr Douzenis was born in 1959 in Athens Greece. Currently is Assistant Professor in Forensic Psychiatry Athens University Medical School and works in the 2nd Psychiatry Department at Attikon University General Hospital in Athens. He graduated from Athens University Medical school in 1985 and received his Master of Medical Sciences at Sheffield University, UK in 1988 and his PhD in 1995 at the University of Athens). He had is post-graduate training in Psychiatry and Forensic Psychiatry at the Charing Cross and Westminster Medical School in London UK. His professional experience includes Locum Consultant Croydon MH and Riverside MHA in London (1995), Organization Against Narcotics (OKANA) being director of the substitution Unit in Athens (1995-2000).
He served as lecturer in Forensic Psychiatry (2000-2005) and currently as assistant profesor in Forensic Psychiatry Athens University Medical School.
His scientific work includes 20 publications included in the SCI and 21 chapters in books (3with international publishers).
He is member of the Royal College of Psychiatrists, European Violence in Psychiatry Research Group and the Greek Psychiatric Association and currently chairs the Section of Forensic Psychiatry of theGreek Psychiatric Association

Erfurth, Andreas
Head of Clin Psychopharmacology and the Bipolar Spectrum Disorders Program, Division of General Psychiatry, Medical University of Vienna, AUSTRIA

Priv.-Doz. Dr. med. Andreas Erfurth was born in Hamburg, Germany in 1961 and received his education at the Conservatorio di Musica di Santa Cecilia, Rome, Italy, the Richard-Strauss-Konservatorium, Munich, Germany and the Medical School, University of Munich, Germany.
He was resident in psychiatry at the University of Munich, Germany and was research fellow at the Laboratory of Neuroendocrine Regulation, Department of Brain and Cognitive Sciences, M.I.T., Cambridge, Massachusetts, U.S.A. Hospital appointments include the University of Munich and the University of Muenster, Germany, where he wrote his habilitation thesis.
At present Dr. Erfurth is secretary of the European Bipolar Forum (www.EuBF.org) and of the Verein für Psychiatrie und Neurologie, Vienna. He was co-founder and secretary of the German Society for Bipolar Disorders.
His is particularly interested in the diagnosis, neurobiology and therapy of affective disorders.

Fagiolini, Andrea
Chairman and Residency Training Director, Division of Psychiatry, University of Siena School of Medicine Siena, ITALY

Andrea Fagiolini received his medical training in Italy at the University of Pisa (Italy) School of Medicine and completed his psychiatric residency at the University of Modena (Italy) Medical School. Since 1998 he has been on the faculty at the University of Pittsburgh Medical School, in the Department of Psychiatry, where he has served as Medical Director of the Bipolar Disorder Center and of the Depression and Manic Depression Prevention Program. More recently, he has joined the faculty at the University of Siena School of Medicine, Siena Italy. Professor Fagiolini's has published several books and papers in peer reviewed international journals. His research interests and publications have primarily focused on Bipolar and Major Depressive disorders. The topics of his research include the pharmacological treatment of mood disorders, suicidality, functional impairment and quality of life in patients with bipolar disease, and the relationship between bipolar disorder and medical conditions such as obesity and other metabolic disturbances.

Figueira Maria Luisa
Professor of Psychiatry, Faculty of Medicine, University of Lisbon, Head of the Psychiatric Department Hospital Santa Maria, University of Lisbon, PORTUGAL

Dr Figueira's area of scientific research is clinical and experimental psychopathology (bipolar disorders) and clinical psychopharmacology. Professor Figueira has been involved in the organisation of various meetings including the 1997 European College of Neuropsychopharmacology (ECNP) regional meeting, the 17th European Congress of Psychiatry that took place in Lisbon 2008 and International Symposia on Bipolar Disorders (1994–2009) since 1997 in cooperation with Hagop Akiskal – Honorary President (Univ. San Diego).
Between 1996 and 2005 she was involved as a principal investigator in many pharmacological clinical trials including six phase III studies and four phase II studies. Professor Figueira has been a fellow of the Collegium Internationale Neuro-psychopharmacologicum (CINP) since 1978, the European Association of Psychiatry (EAP) since 2002 and the International Society of Affective Disorders (ISAD) since 2003. She has published over 100 manuscripts in national and international peer-reviewed journals.

Fuller Bret
Program Coordinator, NW Hepatitis C Resource Center and Staff Psychologist, Portland VA Medical Center, Portland, Oregon, USA

Bret Fuller is a Clinical Psychologist in VA and a clinical member of the Department of Public Health and Preventive Medicine at Oregon Health and Science University. He earned his Ph.D. from the University of Missouri-Columbia in Counseling Psychology and completed a three year post-doctoral fellowship in addiction studies at the University of Michigan. Dr. Fuller spent six years at Oregon Health and Science University where he published in the areas of substance abuse treatment, methadone policy and smoking cessation. Currently, he is the program coordinator for the VA Northwest Hepatitis C Resource Center and a psychologist in the Portland VA Medical Center, Mental Health Division.

Fountoulakis Konstantinos
Assistant Professor of Psychiatry, 3rd Department of Psychiatry, School of Medicine, Aristotle University of Thessaloniki, GREECE

Dr. Fountoulakis received his medical degree (1989), performed his residency in psychiatry (1998), and earned his PhD in psychiatry (1999) at the Aristotle University of Thessaloniki. He received a 3-year fellowship in psychosomatic medicine and a 1-year postdoctoral fellowship for research from the State Scholarships Foundation of Greece. Until 2003 he served as a medical officer in the Greek Armed forces retired with the rank of major. In 2005, Dr. Fountoulakis was a Research Fellow in the Department of Psychiatry, Division of Neuropsychiatry, at the University of Geneva. His teaching areas and of clinical and research interest are: general psychiatry, biological psychiatry, psychopharmacology, mood disorders, schizophrenia and personality disorders. He is an active member of a number of national and international professional organizations, including the EPA, APA, WPA, CINP, ECNP, ISAD, ISBD, EBF, the Cochrane Collaboration and others and was most recently a member of the CINP Advisory Board to the Task Force on the Usefulness of Antidepressants and the Mental Health Economics Task Force of the IPA. He chairs the ISNP and since 2006, he served as Secretary, and since 2008 as co-chair of the Private Practice Section, of the WPA. He is Chair, Neuropsychological and Psychometric Instruments Section, of the Greek Psychiatric Association.
Dr. Fountoulakis is Editor in Chief of Annals of General Psychiatry and is Guest Editor of Current Opinion in Psychiatry. He has coauthored more than 250 papers; more than 90 of them are published in international journals such as IJNP, JAD, Schizophrenia Research, Psychiatry Research, Bipolar Disorders, and the British Journal of Psychiatry. He has received a number of national and international research awards.
In 2009 was appointed member of the Greek Ministry of Health Committee for the Administrative, Economic and Scientific Supervision of the Mental Health Units of the deinstitutionalization project.

Gaebel Wolfgang
Professor of Psychiatry, Director of the Department of Psychiatry and Psychotherapy at the Heinrich-Heine University, Duesseldorf, and Head of the LVR Klinikum Duesseldorf, GERMANY

Wolfgang Gaebel, born 1947 in Braunschweig, Germany, and was qualified in medicine at the Free University of Berlin (FUB), Germany, then took up postgraduate training in Neurology at Rudolf-Virchow-Hospital in Berlin and Psychiatry at the Department of Psychiatry at the FUB. After specializing in Psychiatry, Psychotherapy and Neurology he continued working as Research Assistant, then Senior Psychiatrist at the Department of Psychiatry at the FUB, at the same time becoming appointed as State Physician for Mentally Handicapped Persons at the Senator for Health and Social Affairs in Berlin. In 1989 he obtained a grant of the German Research Foundation for a Research Stay at the Department of Psychology at the University of Lethbridge, Alberta, Canada. In 1992 he took up his present position.
During his career, Professor Gaebel has held positions as President of the German Society of Psychiatry, Psychotherapy and Nervous Diseases (DGPPN, 1995/6), and President of the German Society of Biological Psychiatry (DGBP, 1999/02). He was Chair of the Organizing Committee of the 11th World Congress of Psychiatry, Hamburg, 1999. He is Vice President of the Association of the Scientific Medical Societies in Germany (AWMF), member of the Deutsche Akademie der Naturforscher LEOPOLDINA, member of several National Ethical Committees, chairman of the Section on Schizophrenia as well as co-chairman of the Section on Quality Assurance and honorary member of the World Psychiatric Association (WPA), and chairman of the Taskforce on Nosology and Psychopathology of the World Federation of Societies of Biological Psychiatry (WFSBP).
Prof. Gaebel was again elected as President of the German Society of Psychiatry, Psychotherapy and Nervous Diseases (DGPPN) for the period 2007 – 2008. He was elected as a Board Member of the European Psychiatric Association (EPA) with effect of 01 January 2009 and he was elected as co-chairman of the EPA Section on Schizophrenia.
His research focus includes clinical, pharmacological, and neurophysiological aspects of schizophrenia, experimental psychopathology, treatment guidelines and quality management, and research on stigma and discrimination. His current interest is on the development of diagnosis and classification towards ICD-11 and DSM-V; he is member of the Global Scientific Partnership Network appointed by WHO.
Professor Gaebel has published about 500 scientific articles and is editor or author of about 30 books/supplements on a range of topics.

Galderisi Silvana
Professor of Psychiatry and Director of the Training School in Psychiatry at the University of Naples SUN, ITALY

Silvana Galderisi, is member of the Board of the European Psychiatric Association and Chairperson of the Section on Schizophrenia of the same Association. She is founding member of the European Group for Research in Schizophrenia and Board member of that organisation. Additionally, she is Chairperson of the Psychophysiology Section in Psychiatry of the World Psychiatric Association and President Elect and General Secretary of the EEG & Clinical Neuroscience Society. Her scientific work has been published in high impact international journals including Lancet, American Journal of Psychiatry, British Journal of Psychiatry, Biological Psychiatry, Archives of Clinical Neuropsychology, Neuroimage, Human Brain Mapping, Neuroscience, Schizophrenia Bulletin and Schizophrenia Research.

Ganança Licinia
Psychiatry Resident, Psychiatric Department, Hospital Santa Maria, University of Lisbon and Consultant of the Portuguese Authority of Drugs and Pharmacy, PORTUGAL

Licínia Ganança is a 3rd year psychiatry resident at the Psychiatric Department at the Hospital Santa Maria, University of Lisbon and a consultant of the Portuguese Authority of Drugs and Pharmacy. Her main areas of research are psychogeriatrics and psychiatric disorders in association with Epilepsy. Has participated in around 10 poster presentations in national and international meetings. Licínia Ganança a member of the Portuguese Association of Biological Psychiatry.

Gelenberg Alan
Professor Emeritus, University of Arizona's Department of Psychiatry, and Clinical Professor at the University of Wisconsin-Madison, USA

For 18 years, he was Professor and Head of the University of Arizona's Department of Psychiatry, where he remains Professor Emeritus, and is currently Clinical Professor at the University of Wisconsin-Madison. Has been on the faculties of Harvard, Massachusetts General Hospital, and M.I.T. Since 1987 Dr. Gelenberg has been Editor-in-Chief of the *Journal of Clinical Psychiatry*, Dr. Gelenberg has been lead author of manuscripts in the *Lancet, New England Journal of Medicine,* and *JAMA* and has authored over 260 scientific articles, editorials, and book chapters. He chairs the APA workgroup on Treatment Guidelines for Major Depressive Disorder, was on a joint APA/AMA taskforce on similar guidelines for primary care, has sat on NMIH committees, is a Distinguished Life Fellow of the APA, former chair of its Committee on Research on Psychiatric Treatments, past President of the West Coast College of Biological Psychiatry, fellow of the American College of Neuropsychopharmacology, and member of the American College of Psychiatrists. He now chairs the Data and Safety Monitoring Board of the NIMH study Treating Depression and Insomnia (TRIAD). Listed in *The Best Doctors in America* and *America's Top Doctors*, he received an Exemplary Psychiatrist Award of the National Alliance for the Mentally Ill and two teaching awards at the University of Arizona.

Georgakas Panagiotis
Scientific Director of Argo–Alternative Therapeutic Program for Addicted Individuals, Psychiatric Hospital of Thessaloniki, GREECE

Dr Georgakas completed his residency in psychiatry in 1984, and his PhD in Aristotle University Medical School ("A study about the problems faced by children with addicted parents") and in the Aristotle University Polytechnic School–Department of Architecture ("Therapy centres for addicted individuals and the city"). He served as Psychiatrist in charge of Chronic Psychopaths Unit of P.H.T of Petra Olympou Psychiatric Hospital (1984-8), Psychiatrist in charge of Chronic Psychopaths Unit of P.H.T (1986-8), Counselling Station manager, P.H.T Drug-addicts Rehabilitation Department (1992-4), Scientific Director of Carteron Therapeutic Community (1994-8), P.H.T Detoxification Unit (1996-8), Social Reintegration of Carteron Therapeutic Community past members (1995-2000), Detoxification Unit Programme (1997-8) and is currently Scientific director of the Argo–Alternative Therapeutic Program for Addicted Individuals Psychiatric Hospital of Thessaloniki (1998-).

Giannopoulou Ioanna
Consultant Child and Adolescent Psychiatrist, NHS Community Mental Health Centre of Peristeri, Athens, GREECE

Dr Ioanna Giannopoulou studied medicine at the University of Athens. She pursued her postgraduate studies in Addictions, with support of the Greek State Scholarships Foundation, at the Department of Psychiatry of the Huddinge University Hospital, Karolinska Institute (Sweden) from where she was granted the degree of M.Med.Sci. in psychiatry and then completed her training in psychiatry at the Maudsley and Bethlem Royal Hospitals (London). After becoming a Member of the Royal College of Psychiatrists (U.K.) she continued higher training in child and adolescent psychiatry. Following a successful research grant application to the Mental Health Foundation, she was appointed Clinical Research Fellow at the Academic Department of Child & Adolescent Psychiatry at the Institute of Psychiatry in London (U.K.). She completed her PhD thesis "Preschool hyperactivity: Development of observational and self-regulation measures for detecting hyperkinetic disorder in preschool children", under supervision of Professor Eric Taylor, at the Institute of Psychiatry, University of London. In 1997 she was appointed Consultant Child and Adolescent Psychiatrist at the NHS Community Mental Health Centre of Peristeri and since 2007 has been sharing her clinical time between Peristeri CMHS and the 2nd Department of Psychiatry at the "Attikon" University Hospital. Her varied research and clinical interests include ADHD, training parents in management techniques, fostering and adoption, risk and needs assessment. Much of her time has been devoted recently to studies examining psychological effects in children following exposure to trauma (earthquake, bush fires, school bus accident) and effective treatment interventions for the survivors. She has published papers on the related to her interests' topics, in Greek and English, in the form of journal articles and book chapters.

Goigolea Jose
Psychiatrist, Bipolar Disorders Program of the Hospital Clinic, Barcelona, SPAIN

Dr. Jose M. Goikolea works as a psychiatrist at the Bipolar Disorders Program of the Hospital Clinic, at Barcelona. He attended Medical School at the University of the Basque Country in Spain, and then completed residency in Psychiatry at the Hospital Clínic in Barcelona. Since them, he has worked at the Bipolar Disorders Program in that hospital, headed by Dr. E. Vieta. He has combined a good deal of clinical work with research, mainly focused on novel treatments, both psychological and pharmachological, including atypical antipsychotics, novel antiepileptic drugs and ECT. He is currently leading a research project in first-episode mania. He has co-authored more than 30 articles and several book chapters. In 2005, he received the "Young Minds Award" by the American Psychiatric Association.

Gonda Xenia
Clinical Psychologist and Pharmacist, Faculty of Medicine, Semmelweis University, Budapest, HUNGARY

Xenia Gonda MA PharmD PhD is a clinical psychologist and pharmacist working at the Department of Clinical and Theoretical Mental Health and Department of Pharmacology and Pharmacotherapy, Faculty of Medicine, Semmelweis University Budapest. Her main research interests include personality genetics, neurochemical and genetic correlates of suicidal behaviour and the association of mood states with the fluctuation of reproductive hormone levels.

Grigoriou Panagiotis
Director, NHS Department of Psychiatry, General Hospital of Chalkidiki, Makedonia, GREECE

Panagiotis G.Grigoriou M.D., Ph.D.,is the Medical Director of the Department of Psychiatry at the General Hospital of Chalkidiki, Makedonia, Greece. He received both his M.D. and Ph.D. degrees from the University of Athens. He completed his postgraduate training in Neurology and Psychiatry at the Athens University School of Medicine. He has followed a fellowship in Neurology at the "Clinique des maladies du Systeme Nerveux", Hopital Salpetriere- Paris and another in Psychiatry at the " Institute of Psychiatry and Human Behaviour", University of Maryland-Baltimore MD. He accomplished a long training in Group and Family Therapy at the " Athens Human Study Center" under the supervision of the late George Vassiliou M.D. He has worked as a Neurologist and Psychiatrist at the "Evangelismos" and the "Red Cross' hospitals in Athens earning a rich clinical experience. Since 1988 he voluntarily abandoned his carrier in Athens and was installed in Chalkidiki influenced by the ideals of Social and Community Psychiatry. His primary aim was to provide psychiatric care of high quality to people who never had such an opportunity; Chalkidiki-an otherwise natural "paradise"- was completely naïve of any psychiatric service. Having staffed his working team with excellent mental health professionals and due to his personal devotion and hard efforts he has created a full net of psychiatric services able to meet adequately the needs of the whole region. Another goal he has worked on is the education of the population on mental health issues and the fight against stigma. He participated in several multi-centric clinical studies and attends regularly the most important national and international Psychiatric conferences and congresses.

Hantouche Elie
Director of CTAH, Anxiety and Mood Center, FRANCE

Dr Hantouche is considered as top expert for bipolar disorders and OCD. He is also involved to be the scientific advisor of the French Association of Patients with OCD, and the National Union of Depressive and Manic Depressive Patients. Currently, Dr Hantouche is the director of CTAH, Anxiety and Mood Center
He has published more than 200 papers (64 cited in Pubmed*) and he is the author of 10 books on OCD, Cyclothymia, Bipolar OCD, Juvenile bipolarity, Creativity, Psychoeducation for Cyclothymia, Trilogy of fears and phobias.
In April 2005, he chaired the 5th International Experts Meeting for Bipolar Disorders and launched the European Bipolar Forum – He is co-editor in chief of a new journal "*Aspects of Affect*" dedicated to Bipolar Disorders and reviewer for many international journals

Hauser Peter
VISN 22 Mental Health Services Lead, Long Beach VA Medical Center, Long Beach, California, USA

Dr Hauser was born in Petersburg Virginia. His parents immigrated to the United States from what is now the Czech Republic in the 1950's. Dr Hauser graduated from the University of Virginia with a major in German Literature and then attended the University of Virginia Medical School. He began his psychiatry residency at the Clarke Institute of Psychiatry, University of Toronto and completed his last year of psychiatry residency at Georgetown University in Washington, DC. He then worked at the National Institutes of Health from 1986 until joining the Department of Veteran Affairs (VA) in 1994.
His VA career started in 1994 as the Chief of Psychiatry at the Baltimore VA Medical Center. In 2000 he became the Clinical Director of the Mental Health Division and the Chief of Psychiatry at the Portland VA Medical Center in Oregon and professor in the Departments of Behavioral Neurosciences, Internal Medicine and Psychiatry at the Oregon Health and Sciences University. He was also the Associate Director of the VA Northwest Hepatitis C Resource Center, one of 4 centers in USA dedicated to the treatment of veterans with hepatitis C.
Dr Hauser has served as a member of various VA national committees including the National Committee for Veterans Affairs Major Depressive Disorders Clinical Guidelines, the Department of Defense/Veterans Affairs Practice Guideline Major Depressive Disorders Working Group, the National Committee for Veterans Affairs Psychosis Clinical Guidelines and more recently the Joint Biomedical Laboratory Research and Development as well as the Clinical Science Research and Development Services Scientific Merit Review Boards. He is currently the VISN 22 Mental Health Services Lead in Long Beach, California.
Other accomplishments include his work as a psychiatrist and researcher in the public sector since 1986. His primary research and clinical interests are the psychiatric and substance use disorders co-morbidities in veterans with hepatitis C, the development of educational products for veterans with hepatitis C as well as the healthcare providers who treat these patients, and the treatment and underlying causes of interferon-induced depression. He has edited two books, authored several chapters, and published over 90 articles and letters in journals such as *Molecular Psychiatry*, *New England Journal of Medicine*, *Journal of Affective Disorders* and *Proceedings of the National Academy of Sciences*; the primary focus of his publications has been hepatitis-c, mood disorders and psychoneuroendocrinology. He is dedicated to serving veterans of the United States of America.
He lives with his wife Cathy and their three children - Katia, Anika and Max- in Palos Verdes, California.

