THE BRITISH JOURNAL OF PSYCHIATRY

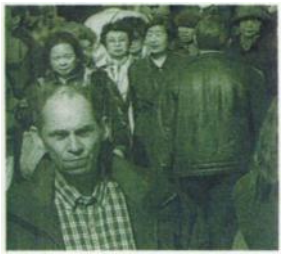
SEPTEMBER 1998 VOL. 173

https://doi.org/10.1017/S0007125000261185 Published online by Cambridge University Press

PUBLISHED BY THE ROYAL COLLEGE OF PSYCHIATRISTS ISSN 0007-1250

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Debbie doesn't know that Cipramil is now indicated for panic disorder



... she just knows her doctor made a logical choice

As a patient with Panic Disorder, Debbie is beginning to appreciate the value of the Cipramil treatment that her doctor has newly prescribed.

Of course, Debbie would no more talk of the recently extended indication for Cipramil than its high selectivity[1,2], good tolerability[3], and low risk of drug interactions[4,5,6]. She just recognises the difference that Cipramil makes to the stability and quality of her life.

Lundbeck

Cipramil
citalopram
now indicated for panic disorder

Presentation: 'Cipramil' tablets 10 mg: PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £12.77. 'Cipramil' tablets 20 mg: PL 0458/0058, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets £21.28. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/recurrence. Treatment of panic disorder, with or without agoraphobia. **Dosage:** ***Treating depression: Adults:*** 20 mg a day. Depending upon individual patient response, this may be increased in 20 mg increments to a maximum of 60 mg. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. Treatment for at least 6 months is usually necessary to provide adequate maintenance against the potential for relapse. ***Treating panic disorder:*** 10 mg daily for the first week, increasing to 20 mg daily. Depending upon individual patient response, dosage may be further increased to a maximum of 60 mg daily. Depending upon individual patient response, it may be necessary to continue treatment for several months. ***Elderly:*** 20 mg a day increasing to a maximum of 40 mg dependent upon individual patient response. ***Children:*** Not recommended. ***Reduced hepatic/renal function:*** Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance <20ml/min). **Contra-Indications:** Combined use of 5-HT agonists. Hypersensitivity to citalopram. ***Pregnancy and Lactation:*** Safety during human pregnancy and lactation has not been established. Use only if potential benefit outweighs possible risk. **Precautions:** Driving and operating machinery. History of mania. Caution in patients at risk of cardiac arrhythmias. Do not use with or within 14 days of MAO inhibitors: leave a seven day gap before starting MAO inhibitor treatment. Use a low starting dose for panic disorder, to reduce the likelihood of an initial anxiogenic effect (experienced by some patients) when starting pharmacotherapy. **Drug Interactions:** MAO inhibitors (see Precautions). Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjusted. **Adverse Events:** Most commonly nausea, sweating, tremor, somnolence and dry mouth. With citalopram, adverse effects are in general mild and transient. When they occur, they are most prominent during the first two weeks of treatment and usually attenuate as the depressive state improves. **Overdosage:** Symptoms have included somnolence, coma, sinus tachycardia, occasional nodal rhythm, episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No specific antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon request. Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LF. 'Cipramil' is a Registered Trade Mark. © 1997 Lundbeck Ltd. Date of preparation: April 1997. **0897/CIP/501/044**

1. Hyttel J. XXII Nordiske Psykiater Kongres, Reykjavic, 11 August 1988:11-21. **2.** Eison AS et al Psychopharmacology Bull 1990; 26 (3): 311-315. **3.** Wade AG et al. Br J Psychiatry 1997; 170: 549-553. **4.** Sindrup SH et al. Ther Drug Monit 1993; 15: 11-17. **5.** Van Harten J. Clin Pharmacokinetics 1993; 24: 203-20. **6.** Jeppesen U et al. Eur J Clin Pharmacol 1996; 51: 73-78.

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

THE BRITISH JOURNAL OF PSYCHIATRY

SEPTEMBER 1998 VOL. 173

EDITOR Greg Wilkinson LIVERPOOL

EDITORIAL BOARD

DEPUTY EDITOR
Alan Kerr
NEWCASTLE UPON TYNE

ASSOCIATE EDITORS
Sidney Crown
LONDON
Julian Leff
LONDON
Sir Martin Roth, FRS
CAMBRIDGE
Sir Michael Rutter, FRS
LONDON
Peter Tyrer
LONDON

EDITORIAL ADVISERS
Howard Croft
OXFORD
Tony Johnson
CAMBRIDGE
Kathleen Jones
YORK
Martin Knapp
LONDON
Herschel Prins
LEICESTER
John Wing
LONDON
Sir John Wood
SHEFFIELD

