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The physical well-being of people with schizophrenia is remarkably neglected. Physical illnesses in these people are underdiagnosed and undertreated. A recent study in Australia showed that, although people with schizophrenia suffer more frequently from cardiovascular problems than the general population, they receive catheter much more rarely. People with schizophrenia have been also reported to be less likely than the general population to receive HbA1c and cholesterol monitoring, to receive a retinal examination for diabetes screening, and to be treated for osteoporosis. They have been also found to be more likely to be treated for physical illnesses only when the latter become life threatening. Among the factors contributing to this underdiagnosis and undertreatment of physical illnesses in people with schizophrenia are a low motivation of patients and their relatives to access medical services, the isolation of psychiatric services from other medical facilities, and a tendency of psychiatrists to overlook physical health problems in their patients. However, the most important factor is likely to be the stigma surrounding schizophrenia. The neglect of physical health in people with schizophrenia should be regarded as an expression of discrimination and disregard for their dignity and their rights as human beings and citizens. Due to the lack of prevention and intervention strategies, people with schizophrenia and their families bear the costs of the mental disorder and those of the concomitant physical illnesses, which can exacerbate psychopathological manifestations and impair the subjects' ability to adhere to treatment. Access to physical health care of the same quality as that available to the rest of the population should be considered a basic right of people with schizophrenia and a crucial dimension on which their quality of life has to be evaluated.

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SS01.01

The art and science of switching in patients with schizophrenia: Strategies for achieving a smooth transition

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Many patients with schizophrenia experience persistent symptoms or side effects on their current antipsychotic regimen. Such patients, particularly those treated with conventional antipsychotic agents may benefit from switching to atypical agents, which offer broader efficacy and improved tolerability compared with earlier counterparts. In addition, patients already receiving treatment with an atypical agent may benefit from switching to an alternative atypical, given that there is great variation in (1) individuals' response to different atypical antipsychotics, and (2) the side-effect profile of the atypicals. With switching from one antipsychotic to another becoming increasingly common, there is an urgent need to define optimal switching strategies. The main goal when switching antipsychotics is to improve or (in stable patients) maintain the symptomatic and functional level, while improving (or not worsening) tolerability. It is important to identify patients who would be likely to benefit from switching and to discuss with them and their carers the advantages and potential problems of the switching process. To date, four strategies have been effective in controlled studies of switching to atypical antipsychotics: therapeutic dose initiation of the new antipsychotic and abrupt discontinuation of the first ('abrupt switch'); gradual dose escalation of the new antipsychotic and abrupt discontinuation of the first ('ascending switch'); therapeutic dose initiation of the new antipsychotic and gradual discontinuation of the first ('descending switch'), and; gradual dose escalation of the new antipsychotic and gradual discontinuation of the first ('cross-titration'). An individualized approach is key to the success of switching, as are patient cooperation and carer support.

SS01.02

Shifting schizophrenia treatment paradigms: The scope for adjunctive therapies

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Combination therapy is well established in bipolar disorder; however, the evidence for this approach in schizophrenia is less robust. Despite the absence of clear guidance, antipsychotic combinations are commonly used in real-life practice, with estimates suggesting that 20–60% of patients receive multiple antipsychotics concurrently. Such polypharmacy may be clinically useful, combining diverse pharmacological actions. However, a clear pharmacological rationale for specific antipsychotic combinations has not yet been elucidated. In this presentation, we consider the varying pharmacological profiles of agents currently used for schizophrenia and explore how best this pharmacology may be exploited to maximize the newer atypicals in clinical practice. For decades schizophrenia has been treated with some success using typical antipsychotics, which are antagonists at dopamine D2 receptors. Atypical antipsychotics were then developed, having D2 antagonism with additional affinity for other receptors, such as serotonin 5-HT2A and 5-HT1A receptors. Most recently, partial D2 agonists have been developed with efficacy to treat schizophrenia and bipolar disorder. These agents have lower intrinsic activity than full agonists, so can act either as functional agonists or antagonists. Additionally, actions to increase noradrenergic function in the prefrontal cortex may be implicated in the efficacy of some antipsychotics. Given the rich pharmacology of antipsychotics, can the combined use of agents with synergistic mechanisms of action provide a true clinical advance in schizophrenia treatment? Polypharmacy is a complex challenge that requires further study in well-designed, randomized, controlled studies. We will review the pharmacological rational for antipsychotic combination therapy and recent clinical evidence for their benefits.

SS01.03

Meeting the need for efficacy without over-sedation in patients with schizophrenia

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Although the induction of sleep was originally considered to be a desirable therapeutic endpoint for the rapid control of agitation, it is

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