Höschl Cyril
Professor of Psychiatry and Chairman, Prague Psychiatric Centre, CZECH REPUBLIC

Cyril Höschl, MD, DSc., FRCPsych., born on 12 November 1949 in Prague (Czechoslovakia).
He received his MUDr. (Doctor of Medicine) grade at the Charles University in Prague in 1974. He started his career in Psychiatric Research Institute (PRI) in Prague and later on at Charles University in Prague. His research interests included psychoneuroendocrinology, psychopharmacology and biological psychiatry. In 1984, prof. Höschl presented his original work on neuroendocrine tests in psychiatry at several Canadian universities. In 1985, he was lecturing at New York University on his pioneering studies on calcium channel blockers in the treatment of affective disorders.
He was elected the Dean of the Third Medical Faculty of the Charles University in Prague (1990-1997) and appointed professor of psychiatry and chairman, Prague Psychiatric Centre. He is fellow of the Royal College of Psychiatry, the Past President of the European Psychiatric Association, the President of the Czech Medical Academy and the President of the Federation of European Medical Academies and a member of many other societies He has received several prestigious awards. He published more than 100 publications, incl. 3 monographs, and co-edited 5 more monographs and textbooks.

Janca Aleksandar
Head of School of Psychiatry and Clinical Neurosciences, University of Western Australia, Perth, AUSTRALIA

Prof. Aleksandar Janca is the Head of School of Psychiatry and Clinical Neurosciences at the University of Western Australia in Perth. He also works as a Consultant Psychiatrist at Royal Perth Hospital and is Director of the WHO Collaborating Centre in Perth. Prof. Janca started his research career in 1987 as a Fulbright Scholar at the Department of Psychiatry, Washington University School of Medicine in St Louis, Missouri. From 1991 to 1997 he worked as a Medical Officer at WHO Headquarters in Geneva and was responsible for coordination of a number of international projects in the areas of psychiatric nosology, psychiatric epidemiology and transcultural psychiatry. Prof. Janca has a particular interest in the development and evaluation of novel psychiatric assessment instruments and outcome measures.

Kahl Kai
Executive Director, Department of Psychiatry, Social Psychiatry and Psychotherapy, Hannover Medical School, GERMANY

After high school graduation in 1984 studies in human medicine, social psychology and philosophy at the Hannover Medical School and Leibniz University Hannover. 1994-1999 assistant at the University of Heidelberg and University of Würzburg, 1999-2007 Assistant and Senior Physician at the University of Lübeck. 2003 accreditation as supervisor for psychotherapy, 2004 accreditation as therapist for dialectical behavioural therapy, 2005 winner of the Falk-von-Reichenbach price with a scientific work on major depression, borderline personality disorder and physical health: late consequences of early traumatic experiences. Since 2008 executive director of the Dep. of Psychiatry, Social Psychiatry and Psychotherapy (Hannover Medical School). Research interests: Psychoneuroendocrinology, diabetes, psychotherapy.

Kahn Rene
Professor and Chair of the Department of Psychiatry and Head of the Division of Neuroscience at the University Medical Center, Utrecht, THE NETHERLANDS

Dr René Kahn received a Fulbright Scholarship for study at Yale in 1995 and subsequently did a Fellowship in Biological Psychiatry at the Montefiore Hospital and Albert Einstein College of Medicine in New York. He then moved to the Mount Sinai School of Medicine where he conducted schizophrenia research and became Unit Chief of one of the research units.
Dr Kahn has received many grants for his research into the origins and treatment of schizophrenia. His current research interests include neuroimaging in schizophrenia and the genetic dissection of complex traits in specific psychiatric disorders. He has published over 350 research papers and book chapters. He is on the editorial boards of Schizophrenia research, Schizophrenia Bulletin, Early Interventions in Psychiatry and European Neuropsychopharmacology. He is Vice-President of the European College for Neuropsychopharmacology and Treasurer of the Schizophrenia International Research Society. He sits on the Neuroscience and Mental Health Board of the Medical Research Council of the UK and on the scientific advisory group for CNS of the European Medicines Agency.

Kalampalikis Vasileios
Psychologist, Head of the KETHEA ITHAKI Therapeutic Program, Thessaloniki, GREECE

Vasileios Kalampalikis studied Psychology (basic studies), Systemic theory and Social planning and management/administration.
The last 15 years he is working on drug-addiction, with drug-addicted people (adolescents, adults and their families) giving services of counseling and therapy. During these years he has also offered seminars about drugs and addiction –problem to teachers, people who work in relative services, doctors and people who work to the municipality.
The last two years I am the head of the KETHEA ITHAKI Therapeutic Program in Thessaloniki.

Kaloterakis Phaedon
Assistant Director of
KETHEA, GREECE

Phaedon Kaloterakis is the Assistant Director of KETHEA (KETHEA is the oldest and largest organization in the addictions field in Greece) and has been involved with the drug addiction field since 1981. He is a member of the Board of Directors of the International Certification and Reciprocity Consortium (ICRC) for Greece, Cyprus, Malta and Bulgaria.He is also the KETHEA representative at the Economic and Social Council (ECOSOC) at the U.N. and a member of the Board of the International Federation of Non Government Organizations (IFNGO).
He served as the first Chairman of the Ethics committee of KETHEA and he was a member of the Organizing and Scientific committee of the 10th European Federation of Therapeutic Communities (EFTC) Conference. He is a member of the Therapeutic Communities Journal's International Editorial Advisory Group.
Mr. Kaloterakis has been supervising Addiction Therapy Centers in Bulgaria, where he also trains drug-addiction specialists (psychiatrists, psychologists and social workers), since 1997.
He holds a Bachelor of Religious Education Degree from R.B.C., Michigan, a Master of Worldview Studies in Philosophy and Psychotherapy from I.C.S. Toronto and his Ph.D thesis at the School of Health Sciences and Social Care at Brunel University, London is: "Relapse Prevention in the Greek Therapeutic Communities : Implications for Service Delivery".
He is also a musician, a recording artist, a composer, a producer and a member of the Board of Directors of "IRAKLIS" Sports Club, General Secretary of the Greek Judo Federation and Honorary President of the Greek Christian Artists Union.

Karam Elie
Professor and Head of the Department of Psychiatry and Clinical Psychology of St. George Hospital, University Medical Center, Balamand University, Faculty of Medicine, Beirut, LEBANON

Prof. Elie Karam founded IDRAAC (Institute for Development, Research, Advocacy and Applied Care) in 1982 and is currently the institution's Executive Director. IDRAAC is an institute solely devoted to Research and Field Services in Mental Health. (www.idraac.org). IDRAAC's research has addressed a variety of important regional and international issues such as violence (including war), depression, suicide, substance abuse, childhood disorders, burden and treatment of mental health disorders, temperament etc... and is the training center for CIDI for the Arab World.
In addition to the researches outlined above, prof. Elie Karam initiated the first national study on mental health in the Arab World – Lebanese Evaluation of the Burden of Ailments and Needs Of the Nation (L.E.B.A.N.O.N.). He is member of several national and international societies. He is on the Editorial Board of several international journals. He has published several articles.
Prof. Elie Karam founded MIND (Medical Institute for Neuropsychological Disorders) in 1985. MIND clinics are best known for this multi-specialist approach delivered by experts in the field of psychiatry, psychology, social work and nursing and has specialists in Child / Adolescent, Adult and Geriatric Mental Health. MIND clinics are equipped with the knowledge, expertise and resources to assess, evaluate and treat every psychiatric and psychological disorder including ADHD, substance use, memory problems, depression, anxiety, bipolar, PTSD, phobias, schizophrenia, eating disorders, sexual dysfunction, delusions, stress etc. (www.mindclinics.org).

Kargopoulos Philippos
Associate Professor of Logic and Philosophy of Mind, Psychology Department, Aristotle University of Thessaloniki, GREECE

Philip V. Kargopoulos was born in Thessaloniki, Greece. Studied philosophy at the University of Chicago from which he graduated with Phi Beta Kappa Honors. He continued his graduate studies in philosophy of science at Boston University (PhD 1981). His post doctoral research was done at the Boston Center for the History and Philosophy of Science. He taught philosophy first at the University of Massachusetts in Boston and then at Brandeis University. After completing his military service in Greece, he was appointed in 1985 as lecturer in Philosophy of Science at the Philosophy Department of the Aristotle University of Thessaloniki. In 1995 he was appointed associate professor of Logic and Philosophy of Mind in the Psychology Department of Aristotle University a position he has held since. He has written books on philosophy of science, logic and philosophy of mind and has edited an anthology on the search for neural correlates of consciousness. His current research is on mental representations in philosophy of mind, cognitive science and cognitive psychology. He is currently the vice president of the Greek Society for the Sciences of Mind and Cognition.

Kasper Siegfried
Professor and Chair, Department of Psychiatry and Psychotherapy, Medical University of Vienna, AUSTRIA

Dr. Kasper published 724 in ISI (http://portal.isiknowledge.com) listed publications (Citation Index: 6989, Hirsch-Index: 43) and more than 200 book chapters, in various areas of psychiatry. Dr. Kasper serves on the executive committees and advisory boards of several national and international societies, such as the European College of Neuropsychopharmacology (ECNP) and the Collegium Internationale Neuro-Psychopharmacologicum (CINP). He is president of the Austrian Society of Drug Safety in Psychiatry (ÖAMSP) and past-president of the Austrian Society of Neuropsychopharmacology and Biological Psychiatry (ÖGPB). Furthermore, he is an honorary member of the Czech and Romanian Societies of Neuropsychopharmacology, the Hungarian Psychiatric Association and a Fellow of the Royal College of Psychiatrists, UK, as well as of the Ukrainian Association of Psychiatry. In 1997, he was the president of the 10th ECNP Congress, was the chairman of the local organizing committee of the WPA Thematic Conference in 2004 and is the co-chair of the local organizing committee of the WFSBP Congress 2005 in Vienna. Furthermore, he has been appointed honorary Professor at the University of Hong Kong, China. Dr. Kasper has been elected as President of the World Federation of Societies of Biological Psychiatry (WFSBP) for the term 2005-2009. Dr Kasper serves on editorial boards of numerous learned journals (total 51), including Journal of Clinical Psychiatry, European Archives of Psychiatry and Neuroscience, Comprehensive Psychiatry, and European Neuropsychopharmacology. He is Co-Editor-in-Chief of the International Journal of Psychiatry in Clinical Practice, Editor of the World Journal of Biological Psychiatry, and Field Editor of the International Journal of Neuropsychopharmacology.

Kastrup Marian
Head, Centre for Transcultural Psychiatry, Psychiatric. Dept. Rigshospitalet, Copenhagen University Hospital, DENMARK

Dr Kastrup received her medical degree in 1973 from the University of Aarhus, Denmark. In 1975 she received the Gold Medal Award in Psychiatry from the University of Odense, in 1983 her Ph.D from the University of Copenhagen, and in 1985 her specialty in Psychiatry from the Danish National Board of Health. Since 2001 she directs the Centre for Transcultural Psychiatry, Psychiatric. Dept. Rigshospitalet, Copenhagen University Hospital, Denmark. From 1992-8 was Associate Professor in Psychiatry, University of Copenhagen and currently is External examiner in Psychiatry, MPH programmes and Bachelor of Public Health, Universities of Copenhagen, Aarhus and Odense, External examiner, University of Odense, External examiner in Psychiatry, University of Copenhagen. She served in various advisory positions of the WHO, the EPA and the WPA among others. She is author/co-author of more than 90 peer-review articles, editor/author of more than 15 books and more than 60 book-chapters and more than 60 technical reports/other publications.

Kokkas Basileios
Professor of Pharmacology and Head of the 1st Department of the Experimental Pharmacology, School of Medicine, Aristotle University of Thessaloniki, GREECE

Dr Kokkas was born in Chalkida Greece in 1944. He obtained his medical degree from the Medical Faculty, Aristotle University of Thessaloniki, Greece in 1969 and was specialized in Radiology in 1975. His post-graduate training at the Université Libre de Bruxelles includes six months of pharmacological research in the field of the vascular wall (Institut de Recherche Interdisciplinaire en Biology Humaine et Nucleaire; 1987), one month of intensive information, as a visitor professor, in the use of the Positron Emission Tomography in the pharmacological research (Hopital Erasme, Services de Medecine Nucleaire; 1989), six months training in therapeutic drug monitoring (Hopital Erasme, Services de Chimie Medicale; 1997) and 193 hours of intensive sessions concerning the whole studies that must be carried for the development and the marketing of a new drug (PHARMED Seminars, Post-Graduate Programme in Pharmacology and Pharmaceutical Medicine; 1997)
He is author or co-author of more than 200 published articles, of which 41 in international journals and 5 books.

Konstantinidis Anastasios
University Hospital for Psychiatry and Psychotherapy, Clinical Division for Biological Psychiatry, Vienna, AUSTRIA

Born 1974 in Thessaloniki, Greece, studied medicine and accomplished medical training in psychiatry in the Medical University of Vienna (MUV). Since 2001 working in the Clinical Division for Biological Psychiatry in Vienna. Main scientific area is psychotropic treatment of psychiatric disorders (including Tourette Syndrome, ADHD in Adults, Recurrent Brief Depression, Seasonal Affective Disorder among others) and more specifically psychotropic polypharmacy and pharmacovigilance in psychiatry (drug safety / drug surveillance). He already published as author and co-author many studies in journals such as Biological Psychiatry, Archives of General Psychiatry or European Neuropsychopharmacology. He also functioned as monitor for imaging studies of his division. He already took part in numerous national and international psychiatry congresses. Recently he was invited to give a speech in the International Congress of the International Society of Pharmacovigilance in Buenos Aires, Argentina.

Koukopoulos Athanasios
Director of the Centro Lucio Bini, Rome ITALY

At present director of the Centro Lucio Bini, a center for the treatment and study of psychiatric conditions, particularly affective disorders, that he and other colleagues founded in 1970. In 1977, he founded the Centro Lucio Bini in Cagliari with Dr. Leonardo Tondo. From 1963 to 1998 he was the Head of the medical staff of the Clinica Belvedere Montello, a private psychiatric in-patient facility in Rome.
His main activity has always been the examination and treatment of psychiatric patients with a particular interest in Affective Disorders. In addition to his clinical activity, he has been performing some clinical research on the course of Manic-Depressive Illness, the pattern of the manic-depressive cycle and the effects of the treatments upon it.
He is also conducting studies on manic-depressive temperament and its importance in the genesis of affective disorders and their course.
Related to the above issues have been the lines of research on the response to prophylactic lithium treatment and the increase of bipolarity and frequency of recurrences following antidepressant drug treatments. The temperement, the course and the concomitant factors of rapid cyclicity have been an important part of his work for more than thirty years. For more than twenty years he has been working on agitated and mixed depression arguing that they are mixed states often induced by antidepressants and requiring a different treatment. His last work was on the "Primacy of Mania" hypothesis i.e manic and hypomanic states should be considered primary and depression would be the consequence of these excitatory processes. The prevention and treatment of the excitatory phases should be considered the focus of prophylaxis.

Koupidis Sotirios
Deputy CEO, Dromokaiteion Psychiatric Hospital of Athens, GREECE

Dr Koupidis was born in 1975 in Veroia, graduated from the Aristotle University of Thessaloniki School of Medicine and the National School of Public Health, and currently works on his PhD at the University of Athens School of Medicine
He serves since 2008 as chair of the Social Collective 'New Horizons' Ltd, who creates employment positions for mental patients. He is also vice chair of the Greek Rescue Team in Imathia county.
He served as deputy CEO of the Psychiatric Hospital of Chania (2005), CEO of the Psychiatric Hospital of Corfu (2005-8) and since 2008 as deputy CEO at the Dromokaiteion Psychiatric Hospital of Athens.
Currently is administrative coordinator of the Administration Task force of the Ministry of Health for the first nation-wide epidemiological surveys for mental disorders in children, adolescents and adults.
He has received awards twice for the most important administrative work, on issues concerning the improvement of functioning of mental health services. Also, he has received an honorary scholarship for his excellence in his studies at the department of Health Units Administration studies at the Kalamata TEI.

Koutras Vasilios
Associate Professor of Health Education, Department of Preschool Education, Ioannina University, and Scientific Director of the Counseling Centre for Combating Drug Abuse in Ioannina, GREECE

Vasilios Koutras is an Associate Professor of Health Education in the Department of Preschool Education, in Ioannina University, in Greece. He was born in Ioannina, in 1961. He graduated from Medical School of Ioannina in 1984, and was awarded a PhD in 1990.
From 1985 to 1988 he worked as an instructor of Physiology Pharmacology at the Department of Nursing in the Technological Education Institute of Ioannina. From 1989 to 1993 he taught Psychophysiology at the Department of Preschool Education in Ioannina.
He was specialized in Psychiatry from 1991 to 1993. He was elected Lecturer in the Department of Preschool Education in Ioannina University, in 1994, Assistant Professor in 2000, and Associate Professor in 2007. Since 1994, he has been the Scientific Director of the Counseling Centre for Combating Drug Abuse in Ioannina, and works in the field of prevention and in drug addiction therapy as well.

Küey Levent
Secretary General, World Psychiatric Association
Associate Professor of Psychiatry, Istanbul
TURKEY

Born in 1957; Medical Doctor in 1981; Specialist of Psychiatry in 1985; Associate Professor of Psychiatry in 1989; Assistant Therapist in Psychodrama Group Psychotherapy in 1993. Work, research and teaching experiences for nearly 30 years in different psychiatric institutional settings, currently practicing, teaching and supervising in Psychology Department of Istanbul Bilgi University and in private practice. Main fields of research and publication are depressive and anxiety disorders, psychiatric epidemiology, case formulation, social and cultural psychiatry, psychopathology, diagnosis and classification. Author of over 50 scientific journal articles. Author and translator of numerous books and book chapters. Research award of the Turkish Journal of Psychiatry, in 1997. Past editor and current member of the scientific board of the leading national and some international journals of psychiatry. Founder member and past Executive Committee member of the Psychiatric Association of Turkey. Past member of the Honorary Board of the Turkish Medical Association-Izmir Branch. Honorary Member of WPA; Member of the WPA Sections on Classification and Diagnossis and Public Policy and Psychiatry; Co-chair of the WPA Standing Committee on Planning. A co-opted member of the European Division of the Royal College of Psychiatrists, UK. Member of the Evaluation Committee in Psychiatry for the UEMS-EACCME (European Union of Medical Specialists-European Accreditation Council for Continuing Medical Education). Secretary General and/or Organizing and Scientific Committee Member in nearly 40 national and international scientific meetings. Lecturer/speaker at over 40 international and 50 national scientific meetings.

Lainas Sotirios
Psychologist, Coordinator of the Self Help Promotion Program, Aristotle University of Thessaloniki,
GREECE

Sotirios Lainas has a bachelor degree in Psychology of the department of Psychology of Aristotle University and a masters degree (Msc) in Social Clinical Psychology of Addictions of the same institution. He is a PhD candidate at the moment in the department of psychology of Aristotle University of Thessaloniki, is the coordinator of the Self Help Promotion Program, of Aristotle University of Thessaloniki. Self Help Promotion Program is the only university program – based on action research philosophy- that focuses on the promotion of self help / mutual aid in the confrontation of addiction and other psycho-social problems.
He has participated as a speaker in various national and international conferences, regarding the prevention and treatment of substance abuse and self help applications in the confrontation of psychosocial problems. He has also published papers in scientific journals around these topics. His main areas of interest are substance abuse treatment and prevention, self help / mutual aid groups, community psychology, humanistic psychology and critical approaches to psychology.

Lieberman Daniel
Associate Professor and Director of Research in the Department of Psychiatry and Behavioral Sciences at George Washington University in Washington, DC, USA

Dr Lieberman is Associate Professor and Director of Research in the Department of Psychiatry and Behavioral Sciences at George Washington University in Washington, DC. He also chairs the university's institutional review board. Dr. Lieberman did his undergraduate work at Saint John's College in Annapolis, Maryland, and attended medical school and did his residency training at New York University. He has been on the faculty of George Washington University since 1996.Dr. Lieberman is active in research, teaching, and patient care. His research has focused on using the Internet to expand access to psychosocial interventions. He developed a Web application for drinkers that mimicked a motivational intervention by providing assessment feedback, allowing the user to identify positive and negative consequences of substance use, and providing direct advice when indicated. This application was able to increase treatment interest in a hidden population of alcohol abusers who were not accessing traditional forms of care. Currently he is working on an open source Web application and iPhone app that makes daily mood charting easier to maintain long term.