ASSISTANT EDITORS
Louis Appleby
MANCHESTER
Alistair Burns
MANCHESTER
Patricia Casey
DUBLIN
John Cookson
LONDON
Tom Fahy
LONDON
Anne Farmer
CARDIFF
Michael Farrell
LONDON
Nicol Ferrier
NEWCASTLE UPON TYNE
Richard Harrington
MANCHESTER
Sheila Hollins
LONDON
Jeremy Holmes
BARNSTAPLE
Michael King
LONDON
Michael Kopelman
LONDON
Alan Lee
NOTTINGHAM
Glyn Lewis
CARDIFF
Shôn Lewis
MANCHESTER
Robin McCreadie
DUMFRIES
Ian McKeith
NEWCASTLE UPON TYNE
J. Spencer Madden
UPTON-BY-CHESTER
David Owens
LEEDS
Ian Pullen
MELROSE
Henry Rollin
LONDON
Jan Scott
NEWCASTLE UPON TYNE
Andrew Sims
LEEDS
George Stein
LONDON

CORRESPONDING EDITORS
Andrew Cheng
TAIWAN
Kenneth Kendler
USA
Arthur Kleinman
USA
Paul Mullen
AUSTRALIA
Michele Tansella
ITALY
J. L. Vázquez-Barquero
SPAIN

STATISTICAL ADVISER
Pak Sham
LONDON

STAFF
PUBLICATIONS MANAGER
Dave Jago
DEPUTY MANAGER
Helen Bolton
SCIENTIFIC EDITOR
Andrew Morris
ASSISTANT SCIENTIFIC EDITORS
Lucretia King
Zoë Stagg
EDITORIAL ASSISTANTS
Zofia Ashmore
Julia Burnside
Rachel Gold
MARKETING ASSISTANT
Briony Stuart

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists (a registered charity, registration number 228636). The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to the Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG. Queries, letters to the Editor and book reviews may also be sent electronically to zashmore@rcpsych.ac.uk.

Instructions to authors

Full instructions to authors are given at the beginning of the January and July issues, and on the Web Site below. Copies are also available from the Journal Office.

Information about the College's publications is available on the World Wide Web at http://www.rcpsych.ac.uk.

Subscriptions

Non-members of the College should contact the Publications Subscription Department, Royal Society of Medicine Press Limited, PO Box 9002, London W1A 0ZA (tel. 0171 290 2928; fax 0171 290 2929). Annual subscription rates for 1998 (12 issues post free) are as follows:

	INSTITUTIONS	INDIVIDUALS
Europe (& UK)	£172	£150
US	$350	$258
Elsewhere	£205	£162

Full airmail is £36/US$64 extra.

Single copies of the Journal are £15, $26 (post free).

Queries from non-members about missing or faulty copies should be addressed within six months to the same address; similar queries from College members should be addressed to the Registration Subscription Department, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.

Payment should be made out to the British Journal of Psychiatry.

Back issues

Back issues published before 1996 may be purchased from William Dawson & Sons Ltd, Cannon House, Folkestone, Kent (tel. 01303 850 101).

Advertising

Correspondence and copy should be addressed to Stephen H. P. Mell, Advertising Manager, PTM Publishers Ltd, 282 High Street, Sutton, Surrey SM1 1PQ (tel. 0181 642 0162; fax 0181 643 2275).

US Mailing Information

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. Subscription price is $350. Second class postage paid at Rathway, NJ. Postmaster send address corrections to the British Journal of Psychiatry, c/o Mercury Airfreight International Ltd Inc., 2323 Randolph Avenue, Avenel, New Jersey 07001.

™The paper used in this publication meets the minimum requirements of the American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Typeset by Dobbie Typesetting Ltd, Tavistock.

Printed by Henry Ling Ltd, The Dorset Press, 23 High East Street, Dorchester, Dorset DT1 1HD.

Past Editors

Eliot Slater	1961–72	John L. Crammer	1978–83
Edward H. Hare	1973–77	Hugh L. Freeman	1984–93

Founded by J. C. Bucknill in 1853 as the *Asylum Journal* and known as the *Journal of Mental Science* from 1858 to 1963.

©1998 The Royal College of Psychiatrists. Unless so stated, material in the *British Journal of Psychiatry* does not necessarily reflect the views of the Editor or the Royal College of Psychiatrists. The publishers are not responsible for any error of omission or fact.

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

New Brief Pulse ECT with *Computer-Assisted* Easy Seizure Monitoring

Somatics Thymatron™ DGx

- **Automatically** monitors your choice of EEG-EEG, EEG-ECG, or EEG-EMG and determines EEG and motor seizure lengths.
- Computer-measured seizure quality, including postictal EEG suppression, seizure energy index.
- Up to 8 seconds stimulus duration; pulsewidth as short as 0.5 ms.
- Single dial sets stimulus charge by age; high-dose option available.
- FlexDial™ adjusts pulsewidth and frequency without altering dose.

