culture, loss of transcultural elements, more social and especially more economical control by the insurance systems and governmental institutions.

Apart from these more global points of criticism there are some critical groups of diagnoses or single diagnoses like depressive disorders, eating disorders or some personality disorders, which are to be discussed critically, at some points in comparison to DSM-IV.

DEVELOPMENTAL ASPECTS IN THE CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS

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Both DSM-IV and ICD-10 have included a somewhat greater developmental perspective than their predecessors, although several unresolved issues remain. Where there is demonstrated continuity between psychiatric conditions in childhood and in adult life, the same diagnostic code is used. This applies to a substantial range of conditions, but queries remain. New categories have been provided for a few disorders that are particularly important in early childhood (eg. attachment disorders) but this constitutes an age group for which the classification remains suboptimal. The same applies to disorders associated with severe mental retardation, apart from the progress in the field of pervasive developmental disorders and of specific disorders of psychological functions (such as language). The paper considers some of the key tasks remaining with respect to developmental issues in relation to the classification of psychiatric disorders.

S24. Recognition and treatment of depressive disorders in primary care

Chairmen: Y Lecrubier, M Ackenheil

THE UTILITY OF MEASURING PLASMA LEVELS OF ANTIDEPRESSANTS IN THE TREATMENT OF AFFECTIVE DISORDERS

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Steady state plasma levels (Css) are determined by different factors such as genetic variations in the P450 enzyme activity, gender, body habitus, smoking, food intake etc. The genotyping of eg. cytochrome CIP2D6 is associated with low or high metabolism. An additional phenotyping, e.g. dextromorphane challenge, includes additional factors.

Both, genotyping and phenotyping cannot totally predict Css plasma levels. The complexity of the interaction of the P450 and isoenzymes is not sufficiently clarified. Therefore, the measurement of plasma levels of antidepressants is necessary in therapeutic studies.

The rate of metabolism of the different antidepressants, which can vary depending on the substance and the individuum, is of therapeutic significance, because the pharmacological effects of metabolites are different as regards norepinephrine reuptake inhibitors. Furthermore, there are competitive interactions with co-medication.

With regard to the therapeutic effect, monitoring of plasma levels prevents non-compliance and side effects due to too high Css.

PSYCHIATRIC CLASSIFICATIONS AND DIAGNOSTIC INSTRUMENTS IN PRIMARY CARE SETTINGS

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More patients with mental disorders are cared for in the primary care sector than in the mental health sector. However primary care physicians in office settings fail to diagnose and treat 50% to 75% of patients suffering of common mental illnesses. In order to facilitate the rapid and accurate diagnosis of psychiatric disorders seen by general practitioners several standardized procedures (brief diagnostic interviews) have been developed during the last years. The structures of these different instruments (MINI, Prime-MD, SDDS) are quite comparable and consist in a self administered screen questionnaire (26 items for Prime-MD, 16 items for SDDS), followed by physician administered diagnostic modules. All of these modules are ICD-10, DSM IIR or IV based. Main disorders explored are the following: Mood Disorders, Anxiety Disorders, Somatoform Disorders, Alcoholism, Eating Disorders. Mean duration of administration of these instruments is approximately 10 mn; a longitudinal tracking form is added for some of them. Validation studies and practical use of these interviews will be discussed.

THE COPRESCRIPTION OF PSYCHOTROPIC AND SOMATIC DRUGS WITH ANTIDEPRESSANTS

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The coprescription of psychotropic and somatic drugs with antidepressants usually leads to clinical interactions. These interactions may account at either pharmacodynamic or pharmacokinetic levels. Pharmacodynamic interactions (the actions of the drug at the target, i.e. receptors) are possible when two or more drugs act in the same way or when two or more drugs act in different ways. The most important pharmacodynamic interactions reported with the different antidepressants are:

TCA's anticholinergics, antagonism of antihypertensive effects of guanetidine-like and clonidine-like agents, potentiation of catecholamines, MAO inhibitors, sympathomimetics, antiarrythmics and β-blockers.

MAO inhibitors: catecholamines and sympathomimetic amines, TCA's SSRI's reserpine, L-DOPA and meperidine.

SSRI: MAOI's, lithium, and L-tryptophan.

The pharmacokinetic interactions (the handling by the body and distribution to the target site: drug absorption, drug distribution and drug elimination) are more frequent and the most important are those that involve drug metabolism via the inhibition of different families of cytochrome P-450. The drugs interacting with antidepressants at drug metabolism level are amphetamines, antiarrythmics (type IC), astemizole, other antidepressants, β-blockers, benzodiazepines, carbamazepine, cimetidine, ciproheptadine, codeine, dextromethorphan, digoxin, nifedipine, pentazozine, prociclidine, phenobarbital, phenytoin, sodium valproate, terfenadine, theophyline, tolbutamide, verapamil, and warfarin.

Theoretical interactions do not mean clinical relevance but the practitioner should have special warnings with anticoagulants, antiarrythmics, antiepileptics, β-blockers, new antihistaminics, opiates, oral hypoglycemic drugs and psychotropic drugs.

THE IDENTIFICATION OF PSYCHIATRIC DISORDERS IN PRIMARY CARE

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The usual rate reported for depression in primary care is very high in western countries (10–20%). Similar figures were found in develop-