Lykouras Lefteris
Professor of Psychiatry, Director of the 2nd Department of Psychiatry, Attikon Hospital, School of Medicine, Athens University, GREECE

Professor Lykouras was born in Piraeus Greece, graduated from the Athens University School of Medicine in 1969 and completed his residency in Neurology and Psychiatry in 1975. He completed his PhD in 1981 and a post-doctorate appointment in 1988. He speaks Greek English and French. He received a Doctoral dissertation scholarship (1974-1975) and a Post-doctoral research scholarship (1978-1981). He was appointed Lecturer in Psychiatry, in 1982, Senior Lecturer in Psychiatry, in 1988, Reader in Psychiatry, in 1996 and Profesor in Psychiatry, School of Medicine Athens University in 2004. He is member of a significant number of national and international scientific societies and participated in the organization of congresses and was invited speaker chairman of session or participant in more than 150 scientific events. He acts are regular reviewer in international journals and is active in the research in Clinical Psychiatry, Biological Psychiatry and Psychopharmacology General Hospital Psychiatry, and Psychiatric Education. He has authored or co-authores more than 500 journal articles and abstracts, received more than 1.000 citations and 10 books

Malliaris Yianni
Department of Health Service and Population Research, Institute of Psychiatry, King's College London, London, UNITED KINGDOM

Yanni Malliaris, BSc. graduated from Stirling University and UCLA with a first class honours degree in Psychology in 1999. During his undergraduate years he developed an interest in the psychosocial factors of affective disorders by studying with Professor Constance Hammen and trained in behaviour modification with Professor Ivar Lovaas. Since completing his military service (2002) he has been working as a research psychologist at the Institute of psychiatry, King's College London, where he is also currently completing his PhD thesis under the supervision of Professors Dinesh Bhugra and Tom Craig. At the Institute, he began his work with Professor Dominic Lam and commenced his own research project (www.bipolarlab.com) following funding from the Medical Research Council. Yanni is exploring the impact of sub-syndromal symptoms in the course of Bipolar disorder and particularly the role of symptom variability in predicting relapse. He is also studying the role of new technologies for tracking the variable course of Bipolar disorder. Yanni is a firm believer in the positive role of self-help organisations and over the last year has founded the Hellenic Bipolar Organisation (www.bipolar.gr), the first NGO for bipolar patients in Greece, in his father's memory.

Malliori Meni
Assistant Professor of Psychiatry, University of Athens Medical School, GREECE

Dr Malliori was born in Patras Greece in 1952, graduated in 1978 from Athens University Medical School and after residency in psychiatry had her post-doctoral training in the Tavistock Clinic London, the Nottingham University and the World Health Organization (WHO), Geneva, in the fields of Mental Health Services Planning, State Psychiatric Services, organizational structure, planning and implementation on drug policy (1979-1984). During 1987 was Consultant in the Mental Health Department of the World Health Organization (WHO), Geneva and from 1987-1997 served as consul to the Minister of Health and responsible for the psychiatric transformation, the closure of big asylums and the social rehabilitation of mental patients During 1997-1999 she served as head of the Organization Against Drug Abuse (OKANA) and during 1999-2004 served as member of the European Parliament and member of the Committee for Public Health, Environment and Consumers Protection. Since 2004 she served as Deputy Chair in the Management Board of the European Centre for Prevention and Control of Diseases (ECDC). Since 2006 she served as member of the Experts Committee for the Health Consumer Powerhouse, for the Code for the Assessment of Health Services. She has also served as member of the Steering Committee for evaluation of the actions undertaken within the framework of the European Community Public Health Program related to the fight against cancer, drugs, AIDS and other communicable diseases, member of the Scientific Committee of the Regional Congress of the World Psychiatric Association in Preventive Psychiatry and since 2008 is member of the Work Group of the European Parliament for Mental Health and Drug Abuse. Her research activity includes publication on the topic of Mental Public Health, Drug Abuse, Consumers Safety and Protection and Environmental Issues

Mandelli Laura
Lecturer in Psychiatry, Institute of Psychiatry, University of Bologna and Assistant Professor of Psychiatric Genetics, University of Molise, Campobasso, ITALY

Laura Mandelli was born in August 13, 1976. She has participated in several national and international research programmes in psychiatry, including projects funded by the European Commission and the Italian Ministry for Research. An invited member of the European College of Neuropsychopharmacology and reviewer for more than 10 international scientific journals, Laura Mandelli has more than 55 peer-reviewed published articles. In the past, she received several prizes as a Young Scientist, including the ECNP fellowship award in 2007 and the CINP Rafaelsen award in 2008.

Mironidou-Tzouveleki Maria
Associate Professor of Pharmacology, A' Department of Pharmacology, Medical School, Aristotle University of Thessaloniki, GREECE

Prof. Mironidou-Tzouveleki studied Medicine and Italian Language and Literature at the Aristotle University of Thessaloniki, Greece. In 1981 she completed her specialization in Anaesthesiology. Since 1982 she has been working and teaching at the Medical School, Aristotle University of Thessaloniki, Greece. Currently she is an an Associate Professor at the A' Department of Pharmacology of the Medical School, where she does teaching and research in general, molecular and clinical pharmacology. Moreover, she organizes and/or participates in other under- und postgraduate programs of the Medical School, with lectures regarding pharmacology, evidence based medicine and research methods. Her scientific fields of interest include pharmacology of pain, molecular pharmacology of inflammation and the role of NO, pharmacology of drug and of contrast media, wound healing, history of Medicine, as well as the translation of I. Papafis archives from Italian into Greek. She has contributed in 6 books and over 300 papers and is member of many Greek and international scientific organisations.

Möller Hans-Jürgen
Professor of Psychiatry and Chairman of the Psychiatric Department, Ludwig-Maximilians University, Munich, GERMANY

Hans-Jürgen Möller has been working in the field of psychiatry for 30 years. After obtaining his Doctor of Medical Science in 1972 from the Universities of Göttingen and Hamburg, Germany, he then specialised in psychiatry and postgraduate training at the Max Planck Institute of Psychiatry in Munich. Professor Möller completed a postdoctoral thesis (habilitation) in psychiatry in 1979. From 1980 to 1988 he was professor of psychiatry at Munich Technical University, and from 1988 to 1994 full professor of psychiatry and chairman of the Psychiatric Department at the University Bonn, Bonn, Germany.
Professor Möller's main scientific contributions include clinical and neurobiological research into psychiatry, schizophrenia and depression and clinical psychopharmacology. He has been a member of the boards (executive committees) of several national and international psychiatric societies. Currently, he is president of the European Psychiatric Association (EPA). He serves as chairman of the Section on Pharmacopsychiatry of the World Psychiatric Association (WPA). For two years he has been a member of the executive committee of the Collegium Internationale Neuro-Psychopharmacologicum (CINP), where he is now president-elect. From 1997 to 2001 he was president of the World Federation of Societies of Biological Psychiatry (WFSBP), where he is now honorary president.
In addition to authoring and co-authoring over 1000 international publications and several books, he is also chief editor of *The World Journal of Biological Psychiatry*, main editor of *European Archives of Psychiatry and Clinical Neuroscience*, and editor of two psychiatric journals, *Nervenarzt* and *Psychopharmakotherapie.* He holds positions on the editorial boards of numerous national and international psychiatric journals.
In 2008 Professor Möller was awarded the prestigious Jean Delay Prize from the World Psychiatric Association.

Molyva Dimitra
Doctoral Student and Academic Associate at the Department of Pharmacology, School of Medicine of Aristotle University Thessaloniki, GREECE

Dimitra Molyva was born in 1979 in Thessaloniki, Greece. She attended Royal Holloway, University of London where she completed a BSc in Biology in 2000. In 2001 she received an MSc in Cognitive Neuroscience from Imperial College London. Since 2003 she has been studying Medicine at the School of Medicine of Aristotle University Thessaloniki. Since 2005 she has been a doctoral student and an academic associate at the Department of Pharmacology in said School. Her research interests include neuroscience, genetics, pharmacogenetics, and pharmacology of inflammation. She is co-author of 12 refereed publications and 19 abstracts and has received 76 citations.

Morasco Benjamin
Assistant Professor,
Department of Psychiatry
at Oregon Health & Science
University, Portland,
Oregon, USA

Dr. Benjamin Morasco is an Assistant Professor in the Department of Psychiatry at Oregon Health & Science University, a Staff Psychologist at the Portland VA Medical Center, and a member of the Northwest Hepatitis C Resource Center, in Portland, Oregon. He earned a doctorate in clinical psychology from Saint Louis University in 2003, and went on to complete postdoctoral fellowships in health psychology and in addictive behaviors. His research is currently funded by the National Institute on Drug Abuse to examine issues of chronic pain and substance use in patients with the hepatitis C virus.

Moussaoui Driss
Professor of Psychiatry and
Psychological Medicine and
Chairman of the Ibn Rushd
University Psychiatric
Centre in Casablanca,
MOROCCO

Dr. Driss Moussaoui is professor of Psychiatry and Psychological Medicine. In 1979, he founded and is still the chairman of the Ibn Rushd University Psychiatric Centre in Casablanca, Morocco, which is a WHO Collaborating Centre in Mental Health and Neurosciences since 1992.
Dr. Moussaoui is past-president of the Moroccan Society of Psychiatry and of the Arab Federation of Psychiatrists. He was also member of the executive committees of the World Association for Social Psychiatry and of the World Federation of Societies of Biological Psychiatry. He was honoured as "Knight of Throne Wissam" of the Kingdom of Morocco and he received the Prize of the President of Tunisia in Medicine.
Dr. Moussaoui founded or co-founded a number of associations in the fields of Psychiatry and Mental Health in Morocco, in the Maghrebian countries, and on the international scene. He published more than 100 articles in international journals and chapters of books. Dr. Moussaoui is member of the editorial board of a number of international journals. He also wrote or edited 10 books.
Dr. Moussaoui worked closely with the World Psychiatric Association (WPA) since 1981. He participated in 1990 to the WPA Visiting Team to USSR, investigating possible political abuse of psychiatry. He was WPA Regional Representative for North Africa and the Middle East from 1993 to 1996 and Secretary for Meetings from 1996 to 2002. He was chairman of the WPA Section on Education in Psychiatry. In this respect, he contributed to the development of many WPA educational programs (Core curriculum in psychiatry for undergraduates, Core curriculum for post-graduates, WPA bulletin on depression, Teaching and learning about schizophrenia, Fighting schizophrenia and its stigma, Depressive disorders).
Dr. Moussaoui initiated and implemented a number of WPA programmes: the Programme for Libraries in Developing Countries, the series "Anthologies of World Psychiatry" of which he is the director (so far from French, Spanish, and Italian and German into English; Greek anthology is in preparation). He also initiated the WPA Jean Delay Prize (40,000 €), the highest of its kind in psychiatry, which awards a person or an institution, who helped best bridging the gap between the biological and the psycho-social aspects of psychiatry.
Dr. Moussaoui was elected member of the French Academy of Medicine in 2007.
He is also currently President-Elect of the World Association for Social Psychiatry (WASP) in 2007.
Dr. Driss Moussaoui was born in 1949 and is father of 3 children.

Ohlsen Ruth
Institute of Psychiatry,
London, UNITED KINGDOM

Ruth I Ohlsen trained as a general and psychiatric nurse in Australia and came to the UK in 1992. She has worked as a Clinical Nurse Specialist in Mood Disorders, run the Maudsley Hospital (London) clozapine clinic, managed a first-episode psychosis service and devised, implemented and supervised programmes to facilitate weight loss and healthy lifestyles for mentally ill people experiencing adverse drug reactions (ADRs) of medications used in psychiatry. Her special interest is in psychopharmacology, especially in ADRs and in physical comorbidity in mental illness. She has recently completed a doctoral thesis in the aetiology and management of antipsychotic-induced weight gain and is currently employed as a researcher on the GAP/IMPACT Team at the Institute of Psychiatry, London, with an attachment to the MRC SGCP Centre, where she is examining genetic moderators of antipsychotic-induced weight gain in collaboration with Dr Katherine Aitchison and others. She has published extensively, including lead authorship of the Maudsley Antipsychotic Medication Review Guidelines, invited reviews and numerous research publications. She is an experienced Lecturer at academic meetings and conferences at both national and international levels.

Papageorgiou George
Psychiatrist, NHS Director,
Department of Psychiatry,
Evangelismos Hospital,
Athens, GREECE

Dr. Papageorgiou was born in Athens, Greece in 1954, received his degree in Medicine from Athens University in 1979 and his MD Thesis from the Dpt of Pathology, Athens University, Summa Cum Laude in 1984 (title: Astrocytes of The Cerebral Hemispheres: Anatomoclinical Correlations).
He served as staff psychiatrist in the Adolescent Unit, Athens General Hospital During (1985-6), Consultant Psychiatrist , Sismanoglion Hospital, Athens (1986-7), Consultant Psychiatrist, Evangelismos Hospital, Athens(1987), Director, Leros Psychiatric Hospital, Leros , Dodecanese Islands (1987-9), Postdoctoral Fellow, UMDS Guy's Hospital, London (1990-1), Locum Lecturer, Brook General Hospital, Woolwich, London (1991), Consultant ,Outpatient Department and Consultation-liaison Department, Evangelismos General Hospital, Dpt of Psychiatry (1991-today), Deputy Director (2006-9), Chairman, Outpatient Department, Evangelismos Hospital (2008-today). In 2009 he was promoted to Director, National Health Service.
He is author or co-author of over 50 papers in published in Greek and International Journals, 50 posters in International and Greek Congresses, chapters in Textbooks of Consultation-Liaison Psychiatry and General Hospital Psychiatry. He participated in many psychopharmacology trials.
He is founding member of the Greek Society of Clinical Psychopharmacology, with extensive educational work in Greek Psychiatrists all over Greece. He is engaged in many Psychopharmacology Protocols, Scientific Writing, Teaching , Administrative and Clinical Work.

Papaioannidou Paraskevi
Associate Professor of Pharmacology, 1st Department of Pharmacology, School of Medicine, Aristotle University of Thessaloniki, GREECE

Paraskevi Papaioannidou graduated in Chemistry and Medicine at the Aristotle University of Thessaloniki, has a Ph.D. in Pharmacology, post-graduate education in the Department of Pharmacology, Medical Faculty, University of Alberta, Canada, and a post-doctoral education in Gas Chromatography, in Unicam Laboratories, Cambridge, UK. She was a visiting researcher in the 1st Clinic of Obstetrics and Gynecology (Division of Assisted Reproduction, Sant' Orsola Hospital) in Medical Faculty of the University of Bologna for one year. She has been an invited lecturer and researcher in the Department of Pharmacology, Clinical Pharmacology and Toxicology, of the Faculty of Medicine in the University of Novi Sad, and in the Department of Pharmacology and Clinical Pharmacology of the Faculty of Medicine in the University of Kragujevac.
She has published more than 200 articles in peer review journals on Antimicrobial Chemotherapy, Reproductive Pharmacology, Gender related Pharmacology, Sexual differentiation of the brain, Prostaglandins and Drug Interactions. She has created and is the co-ordinator of two European research networks supported by the Aristotle University: follicle net (website: folliclenet.web.auth.gr) and AntibioSurv (website: antibiosurv.web.auth.gr). She is reviewer in peer review international journals and Congresses and has been invited speaker in International Congresses. She has organized and is the coordinator of medical and interdisciplinary institutional and inter-institutional post-graduate programs.
She has organized and participated in many multicentric European and international research projects. She is the organizer and leader of ASPPOC (a multicentric European project with participation of 40 Surgery and Pharmacology Departments from 12 countries), she has participated in SIG-DUR (an international multicentric study of ISPE on cross-national comparison of Drug Utilization, with the participation of 24 countries), and she had a collaboration with NIH, Bethesda, USA. One of her PhD students has received the Milton Huppert Graduate Student Award of the Medical Mycological Society of the Americans (May 2007, Toronto, Canada).

Paraskevopoulos Nikolaos
Professor of Criminal Law, Law Faculty, Aristotle University of Thessaloniki, GREECE

Nikolaos Paraskevopoulos was born in Athens in 1949, completed his dissertation (1979) and readership (1982) in the University of Thessaloniki, Law Faculty, in Criminal Law. Since 1987, he is Professor of Criminal Law at the above Faculty. His books include The Extinction of Penalties (1982), Criminal Responsibility and Personality (1987), Criminal Law concerning Drugs in Greece (2nd ed 2004), Penology (with Prof. L. Margaritis, 7th ed. 2005), Basic Concepts of Criminal law (2008).
Since 1999 he is regular columnist of the daily newspaper Eleftherotypia. During 1989-1996 he was scientific supervisor of research and activities concerning the resettlement of ex-offenders and minors with deviant activities (funded by E.U and Aristotle University of Thessaloniki). During 1990-2003, was member of official committees drafting laws, 1993-1995 advisor of the Greek Ministry of Justice in the field of the Criminal Law and of the Prison system, in 1995-1999 he was elected Dean of the Law Faculty, University of Thessaloniki and in 1999-2005 was CEO of Kethea (Therapy Center for Depended Individuals) organization having since 2001 consultative status with the United Nations Economic and Social Council (ECOSOC). During 2001-2004, he was member of the Committee of Experts on the Operation of European Conventions in the Penal Field (PC-OC), and in 2002 member of the European Committee on Crime problems (CDPC) of the Council of Europe.

Perrin Raymond
Honorary Senior Lecturer at the School of Public Health and Clinical Sciences, UCLAN, UNITED KINDGOM

Dr Raymond Perrin is Honorary Senior Lecturer at the School of Public Health and Clinical Sciences, UCLAN and a Registered Osteopath and Specialist in Chronic Fatigue Syndrome. He is Director of The Perrin Clinic Ltd., Research Director of F.O.R.M.E. Trust, and Visiting Lecturer at The British School Of Osteopathy, London. He has held the positions of Honorary Advisor to the Northern Branch of The International Spinal Research Trust (1985-1990) and Official Osteopath to the World Student Games, Sheffield (1999). He obtained his D.O. at The British School of Osteopathy, London (1984) and his Ph.D. Biosciences, The University of Salford (2005). Dr. Perrin has lectured extensively internationally and has published medical and scientific papers on chronic fatigue syndrome/myalgic encephalomyelitis. He is the author of the book *The Perrin Technique* (2007).

Perugi Giulio
Professor of Clinical Psychiatry and Psychopharmacotherapy, University of Pisa, ITALY

Giulio Perugi, MD, received his medical degree at the University of Pisa in 1981 and he was trained in Psychiatry until 1985. He works as the co-director of the Day-Hospital unit of the Department of Psychiatry of the University of Pisa. Dr Giulio Perugi is professor of Clinical Psychiatry and Psychopharmacotherapy at the University of Pisa, Italy. From December 2000, Dr Perugi is the director of the Institute of Behavioural Sciences "G.Delisio", in Pisa. He is involved in the International Research Project on Mood Disorders in collaboration with the University of South California at San Diego. In this field he has developed and directed many research projects on Mixed States, Mania, Anxious-Bipolar Co-morbidity and Atypical Depression-Bipolar II-Borderline connection. In the field of anxiety disorders he has directed several studies on clinical features and long-term naturalistic treatment of Panic Disorder-Agoraphobia, Obsessive-Compulsive Disorder and Social Phobia. He is part of the editorial board of the Journal of Affective Disorder and other 5 International Journals. He is the author of 3 books and over 350 papers, published in national and international Journals (about 120 peer reviewed), on psychopathology, clinical psychopharmacology, and pharmacotherapy of affective disorders.

Pi Edmond
Associate Chair for Clinical Affairs, Professor of Clinical Psychiatry, University of Southern California (USC) Keck School of Medicine and Director of Psychiatric Consultation and Liaison Service (Psychosomatic Medicine), Los Angeles County and USC Medical Center, USA

Edmond Hsin-tung Pi, M.D. has outstanding achievements in clinical care, teaching, research, and administration. He has been included in "The Best Doctors in America" since 1994. He is also a Visiting Professor of Psychiatry at the Tsinghua University in Beijing, China. Dr. Pi is an accomplished researcher in the field of cross-cultural psychiatry, psychopharmacology, and movement disorders, with more than 150 publications and one book. He was honored as the recipient of the 2009 Asian American (Kun-po Soo) Award of the American Psychiatric Association (APA). Dr. Pi has been very active on both the US and the international scenes in the field of psychiatry including serving as President of the Association of Chinese American Psychiatrists; Member of the International Advisory Committee of World Psychiatric Association (WPA) Regional Meetings, the Pacific Rim College of Psychiatrists Scientific Meeting, and the Latin American Psychiatric Congress; Member of the Organizing-Liaison Committee of the First World Congress of Cultural Psychiatry; Member of the Scientific Program Committee of the APA. Dr. Pi has held substantial administrative positions over the last 30 years including serving as the Medical Director of the Department of Mental Health (DMH), State of California, the most populous state in the USA with 32 million residents. The DMH had oversight over almost $2 billion public mental health annual budget and Dr. Pi was the Department's highest level psychiatrist.

Pilling Stephen
Director of the Centre for Outcomes Research and Effectiveness, Research Department of Clinical, Health and Educational Psychology, University College London, UNITED KINGDOM

Stephen Pilling PhD is a clinical psychologist and Director of the Centre for Outcomes Research and Effectiveness in the Research Department of Clinical, Health and Educational Psychology at University College London. He is also the Joint Director of the National Collaborating Centre for Mental Health which produces clinical practice guidelines in mental health for the UK National Institute for Health and Clinical Excellence (NICE). He has interest in the development and evaluation of psychological treatments for depression and oversees a training programme in low intensity cognitive behavioural interventions for common mental disorders. He has been a consultant advisor to the UK Department of Health where he worked to establish the Mental Health Research Network, a UK wide research network. He has published extensively in the areas of clinical guidelines, health service research and most recently in the development of competence frameworks for psychological therapists.

Puri Basand
Professor of Psychiatry, Imperial College London, UNITED KINGDOM

Professor Basant K. Puri received his primary and postgraduate degrees in medicine from the University of Cambridge, and carried out post-doctoral work in molecular genetics at the University of Cambridge and in imaging at the Royal Postgraduate Medical School at Hammersmith Hospital, London. He also has postgraduate degrees in mathematics and is a member of the Royal College of Psychiatrists. While at Hammersmith Hospital and the MRC he contributed to our understanding of the effects of lipids on brain structure and chemistry and directed a clinical programme to study the effects of lipids on major neurological and psychiatric disorders. He demonstrated the benefits of lipids on the clinical symptomatology and cerebral atrophy of Huntington's disease, and has helped develop methods to quantify the effects of PUFAs on brain structure. He is the author of over 30 books and 150 papers.