Distributed in the U.K. by:
DANTEC Electronics, Ltd.
Garonor Way
Royal Portbury
Bristol BS20 9XE
TEL (44) 1275-375333
FAX (44) 1275-375336

Distributed in Australia by:
MEECO Holdings Pty. Ltd.
10 Seville St.
North Parramatta NSW 2151
Australia
TEL (61) 2630-7755
FAX (61) 2630-7365

Distributed in New Zealand by:
WATSON VICTOR, Ltd.
4 Adelaide Rd.
Wellington, New Zealand
TEL (64) 4-385-7699
FAX (64) 4-384-4651

Distributed in Ireland by:
BRENNAN & CO.
Dublin
TEL (353) 1-295-2501
FAX (353) 1-295-2333

Distributed in India by:
DIAGNO.SYS
New Delhi
TEL (91) 11-644-0546
FAX (91) 11-622-9229

Distributed in South Africa by:
DELTA SURGICAL
Craighall
TEL (27) 11-792-6120
FAX (27) 11-792-6926

Distributed in U.S.A. and Canada by:
SOMATICS, INC., 910 Sherwood Drive # 17, Lake Bluff, IL, 60044, U.S.A.
Fax: (847) 234-6763; Tel: (847) 234-6761

BBR
MEDICAL
EDUCATION

Formerly BPP Medical Education

Intensive weekend courses

MRCPsychiatry Parts I & II
Written and Clinical skills courses

1998
Part I Written 12–13 September
Part II Written 12–13 September
Clinical 31 October & 1 November

BBR Courses are
Stimulating, entertaining and successful.

Telephone or Fax 0181-959-7562
33 Flower Lane, Mill Hill, London NW7

dma Direct Medical Appointments

CONSULTANTS

dma Direct Medical Appointments

Choose your quality locum positions now!!!

Short or long term
Competitive rates
All areas of the U.K.
Excellent 'on call' posts
1:7 or better
Documentation/visas arranged

Permanent positions also available

Call DIRECT MEDICAL APPOINTMENTS

THE CONSULTANTS CHOICE

for a professional and prompt service

Tel: +44 (0)1792 472525
Fax: +44 (0)1792 472535
Email: dma.central@virgin.net

NB
MEDICAL EDUCATION

MRCPSYCH PART I
LONDON : DUBLIN

Intensive exam-orientated weekend courses

- Theory for *new syllabus*.
- Technique and tactics.
- Over 2000 relevant MCQ's.
- Practice MCQ exams.
- HM67(27) approved for study leave.

London 5, 6 & 12, 13 September (4 days).
Dublin 19, 20 September (2 days).

Details: NB Medical Education, PO Box 767, OXFORD OX1 1XD. Tel/fax. 01865 842206.

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Available on-line in 1998

Australian and New Zealand Journal of Psychiatry

OFFICIAL JOURNAL OF THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

EDITOR
Sidney Bloch

Australian and New Zealand Journal of Psychiatry is the premier psychiatric journal published in Australia and New Zealand. It is distributed to all members and fellows of The Royal Australian and New Zealand College of Psychiatrists. The journal publishes original articles which describe research or report opinions of interest to psychiatrists.

ISSN 0004-8674
Bimonthly
Institutional:
Aus$259 (Australasia)
US$275 (Overseas)
Personal:
Aus$142 (Australasia)
US$150 (Overseas)

ABSTRACTING AND INDEXING

The journal is covered by *ASSIA, Biosis, Cambridge Scientific Abstracts, CINAHL, Current Contents/Clinical Medicine, Current Contents/Social and Behavioural Sciences, Current Opinion in Psychiatry, Excerpta Medica, Index Medicus, Innovations and Research, Inpharma Weekly, MEDLINE, Nursing Bibliography, Psychiatric Rehabilitation Journal, PsycINFO, PsycLIT, Science Citation Index, SciSearch, Social Sciences Citation Index, Social SciSearch, Sociological Abstracts, University Microfilms* and *Year Book, Psychiatric and Mental Health.*

SUBSCRIPTION RATES

The *Australian and New Zealand Journal of Psychiatry* is published bimonthly and the subscription rates for 1998 are:

Institutional: Aus$259 (Australasia) and US$275 (Overseas)
Personal: Aus$142 (Australasia) and US$150 (Overseas)

Order form

☐ I would like to receive a FREE sample copy of *Australian and New Zealand Journal of Psychiatry*

☐ I would like to subscribe to *Australian and New Zealand Journal of Psychiatry* at the 1998 subscription rate.

