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All the available evidence from randomised controlled studies indicates that antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness. 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 similar or superior efficacy in preventing relapse and suppression (or even improvement) of symptoms compared 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, as observed in most studies, the superior efficacy in improving negative, cognitive and depressive symptoms together with at least comparable (for some agents, e.g., risperidone, olanzapine, superior) efficacy in relapse prevention, second-generation antipsychotics should be preferred in long-term treatment. Given all the known problems in compliance and discontinuation, which were underlined by the CATIE study, depot preparations should be considered for optimum effectiveness in preventing relapse. Randomised, control-group studies to determine the advantages of depot preparations of atypical neuroleptics compared to depots of typical neuroleptics are still lacking. 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.

CS08.02

Long-term treatment of unipolar depression

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There is a need for long-term treatment of unipolar depression. With the older medication, tricyclic antidepressants, acute treatment was possible, but unfortunately, the patients did not take the long-term medication, specifically in the correct dosage. With the introduction of modern antidepressants, this dilemma has been partly solved, as the patients are more willing to take their medication. However, compliance studies indicate that this is only the case for a very low percentage. The European Health Regulatory authorities (EMEA) demand for every antidepressant introduced into the market to demonstrate efficacy for at least 6 months. These requirements are not necessary for the American counterpart, the Food and Drug Administration (FDA). Therefore, all the modern medications demonstrate this efficacy, a few of them even for a longer period. The question arises if this benefit can also be achieved for children and adolescents as well as for the elderly. Just a few studies suggest this also for the younger and older population. Side effects as well as the failure of understanding the nature of unipolar depression limit the necessary long-term usage of antidepressants. Education programmes, which indicate that depression is a disease like hypertension, asthma or diabetes, help the patients understand the disease and the triggers, which might accompany the long-term outcome.

During the lecture the unmet needs for treatment of unipolar depression as well as modern outcome studies of recently introduced medication will be presented.

CS08.03

Long-term treatment of bipolar depression

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Bipolar depression, and particularly its long-term treatment, represents a challenge nowadays. Although mania and hypomania are the distinctive mood disturbances in bipolar disorder, it is becoming increasingly apparent that depression is the predominant mood alteration in bipolar disorder, and the main cause of dysfunction and mortality for patients. However, despite the clear clinical and public health implications of these facts, research has traditionally neglected bipolar depression, and clinicians continue to encounter many difficulties in the management of patients. Lithium and anticonvulsants, with the exception of lamotrigine, appear to be more effective in mania than in depression. Antidepressants, particularly tricyclics and dual acting compounds, may induce mania, especially when used in the absence of an antimanic drug. The evidence on this safety concern is less compelling as far as SSRIs are concerned. Changes in dopaminergic activity have been implicated in the pathogenesis of bipolar depression and now two apparently opposite strategies are being used to improve depressive symptoms in bipolar patients: adjunctive dopamine agonists, such as pramipexole, or dopamine antagonists, such as atypical antipsychotics. Three recent placebo-controlled studies support the use of olanzapine, and particularly quetiapine, in the treatment of bipolar depressed patients. Electroconvulsive therapy remains as an option in treatment-resistant patients. Cognitive-behavioral therapy and psychoeducation seem much better for the prevention of relapse than for the treatment of acute episodes. Further studies are ongoing to test novel strategies for the long-term treatment of bipolar depression.

CS08.04

Long term treatment of anxiety disorders

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Anxiety disorders, including panic disorder (PD), generalized anxiety disorder, and social anxiety disorder (SAD), generally have a chronic course.

Based on clinical experience, experts recommend that effective treatment be continued for at least 12 months. Only in the recent years, randomized long-term and relapse prevention studies with a duration of 24-52 weeks have been conducted to establish sustained efficacy of drug treatment, triggered by the requirements of the regulatory authorities. Now, an expanding body of evidence from controlled trials demonstrates the long-term efficacy and tolerability of the serotonin selective reuptake inhibitors (SSRIs) such as escitalopram, fluvoxamine, paroxetine, or sertraline, the serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine, the calcium channel modulator pregabalin, the reversible inhibitor of MAO-A moclobemide and other drugs for the long-treatment of anxiety disorders.

All these studies confirm the necessity of continuous treatment over at least several months, as differences to placebo were still observable after treatment over half a year. Generally, the drugs were tolerated well during maintenance therapy. In the long-term treatment of anxiety disorders the same doses are usually prescribed as in the acute treatment phase.

There is also evidence for the effectiveness of cognitive-behavioral therapy (CBT). CBT and drug treatment can be combined, and at least for panic disorder, synergistic effects have been observed.

https://doi.org/10.1016/j.eurpsy.2007.01.282 Published online by Cambridge University Press