Rihmer Zoltan
Professor of Psychiatry, Department of Psychiatry and Psychotherapy, and Scientific Director, Department of Clinical and Theoretical Mental Helath, Semmelweis University, Faculty of Medicine, Budapest, HUNGARY

Prof. Zoltan Rihmer, Md, PhD, DSc, received his medical diploma in 1971. Since then he has been working at the National Institute for Psychiatry and Neurology, Budapest, Hungary. From 2007 he is professor of psychiatry at the Department of Psychiatry and Psychotherapy, and scientific director at the Department of Clinical and Theoretical Mental Helath, Semmelweis University, Faculty of Medicine, Budapest.
Dr. Rihmer has three special examinations: psychiatry (1976), neurology (1979) and clinical pharmacology (1990). He received his PhD at the Hungarian Academy of Sciences in 1993, and his DSc in 2004. His special interest is the clinical and biological aspects of mood and anxiety disorders, with particular regards to prediction of treatment response and prevention of suicide. He has published more than 350 scientific articles/book chapters (more than 180 in English) and four books. He received the Brickell Suicide Research Award of the Department of Child and Adolescent Psychiatry, Columbia University, New York, and the Life Achievement Award of the Hungarian Psychiatric Association. He is National Clinical Audit Lead in Psychiatry of Hungary. Professor Rihmer is a member of several Hungarian and international scientific boards and associations, including the editorial board of Journal of Affective Disorders, International Journal of Psychiatry in Clinical Practice, Neuropsychobiology and World Journal of Biological Psychiatry . He is also a member of the Executive Committee of the European College of Neuropsychopharmacology.

Rybakowski Janus
Head of Department of Adult Psychiatry, University of Medical Sciences, Poznan, POLAND

Prof. Rybakowski graduated in 1969 at Medical Academy Poznan, Poland. In 1976-77 he was NIH Fogarty Research Fellow at Department of Psychiatry, University of Pennsylvania, Philadelphia. In 1985-1995 he was Chairman, Department of Psychiatry, Medical Academy, Bydgoszcz, and since 1994, the Head of Department of Adult Psychiatry, University of Medical Sciences, Poznan, Poland.
Prof. Rybakowski has authored over 500 publications and serves on editorial boards of Neuropsychobiology, Bipolar Disorders, Pharmacopsychiatry, International Journal of Psychiatry in Clinical Practice, and Cardiovascular Psychiatry and Neurology.
Prof. Rybakowski was the President of Polish Psychiatric Association in 1998-2001, and Board Member of Association of European Psychiatrists in 1998-2004. Currently, he is a member of ECNP, CINP, Society of Biological Psychiatry, International Society of Bipolar Disorders, International Society of Psychiatric Genetics, International Society of Affective Disorders, International Neuropsychiatric Association, International Group for the Study of Lithium-Treated Patients, and European Group for the Research in Schizophrenia.

Samolis, Stavros
Psychiatrist NHS, Psychiatric Department, General Hospital of Thessaloniki 'Ippokratio', GREECE

Dr. Samolis graduated from Medical school of the Aristotelian University of Thessaloniki. He underwent his residency in Psychiatry at the 3rd University Psychiatric Clinic of AHEPA Hospital. He has also 2,5 years of training in systemic family psychotherapy. After this he worked as specialist for three years at a private psychiatric clinic in North West Greece, being the doctor –in- charge of a department of the clinic. He currently works as psychiatrist of the National Health System at the Psychiatric department of General Hospital of Thessaloniki 'Ippokratio' performing outpatient unit and consultation- liaison services. He has participated as co-investigator in five phase III and IV pharmacological trials. He has participated in the authoring of several research works presented in congresses and published in journals.
He is member of the Hellenic Psychiatric Association and the International Society of Quality in Clinical Practice. He is fluent in English.

Sartorius Norman
Professor of Psychiatry,
Geneva, SWITZERLAND

Dr Norman Sartorius, MD, MA, DPM, PhD, FRCPsych, obtained his M.D. in Zagreb (Croatia). He specialized in neurology and psychiatry and subsequently obtained a Masters Degree and a Doctorate in psychology (Ph.D.). He carried out clinical work and research and taught at graduate and postgraduate levels at the University of Zagreb, at the Institute of Psychiatry in London, at the University of Geneva and elsewhere.
Dr Sartorius joined the World Health Organization (WHO) in 1967 and soon assumed charge of the programme of epidemiology and in social psychiatry. He was also principal investigator of several major international studies on schizophrenia, on depression and on health service delivery. In 1977, he was appointed Director of the Division of Mental Health of WHO, a position which he held until mid-1993. In June 1993 Professor Sartorius was elected President of the World Psychiatric Association (WPA) and served as President-elect and then President until August 1999. In January 1999, Professor Sartorius took up his functions as President of the Association of European Psychiatrists (AEP) and is now the President of the International Association for the Promotion of Mental Health Programmes and President of the Board of the Prize of Geneva Foundation. Dr Sartorius holds professorial appointments at the Universities of London, Prague and Zagreb and at several other universities in the USA and China. He is a Senior Associate of the Faculty of the Johns Hopkins School of Public Health in Baltimore, Maryland.
Professor Sartorius has published more than 300 articles in scientific journals, authored or co-authored several books and edited a number of others.
Professor Sartorius is a corresponding member of the Croatian Academy of Arts and Sciences and a Corresponding Member of the Spanish Royal Academy of Medicine and of the Medical Academies of Peru and Mexico. He is a Doctor of Medicine *Honoris Causa* of the Universities of Umea and of Prague and a Doctor of Science *Honoris Causa* of the University of Bath. He is an Honorary Fellow of the Royal College of Psychiatrists of the United Kingdom of Great Britain and of the Royal Australian and New Zealand College of Psychiatrists. He is also a Distinguished Fellow of the American Psychiatric Association. He is an Honorary Member of numerous professional associations and advisory boards, both national and international. He is also the Co-editor of three journals and a member of editorial and advisory boards of many scientific journals.
He speaks Croatian, English, French, German, Russian and Spanish.

Simões do Couto Frederico
PhD Student on the Neuroscience Department of the Institute of Molecular Medicine, Lisbon,
PORTUGAL

Frederico Simões do Couto took his MD degree in 1997, and specialized in Psychiatry in 2005.
His main area of interest has been biological psychiatry. Working as basic and clinical researcher he has published 4 papers in international peer reviewed journal with an impact factor over 2, and has participated in more than 20 clinical trials, phases II to IV, either as co- or principal investigator.
He is currently a PhD student on the Neuroscience Department of the Institute of Molecular Medicine, Lisbon.

Simos Grigoris
Assistant Professor of Developmental Psychopathology, Department of Educational and Social Policy, University of Macedonia, Thessaloniki, GREECE

Gregoris Simos graduated from the Medical School of the Aristotelian University of Thessaloniki, Greece, and trained in Psychiatry and Psychotherapy at its 2nd University Department of Psychiatry. He also earned his PhD from the same University. During 1989-1990 he worked at the Institute of Psychiatry, University of London/ Maudsley and the Royal Betlem Hospitals, where he was attached at Prof. Isaac M. Marks Psychological Treatment Unit, Dr Michael Crowe's Sex and Marital Clinic, and Prof. Gerald Russell's Eating Disorders Clinic. He was consequently accredited as a Cognitive and Behavioural Therapist by the BABCP, and also registered with the United Kingdom Council of Psychotherapy (UKCP) as a Cognitive Behaviour therapist. During 1993 Dr Simos visited Prof. Aaron T. Beck's Centre for Cognitive Therapy at the University of Pennsylvania and trained at Cognitive Therapy. He also became a Founding Fellow of the Academy of Cognitive Therapy in 1999.
Dr Simos and his colleagues founded the Greek Association for Cognitive and Behavioural Psychotherapies (GACBP) in 1994 and has been its elected and re-elected President since then. He is also at the Board of the International Association for Cognitive Psychotherapy (post of the International Representative). Dr Simos has published several books, book chapters, and journal articles in Greek and in English.

Soghoyan Armen
Deputy Director of National Psychiatric Center and Associate Professor at the Department of Psychiatry at M. Heratsi State Medical University, ARMENIA

Dr Soghoyan obtained his MD and PhD from M. Heratsi Yerevan State Medical University in Yerevan, Armenia. He is currently Deputy Director of National Psychiatric Center and Associate Professor at the Department of Psychiatry at M. Heratsi State Medical University. He also serves as Zone Representative for the World Psychiatric Association for Eastern Europe. He has also been a member of the GIP Network of Reformers since 1997. Since September 2009 President of Armenian Psychiatric Association, served also as Secretary General, Armenian Medical Association (2002-4), 2005 to present Vice-President, Armenian Medical Association, 2005 to present Zonal Representative of World Psychiatric Association in Eastern Europe /Zone 10/, 2005 to present Board Member of Geneva Initiative on Psychiatry-Tbilisi, 2007 to present Vice-President of Asian Federation of Psychiatric Associations and 2007 to present National Secretary of WAPR in Armenia. Dr Soghoyan's principal research areas include epidemiology, mental health policy and economics and he is the author of more then 25 articles and papers.

Sotiriou Michael
Director, Psychiatric Adult Unit,Kavala General Hospital, NHS
Kavala, GREECE

Michael J.Sotiriou,is Director of the Psychiatric Adult Unit NHS General Hospital in Kavala, East Macedonia,Greece.
He earned his medical degree and completed his residency in psychiatry at Aristotelian University, in Thessaloniki,Greece. Then,having awarded a scholarship from Greek State Fountation(IKY) he worked in UK (Department of Psychiatry, Guy,s Hospital, University of London).
In Greece, he worked in Thessaloniki, Serres and Kavala (Psychiatric Units, Day Hospitals, Community Mental Health Centers).

Taylor David
Chief Pharmacist at the Maudsley Hospital and Professor of Psychopharmacology at King's College, London, UNITED KINGDOM

David Taylor has also previously been President of the College of Mental Health Pharmacists and Chairman of the UK Psychiatric Pharmacy Group. Professor Taylor has published over 150 research and review papers in psychiatric peer-reviewed journals and received around 2000 citations (H index, 24). His interests include naturalistic outcome studies, pharmacokinetics and pharmacoeconomics. He has also written or edited several books including Schizophrenia in Focus (Pharmaceutical Press), The Use of Drugs in Psychiatry (Gaskell) and Case Studies in Psychopharmacology (Dunitz). Professor Taylor has been the lead author of the Maudsley Prescribing Guidelines since their inception in 1993. The Maudsley Guidelines represent one of the most influential texts in psychiatric prescribing having sold around 150,000 copies.

Touloumis Charalambos
Deputy Clinic Director, 10th Psychiatric Department, Psychiatric Hospital of Athens, GREECE

Dr Touloumis was born in Chalkis of Evia, in Greece. He graduated from Medical School of Athens University and received his specialty in Psychiatry from Psychiatric Hospital of Athens and Evangelismos Hospital.
Since 1987, he has been working as Psychiatrist in Psychiatric Hospital of Athens (nowadays in the position of Deputy Clinic Director in the 10th Psychiatric Department). He has published more than 50 scientific publications through greek and international biomedical magazines. He has made more than 70 scientific presentations in medical conferences. He is interested specifically in Clinical Psychiatry and Psychopharmacology.

Treasaden Ian
Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College, London, and Clinical Director, Three Bridges Medium Secure Unit for Mentally Disordered Offenders, West London Mental Health NHS Trust, UNITED KINGDOM

Dr I H Treasaden M.B., B.S., LRCP., MRCS., FRCPsych. LLM. is Head of Forensic Neurosciences, Lipid Neuroscience Group, Imperial College, London, England and, since 1984, he has been Consultant Forensic Psychiatrist at The Three Bridges Medium Secure Unit for mentally disordered offenders, West London Mental Health NHS Trust, where he has also been Clinical Director.
He qualified in medicine from the London Hospital Medical College, University of London, in 1975 where he was awarded the James Anderson Prize in Clinical Medicine. He undertook training in forensic psychiatry at the Maudsley & Bethlem Royal Hospitals in London and Broadmoor Special Hospital, Berkshire, England between 1982 and 1984.
Author of papers on forensic and general psychiatry, he is also co-author of the books Textbook of Psychiatry, Mental Health Law: A Practical Guide and Emergencies in Psychiatry. His current research interests include lipid and neuro-imaging abnormalities in psychiatric disorders and also violence, including among those with schizophrenia.

Tsaluchidu Sofia
University of Bologna, ITALY

Dr. Sofia Tsaluchidu received her degreee from the University of Bologna IT (Alma Mater Studiorum Università di Bologna) based on her thesis "New Therapeutic Approaches to the Pathology of Parkinson's Disease", involving a detailed study of adenosine A2 antagonists, neuroprotective drugs and neuromelanin inhibitors.
She has a particular expertise in fatty acids and oxidative stress and her postgraduate work has included published studies in: comparing oxidative stress in smokers and non-smokers (an *in vivo* human quantitative study of *n*-3 lipid peroxidation); the use of artificial neural networks to study fatty acids in neuropsychiatric disorders; and fatty acids and oxidative stress in psychiatric disorders.
She is the co-author of the following major paper that is in press in the World Review of Nutrition and Dietetics: The application of serial structural magnetic resonance imaging analysis and proton and 31-phosphorus magnetic resonance spectroscopy to the investigation of cerebral fatty acids in major depressive disorder, Huntington's disease

Tsapakis Evangelia
Visiting Research Associate, MRC SGDP Centre, Institute of Psychiatry at King's College, London, UNITED KINGDOM

Dr Tsapakis studied Pharmacology at King's College London and Medicine at St. George's Hospital Medical School, University of London. Having earned the First Prize in Psychological Medicine (the Arthur Crisp Prize), she went on to train in Psychiatry at the Maudsley Hospital. She has worked under Ross Baldessarini's mentorship at Harvard Medical School whilst on a Traveling Fellowship awarded by the Royal College of Psychiatrists. In 2007, she gained a Masters in Affective Neuroscience from the University of Maastricht. In 2009, she earned a PhD in Pharmacogenetics (on the role of metabolic enzyme variants in response to treatment with psychotropic agents) and Pharmacogenomics (on differential gene expression induced by antidepressants in juvenile rats) from King's College London, University of London. Dr Tsapakis' awards include a Young Scientist Award at the 11th Biennial Winter Workshop on Schizophrenia (2002), a Research Award at the 5th International Neuropsychiatry Congress (2004), a Young Investigator Award for the 20th International Congress in Schizophrenia Research (2005), and a Poster Prize at the 3rd International Congress on Brain and Behaviour (2007). Dr Tsapakis is a Visiting Research Associate at the Institute of Psychiatry, King's College London and at Harvard Medical School, Boston, MA. Since 2009, she has been the Director of a private Mental Health Unit in Heraklion, Crete.

Tsopelas Christos
NHS, Consultant in Adult General Psychiatry, Psychiatric Hospital of Attica, GREECE

Dr Tsopelas is a graduate of the Medical School of Athens. His psychiatric training was completed in Aeginition Hospital , Athens, and Charring Cross Psychiatric training Scheme, London, UK. He has worked in London in various posts, like Community Drug and Alcohol Teams and Crisis Resolution Home Treatment team. The last post was as consultant at South London and Maudsley Trust before he returned to Greece in late 2005 and been part of Greek National Health system and worked for the last 3 years at the Psychiatric Hospital of Attica.
He completed his MSc in Psychiatric Research at Institute of Psychiatry, London, UK. He is in the process of finishing his PhD. He has training in Brief Solution Focused Therapy and Interpersonal Psychotherapy.
His special interests include Epidemiology, Forensic Psychiatry, patients' rights and community psychiatry. He is secretary of Forensic Psychiatric Section of Hellenic Psychiatric Association and actively involved in organizing and teaching at European co-funded educational programs about de-institutionalization, community psychiatry and forensic psychiatry.

Van Laerhoven Kristof
Multimodal Interactive Systems, Department of Computer Science Technische, Universität Darmstadt, GERMANY

Kristof Van Laerhoven gained his Masters degree from the University of Brussels, Belgium, his PhD from Lancaster University, UK, and is working now as a post-doc at the TU-Darmstadt, Germany. He worked on a large number of national projects in Belgium, the UK, and Germany, as well as numerous EU-funded projects and occasionally acts as expert in EU calls. He is a program committee member of -- among others -- the International Conference on Pervasive Computing (Pervasive) and the International Symposium on Wearable Computers (ISWC) since the last few years. His main interests are in the use of machine learning techniques on sensory data, with practical applications in ubiquitous computing and wearable computing, building systems that are deployable in real-world unpredictable situations, rather than in simulation or controlled lab trials. His core research challenges in these are adopting machine learning techniques in embedded sensors and sensor networks.

Vartzopoulos Dimitrios
Psychiatrist, Chair of the 'Stasinopoulos Neuropsychiatric Clinics', Thessaloniki, GREECE

Dr Varzopoulos received his medical degree from the Aristotle University Medical School in 1981, with a scholarship from IKY during his studies. He was specialized in psychiatry in 1986, and worked in the university psychiatric departments in Bonn (1986) and Colon (1987-9). He was trained in cognitive, family and neurolinguistic reprogramming therapies and received his doctorate from the University of Bonn in 1990. He participated in the teaching and training of students of the Medical School of AUTh and psychiatric residents, with special interest in psychopharmacology and forensic psychiatry. He is co-author of a significant number of papers 14 of which are published in international journals.
During 2004-9 he served CEO of the 2nd PESYP and latter 3rd YPE of central Macedonia, while in 2009 served as chair of the committee for economic issues and logistics of the Greek Ministry of Health.
Currently he is chair of the 'Stasinopoulos Neuropsychiatric Clinics'.

Vieta Eduar
Professor of Psychiatry and Director of the Bipolar Disorders Program, Hospital Clinic at the University of Barcelona, SPAIN

Eduard Vieta is Professor of Psychiatry and the Director of the Bipolar Disorders Program of the Hospital Clinic at the University of Barcelona, Spain. He also serves as Director of Research at the Clinical Institute of Neuroscience at the same institution. His research focuses on the neurobiology and treatment of bipolar disorder. His programme examines novel pharmacological and psychological treatments, including atypical antipsychotics, antiepileptic drugs, and psychoeducation. Since 2001 his research has been funded by the Stanley Research Medical Institute (Bethesda, USA) and he is the current Director of the Bipolar Research Program at the Spanish Center of Biomedical Research Network on Mental Health (CIBERSAM), funded by the Ministry of Science and Innovation. He has made significant contributions to many of the published bipolar disorder treatment guidelines, and has authored more than 300 original articles, 100 book chapters and 26 complete books, including the recently published 2nd Edition of Bipolar Disorder in Clinical Practice (Current Medicine Group, 2009). He sits on the editorial board of 20 international scientific journals, including The Journal of Clinical Psychiatry, Bipolar Disorders, Psychotherapy Psychosomatics, the Journal of Affective Disorders, and Psychopathology, and he reviews articles for more than 40 others. In 2007, he received the Aristotle award and, ex-aequo with Francesc Colom, the Mogens Schou Award for excellence in bipolar disorder research.

Vourdas Apostolos
Consultant in Child and Adolescent Psychiatry, Medical Director of Hallowell Center, Athens, GREECE

Dr Vourdas graduated from the Medical School of Athens, Greece, where he was awarded his PhD in 1996. He was trained in Cambridge and at the Maudsley Hospital in London. He has been an elected Member of the Royal College of Psychiatrists since 2000. He is a trained cognitive and behavioral psychotherapist for children and adolescents. His research interest has been focused on early developmental difficulties in children with psychiatric problems and has been presented in a number of conferences. He worked as a consultant at the Maudsley Hospital before he returned to Greece in 2006. Currently, he is the medical director of Hallowell Center in Athens which specializes in treating people with Attention Deficit Disorder (ADD) and Learning Difficulties. He is also the secretary of forensic psychiatry branch of Hellenic Psychiatric Association and teaches regularly at the Medical School of Athens.

Yesavage Jerom
Associate Chief of Staff for Mental Health, VA Palo Alto Heath Care System and Professor of Psychiatry, Stanford University School of Medicine, USA

Dr. Yesavage received his MD from Stanford, where he completed his residency in psychiatry. He is Associate chief of staff for Mental Health at the VA Palo Alto Health Care System. He is a member of the American Psychiatric Association, the American Geriatrics Society and the Gerontological Society of America. He has over 400 scientific publications and won the 2009 American Association for Geriatric Psychiatry Distinguished Scientist Award. He directs the Mental Health Research and Education Clinical Center at the VA Palo Alto Health Care System which is devoted to the study of cognitive losses in older veterans suffering from Post-traumatic Stress Disorder (PTSD).

Seroquel® XR
Δισκία Παρατεταμένης Αποδέσμευσης
quetiapine

Ποσοτική & ποιοτική σύνθεση:	Τα δισκία Seroquel® XR **50, 200, 300, 400** mg, περιέχουν αντιστοίχως **50, 200, 300, 400** mg quetiapine (ως quetiapine fumarate).