I will pay by: ☐ cheque/bank draft/postal order payable to Blackwell Science Asia

☐ Visa ☐ Mastercard ☐ Bankcard ☐ AMEX ☐ Diners Club ☐ JCB

Please debit my card number

| | | | | | | | | | | | | | | | |

Amount ..... Expiry Date ..... Signature.....

Name .....

Address.....

..... Postcode.....

Telephone ..... Facsimile.....

Please return this form to:

• Marnie Hannagan, Medical Journals Marketing Coordinator, Blackwell Science Asia •
• 54 University Street (PO Box 378), Carlton South, Victoria 3053, Australia •
• Home Page: http://www.blackwell-science.com/australi/ •
• Tel: (61 3) 9347 0300 • Fax: (61 3) 9347 5001 • Email: Marnie.Hannagan@blacksci-asia.com.au •

Blackwell Science Asia

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

New Books from Gaskell
Autumn 1998

Seminars in Old Age Psychiatry

Edited by Rob Butler and Brice Pitt

An impressive and comprehensive review of the diagnosis and management of psychiatric problems associated with old age. All the major disorders and approaches to treatment are covered. An essential text for trainees and clinicians

1998 352pp ISBN 1 901242 21 8 £17.50

Acute Psychosis, Schizophrenia and Comorbid Disorders

Recent Topics from Advances in Psychiatric Treatment, Volume I

Edited by Alan Lee

Volume I covers the management of acutely disturbed in-patients, drug and psychosocial approaches to the treatment of schizophrenia, and the problems of comorbid substance misuse and homelessness. There are chapters on risk and childbirth, psychoses in the elderly, and the special problems of identifying and treating psychiatric disorders in those with learning disability. There is also practical advice on assessing fitness to be interviewed by the police, and on preparing medico-legal reports. The book will be especially useful in conjunction with the *College Seminars* titles for those preparing for the College Membership exams.

1998 152pp ISBN 1 901242 16 1 £15.00

Clinical Topics in Psychotherapy

Edited by Digby Tantam

The focus of this book is on specific conditions for which psychotherapy is the main treatment currently in use. Common syndromes which patients present to the psychotherapist and to general psychiatrists are covered. Contributors provide a succinct review of what treatment works in each condition, and how it works. Some of the chapters have been published previously in the *British Journal of Psychiatry.*

1998 304pp ISBN 1 901242 22 6 £30.00

Ethnicity: An Agenda for Mental Health

Edited by Dinesh Bhugra

This book sets the scene for identifying and meeting the mental health needs of black and minority ethnic groups. Clinicians, researchers, academics, hospital managers, commissioners and voluntary organisation workers come together to discuss the problems in health care delivery and the way of moving the agenda forward. In addition to multi-disciplinary working, the key emphasis here is in involving commissioners and voluntary organisations in deciding how best to meet the needs of the communities.

1998 240pp ISBN 1 901242 15 3 £25.00

Seminars in Psychosexual Disorders

Series Editors: Hugh Freeman, Ian Pullen, George Stein and Greg Wilkinson

This book presents expert contributions on the diagnosis and management of sexual problems from a number of perspectives, looking at medical, psychological and sociological models. As well as considering what may go wrong between couples and ways of dealing with these problems, the contributors also discuss disorders of sexual direction, and examine the background and management associated with deviant sexual behaviour, with homosexual expression and gender problems. This book will be invaluable reading for psychiatric trainees and clinicians, psychologists, psychotherapists, general practitioners and counsellors.

1998 216pp ISBN 1 901242 03 X £15.00

Gaskell is the imprint of the Royal College of Psychiatrists. Gaskell books are available from good bookshops and from the Book Sales Department, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Telephone +44 (0)171 235 2351 extension 146, fax +44 (0)171 245 1231. Credit card orders can be taken over the telephone. The latest information on College publications can be seen on the Internet at www.rcpsych.ac.uk

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

DIRECT MEDICAL SERVICES

SPECIALISTS IN MEDICAL RECRUITMENT

PSYCHIATRY

A WONDERFUL OPPORTUNITY TO EARN EXTRA MONEY WITH VARIED OPPORTUNITIES FOR SHORT AND LONG TERM ASSIGNMENTS

VACANCIES AVAILABLE FROM NOW WITH 1 IN 2 TO 1 IN 7 ON-CALL

CONSULTANTS NEEDED (With Section 12 or 20 (Scotland) Approval) TO SHO LEVEL IN ALL SPECIALITIES OF PSYCHIATRY (DOCTORS ALSO REQUIRED FOR G.P.)

VACANCIES AVAILABLE ACROSS THE U.K. FOR FULLY REGISTERED DOCTORS BUT WORK PERMITS CAN BE ARRANGED THROUGH DMS LTD

ACCOMMODATION PROVIDED AT NO COST TO THE DOCTOR AND CONTRIBUTIONS MADE TOWARDS TRAVELLING EXPENSES (DESTINATIONS IN THE U.K. ONLY)

EXCELLENT RATES OF PAY

CALL US, WE REALLY DO PUT OUR MONEY WHERE OUR MOUTH IS!!!