SER/00087/0/1009

Για πλήρεις συνταγογραφικές πληροφορίες επικοινωνήστε με την εταιρεία.

AstraZeneca

Θεοτοκοπούλου 4 & Αστροναυτών, 151 25 Μαρούσι, Τηλ.: 210 68 71 500,
Fax: 210 68 59 195, Τηλ. Παραγγελιών: 210 55 96 970-2,
Fax: 210 55 96 973, www.astrazeneca.gr

Boehringer Ingelheim

Xeristar®
duloxetine HCl

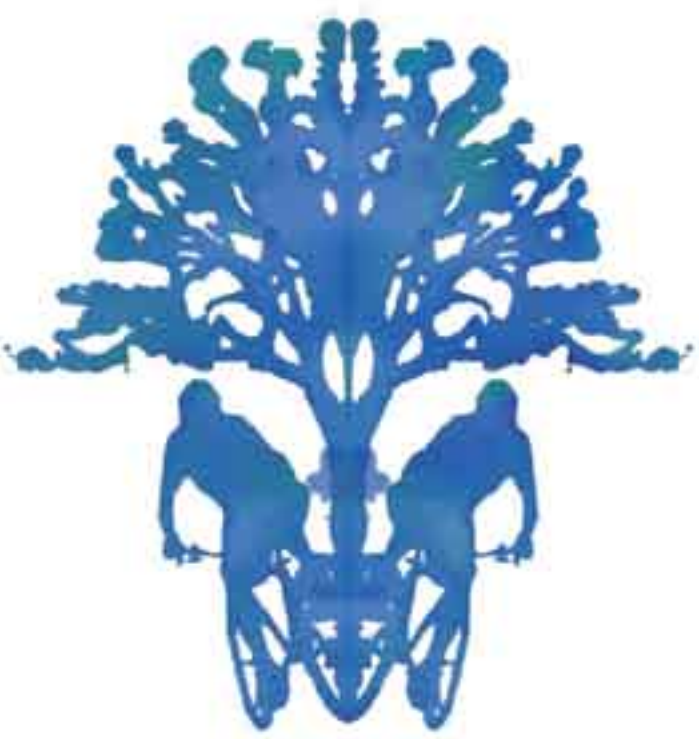
ARI-02009-4

ARICEPT (donepezil hydrochloride)
ΕΠΙΚΑΛΥΜΜΕΝΟ ΜΕ ΛΕΠΤΟ ΥΜΕΝΙΟ ΔΙΣΚΙΟ 5mg/tab, 10mg/tab
ΕΝΔΕΙΞΕΙΣ: Συμπτωματική θεραπεία ήπιας έως μέτριας βαρύτητας άνοιας Alzheimer. **ΧΡΗΣΗ ΣΕ ΠΑΙΔΙΑ:** Δεν συνιστάται. **ΑΝΤΕΝΔΕΙΞΕΙΣ:** Ασθενείς με γνωστή υπερευαισθησία στην υδροχλωρική δονεπεζίλη, στα παράγωγα πιπεριδίνης ή σε κάποιο από τα έκδοχα που περιέχονται στη σύνθεσή του. **ΠΡΟΕΙΔΟΠΟΙΗΣΕΙΣ-ΠΡΟΦΥΛΑΞΕΙΣ:** Η χρήση του σε ασθενείς με βαριάς μορφής άνοια Alzheimer, άλλων μορφών άνοιας ή άλλων δυσλειτουργιών της μνήμης (π.χ. εξασθένηση της γνωστικής λειτουργίας λόγω ηλικίας), δεν έχει ερευνηθεί. *Αναισθησία:* Ως αναστολές της χολινεστεράσης, είναι πιθανό να επιτείνει την μυοχάλαση τύπου συκινυλοχολίνης κατά τη διάρκεια της αναισθησίας. *Καρδιοαγγειακές Καταστάσεις:* Λόγω της φαρμακολογικής τους δράσης, οι αναστολείς της χολινεστεράσης μπορεί να έχουν παρασυμπαθητικομιμητική δράση στην καρδιακή συχνότητα (π.χ. βραδυκαρδία). Η πιθανότητα εμφάνισης της δράσης αυτής μπορεί να είναι ιδιαίτερα σημαντική σε ασθενείς με σύνδρομο νοσούντος φλεβόκομβου ή άλλες υπερκοιλιακές διαταραχές της καρδιακής αγωγιμότητας, όπως φλεβοκομβοκολπικός ή κολποκοιλιακός αποκλεισμός. Υπάρχουν αναφορές αιφνίδιας απώλειας συνειδήσεως και σπασμών. Κατά τη μελέτη των ασθενών αυτών πρέπει να εξετάζεται η πιθανότητα ανάπτυξης κολποκοιλιακού αποκλεισμού ή μακρών διακοπών της αγωγιμότητας ως συνέπεια διαταραχών του φλεβόκομβου. *Γαστρεντερικές Καταστάσεις:* Ασθενείς με αυξημένο κίνδυνο για εμφάνιση έλκους, π.χ., αυτοί με ιστορικό έλκους ή εκείνοι που λαμβάνουν ταυτόχρονα μη στεροειδή αντιφλεγμονώδη φάρμακα, πρέπει να παρακολουθούνται για τυχόν εμφάνιση σχετικών συμπτωμάτων. Ωστόσο, οι κλινικές μελέτες με ARICEPT δεν έδειξαν καμία αύξηση, σε σχέση με το εικονικό φάρμακο (placebo), της συχνότητας ανάπτυξης πεπτικού έλκους ή αιμορραγίας από το γαστρεντερικό στους ασθενείς. *Ουροποιογεννητικό:* Αν και δεν έχει παρατηρηθεί σε κλινικές μελέτες με ARICEPT, τα χολινεργικά φάρμακα μπορούν να προκαλέσουν απόφραξη του αυχένα της ουροδόχου κύστης. Νευρολογικές Καταστάσεις: Σπασμοί: Τα χολινεργικά φάρμακα πιστεύεται ότι έχουν τη δυνατότητα να προκαλούν γενικευμένους σπασμούς. Ωστόσο, η εμφάνιση σπασμών μπορεί επίσης να αποτελεί εκδήλωση της νόσου του Alzheimer. Τα χολινομιμητικά μπορεί να έχουν τη δυνατότητα να επιδεινώσουν ή να επάγουν εξωπυραμιδικά συμπτώματα. *Πνευμονικές Καταστάσεις:* Λόγω της χολινεργικής δράσης τους, οι αναστολείς της χολινεστεράσης πρέπει να συνταγογραφούνται με προσοχή σε ασθενείς με ιστορικό άσθματος ή αποφρακτικής πνευμονοπάθειας. Η ταυτόχρονη χορήγηση του ARICEPT με άλλους αναστολείς της ακετυλοχολινεστεράσης, αγωνιστές ή ανταγωνιστές του χολινεργικού συστήματος πρέπει να αποφεύγεται. *Βαριάς μορφής ηπατική ανεπάρκεια:* Δεν υπάρχουν στοιχεία για ασθενείς με βαριάς μορφής ηπατική ανεπάρκεια. **Αυτό το φαρμακευτικό προϊόν περιέχει λακτόζη.** Οι ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στην γαλακτόζη, σε έλλειψη λακτάσης Lapp ή σε δυσαπορρόφηση γλυκόζης-γαλακτόζης, δεν θα πρέπει να λαμβάνουν αυτό το φάρμακο. ***Θνησιμότητα σε Κλινικές Δοκιμές Άγγειακής Άνοιας:*** Διεξήχθησαν τρεις κλινικές δοκιμές, διάρκειας 6 μηνών, στις οποίες μελετήθηκαν άτομα που πληρούσαν τα διαγνωστικά κριτήρια NINDS-AIREN, για πολύ πιθανή ή πιθανή αγγειακή άνοια (VaD-Vascular dementia). Τα κριτήρια NINDS-AIREN είναι σχεδιασμένα να αναγνωρίζουν ασθενείς των οποίων η άνοια φαίνεται να οφείλεται μόνο σε αγγειακά αίτια και να αποκλείουν ασθενείς με νόσο του Alzheimer. Στην πρώτη μελέτη, τα ποσοστά θνησιμότητας ήταν 2/198 (1,0%) υπό θεραπεία με υδροχλωρική δονεπεζίλη 5mg, 5/206 (2,4%) υπό θεραπεία με υδροχλωρική δονεπεζίλη 10mg και 7/199 (3,5%) υπό θεραπεία με εικονικό φάρμακο. Στη δεύτερη μελέτη, τα ποσοστά θνησιμότητας ήταν 4/208 (1,9%) υπό θεραπεία με υδροχλωρική δονεπεζίλη 5mg, 3/215 (1,4%) υπό θεραπεία με υδροχλωρική δονεπεζίλη 10mg και 1/193 (0,5%) υπό θεραπεία με εικονικό φάρμακο. Στην τρίτη μελέτη, τα ποσοστά θνησιμότητας ήταν 11/648 (1,7%) υπό θεραπεία με υδροχλωρική δονεπεζίλη 5mg και 0/326 (0%) υπό θεραπεία με εικονικό φάρμακο (p < 0,02). Το ποσοστό θνησιμότητας για τις τρεις συνδυασμένες μελέτες VaD στην ομάδα υδροχλωρικής δονεπεζίλης (1,7%) ήταν αριθμητικά υψηλότερο από αυτό της ομάδας υπό θεραπεία με εικονικό φάρμακο (1,1%), ωστόσο, η διαφορά αυτή δεν ήταν στατιστικά σημαντική. Η πλειοψηφία των θανάτων σε ασθενείς που λάμβαναν είτε υδροχλωρική δονεπεζίλη ή εικονικό φάρμακο, φαίνεται ότι απορρέει από διάφορες αγγειακά συσχετιζόμενες αιτίες, που θα μπορούσαν να είναι αναμενόμενες σε αυτόν τον ηλικιωμένο πληθυσμό με υποκείμενη αγγειακή νόσο. Μία ανάλυση όλων των σοβαρών, μη-θανατηφόρων και θανατηφόρων αγγειακών συμβαμάτων, δεν υπέδειξε διαφορά στο ποσοστό εμφάνισης στην ομάδα υδροχλωρικής δονεπεζίλης, σε σχέση με την ομάδα υπό θεραπεία με εικονικό φάρμακο. Σε αθροιστικές μελέτες της νόσου Alzheimer (n=4146) και όταν αυτές οι μελέτες της νόσου Alzheimer αθροιστήκαν με άλλες μελέτες άνοιας, συμπεριλαμβανομένων των μελετών για την αγγειακή άνοια (σύνολο n=6888), το ποσοστό θνησιμότητας στις ομάδες υπό θεραπεία με εικονικό φάρμακο, υπερέβαινε αριθμητικά το ποσοστό των ομάδων υπό θεραπεία με υδροχλωρική δονεπεζίλη. **ΚΥΗΣΗ ΚΑΙ ΓΑΛΟΥΧΙΑ:** Δεν πρέπει να χρησιμοποιείται κατά τη διάρκεια της κύησης, εκτός αν είναι απολύτως απαραίτητο. Δεν πρέπει να χρησιμοποιείται από τη θηλάζουσα μητέρα. **ΑΝΕΠΙΘΥΜΗΤΕΣ ΕΝΕΡΓΕΙΕΣ:** Οι πιο συχνές ανεπιθύμητες ενέργειες είναι διάρροια, μυϊκές κράμπες, κόπωση, ναυτία, εμετός και αϋπνία. Ανεπιθύμητες ενέργειες που αναφέρθηκαν σε περισσότερες από μία μεμονωμένες περιπτώσεις: **Πολύ Συχνές:** Διάρροια, Ναυτία, Κεφαλαλγία. **Συχνές:** Κοινό κρυολόγημα, Ανορεξία, Ψευδαισθήσεις**, Ψυχοκινητική διέγερση**, Επιθετική συμπεριφορά**, Συγκοπτικό επεισόδιο*, Ζάλη, Αϋπνία, Έμετος, Κοιλιακές διαταραχές, Εξάνθημα, Κνησμός, Μυϊκές κράμπες, Ακράτεια ούρων, Κόπωση, Άλγος, Ατύχημα.**Όχι συχνές:** Σπασμοί*, Βραδυκαρδία, Γαστρεντερική αιμορραγία, Γαστρικό και δωδεκαδακτυλικό έλκος, Μικρή αύξηση της συγκέντρωσης της μυϊκής κινάσης της κρεατίνης στον ορό. **Σπάνιες:** Εξωπυραμιδικά συμπτώματα, Φλεβοκομβοκολπικός αποκλεισμός, Κολποκοιλιακός αποκλεισμός, Ηπατική δυσλειτουργία, συμπεριλαμβανομένης της ηπατίτιδας***. * Όταν ελέγχεται η περίπτωση συγκοπτικού επεισοδίου ή σπασμών, πρέπει να εξετάζεται η πιθανότητα καρδιακού αποκλεισμού ή παρατεταμένων φλεβοκομβικών παύσεων. **Περιστατικά ψευδαισθήσεων, ψυχοκινητικής διέγερσης και επιθετικής συμπεριφοράς, που αναφέρθηκαν, εξαλείφθηκαν μετά από μείωση της δόσης ή διακοπή της θεραπείας. ***Σε περιπτώσεις εμφάνισης ανεξήγητων ηπατικών διαταραχών πρέπει να εξεταστεί το ενδεχόμενο διακοπής του φαρμάκου. **ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** PFIZER HELLAS A.E., Λ. Μεσογείων 243, 154 51, Ν. Ψυχικό, Τηλέφωνο: 210 6785800, Fax: 210 6785968. **ΗΜΕΡΟΜΗΝΙΑ ΑΝΑΘΕΩΡΗΣΗΣ ΤΟΥ ΚΕΙΜΕΝΟΥ:** 20-11-2007. **ΔΙΑΝΙΚΕΣ ΤΙΜΕΣ & ΑΡΙΘΜΟΣ(ΟΙ) ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ:** Aricept f.c. tab 28 x 5mg, Λ.Τ.: 101,47 € & 75518/20-11-2007, Aricept f.c. tab 28 x 10mg, Λ.Τ.: 122,68 € & 75519/20-11-2007. **ΦΑΡΜΑΚΕΥΤΙΚΟ ΠΡΟΪΟΝ ΓΙΑ ΤΟ ΟΠΟΙΟ ΑΠΑΙΤΕΙΤΑΙ ΙΑΤΡΙΚΗ ΣΥΝΤΑΓΗ**

Για πλήρεις συνταγογραφικές πληροφορίες συμβουλευτείτε την Περίληψη Χαρακτηριστικών του Προϊόντος που διατίθεται από:

PFIZER HELLAS A.E.
Λεωφ. Μεσογείων 243, 154 51 Ν. Ψυχικό,
Τηλ.: 210 6785800, Τηλ. Παραγγελιών: 210 8199060

Πνεύμα και σώμα



σε ισορροπία

GEODON®
(ziprasidone)

Το αντιψυχωτικό για το πνεύμα και το σώμα

GEODON 20, 40, 60, 80 mg καψάκια, σκληρά, GEODON 10 mg/ml πόσιμο εναιώρημα
Κάθε καψάκιο σκληρό περιέχει μονοϋδρική υδροχλωρική ζιπρασιδόνη ισοδύναμη με 20 mg, 40 mg, 60 mg ή 80 mg ζιπρασιδόνη.
Κάθε ml πόσιμου εναιωρήματος περιέχει μονοϋδρική υδροχλωρική ζιπρασιδόνη ισοδύναμη με 10 mg ζιπρασιδόνης.

Ενδείξεις: Ενδείκνυται για τη θεραπεία της σχιζοφρένειας. Ενδείκνυται για τη θεραπεία των μανιακών ή μεικτών επεισοδίων μετρίου βαθμού σοβαρότητας στη διπολική διαταραχή (η πρόληψη επεισοδίων διπολικής διαταραχής δεν έχει επιβεβαιωθεί). Οι συνταγογραφούντες ιατροί πρέπει να λαμβάνουν υπόψη τους το ενδεχόμενο η ζιπρασιδόνη να προκαλέσει παράταση του διαστήματος QT. **Αντενδείξεις:** Γνωστή υπερευαισθησία στη ζιπρασιδόνη ή σε οποιοδήποτε από τα έκδοχα. Γνωστή παράταση του διαστήματος QT. Συγγενές σύνδρομο παρατεταμένου QT. Πρόσφατο οξύ έμφραγμα του μυοκαρδίου. Μη αντιρροπούμενη καρδιακή ανεπάρκεια. Αρρυθμίες που αντιμετωπίζονται με αντιαρρυθμικά φαρμακευτικά προϊόντα Τάξης ΙΑ και ΙΙΙ. Ταυτόχρονη θεραπεία με φαρμακευτικά προϊόντα, τα οποία προκαλούν παράταση του διαστήματος QT, όπως αντιαρρυθμικά φάρμακα Τάξης ΙΑ και ΙΙΙ, τριοξείδιο του αρσενικού, αλοφαιτρίνη, οξεική λεβομεθαδίλη, μεζοριδαζίνη, θειοριδαζίνη, πιμοζίδη, σπαρφλοξασίνη, γκατιφλοξασίνη, μοξιφλοξασίνη, μεθανοσουλφονική δολασετρόνη, μεφλοκίνη, σερτινδόλη ή σιζαπρίδη. **Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση:** Πρέπει να λαμβάνεται το ιατρικό ιστορικό του ασθενούς, που περιλαμβάνει αξιολόγηση του οικογενειακού του ιστορικού, καθώς επίσης να πραγματοποιείται και κλινική εξέταση προκειμένου να αναγνωριστούν οι ασθενείς για τους οποίους δεν συνιστάται η θεραπεία με ζιπρασιδόνη. *Διάστημα QT:* Η ζιπρασιδόνη προκαλεί δοσοεξαρτώμενη ελαφρά έως μέτριου βαθμού παράταση του διαστήματος QT. Κατά συνέπεια, η ζιπρασιδόνη δεν πρέπει να χορηγείται μαζί με φαρμακευτικά προϊόντα που είναι γνωστό ότι προκαλούν παράταση του διαστήματος QT. Προσοχή συνιστάται σε ασθενείς με σημαντική βραδυκαρδία. Ηλεκτρολυτικές διαταραχές, όπως υποκαλιαιμία και υπομαγνησιαιμία αυξάνουν τον κίνδυνο να εμφανιστούν κακοήθεις αρρυθμίες και πρέπει να διορθώνονται πριν από την έναρξη της θεραπείας με ζιπρασιδόνη. Όταν ασθενείς με σταθεροποιημένη καρδιακή νόσο πρόκειται να υποβληθούν σε θεραπεία με το φάρμακο, πρέπει να προηγείται ηλεκτροκαρδιογραφικός έλεγχος πριν από την έναρξη της θεραπείας. Εάν εμφανιστούν καρδιακά συμπτώματα, όπως αίσθημα παλμών, ίλιγγος, λιποθυμία ή απασμοί τότε πρέπει να εξεταστεί η πιθανότητα κακοήθους αρρυθμίας και να γίνει εκτίμηση της καρδιακής λειτουργίας που να περιλαμβάνει και ΗΚΓ έλεγχο. Συνιστάται διακοπή της θεραπείας εφόσον το διάστημα QTc είναι > 500 msec. Έχουν υπάρξει σπάνιες αναφορές μετά την κυκλοφορία του προϊόντος, κοιλιακής ταχυκαρδίας δίκην ριπιδίου (torsade de pointes) σε ασθενείς που ελάμβαναν ζιπρασιδόνη, με ασαφείς πολλαπλούς παράγοντες κινδύνου. *Παιδιά και έφηβοι:* Η ασφάλεια και η αποτελεσματικότητα της ζιπρασιδόνης σε παιδιά και εφήβους δεν έχει εκτιμηθεί. *Κακοήθες νευροληπτικό σύνδρομο (Neuroleptic Malignant Syndrome - NMS):* Το NMS, είναι ένα σπάνιο αλλά ενδεχομένως θανατηφόρο σύνδρομο, που έχει συσχετισθεί με τη χρήση άλλων αντιψυχωσικών φαρμακευτικών προϊόντων, συμπεριλαμβανομένης και της ζιπρασιδόνης. Η αντιμετώπιση του NMS πρέπει να περιλαμβάνει άμεση διακοπή όλων των αντιψυχωσικών φαρμακευτικών προϊόντων. *Όψιμη δυσκινησία:* Υπάρχει πιθανότητα εμφάνισης όψιμης δυσκινησίας καθώς και άλλων όψιμων εξαπομιμιδικών συνδρόμων μετά από μακρές διάρκειας θεραπείας με ζιπρασιδόνη. Είναι γνωστό πως οι ασθενείς με διπολική διαταραχή είναι ιδιαίτερους ευπαθείς σε αυτή την κατηγορία συμπτωμάτων. Τα συμπτώματα αυτά εμφανίζονται επίσης συχνότερα με την αυξημένη διάρκεια και με την πάροδο της ηλικίας. Εάν εμφανιστούν σημεία και συμπτώματα όψιμης δυσκινησίας πρέπει να εξετασθεί η περίπτωση ελάττωσης της δόσης ή και διακοπής της χορήγησης ζιπρασιδόνης. *Σπασμοί:* Συνιστάται προσοχή κατά τη θεραπεία ασθενών με ιστορικό σπασμών. *Ηπατική ανεπάρκεια:* Δεν υπάρχει επαρκής εμπειρία σε ασθενείς με σοβαρή ηπατική ανεπάρκεια και κατά συνέπεια η χρήση της ζιπρασιδόνης σε αυτή την ομάδα των ασθενών απαιτεί προσοχή. *Φαρμακευτικά προϊόντα που περιέχουν λακτόζη:* Επειδή το καψάκιο περιέχει το έκδοχο λακτόζη, οι ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στην γαλακτόζη, σε έλλειψη λακτάσης Lapp ή σε δυσαπορρόφηση γλυκόζης-γαλακτόζης, δεν θα πρέπει να λαμβάνουν αυτό το φάρμακο. *Αυξημένος κίνδυνος αγγειακών εγκεφαλικών επεισοδίων στον πληθυσμό με άνοια:* Σε τυχαιοποιημένες, ελεγχόμενες με εικονικό φάρμακο, κλινικές δοκιμές στον πληθυσμό με άνοια με κάποια άτυπα αντιψυχωσικά έχει παρατηρηθεί ένας κατά προσέγγιση τριπλά αυξημένος κίνδυνος αγγειακών εγκεφαλικών ανεπιθύμητων συμβαμάτων. Δεν είναι γνωστός ο μηχανισμός για τον οποίο υπάρχει αυτός ο αυξημένος κίνδυνος. Αυξημένος κίνδυνος δεν μπορεί να αποκλειστεί και για άλλα αντιψυχωσικά ή και για άλλους πληθυσμούς ασθενών. Το GEODON πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με παράγοντες κινδύνου για εγκεφαλικό επεισόδιο. Το GEODON 10 mg/ml πόσιμο εναιώρημα περιέχει methyl parahydroxybenzoate και propyl parahydroxybenzoate που μπορεί να προκαλέσουν αλλεργικές αντιδράσεις (πιθανώς με καθυστέρηση), και σε εξαιρετικές περιπτώσεις, βρογχόσπασμο. **Ανεπιθύμητες ενέργειες: Ανεπιθύμητες ενέργειες:** Η από του στόματος χορηγούμενη ζιπρασιδόνη έχει χορηγηθεί σε κλινικές δοκιμές, σε περίπου 6500 ασθενείς. Οι πιο συχνές ανεπιθύμητες ενέργειες σε κλινικές δοκιμές για τη σχιζοφρένεια, ήταν η καταστολή και η ακαθησία. Σε κλινικές δοκιμές για τη διπολική μανία, οι πιο συχνές ανεπιθύμητες ενέργειες ήταν η καταστολή, η ακαθησία, η εξωπυραμιδική διαταραχή και η ζάλη. Ο παρακάτω πίνακας περιέχει ανεπιθύμητα συμβάματα που βασίζονται σε συνδυασμένες, βραχυχρόνιες (4-6 εβδομάδες), σταθερής δόσης μελέτες στη σχιζοφρένεια και βραχυχρόνιες (3 εβδομάδες) μελέτες, διακυμαίνμενης δόσης, στη διπολική μανία, με πιθανή η ενδεχόμενη συσχέτιση με τη θεραπεία με ζιπρασιδόνη και που εμφανίζονται με συχνότητα μεγαλύτερη από το εικονικό φάρμακο. Όλες οι ανεπιθύμητες ενέργειες αναφέρονται ανά συχνότητα (πολύ συχνές (>1/10), συχνές (>1/100, <1/10), όχι συχνές (>1/1000, <1/100), σπάνιες (<1/1000). Οι ανεπιθύμητες ενέργειες που αναφέρονται παρακάτω μπορεί επίσης να σχετίζονται με την υποκείμενη νόσο και/ή τα συγχορηγούμενα φάρμακα. Συχνές: Αιτιοχηξία, δυστονία, ακαθησία, εξωπυραμιδική διαταραχή, παρκινσονισμός (συμπεριλαμβανομένων των: σημείου οδοντωτού τροχού, βραδυκινησίας, υποκινησίας), τρόμος, ζάλη, καταστολή, υπνηλία, κεφαλαλγία, θάμβος όρασης, ναυτία, έμετος, δυσκοιλιότητα, δυσπεψία, διάρροια, υπερέκκριση σιέλου, μυοσκελετική ακαμψία, εξασθένιση, κόπωση. Όχι συχνές: Αυξημένη όρεξη, διέγερση, άγχος, συναγερτικό αίσθημα λαιμού, εφιάλτης, γενικευμένοι τονικοκλονικοί σπασμοί, όψιμη δυσκινησία, δυσκινησία, ακουσία εκροή σιέλου από το στόμα, ataξία, δυσαρθρία, κρίση περιστροφής οφθαλμικών βολβών, διαταραχή στην προσοχή, υπερυπνία, υπαισθησία, παραισθησία, λήθαργος, αίσθημα παλμών, ταχυκαρδία, φωτοφοβία, ίλιγγος, εμβοές, υπερτασική κρίση, υπέρταση, ορθοστατική υπόταση, υπόταση, δύσπνοια, κυνάγχη, διάρροια, δυσφαγία, γαστρίτιδα, γαστρεντερική δυσφορία, διογκωμένη γλώσσα, παχιά γλώσσα, μετεωρισμός, κνίδωση, εξάνθημα, κηλιδοβλατιδώδες εξάνθημα, ακμή, μυοσκελετική δυσφορία, μυϊκή ρράμπα, πόνος του άκρου, δυσκαμψία άρθρωσης, θωρακική δυσφορία, μη φυσιολογικό βάδισμα, άλγος, δίψα, αύξηση ηπατικών ενζύμων. Σπάνιες: Ρινίτιδα, υπαισθεσιαμμία, κρίση πανικού, καταθλιπτικό σύμπτωμα, βραδυφρενία, επίπεδο συναίσθημα, ανοργασμία, βαιβόκραμο, πάρεση, ακινησία, υπερτονία, σύνδρομο ανησυχων κνημων, λειμοδεπενία, αμβλυωπία, οπτική διαταραχή, κνησμώδες του οφθαλμού, ξηροφθαλμία, ιατλγία, συστολική υπέρταση, διαστολική υπέρταση, αστοθής αρτηριακή πίεση, λιποθυμος, γαστροοισοφαγική παλινδρόμηση, χαλαρά κόπρανα, ψωρίαση, αλλεργική δερματίτιδα, αλωπεκία, οίδημα προσώπου, ερύθημα, βλατιδώδες εξάνθημα, ερεθισμός δέρματος, τριγώδες, ακράτεια ούρων, δυσουρία, στυτική δυσλειτουργία, αυξημένη στύση, γαλακτόρροια, γυναικομαστία, πυρεξία, αίσθημη θερμού, παράταση του διαθέμενου διαστήματος QT στο ηλεκτροκαρδιογράφημα, μη φυσιολογική δοκιμασία ηπατικής λειτουργίας, αυξημένη γαλακτική αφυδρογονάση αίματος, αυξημένος αριθμός ηωσινοφίλωνΣε βραχυχρόνιες και μακροχρόνιες κλινικές δοκιμές με ζιπρασιδόνη, στη σχιζοφρένεια και στη διπολική μανία, η συχνότητα εμφάνισης τονικοκλονικών σπασμών και υπότασης δεν ήταν συχνή, εμφανίζόμενη σε ποσοστό μικρότερο του 1% μεταξύ των ασθενών που ελάμβαναν ζιπρασιδόνη. Η ζιπρασιδόνη προκαλεί ήπια έως μέτρια δοσοεξαρτώμενη παράταση του διαστήματος QT. Σε κλινικές δοκιμές στη σχιζοφρένεια, παράταση 30-60 msec παρατηρήθηκε στο 12,3% (976/7941) των καταγραφών του ΗΚΓ επί ασθενών που βρίσκονταν υπό θεραπεία με ζιπρασιδόνη και 7,5% (73/975) των καταγραφών του ΗΚΓ επί ασθενών που βρίσκονταν υπό θεραπεία με το εικονικό φάρμακο. Παράταση >60 msec παρατηρήθηκε στο 1,6% (128/7941) και 1,2% (12/975) των καταγραφών των ασθενών που βρίσκονταν υπό θεραπεία με ζιπρασιδόνη και με το εικονικό φάρμακο αντίστοιχα. Παράταση του διαστήματος QTc πέραν των 500 msec εμφανίστηκε σε 3 από συνολικά 3266 ασθενείς (0,1%), οι οποίοι βρίσκονταν υπό θεραπεία με ζιπρασιδόνη και με το εικονικό φάρμακο. Συγκρίσιμα αποτελέσματα παρατηρήθηκαν και σε κλινικές δοκιμές στη διπολική μανία. Σε κλινικές δοκιμές εφαρμογής μακροχρόνιας θεραπείας συνήτησης, στη σχιζοφρένεια, ασθενείς που ελάμβαναν ζιπρασιδόνη εμφάνισαν μερικές φορές αυξημένα επίπεδα προλακτίνης, αλλά στους περισσότερους οι τιμές επανήλθαν στα φυσιολογικά επίπεδα χωρίς να γίνει διακοπή της θεραπείας. Επιπλέον, οι δυνητικές κλινικές εκδηλώσεις (π.χ. γυναικομαστία και αύξηση μεγέθους των μαστών) ήταν σπάνιες. Μετά την κυκλοφορία του προϊόντος: Ο ακόλουθος πίνακας με ανεπιθύμητα συμβάματα είναι βασισμένος σε αναφορές από την εμπειρία με την ζιπρασιδόνη μετά την κυκλοφορία του προϊόντος: Αϊπνία, Κακόηθες νευροληπτικό σύνδρομο, Κοιλιακή ταχυκαρδία δίκην ριπιδίου (torsade de pointes), Υπερευαισθησία. **Κάτοχος αδείας κυκλοφορίας:** PFIZER HELLAS AE, Λ. Μεσογείων 243, 154 51 Ν. Ψυχικό. **Ημερομηνία αναθεώρησης του κειμένου:**5-12-2006. **Φαρμακευτικό προϊόν για το οποίο απαιτείται ιατρική συνταγή: ΑΡΙΘΜΟΙ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ/ΙΑΝΙΚΕΣ ΤΙΜΕΣ:** GEODON καψάκια σκληρά, 56 x 20 mg, Α.Α.Κ.: 76309/5-12-2006, Α.Τ.: 165,15 €, GEODON καψάκια σκληρά, 56 x 40 mg, Α.Α.Κ.: 76310/5-12-2006, Α.Τ.: 171,24 €, GEODON καψάκια σκληρά, 56 x 60 mg, Α.Α.Κ.: 76311/5-12-2006, Α.Τ.: 178,89 €, GEODON καψάκια σκληρά, 56 x 80 mg, Α.Α.Κ.: 76312/5-12-2006, Α.Τ.: 255,63 €. GEODON 10 mg/ml πόσιμο εναιώρημα, BT x 60 ml, α.Α.Κ.: 76308/5-12-2006, Α.Τ.: 60,83 €.
ΓΙΑ ΠΛΗΡΕΙΣ ΣΥΝΤΑΓΟΓΡΑΦΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ ΠΑΡΑΚΑΛΕΙΣΘΕ ΝΑ ΑΠΕΥΘΥΝΘΕΙΤΕ ΣΤΗΝ ΕΤΑΙΡΙΑ.

PFIZER HELLAS A.E. ΜΕΣΟΓΕΙΩΝ 243 - 154 51 Ν. ΨΥΧΙΚΟ, ΤΗΛ.: Επιστημονικής Ενημέρωσης 210 6785800, Παραγγελιών 210 8199060

PFIZER HELLAS A.E.
ΜΕΣΟΓΕΙΩΝ 243 - 154 51 Ν. ΨΥΧΙΚΟ
ΤΗΛ.: Επιστημονικής Ενημέρωσης 210 6785800
Παραγγελιών 210 8199060

LYR-P2008-1

ZOLO-MA01-October 2009

Για πλήρεις συνταγογραφικές πληροφορίες συμβουλευθείτε την Περίληψη Χαρακτηριστικών του Προϊόντος

PFIZER HELLAS A.E.
Λεωφ. Μεσογείων 243, 15451 Ν. Ψυχικό, Τηλ.: 210 6785800, Τηλ. Παραγγελιών: 210 8199060

Valdoxan

Αποτελεσματικό σε κάθε στάδιο της αντικαταθλιπτικής αγωγής[1,2,3]

ΝΕΟ ΣΤΗΝ ΚΑΤΑΘΛΙΨΗ

73% με πληρογνώσεση

78% χωρίς απόκρουσες

76% ανταποκρίνονται

Σημαντική Βελτίωση

* ασθενείς υπό αγωγή με Valdoxan

SERVIER

www.servier.com
Les Laboratoires Servier France
Υπεύθυνος κυκλοφορίας
ΣΕΡΒΙΕ ΕΛΛΑΣ ΦΑΡΜΑΚΕΥΤΙΚΗ Ε.Π.Ε.
Εθνικής Αντιστάσεως 72 & Αγαμέμνονος, 152 31 Χαλάνδρι, Τηλ.: 2109391000

1 δισκίο την ημέρα πριν τη βραδινή κατάκλιση

1. Lemoine P, Guilleminault C, Alvarez E. J Clin Psychiatry. 2007;68:1723-1732. 2. Kennedy SH, Rizvi S, Fulton K, Rasmussen J. J Clin Psychopharmacol. 2008;28:329-333.
3. Goodwin G, Rouillon F, Emsley R. Eur Neuropsychopharmacol. 2008;18(suppl4):S338. Abstract P2c025.

Πριν την συνταγογράφηση συμβουλευτείτε την Περίληψη Χαρακτηριστικών του προϊόντος που βρίσκεται στη δίπλα σελίδα

ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ Valdoxan 25 mg επικαλυμμένα με λεπτό υμένιο δισκία **ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ** Κάθε επικαλυμμένο με λεπτό υμένιο δισκίο περιέχει 25 mg αγομελατίνης. **Θεραπευτικές ενδείξεις** Θεραπευτική αγωγή των μειζόνων καταθλιπτικών επεισοδίων σε ενήλικες. **Αντενδείξεις** Υπερευαισθησία στη δραστική ουσία ή σε κάποιο από τα έκδοχα. Ηπατική δυσλειτουργία (δηλαδή κίρρωση ή ενεργή ηπατική νόσος) (βλέπε παραγράφους 4.2 και 4.4). Ταυτόχρονη χρήση ισχυρών αναστολέων του CYP1A2 (π.χ. φλουβοξαμίνη, σιπροφλοξασίνη) (βλέπε παράγραφο 4.5). **Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση** *Χρήση σε παιδιά και εφήβους:* Το Valdoxan δε συνιστάται για τη θεραπευτική αγωγή της κατάθλιψης σε ασθενείς κάτω των 18 ετών, εφόσον δεν έχει αποδειχτεί η ασφάλεια και η αποτελεσματικότητα του Valdoxan σε αυτή την ηλικιακή ομάδα. Σε κλινικές δοκιμές σε παιδιά και εφήβους που ακολούθησαν αγωγή με άλλα αντικαταθλιπτικά, παρατηρήθηκε συχνότερα αυτοκτονική συμπεριφορά (απόπειρα αυτοκτονίας και αυτοκτονικές σκέψεις) και εχθρότητα (κυρίως επιθετικότητα, αντιδραστική συμπεριφορά και οργή) συγκριτικά με όσους έλαβαν εικονικό φάρμακο. *Χρήση σε ηλικιωμένους ασθενείς με άνοια:* Το Valdoxan δε θα πρέπει να χρησιμοποιείται για τη θεραπευτική αγωγή μειζόνων καταθλιπτικών επεισοδίων σε ηλικιωμένους ασθενείς με άνοια, εφόσον δεν έχει αποδειχτεί η ασφάλεια και η αποτελεσματικότητα του Valdoxan σε αυτούς τους ασθενείς. *Μανία / Υπομανία:* Το Valdoxan θα πρέπει να χορηγείται με προσοχή σε ασθενείς με ιστορικό μανίας ή υπομανίας και θα πρέπει να διακόπτεται εάν κάποιος ασθενής εκδηλώσει συμπτώματα μανίας. *Αυτοκτονία/αυτοκτονικές σκέψεις:* Η κατάθλιψη συνδέεται με αυξημένο κίνδυνο αυτοκτονικών σκέψεων, αυτοκαταστροφής και αυτοκτονίας (αυτοκτονικά επεισόδια). Ο κίνδυνος αυτός επιμένει έως ότου επέλθει σημαντική ύφεση. Επειδή η βελτίωση μπορεί να μην εκδηλωθεί κατά τις πρώτες εβδομάδες αγωγής ή και αργότερα, οι ασθενείς θα πρέπει να παρακολουθούνται στενά μέχρις ότου σημειωθεί αυτή η βελτίωση. Σύμφωνα με τη γενική κλινική εμπειρία, ο κίνδυνος αυτοκτονίας μπορεί να αυξηθεί κατά τα πρώτα στάδια της ανάρρωσης. Είναι γνωστό ότι οι ασθενείς με ιστορικό αυτοκτονικών επεισοδίων ή εκείνοι που εκδηλώνουν σημαντικό βαθμό αυτοκτονικού ιδεασμού πριν την έναρξη της αγωγής αντιμετωπίζουν μεγαλύτερο κίνδυνο αυτοκτονικών σκέψεων ή απόπειρας αυτοκτονίας και θα πρέπει να τυγχάνουν προσεκτικής παρακολούθησης κατά τη διάρκεια της αγωγής. Μια μετα-ανάλυση ελεγχόμενων με εικονικό φάρμακο κλινικών δοκιμών με αντικαταθλιπτικά σε ενήλικες ασθενείς με ψυχιατρικές διαταραχές έδειξε αυξημένο κίνδυνο αυτοκτονικής συμπεριφοράς με αντικαταθλιπτικά, συγκριτικά με το εικονικό φάρμακο, σε ασθενείς κάτω των 25 ετών. Στενή επίβλεψη των ασθενών και ιδιαίτερα των ασθενών υψηλού κινδύνου θα πρέπει να συνοδεύει την αγωγή, κυρίως κατά τα πρώτα στάδια της αγωγής και μετά από κάθε τροποποίηση της δόσης. Οι ασθενείς (και οι περιθάλποντες αυτούς) θα πρέπει να είναι σε επαγρύπνηση για την αναγκαιότητα παρακολούθησης κάθε κλινικής επιδείνωσης, αυτοκτονικής συμπεριφοράς ή σκέψεων και ασυνήθιστων μεταβολών της συμπεριφοράς και να αναζητούν άμεσα ιατρική συμβουλή εάν εκδηλωθούν τέτοιου είδους συμπτώματα. *Συνδυασμός με αναστολείς του CYP1A2 (βλέπε παραγράφους 4.3 και 4.5)* Ο συνδυασμός με ισχυρούς αναστολείς του CYP1A2 αντενδείκνυται. Προσοχή θα πρέπει να δίδεται όταν το Valdoxan συνταγογραφείται με μέτριους αναστολείς του CYP1A2 (π.χ. προπρανολόλη, γρεπαφλοξασίνη, ενοξασίνη) γιατί μπορεί να έχει ως αποτέλεσμα αυξημένη έκθεση στην αγομελατίνη. *Αυξημένες τρανσαμινάσες του ορού:* Σε κλινικές μελέτες, έχουν παρατηρηθεί αυξήσεις των τρανσαμινασών του ορού (>3 φορές από το ανώτατο όριο του φυσιολογικού εύρους), σε ασθενείς που λαμβάνουν Valdoxan και ιδιαίτερα τη δόση των 50 mg (βλέπε παράγραφο 4.8). Όταν το Valdoxan διακοπτόταν σε αυτούς τους ασθενείς, οι τρανσαμινάσες του ορού επανέρχονταν συνήθως στα φυσιολογικά επίπεδα. Δοκιμασίες της ηπατικής λειτουργίας θα πρέπει να γίνονται σε όλους τους ασθενείς: κατά την έναρξη της αγωγής και στη συνέχεια περιοδικά, μετά από περίπου έξι εβδομάδες (λήξη της οξείας φάσης), μετά από περίπου δώδεκα και εικοσιτέσσερις εβδομάδες (λήξη της φάσης συντήρησης) και από εκεί και στο εξής όποτε ενδείκνυται κλινικά. Κάθε ασθενής που παρουσιάζει αυξημένες τρανσαμινάσες του ορού θα πρέπει να επαναλαμβάνει τις δοκιμασίες ηπατικής λειτουργίας εντός 48 ωρών. Η αγωγή θα πρέπει να διακόπτεται εάν η αύξηση των τρανσαμινασών του ορού υπερβαίνει κατά 3Χ το ανώτατο φυσιολογικό όριο και οι δοκιμασίες της ηπατικής λειτουργίας θα πρέπει να πραγματοποιούνται τακτικά μέχρι την αποκατάσταση των τρανσαμινασών του ορού σε φυσιολογικά επίπεδα. Εάν κάποιος ασθενής εκδηλώσει συμπτώματα που υποδηλώνουν ηπατική δυσλειτουργία, πρέπει να πραγματοποιηθούν δοκιμασίες της ηπατικής λειτουργίας. Η απόφαση εάν ο ασθενής θα συνεχίσει την αγωγή με Valdoxan θα πρέπει να καθοδηγείται από την κλινική κρίση, εν αναμονή της αξιολόγησης των εργαστηριακών εξετάσεων. Εάν παρατηρηθεί ίκτερος, η αγωγή θα πρέπει να διακόπτεται. Απαιτείται προσοχή όταν το Valdoxan χορηγείται σε ασθενείς που καταναλώνουν μεγάλη ποσότητα οινοπνεύματος ή ακολουθούν αγωγή με φαρμακευτικά προϊόντα που σχετίζονται με κίνδυνο ηπατικής βλάβης. *Δυσανεξία στη λακτόζη:* Το Valdoxan περιέχει λακτόζη. Οι ασθενείς με σπάνια κληρονομικά προβλήματα δυσανεξίας στη γαλακτόζη, ανεπάρκεια λακτάσης Lapp ή δυσαπορρόφηση γλυκόζης-γαλακτόζης δεν πρέπει να παίρνουν αυτό το φάρμακο. **Κύηση και γαλουχία** Δε διατίθενται κλινικά δεδομένα σχετικά με έκθεση κατά την εγκυμοσύνη στην αγομελατίνη. Μελέτες σε ζώα δεν κατέδειξαν άμεσες ή έμμεσες επικίνδυνες επιπτώσεις στην εγκυμοσύνη, στην ανάπτυξη του εμβρύου, στον τοκετό ή στη μεταγεννητική ανάπτυξη (βλέπε παράγραφο 5.3). Η χορήγηση σε έγκυες γυναίκες πρέπει να πραγματοποιείται με ιδιαίτερη προσοχή. Δεν είναι γνωστό εάν η αγομελατίνη απεκκρίνεται στο ανθρώπινο μητρικό γάλα. Η αγομελατίνη ή οι μεταβολίτες της απεκκρίνονται στο γάλα αρουραίων που είναι σε περίοδο γαλουχίας. Δεν έχουν αποδειχτεί οι εν δυνάμει επιδράσεις της αγομελατίνης στο βρέφος που θηλάζει. Εάν η αγωγή με Valdoxan θεωρείται απαραίτητη, πρέπει να διακόπτεται ο θηλασμός. **Ανεπιθύμητες ενέργειες** Σε κλινικές δοκιμές, έχουν λάβει Valdoxan πάνω από 3.900 καταθλιπτικοί ασθενείς. Οι ανεπιθύμητες ενέργειες ήταν συνήθως ήπιες ή μέτριες και εκδηλώθηκαν κατά τις δύο πρώτες εβδομάδες αγωγής. Οι συνηθέστερες ανεπιθύμητες ενέργειες ήταν ναυτία και ζάλη. Αυτές οι ανεπιθύμητες ενέργειες ήταν συνήθως παροδικές και δεν οδηγούσαν γενικά σε διακοπή της αγωγής. Οι καταθλιπτικοί ασθενείς εκδηλώνουν μία σειρά συμπτωμάτων που συνδέονται με την ίδια τη νόσο. Είναι, επομένως, ορισμένες φορές, δύσκολο να διαπιστωθεί ποια συμπτώματα είναι αποτέλεσμα της ίδιας της νόσου και ποια είναι αποτέλεσμα της αγωγής με Valdoxan. Οι ανεπιθύμητες ενέργειες αναφέρονται στη συνέχεια με βάση την ακόλουθη συνθήκη: πολύ συχνές (≥1/10), συχνές (≥1/100 έως <1/10), όχι συχνές (≥1/1.000 έως <1/100), σπάνιες (≥1/10.000 έως <1/1.000), πολύ σπάνιες (<1/10.000), μη γνωστές (δεν μπορούν να εκτιμηθούν με βάση τα διαθέσιμα δεδομένα). Οι συχνότητες δεν είναι προσαρμοσμένες ως προς το εικονικό φάρμακο. *Διαταραχές του νευρικού συστήματος:* Συχνές: κεφαλαλγία, ζάλη, υπνηλία, αϋπνία, ημικρανία Όχι συχνές: παραισθησία *Οφθαλμικές διαταραχές:* Όχι συχνές: θαμπή όραση *Διαταραχές του γαστρεντερικού συστήματος:* Συχνές: ναυτία, διάρροια, δυσκοιλιότητα, άλγος άνω κοιλιακής χώρας *Διαταραχές του δέρματος και του υποδόριου ιστού:* Συχνές: υπεριδρωσία Όχι συχνές: έκζεμα Σπάνιες: ερυθηματώδες εξάνθημα *Διαταραχές του μυοσκελετικού συστήματος και του συνδετικού ιστού:* Συχνές: οσφυαλγία *Γενικές διαταραχές και καταστάσεις της οδού χορήγησης:* Συχνές: κόπωση *Διαταραχές του ήπατος και των χοληφόρων:* Συχνές: αυξήσεις (>3 φορές από το ανώτατο όριο του φυσιολογικού εύρους) των ALAT και/ ή ASAT (δηλ. 1,1% με την αγομελατίνη 25/50 mg έναντι 0,7% για το εικονικό φάρμακο). Σπάνιες: ηπατίτιδα. *Ψυχιατρικές διαταραχές:* Συχνές: άγχος Μη γνωστή συχνότητα: Αυτοκτονικές σκέψεις ή συμπεριφορά (βλέπε παράγραφο 4.4) **ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ** Les Laboratoires Servier 22, rue Garnier F-92200 Neuilly-sur-Seine Γαλλία **ΛΙΑΝΙΚΗ ΤΙΜΗ & ΑΡΙΘΜΟΣ(ΟΙ) ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ** Valdoxan f.c. tab 25 mg (BTx28) Λ.Τ. €68,69, EU/1/08/499/003
ΦΑΡΜΑΚΕΥΤΙΚΟ ΠΡΟΪΟΝ ΓΙΑ ΤΟ ΟΠΟΙΟ ΑΠΑΙΤΕΙΤΑΙ ΙΑΤΡΙΚΗ ΣΥΝΤΑΓΗ