Call Hannah (South): Tel. 01703 393988; Fax. 01703 393908; Email: hannah@direct.medical.com
Call Julie (North): Tel. 01612 902020; Fax. 01612 903030; Email: dms.north@virgin.net

Visit the College Web site...

The Royal College of Psychiatrists Web site is at:

http://www.rcpsych.ac.uk

- For up-to-date and detailed information on College publications: books, reports, and journals
- Provides order forms and links to related sites
- Expanding in Autumn 1998 to include more information about College services

THE PORTMAN CLINIC

The Psycho-analytical Understanding of Violence, Delinquency and Sexual Deviation
Two day inter-disciplinary Conference
10th & 11th September 1998

This is a two day inter-disciplinary Conference run by the Portman Clinic. The type of patient seen at the Portman Clinic tends to be adults, adolescents and children who present with problems that are expressed through acting out their sexual and aggressive phantasies on the minds and bodies of both themselves and others. These problems create many difficulties for those trying to understand these behaviours in their professional settings. This conference is aimed at providing a forum for thinking about the aetiology and treatment of these patients using psycho-analytic ideas and would be suitable for all professionals who have interest in this field, i.e. Psychiatry, Psychology, Social Work, Education, Probation Services, Law, Psychotherapy and Counselling.

For further information contact:
Jenni Hudson, Conference Unit,
The Tavistock & Portman NHS Trust,
Tavistock Centre, 120 Belsize Lane,
London NW3 5BA.
Tel: 0171 447 3715 Fax: 0171 447 3837
Email: jhudson.tavi-port.org

TAVISTOCK & PORTMAN NHS TRUST

(Ref.C58)

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

New Council Reports

CR65 *Guidance for Videotaping, £5.00, July 1998*
Guidance for doctors recording medical procedures involving patients. This report covers: Use of recorded material; Confidentiality; Media recordings; In advance of the recording; During the recording; After the recording; References and source material.

CR66 *Reciprocity Between the Royal College of Psychiatrists and the Royal Australian and New Zealand College of Psychiatrists. Revised Statement, £5.00, July 1998*
The Royal College of Psychiatrists and the Royal Australian and New Zealand College of Psychiatrists have collaborated to produce a statement of reciprocity between the two Colleges. This statement replaces the earlier version published as CR45.

Available from Booksales, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (Tel. +44 (0) 171 235 2351, extension 146). The latest information on College publications is available on the INTERNET at: www.rcpsych.ac.uk

ROYAL COLLEGE OF PSYCHIATRISTS

TRAINING DAY IN ELECROCONVULSIVE THERAPY
ROYAL HORTICULTURAL HALLS & CONFERENCE CENTRE
GREYCOAT STREET, LONDON SW1
TUESDAY, 10 NOVEMBER 1998

The Royal College of Psychiatrists' Special Committee on Electroconvulsive Therapy is to offer another ECT Training Day at the Royal Horticultural Halls in London. The format will be a combination of presentations and participatory workshops. The Training Day has proved to be very popular in recent years and we have decided to repeat it for a second time this year. It will be of particular interest to psychiatrists, nurses and anaesthetists involved in ECT practice.

Dr Chris Freeman (*Royal Edinburgh Hospital*) will give a presentation on ***Recent Developments in the Theory and Practice of ECT***, Dr Karen Simpson *(St James's University Hospital, Leeds)* on ***Anaesthesia for ECT*** and Dr John Lumsden (*Broadmore Hospital)* on ***EEG Monitoring of ECT***. Dr Richard Duffet (*College Research Unit*), Dr Allan Scott (*Royal Edinburgh Hospital*), Dr Susan Benbow (*Manchester Royal Infirmary),* Dr Grace Fergusson (*Argyll and Bute Hospital)* and Mrs Heide Baldwin *(ECT Nurses Forum)* will run a series of morning and afternoon workshops.

The workshops will include stimulus dosing with the Ectron ECT machine, stimulus dosing with the Thymatron machine, ECT in the elderly, audit and a workshop specifically for nursing staff with a special interest in ECT. Delegates will be offered attendance at one workshop in the morning and one workshop in the afternoon .

Further information, a full programme and a booking form can be obtained from Mrs J Carroll, CPD Unit, Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG, Tel: 0171 235 2351 x 108, Fax: 0171 259 6507, E-mail: jcarroll@rcpsych.ac.uk

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

EDINBURGH HEALTHCARE NHS TRUST

SOUTH OF SCOTLAND COGNITIVE THERAPY COURSE 1999

A course in the theory and practice of Cognitive Behavioural Therapy, based in the south of Scotland. The course has been specifically designed to minimise costs and travelling time for busy clinical staff.