Για πλήρεις συντομογραφικές πληροφορίες συμβουλευτείτε την Περίληψη Χαρακτηριστικών του Προϊόντος που διατίθεται από την ΣΕΡΒΙΕ ΕΛΛΑΣ ΦΑΡΜΑΚΕΥΤΙΚΗ Ε.ΠΕ. Εθνικής Αντιστάσεως 72& Αγαμέμνονος, 152 31 Χαλάνδρι, Τηλ.: 2109391000

Author's Index

Author's Index

Author's Index

Author's Index

Speakers' & Chairpersons' Index

AKNOWLEGMENTS

The organizing committee wishes to thank the below - mentioned companies.

ΠΕΡΙΛΗΨΗ ΤΩΝ ΧΑΡΑΚΤΗΡΙΣΤΙΚΩΝ ΤΟΥ ΠΡΟΪΟΝΤΟΣ (SPC) RISPERDAL® CONSTA (ρισπεριδόνη)

ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ. RISPERDAL CONSTA 25mg κόνις και διαλύτης για ενέσιμο εναιώρημα παρατεταμένης αποδέσμευσης για ενδομυϊκή χρήση. RISPERDAL CONSTA 37,5mg κόνις και διαλύτης για ενέσιμο εναιώρημα παρατεταμένης αποδέσμευσης για ενδομυϊκή χρήση. RISPERDAL CONSTA 50mg κόνις και διαλύτης για ενέσιμο εναιώρημα παρατεταμένης αποδέσμευσης για ενδομυϊκή χρήση. **ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ.** Ένα φιαλίδιο περιέχει 25mg ρισπεριδόνης. Ένα φιαλίδιο περιέχει 37,5mg ρισπεριδόνης. Ένα φιαλίδιο περιέχει 50mg ρισπεριδόνης. Το RISPERDAL CONSTA είναι ρισπεριδόνη υπό μορφή μικροσφαιριδίων παρατεταμένης αποδέσμευσης, που παρασκευάστηκε από ρισπεριδόνη μικροενκαψωλιωμένη σε polyactide-co-glycolide, σε συγκέντρωση 381mg ρισπεριδόνης ανά γραμμάριο μικροσφαιριδίων. 1ml αναδυσπαθέντος εναιωρήματος περιέχει 12,5mg ρισπεριδόνης. 1ml αναδυσπαθέντος εναιωρήματος περιέχει 18,75mg ρισπεριδόνης. 1ml αναδυσπαθέντος εναιωρήματος περιέχει 25mg ρισπεριδόνης. Έκδοχα: 1ml αναδυσπαθέντος εναιωρήματος περιέχει 3mg νατρίου. **ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ. Θεραπευτικές ενδείξεις:** Το RISPERDAL CONSTA ενδείκνυται για θεραπεία συντήρησης της σχιζοφρένειας σε ασθενείς σταθεροποιημένους με από του στόματος αντιψυχωσικά. **Αντενδείξεις:** Υπερευαισθησία στη δραστική ουσία ή σε κάποιο από τα έκδοχα. **Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση:** Για ασθενείς που δεν έχουν λάβει προγενέστερη θεραπεία με ρισπεριδόνη, συνιστάται να καθορισθεί η ανοχή με από του στόματος ρισπεριδόνη πριν από την έναρξη της θεραπείας με RISPERDAL CONSTA (βλ. παράγραφο Δοσολογία και τρόπος χορήγησης). Ηλικιωμένοι ασθενείς με άνοια: Το RISPERDAL CONSTA δεν έχει μελετηθεί σε ηλικιωμένους ασθενείς με άνοια, επομένως δεν ενδείκνυται για χρήση σε αυτόν τον πληθυσμό ασθενών. *Συνολική θνησιμότητα:* Σε μία μετα-ανάλυση 17 ελεγχόμενων κλινικών δοκιμών με άτυπα αντιψυχωσικά, συμπεριλαμβανομένου του από του στόματος RISPERDAL, οι ηλικιωμένοι ασθενείς με άνοια που ακολούθησαν θεραπεία με άτυπα αντιψυχωσικά παρουσίασαν μία αυξημένη θνησιμότητα σε σύγκριση με το εικονικό φάρμακο (placebo). Σε ελεγχόμενες με εικονικό φάρμακο δοκιμές με από του στόματος RISPERDAL στον ίδιο πληθυσμό, το ποσοστό θνησιμότητας ήταν 4,0% για τους ασθενείς που ακολούθησαν θεραπεία με RISPERDAL σε σύγκριση με το 3,1% για τους ασθενείς που ακολούθησαν θεραπεία με εικονικό φάρμακο. Ο λόγος των πιθανοτήτων (odds ratio – 95% ακριβές διάστημα εμπιστοσύνης) ήταν 1,21 (0,7-2,1). Η μέση ηλικία (εύρος) των ασθενών που απεβίωσαν ήταν 86 έτη (εύρος 67-100). *Ταυτόχρονη χρήση με φουροσεμίδη:* Στις ελεγχόμενες με εικονικό φάρμακο δοκιμές με από του στόματος RISPERDAL σε ηλικιωμένους ασθενείς με άνοια, παρατηρήθηκε υψηλότερη θνησιμότητα σε ασθενείς που ακολούθησαν θεραπεία με φουροσεμίδη μαζί με ρισπεριδόνη (7,3%, μέση ηλικία 89 έτη, εύρος 75-97 έτη) σε σύγκριση με τους ασθενείς που ακολούθησαν θεραπεία μόνο με ρισπεριδόνη (3,1%, μέση ηλικία 84 έτη, εύρος 70-96 έτη) ή μόνο με φουροσεμίδη (4,1%, μέση ηλικία 80 έτη, εύρος 67-90 έτη). Η αύξηση της θνησιμότητας σε ασθενείς που ακολούθησαν θεραπεία με φουροσεμίδη μαζί με ρισπεριδόνη παρατηρήθηκε σε δύο από τις τέσσερις κλινικές δοκιμές. Ταυτόχρονη χρήση ρισπεριδόνης με άλλα διουρητικά (κυρίως θειαζιδικά διουρητικά που χρησιμοποιούνται σε μικρές δόσεις) δεν συνδέθηκε με παρόμοια αυρήματα. Δεν έχει αναγνωριθεί κανένας παθοφυσιολογικός μηχανισμός που να εξηγεί αυτό το εύρημα και δεν παρατηρήθηκε κανένα σύνηθες αίτιο θανάτου. Παρόλα αυτά, πρέπει να δίδεται προσοχή και οι κίνδυνοι και τα οφέλη αυτού του συνδυασμού ή της συγχορήγησης άλλων ισχυρών διουρητικών πρέπει να εξετάζονται πριν από την απόφαση χρήσης τους. Δεν εμφανίστηκε αυξημένη θνησιμότητα μεταξύ των ασθενών που ελάμβαναν άλλα διουρητικά ως συγχορηγούμενα φάρμακα με τη ρισπεριδόνη. Ανεξαρτήτως θεραπείας, η αφυδάτωση ήταν ένας γενικός παράγοντας κινδύνου θνησιμότητας και για το λόγο αυτό πρέπει να απαρέγκλιτα προσεκτικά σε ηλικιωμένους ασθενείς με άνοια. Ανεπιθύμητες Ενέργειες από Διαταραχές των Αγγείων του Εγκεφάλου: Σε ελεγχόμενες με εικονικό φάρμακο δοκιμές σε ηλικιωμένους ασθενείς με άνοια, παρατηρήθηκε σημαντικά υψηλότερη συχνότητα εμφάνισης (αυξημένη περίπου κατά 3 φορές) ανεπιθύμητων συμβαμάτων από διαταραχές των εγκεφαλικών αγγείων, όπως εγκεφαλικό επεισόδιο (περιλαμβανομένων μοιραίων) και παροδικά ισχαιμικά επεισόδια, σε ασθενείς που ακολούθησαν θεραπεία με RISPERDAL σε σύγκριση με ασθενείς που ακολουθούσαν θεραπεία με εικονικό φάρμακο (μέση ηλικία 85 έτη, εύρος 73-97 έτη). Τα συγκεντρωτικά δεδομένα (pooled data) από έξι ελεγχόμενες με εικονικό φάρμακο μελέτες σε ηλικιωμένους κυρίως ασθενείς (ηλικίας > 65 ετών) με άνοια, έδειξαν ότι τα ανεπιθύμητα συμβάματα από διαταραχές των εγκεφαλικών αγγείων (σοβαρές και όχι σοβαρές, μαζί) παρουσιάσθηκαν στα 3,3% (33/1009) των ασθενών που ακολούθησαν θεραπεία με ρισπεριδόνη και στο 1,2% (8/712) των ασθενών που ακολούθησαν θεραπεία με εικονικό φάρμακο. Ο λόγος των πιθανοτήτων (odds ratio – 95% ακριβές διάστημα εμπιστοσύνης) ήταν 2,96 (1,34-7,50). Ο μηχανισμός για τον αυξημένο αυτό κίνδυνο δεν είναι γνωστός. Ο αυξημένος κίνδυνος δεν μπορεί να αποκλειστεί για άλλα αντιψυχωσικά ή άλλους πληθυσμούς ασθενών. Το RISPERDAL CONSTA πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με παράγοντες κινδύνου για αγγειακό εγκεφαλικό επεισόδιο. Ορθοστατική υπόταση: Εξαιτίας της δράσης της ρισπεριδόνης στους α-υποδοκείς, μπορεί να εμφανισθεί (ορθοστατική) υπόταση, ειδικά κατά τη διάρκεια έναρξης της θεραπείας. Κλινικώς σημαντική υπόταση έχει παρατηρηθεί μετά την κυκλοφορία του προϊόντος με τη σύγχρονη χρήση ρισπεριδόνης και αντιυπερτασικής θεραπείας. Η ρισπεριδόνη πρέπει να χρησιμοποιείται με προσοχή σε ασθενείς με γνωστή καρδιαγγειακή νόσο (π.χ. καρδιακή ανεπάρκεια, έμφραγμα του μυοκαρδίου, διαταραχές αγωγιμότητας, αφυδάτωση, ελαττωμένο όγκο αίματος ή αγγειακή εγκεφαλική νόσο). Ο λόγος κινδύνου/οφέλους περαιτέρω θεραπείας με RISPERDAL CONSTA πρέπει να αξιολογηθεί, εάν επμένει η κλινικώς σχετιζόμενη ορθοστατική υπόταση. Βραδυκινησία/Εξωπυραμιδικά Συμπτώματα: Φάρμακα που διαθέτουν ιδιότητες ανταγωνισμού των υποδοκέων της ντοπαμίνης έχουν σχετιστεί με την επαγωγή βραδυκινησίας, η οποία χαρακτηρίζεται από ρυθμικές, ακούσιες κινήσεις, κυρίως της γλώσσας και/ή του προσώπου. Η έναρξη εξωπυραμιδικών συμπτωμάτων απoτελεί παράγοντα κινδύνου για βραδυκινησία. Εάν εμφανιστούν σημεία και συμπτώματα βραδυκινησίας, πρέπει να εξετασθεί το ενδεχόμενο διακοπής όλων των αντιψυχωσικών. Κακοήθες νευρολεπτικό σύνδρομα (ΝΜS): Το Κακοήθες Νευρολεπτικό Σύνδρομο (ΝΜS), το οποίο χαρακτηρίζεται από υπερθερμία, μυϊκή ακαμψία, αστάθεια του αυτόνομου νευρικού συστήματος, μεταβλητότητα συνείδησης και συξυμένα επίπεδα κρεατινοφωσφοκινάσης του ορού, έχει αναφερθεί ότι παρατηρείται με τα αντιψυχωσικά. Επιπρόσθετα σημεία μπορεί να περιλαμβάνουν μυοσφαιρινουρία (ραβδομυόλυση) και οξεία νεφρική ανεπάρκεια. Σε αυτή την περίπτωση, πρέπει να διακοπούν όλα τα αντιψυχωσικά, περιλαμβανομένου και του RISPERDAL CONSTA. Νόσος του Πάρκινσον και άνοια με σωμάτια Lewy: Οι ιατροί πρέπει να σταθμίζουν τους κινδύνους έναντι των οφελών όταν συνταγογραφούν αντιψυχωσικά, περιλαμβανομένου και του RISPERDAL CONSTA, σε ασθενείς με νόσο του Πάρκινσον ή άνοια με Σωμάτια Lewy (DLB). Η νόσος του Πάρκινσον μπορεί να επιδεινωθεί με τη ρισπεριδόνη. Και οι δύο ομάδες μπορεί να διατρέχουν αυξημένο κίνδυνο εμφάνισης Νευροληπτικού Κακοήθους Συνδρόμου, καθώς και να εμφανίζουν αυξημένη ευαισθησία στα αντιψυχωσικά φαρμακευτικά προϊόντα. Οι ασθενείς αυτοί εξαιρέθηκαν από τις κλινικές δοκιμές. Οι εκδηλώσεις αυτής της αυξημένης ευαισθησίας μπορεί να περιλαμβάνουν, επιπλέον των εξωπυραμιδικών συμπτωμάτων, και αύγωση, θόλωση της συνείδησης, σατάθεια θέσης του σώματος με συχνές πτώσεις. Υπεγλυκαιμία: Σε πολύ σπάνιες περιπτώσεις έχουν αναφερθεί υπεγλυκαιμία ή παρόξυνση προϋπάρχοντος διαβήτη κατά τη διάρκεια θεραπείας με RISPERDAL CONSTA. Συνιστάται κατάλληλη κλινική παρακολούθηση σε διαβητικούς ασθενείς και σε ασθενείς με παράγοντες κινδύνου για την ανάπτυξη σακχαρώδους διαβήτη. Υπεγλυκαλιαιμία: Μελέτες που έγιναν σε καλλιέργειες ιστών υποδεικνύουν ότι η ανάπτυξη των κυττάρων σε όγκους του μαστού σε ανθρώπους μπορεί να διεγείρεται από την προλακτίνη. Παρόλο που δεν έχει μέχρι στιγμής καταδειχθεί σαφής συσχετισμός με τη χορήγηση αντιψυχωσικών σε κλινικές και επιδημιολογικές μελέτες, συνιστάται προσοχή σε ασθενείς με ανεπικό ιατρικό ιστορικό. Το RISPERDAL CONSTA πρέπει να χορηγείται με προσοχή σε ασθενείς με προϋπάρχουσα υπερπρολακτιναιμία και σε ασθενείς με πιθανούς όγκους ακετζάμενους με την προλακτίνη. Παράταση του QT: Η παράταση του QT έχει αναφερθεί πολύ σπάνια μετά την κυκλοφορία του προϊόντος. Όπως και με άλλα αντιψυχωσικά, πρέπει να δίδεται προσοχή όταν η ρισπεριδόνη συνταγογραφείται σε ασθενείς με γνωστή καρδιαγγειακή νόσα, με οικογενειακό ιστορικό παράτασης του QT, βραδυκαρδία ή με διαταραχή των ηλεκτρολυτών (υποκαλιαιμία, υπομαγνησιαιμία), καθώς μπορεί να αυξήσει τον κίνδυνο αρρυθμιογόνων επιδράσεων, και κατά τη συνδυασμένη χρήση με φάρμακα που είναι γνωστό ότι παρατείνουν το διάστημα QT. Επιληπτικοί σπασμοί: Το RISPERDAL CONSTA πρέπει να χορηγείται με προσοχή σε ασθενείς με ιστορικό επιληπτικών σπασμών ή άλλων καταστάσεων που δυνητικά ελαττώνουν τον ουδό των σπασμών. Priapismός: Μπορεί να εμφανισθεί priapismός με τη θεραπεία με RISPERDAL CONSTA εξαιτίας της αναστολητικής δράσης του στους α-αδρενεργικούς υποδοκείς. Ρύθμιση της θερμοκρασίας του σώματος: Η παρεμβολή στην ικανότητα του σώματος να ελαττώνει την κεντρική του θερμοκρασία έχει αποδοθεί σε αντιψυχωσικά φάρμακα. Συνιστάται η κατάλληλη φροντίδα όταν συνταγογραφείται το RISPERDAL CONSTA σε ασθενείς που θα εμπλακούν σε καταστάσεις, οι οποίες μπορεί να συμβάλλουν σε αύξηση της κεντρικής θερμοκρασίας του σώματος, π.χ. πολύ έντονη σωματική άσκηση, έκθεση σε πολύ υψηλές θερμοκρασίες, ταυτόχρονη θεραπεία με αντικολινεργική δράση, ή αφυδάτωση. Αύξηση σωματικού βάρους: Όπως και με άλλα αντιψυχωσικά, οι ασθενείς πρέπει να ενημερώνονται για το ενδεχόμενο αύξησης του σωματικού βάρους. Το βάρος πρέπει να μετράται τακτικά. Νεφρική ή ηπατική δυσλειτουργία: Παρόλο που η από του στόματος ρισπεριδόνη έχει μελετηθεί, το RISPERDAL CONSTA δεν έχει μελετηθεί σε ασθενείς με νεφρική ή ηπατική δυσλειτουργία. Το RISPERDAL CONSTA πρέπει να χορηγείται με προσοχή σε αυτή την ομάδα ασθενών (βλ. παράγραφο Δοσολογία και τρόπος χορήγησης). Χορήγηση: Πρέπει να δίδεται προσοχή για την αποφυγή ακούσιας ένεσης του RISPERDAL CONSTA σε αιμοφόρο αγγείο. Έκδοχα: Το προϊόν αυτό περιέχει λιγότερο από 1mmol νάτριο (23mg) ανά δόση, δηλ. είναι ακεδόν «ελεύθερο νατρίου». **Ανεπιθύμητες ενέργειες:** Οι πιο συχνά αναφερόμενες ανεπιθύμητες ενέργειες φαρμάκου (ΑΕΦ) (σε συχνότητα ≥1/10) είναι: Αϋπνία, άγχος, κεφαλαλγία, λοίμωξη του ανώτερου αναπνευστικού συστήματος, παρκινσονισμός, κατάθλιψη, και ακαθησία. Ακολουθούν όλες οι ΑΕΦ που αναφέρθηκαν κατά τις κλινικές δοκιμές και μετά την κυκλοφορία του προϊόντος. Χρησιμοποιούνται οι ακόλουθοι όροι και συχνότητες: πολύ συχνές (≥ 1/10), συχνές (≥ 1/100 έως < 1/10), όχι συχνές (≥ 1/1000 έως < 1/100), σπάνιες (≥ 1/10.000 έως < 1/1.000), πολύ σπάνιες (< 1/10.000) και μη γνωστές (δεν μπορούν να εκτιμηθούν με βάση τα διαθέσιμα δεδομένα από κλινικές δοκιμές). Εντός κάθε κατηγορίας συχνότητας εμφάνισης, οι ανεπιθύμητες ενέργειες παρατίθενται κατά φθίνουσα σειρά σοβαρότητας. **Ανεπιθύμητες Ενέργειες Φαρμάκου ανάλογα με την Κατηγορία Οργάνου Συστήματος και τη Συχνότητα. Παρακλινικές εξετάσεις.** *Συχνές:* Ηλεκτροκαρδιογράφημα μη φυσιολογικό, Αυξημένη προλακτίνη αίματος[α], Αυξημένη γλυκόζη αίματος αυξημένη, Αύξηση των ηπατικών ενζύμων, Αυξημένες τρανσαμινάσες, Αυξημένη γ- γλουταμυλτρανσφεράση, Σωματικό βάρος αυξημένο, Σωματικό βάρος μειωμένο. *Όχι συχνές:* Διάστημα QT παρατεταμένο στο ηλεκτροκαρδιογράφημα. **Καρδιακές διαταραχές.** *Συχνές:* Καλπονοειδιακός απονοειμός, Ταχυκαρδία. *Όχι συχνές:* Σκελικός αποκλεισμός, Κολπική μαρμαρυγή, Βραδυκαρδία, Φλεβοκομβική βραδυκαρδία, Αίσθημα παλμών. **Διαταραχές του αιμοποιητικού και του λεμφικού συστήματος.** *Συχνές:* Αναιμία. *Όχι συχνές:* Θρομβοκυτοπενία, Ουδετεροπενία. *Μη γνωστές:* Ακοκκιοκυτταραιμία. **Διαταραχές του νευρικού συστήματος.** *Πολύ συχνές:* Παρκινσονισμός[β], Ακαθησία[β], Κεφαλαλγία. *Συχνές:* Σάλη, Καταστολή, Υπνηλία, Τρόμος, Δυστονία[β], Βραδυκινησία, Δυσκινησία[β]. *Όχι συχνές:* Σπασμός, Συγκοπή, Σάλη θέσης, Υπαισθησία, Παραισθησία, Λήθαργος, Υπερυπνία. **Οφθαλμικές διαταραχές.** *Συχνές:* Όραση θαμπή, Επιπεφυκίτιδα. *Μη γνωστές:* Απόφραξη της αμφιβληστροειδικής αρτηρίας. **Διαταραχές του ώτός και του λαβυρίνθου.** *Συχνές:* Ίλιγγος. *Όχι συχνές:* Ωταλγία. **Διαταραχές του αναπνευστικού συστήματος, του θώρακα και του μεσοθωράκιου.** *Συχνές:* Δύσπνοια, Βήχας, Ρινική συμφόρηση, Φαρυγγολαρυγγικό άλγος. *Όχι συχνές:* Σύνδρομο άπνοιας κατά τον ύπνο. **Διαταραχές του γαστρεντερικού.** *Συχνές:* Έμετος, Διάρροια, Δυσκοιλιότητα, Ναυτία, Κοιλιακό άλγος, Δυσπεψία, Οδονταλγία, Ξηροστομία, Στομακικές ενοχλήσεις, Γαστρίτιδα. *Σπάνιες:* Εντερική απόφραξη, Παγκρεατίτιδα. **Διαταραχές των νεφρών και των ουροφόρων οδών.** *Συχνές:* Ακράτεια ούρων. **Διαταραχές το δέρματος και του υποδόριου ιστού.** *Συχνές:* Εξάνθημα, Έκζεμα. *Όχι συχνές:* Αγγειοοίδημα, Κνησμός, Ακμή, Αλωπεκία, Ξηροδερμία. **Διαταραχές του μυοσκελετικού συστήματος και του συνδετικού ιστού.** *Συχνές:* Αρθραλγία, Οσφυαλγία, Άγχος στα άκρα, Μυαλγία. *Όχι συχνές:* Μυϊκή αδυναμία, Αυχεναλγία, Πόνος στους γλουτούς, Μυοσκελετικός πόνος του θώρακα. **Διαταραχές του ενδοκρινικού συστήματος.** *Σπάνιες:* Απρόσφορη έκκριση αντιδιουρητικής ορμόνης. **Διαταραχές του μεταβολισμού και της θρέψης.** *Όχι συχνές:* Αυξημένη όρεξη, Μειωμένη όρεξη. *Πολύ σπάνιες:* Διαβητική κετοξέωση. *Μη γνωστές:* Δηλητηρίαση από ύδωρ. **Λοιμώξεις και παρασιτώσεις.** *Πολύ συχνές:* Λοίμωξη του ανώτερου αναπνευστικού συστήματος. *Συχνές:* Πνευμονία, Γρίππη, Λοίμωξη του κατώτερου αναπνευστικού συστήματος Βρογχίτιδα, Ουρολοίμωξη, Λοίμωξη του ώτός, Κολπίτιδα, Ιογενής λοίμωξη. *Όχι συχνές:* Κυστίτιδα, Γαστρεντερίτιδα, Λοίμωξη, Εντοπισμένη λοίμωξη, Υποδόριο απόστημα. **Κακώσεις, δηλητηριάσεις και επιπλοκές θεραπευτικών χειρισμών.** *Συχνές:* Πτώση. *Όχι συχνές:* Πόνος κατά τα θεραπευτικό χειρισμό. **Αγγειακές διαταραχές.** *Συχνές:* Υπέρταση, Υπόταση. *Όχι συχνές:* Ορθοστατική υπόταση. **Γενικές διαταραχές και καταστάσεις της οδού χορήγησης.** *Συχνές:* Πυρεξία, Οίδημα περιφερικά, Θωρακικό άλγος, Κόπωση, Πόνος, Πόνος στο σημείο της ένεσης, Εξασθένιση, Γριπποώδης συνδρομή. *Όχι συχνές:* Μη φυσιολογική αίσθηση του εαυτού, Θωρακική δυσφορία, Σκλήρυνση, Σκλήρυνση της θέσης ένεσης, Νωθρότητα, Αντίδραση της θέσης ένεσης. *Σπάνιες:* Υποθερμία. **Διαταραχές του ανοσοποιητικού συστήματος.** *Όχι συχνές:* Υπερευαισθησία. *Μη γνωστές:* Αναφυλακτική αντίδραση. **Διαταραχές του ήπατος και των χοληφόρων.** *Σπάνιες:* Ίκτερος. **Διαταραχές του αναπαραγωγικού συστήματος και του μαστού.** *Συχνές:* Αμηνόρροια, Στυτική δυσλειτουργία, Γαλακτόρροια. *Όχι συχνές:* Σεξουαλική δυσλειτουργία, Γυναικομαστία. *Μη γνωστές:* Priapismός. **Ψυχιατρικές διαταραχές.** *Πολύ συχνές:* Κατάθλιψη, Αϋπνία, Άγχος. *Συχνές:* Διέγερση, Διαταραχή ύπνου. *Όχι συχνές:* Μανία, Γενετίσιο ορμή μειωμένη, Νευρικότητα.