Course Directors

Dr Chris Freeman, Edinburgh
Dr Kate Davidson, Glasgow

Structure

The teaching programme will run from February to October, starting with a three day Induction Block. Thereafter, fortnightly whole-day teaching sessions, alternating with fortnightly individual supervision.

Cost: £2,150

Further Information

Course Administrator, Mrs Diane Matheson, The Cottage, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF. Tel: 0131 537 6707. Fax: 0131 537 6104.

SSR Medical Services
SPECIALISTS IN PSYCHIATRY

Locum and substantive posts available in London and all major cities throughout the UK

We would be pleased to discuss the assignments currently available. Please contact Liz Goodwin or her team on:-

Telephone 0181 626 3117
Fax 0181 626 3101
email: lgoodwin@ssrgroup.com

We work for you, when you work for us.

We are confident you will enjoy dealing with our professional, knowledgeable and caring consultants.

ISO9002

SSR Group Services Ltd
FREEPOST
London E17 6BR

FRES

SSR Medical Services is a division of SSR Group Services Ltd

Academic Positions

The University of Calgary Department of Psychiatry and the Calgary Regional Health Authority invite applications for the following full-time academic positions:

- *Head, Division of Forensic Psychiatry* - this position involves academic and regional administrative responsibilities, in addition to research, teaching and clinical service. The selected individual will also become Director, Division of Forensic Psychiatry, at the Peter Lougheed Centre.
- *Four academic positions* - at the Assistant Professor level or higher are available in a number of specialist and general services and involve integrated duties in research, teaching and clinical practice.

Qualifications include an MD or equivalent, certification in Psychiatry, a proven record of teaching and research, and eligibility for licensure in the Province of Alberta. Previous administrative experience will be an asset for applicants for the Division Head position.

In accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada. The University of Calgary respects, appreciates and encourages diversity.

Please submit a curriculum vitae, a statement of research interests, and the names of three referees by October 15, 1998, to:

Dr. Donald Addington, Head
Department of Psychiatry
University of Calgary, 1403 - 29 Street N.W.
Calgary, Alberta, Canada T2N 2T9

UNIVERSITY OF CALGARY

www.ucalgary.ca

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Forthcoming RCOG meeting of interest to Psychiatrists

WHY MOTHERS DIE

LESSONS FROM THE 1994-6 REPORT ON CONFIDENTIAL ENQUIRIES INTO MATERNAL DEATHS IN THE UK

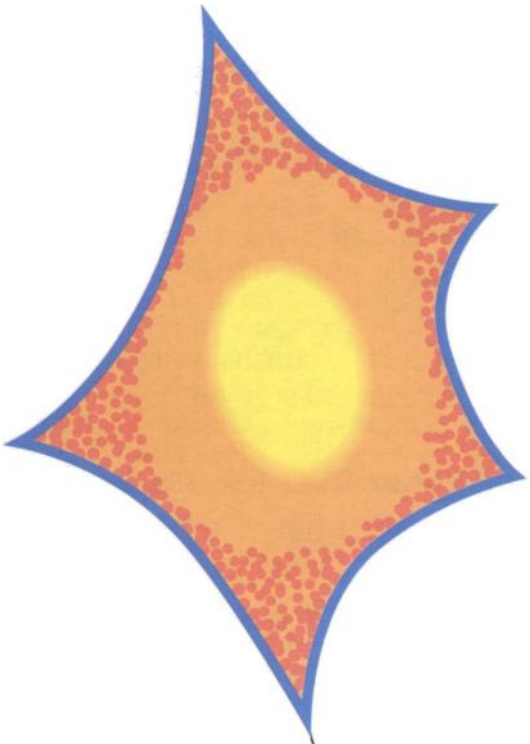
23 November 1998, RCOG London

Topics to include: Introduction (Baroness Jay), overview, thromboembolism; medical deaths; hypertension; early pregnancy deaths including ectopic; sepsis and uterine rupture; maternal suicide; fortuitous deaths (and violence against women); consumer's view; anaesthetic deaths; near misses; closing remarks (Chief Medical Officer - to be confirmed).

PGEA approval: 6 hours in disease management.

For further details and a registration form, contact:
Postgraduate Education Department, RCOG
27 Sussex Place, Regent's Park, London NW1 4RG
Tel: 0171 772 6245 e-mail: bhex@rcog.org.uk
To register on-line, please visit our web-site at www.rcog.org.uk

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press



1998 Pfizer Psychiatry Awards

As part of our continuing commitment to improving the management of psychiatric illness, Pfizer will be awarding five research grants of £5,000 each to support projects in the field of mental health; £2,000 will be given to the winning institution and £3,000 to the author.

The awards are open to any hospital physician or research scientist with an interest in psychiatry who has carried out previously unpublished research in schizophrenia, dementia or depression.

For more details, including an entry form, contact your Pfizer representative, call Freephone 0800 0681915, or write to:

1998 Pfizer Psychiatry Awards
FREEPOST
London
WC2B 6BR

Closing date for registering entries: 30 September 1998

Pfizer
Psychiatry Awards
UCG
University College Galway, Ireland

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Add life to living with schizophrenia

Solian is a new benzamide antipsychotic, with the ability to treat both the positive[1] and negative[2] symptoms of schizophrenia.

Solian offers a lower incidence of EPS than standard neuroleptics such as haloperidol,[3] as well as avoiding some of the drawbacks of certain atypicals: it does not require routine cardiovascular[4,5] or haematological[4,6] monitoring and patients gain significantly less weight than those treated with risperidone.[2]

So when patients need the ability to cope with their condition, Solian has the power to treat their positive[1] *and* their negative[2] symptoms whilst still allowing them to do the everyday things that the rest of us take for granted.

Solian®
AMISULPRIDE

Efficacy that patients can live with

Prescribing Information - Solian 200 and Solian 50 ▼ Presentation: Solian 200mg tablets contain 200mg amisulpride and Solian 50mg tablets contain 50mg amisulpride. **Indication:** Acute and chronic schizophrenia in which positive and/or negative symptoms are prominent. **Dosage:** Acute psychotic episodes: 400-800mg/day, increasing up to 1200mg/day according to individual response (dose titration not required), in divided doses. Predominantly negative symptoms: 50-300mg once daily adjusted according to individual response. Elderly: administer with caution due to the risk of hypotension or sedation. Renal insufficiency: reduce dose and consider intermittent therapy. Hepatic insufficiency: no dosage adjustment necessary. Children: contraindicated in children under 15 years (safety not established). **Contraindications:** Hypersensitivity; concomitant prolactin-dependent tumours e.g. pituitary gland prolactinaemias and breast cancer; phaeochromocytoma; children under 15 years; pregnancy; lactation; women of child-bearing potential unless using adequate contraception. **Warning and Precautions:** As with all neuroleptics, neuroleptic malignant syndrome may occur (discontinue Solian). Caution in patients with a history of epilepsy and Parkinson's disease. **Interactions:** Caution in concomitant administration of CNS depressants (including alcohol), antihypertensives and other hypotensive medications, and dopamine agonists. **Side Effects:** Insomnia, anxiety, agitation. Less commonly somnolence and GI disorders. In common with other neuroleptics: Solian causes a reversible increase in plasma prolactin levels; Solian may also cause weight gain, acute dystonia, extrapyramidal symptoms, tardive dyskinesia, hypotension and bradycardia; rarely, allergic reactions, seizures and neuroleptic malignant syndrome have been reported. **Basic NHS Cost:** Blister packs of: 200mg x 60 tablets - £60.00; 200mg x 90 tablets - £90.00; 50mg x 60 tablets - £16.45; 50mg x 90 tablets - £24.69. **Legal Category:** POM. **Product Licence Numbers:** Solian 200 - PL 15819/0002, Solian 50 - PL 15819/0001. **Product Licence Holder:** Lorex Synthélabo UK and Ireland Ltd, Foundation Park, Roxborough Way, Maidenhead, Berks, SL6 3UD. **References:** 1. Freeman HL. Int Clin Psychopharmacol 1997;12(Suppl 2):S11-S17. 2. Möller HJ. 6th World Congress of Biological Psychiatry, Nice, France, June 22-27 1997. 3. Coukell AJ, Spencer CM, Benfield P. CNS Drugs (Adis) 1996 Sep 6 (3):237-256. 4. Solian SPC. Lorex Synthélabo. 5. Sertindole SPC. Lundbeck Ltd. 6. Clozapine SPC.