[α] Η υπερπρολακτιναιμία μπορεί σε μερικές περιπτώσεις να οδηγήσει σε γυναικομαστία, διαταραχές της έμμηνου ρύσεως, αμηνόρροια, γαλακτόρροια.
[β] Μπορεί να συμβεί εξωπυραμιδική διαταραχή. Παρκινσονισμός (υπερέκκριση σιέλου, μυοσκελετική δυσκαμψία, παρκινσονισμός, ακουσία εκροή σιέλου από το στόμα, σημείο οδοντωτού τροχού, βραδυκινησία, υποκινησία, καθηλωμένο προσωπείο, μυϊκό σφίξιμο, ακινησία, συκευνική ακαμψία, μυϊκή ακαμψία, παρκινσονικό βάδισμα και μειόδρομο αντανακλαστικά μη φυσιολογικό), ακαθησία (ακαθησία, ανησυχία, υπερκινησία, και σύνδρομο ανήσυχων ποδιών), τρόμος, δυσκινησία (δυσκινησία, μυϊκές δεσμιδώσεις, χορειοαθέτωση, αθέτωση και μυοκλονια), δυστονία. Η δυστονία περιλαμβάνει δυστονία, μυϊκούς σπασμούς, υπερτονία, βλεφύρασμο, μυϊκές συσπάσεις ακούσιες, μυϊκή σύσπαση, βλεφαρόσπασμο, κίνηση των οφθαλμών, παράλυση γλώσσας, σπασμό προσώπου, λαρυγγόσπασμο, μυοτονία, οπισθότονος, σπασμό στοματοφάρυγγα, πλαγιότονο, σπασμό της γλώσσας και τριγμό. Ο τρόμος περιλαμβάνει τρόμο και παρκινσονικό τρόμο ηρεμίας. Πρέπει να σημειωθεί ότι έχει περιληφθεί ένα ευρύτερο φάσμα συμπτωμάτων, τα οποία δεν έχουν απαραίτητα εξωπυραμιδική προέλευση.

Οι ακόλουθες ανεπιθύμητες ενέργειες είναι μία λίστα των πρόσθετων ΑΕΦ ανεπιζόμενων με τη ρισπεριδόνη, που έχουν αναγνωρισθεί ως ΑΕΦ κατά τη διάρκεια κλινικών δοκιμών που διερευνούσαν την από του στόματος μορφή ρισπεριδόνης (RISPERDAL) αλλά δεν προσδιορίστηκε ότι είναι ΑΕΦ στις κλινικές δοκιμές που διερευνούσαν το RISPERDAL CONSTA. **Επιπρόσθετες Ανεπιθύμητες Ενέργειες Φαρμάκου που αναφέρθηκαν με από του στόματος RISPERDAL αλλά όχι με RISPERDAL CONSTA βάσει Κατηγορία Οργάνου Συστήματος. Παρακλινικές εξετάσεις:** Θερμοκρασία σώματος αυξημένη, Αυξημένος αριθμός ηωσινόφιλων, Μειωμένος αριθμός λευκών αιμοσφαιρίων, Μειωμένη αιμοσφαιρίνη, Αυξημένη φωσφορινάση κρεατινίνης στο αίμα, Θερμοκρασία σώματος μειωμένη. **Λοιμώξεις και παρασιτώσεις.** Αμυγδαλίτιδα, Κυτταρίτιδα, Μέση ωτίτιδα, Λοίμωξη του οφθαλμού, Δερματίτιδα από ακάρεα, Λοίμωξη του αναπνευστικού συστήματος, Ουνυχομυκητίαση, Μέση ωτίτιδα χρονία. **Διαταραχές του αιμοποιητικού και του λεμφικού συστήματος.** Κοκκιοκυτταροπενία. **Διαταραχές του ανοσοποιητικού συστήματος.** Υπερευαισθησία σε φάρμακα. **Διαταραχές του μεταβολισμού και της θρέψης.** Ανορεξία, Πολυδιψία. **Ψυχιατρικές διαταραχές.** Συγχυτική κατάσταση, Νωθρός, Ανοργασμία, Αμβλύ συναίσθημα. **Διαταραχές του νευρικού συστήματος.** Μη φυσιολογικός σε ερεθίσματα, Απώλεια συνείδησης, Κακοήθες νευρολεπτικό σύνδρομα, Διαβητικό κώμα, Αγγειακό εγκεφαλικό επεισόδιο, Επηρεασμένο επίπεδο συνείδησης, Εγκεφαλική ισχαιμία, Διαταραχή των αγγείων του εγκεφάλου, Παροδικό ισχαιμικό επεισόδιο, Δυσαρθρία, Διαταραχή στην προσοχή, Διαταραχή ισορροπίας, Διαταραχή λόγου, Μη φυσιολογικός συντονισμός, Διαταραχή κίνησης. **Οφθαλμικές διαταραχές.** Υπεραιμία του οφθαλμού, Οφθαλμικό έκκριμα, Οίδημα του οφθαλμού, Ξηροφθαλμία, Δακρύρροια αυξημένη, Φωτοφοβία, Οπτική οξύτητα μειωμένη, Συστροφή του οφθαλμικού βολβού, Γλαύκωμα. **Διαταραχές του ώτός και του λαβυρίνθου.** Εμβοές. **Αγγειακές διαταραχές.** Εξάψεις. **Διαταραχές του αναπνευστικού συστήματος, του θώρακα και του μεσοθωράκιου:** Συριγμός, Πνευμονία από εισρόφηση, Πνευμονική συμφόρηση, Διαταραχή αναπνευστικού συστήματος, Ρόγχοι, Επίσταξη, Συμφόρηση αναπνευστικής οδού, Υπεραερισμός, Δυσφωνία. **Διαταραχές του γαστρεντερικού:** Δυσφαγία, Ακράτεια κοπράνων, Κόπρωμα, Οίδημα χειλών, Χειλίτιδα. **Διαταραχές του δέρματος και του υποδόριου ιστού:** Βλάβη δέρματος, Διαταραχή δέρματος, Δυσχρωματισμός δέρματος, Ξηνγυατοροϊκή δερματίτιδα, Υπερκεράτωση, Πτυρίδα, Ερύθημα. **Διαταραχές του μυοσκελετικού συστήματος και του μυοσκελετικού συστήματος και του συνδετικού ιστού:** Ραβδομυόλυση, Διόγκωση άρθρωσης, Στάση σώματος μη φυσιολογική, Δυσκαμψία άρθρωσης. **Διαταραχές των νεφρών και των ουροφόρων οδών:** Ενούρηση, Δυσουρία, Πολυουρία. **Διαταραχές του αναπαραγωγικού συστήματος και του μαστού:** Διαταραχές εκσπερμάτισης, Κολπικό έκκριμα, Διαταραχές εμμήνου ρύσης. **Γενικές διαταραχές και καταστάσεις της οδού χορήγησης:** Γενικευμένο αίσθημα, Οίδημα προσώπου, Διαταραχή βαδίσματος, Δίψα, Ρίγη, Περιφερική ψυχρότητα, Σύνδρομο από απόσυρση φαρμάκου.

Ανεπιθύμητες ενέργειες αυτής της κατηγορίας: Όπως και με άλλα αντιψυχωσικά, έτσι και με τη ρισπεριδόνη έχουν αναφερθεί, μετά την κυκλοφορία του προϊόντος, πολύ σπάνιες περιπτώσεις παράτασης του διαστήματος QT. Άλλες καρδιακές ανεπιθύμητες ενέργειες που σχετίζονται με αυτή την κατηγορία, οι οποίες παρατείνουν το διάστημα QT και έχουν αναφερθεί με αντιψυχωσικά, περιλαμβάνουν κοιλιακή αρρυθμία, κοιλιακή μαρμαρυγή, κοιλιακή ταχυκαρδία, αιφνίδιο θάνατο, καρδιακή ανακοπή και κοιλιακή ταχυκαρδία δίκην ριπιδίου (Torsades de Pointes). *Αύξηση σωματικού βάρους:* Σε μία διπλά τυφλή, ελεγχόμενη με εικονικό φάρμακο μελέτη διάρκειας 12 εβδομάδων, στο 9% των ασθενών που ακολούθησαν θεραπεία με RISPERDAL CONSTA σε σύγκριση με το 6% των ασθενών που ακολούθησαν θεραπεία με εικονικό φάρμακο, αυξήθηκε το σωματικό βάρος κατά ≥ 7% στο καταλληλό σημείο. Στην ανοικτή μελέτη διάρκειας 1 έτους του RISPERDAL CONSTA οι μεταβολές στο σωματικό βάρος μεμονωμένων ασθενών ήταν γενικά εντός ± 7% από τη βάση αναφοράς. Στο 25% των ασθενών αυξήθηκε το σωματικό βάρος κατά ≥ 7%. **ΤΡΟΠΟΣ ΔΙΑΘΕΣΗΣ:** Φαρμακευτικό προϊόν για το οποίο απαιτείται ιατρική συνταγή.

ΣΥΣΚΕΥΑΣΙΕΣ/ΤΙΜΕΣ

Περιεκτικότητα	Μέγεθος συσκευασίας	Νοσοκομειακή Τιμή	Λιανική Τιμή
25mg/Vial	BTxIVial+1PF SYR. SOL.	80,73 €	136,54 €
37,5mg/Vial	BTxIVial+1PF SYR.SOL.	109,71 €	185,56 €
50mg/Vial	BTxIVial+1PF SYR. SOL.	138,70 €	234,59 €

Για περισσότερες πληροφορίες παρακαλούμε επικοινωνήστε με την εταιρεία Janssen-Cilag Φαρμακευτική Α.Ε.Β.Ε., Λ. Ειρήνης 56, 151 21 Πεύκη, τηλ. 210 6140061

Βοηθήστε να γίνουν τα φάρμακα πιο ασφαλή.
Συμπληρώστε την **«ΚΙΤΡΙΝΗ ΚΑΡΤΑ»**
Αναφέρατε:
- **ΟΛΕΣ** τις ανεπιθύμητες ενέργειες για τα **Νέα φάρμακα** [N]
- Τις **ΣΟΒΑΡΕΣ** ανεπιθύμητες ενέργειες για τα **Γνωστά φάρμακα**

Πρόληψη υποτροπών

ΠΡΟΟΠΤΙΚΗ ΖΩΗΣ

RISPERIDONE

Risperdal CONSTA

ΑΔΙΑΚΟΠΗ ΔΡΑΣΗ

Για την Περίληψη των Χαρακτηριστικών του Προϊόντος βλέπετε εσωτερική σελίδα

JANSSEN-CILAG
ΦΑΡΜΑΚΕΥΤΙΚΗ Α.Ε.Β.Ε.

Αθήνα: Λεωφόρος Ειρήνης 56, 151 21 Πεύκη, τηλ. 210 6140061
Θεσσαλονίκη: 12,5 χλμ Θεσσαλονίκης - Μουδανιών, 570 01 Κόμβος Θέρμης, τηλ. 2310 470800
www.janssen-cilag.gr