SYNTHELABO
CNS DIVISION

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Please refer to Summary of Product Characteristics before prescribing Risperdal (risperidone). **USES** The treatment of acute and chronic schizophrenia, and other psychotic conditions, in which positive and/or negative symptoms are prominent. Risperdal also alleviates affective symptoms associated with schizophrenia. **DOSAGE** Where medically appropriate, gradual discontinuation of previous antipsychotic treatment while Risperdal therapy is initiated is recommended. Where medically appropriate, when switching patients from depot antipsychotics, consider initiating Risperdal therapy in place of the next scheduled injection. The need for continuing existing antiparkinson medication should be re-evaluated periodically. **Adults:** Risperdal may be given once or twice daily. All patients, whether acute or chronic, should start with 2 mg/day. This should be increased to 4 mg/day on the second day and 6 mg/day on the third day. However, some patients such as first-episode psychotic patients may benefit from a slower rate of titration. From then on the dosage can be maintained unchanged, or further individualised if needed. The usual effective dosage is 4 to 8 mg/day although in some patients an optimal response may be obtained at lower doses. Doses above 10 mg/day may increase the risk of extrapyramidal symptoms and should only be used if the benefit is considered to outweigh the risk. Doses above 16 mg/day should not be used. **Elderly, renal and liver disease:** A starting dose of 0.5 mg bd is recommended. This can be individually adjusted with 0.5 mg bd increments to 1 to 2 mg bd. Risperdal is well tolerated by the elderly. Use with caution in patients with renal and liver disease. Not recommended in children aged less than 15 years. **CONTRA-INDICATIONS, WARNINGS, ETC. Contra-indications:** Known hypersensitivity to Risperdal. **Precautions:** Orthostatic hypotension can occur (alpha-blocking effect). Use with caution in patients with known cardiovascular disease. Consider dose reduction if hypotension occurs. For further sedation, give an additional drug (such as a benzodiazepine) rather than increasing the dose of Risperdal. Drugs with dopamine antagonistic properties have been associated with tardive dyskinesia. If signs and symptoms of tardive dyskinesia appear, the discontinuation of all antipsychotic drugs should be considered. Caution should be exercised when treating patients with Parkinson's disease or epilepsy. Patients should be advised of the potential for weight gain. Risperdal may interfere with activities requiring mental alertness. Patients should be advised not to drive or operate machinery until their individual susceptibility is known. **Pregnancy and lactation:** Use during pregnancy only if the benefits outweigh the risks. Women receiving Risperdal should not breast feed. **Interactions:** Use with caution in combination with other centrally acting drugs. Risperdal may antagonise the effect of levodopa and other dopamine agonists. On initiation of carbamazepine or other hepatic enzyme-inducing drugs, the dosage of Risperdal should be re-evaluated and increased if necessary. On discontinuation of such drugs, the dosage of Risperdal should be re-evaluated and decreased if necessary. **Side effects:** Risperdal is generally well tolerated and in many instances it has been difficult to differentiate adverse events from symptoms of the underlying disease. Common adverse events include: insomnia, agitation, anxiety, headache. Less common adverse events include: somnolence, fatigue, dizziness, impaired concentration, constipation, dyspepsia, nausea/vomiting, abdominal pain, blurred vision, priapism, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, urinary incontinence, rhinitis, rash and other allergic reactions. The incidence and severity of extrapyramidal symptoms are significantly less than with haloperidol. However, the following may occur: tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. If acute, these symptoms are usually mild and reversible upon dose reduction and/or administration of antiparkinson medication. Rare cases of Neuroleptic Malignant Syndrome have been reported. In such an event, all antipsychotic drugs should be discontinued. Occasionally, orthostatic dizziness, hypotension (including orthostatic), tachycardia (including reflex) and hypertension have been observed. An increase in plasma prolactin concentration can occur which may be associated with galactorrhoea, gynaecomastia and disturbances of the menstrual cycle. Oedema and increased hepatic enzyme levels have been observed. A mild fall in neutrophil and/or thrombocyte count has been reported. Rare cases of water intoxication with hyponatraemia, tardive dyskinesia, body temperature dysregulation and seizures have been reported. **Overdosage:** Reported signs and symptoms include drowsiness and sedation, tachycardia and hypotension, and extrapyramidal symptoms. A prolonged QT interval was reported in a patient with concomitant hypokalaemia who had ingested 360 mg. Establish and maintain a clear airway, and ensure adequate oxygenation and ventilation. Gastric lavage and activated charcoal plus a laxative should be considered. Commence cardiovascular monitoring immediately, including continuous electrocardiographic monitoring to detect possible arrhythmias. There is no specific antidote, so institute appropriate supportive measures. Treat hypotension and circulatory collapse with appropriate measures. In case of severe extrapyramidal symptoms, give anticholinergic medication. Continue close medical supervision and monitoring until the patient recovers. **PHARMACEUTICAL PRECAUTIONS** Tablets: Store below 30°C. Liquid: Store below 30°C; protect from freezing. **LEGAL CATEGORY** POM. **PRESENTATIONS, PACK SIZES, PRODUCT LICENCE NUMBERS & BASIC NHS COSTS** White, oblong tablets containing 1 mg risperidone in packs of 20. PL 0242/0186 £13.45. Pale orange, oblong tablets containing 2 mg risperidone in packs of 60. PL 0242/0187 £79.56. Yellow, oblong tablets containing 3 mg risperidone in packs of 60. PL 0242/0188 £117.00. Green, oblong tablets containing 4 mg risperidone in packs of 60. PL 0242/0189 £154.44. Yellow, circular tablets containing 6 mg risperidone in packs of 28. PL 0242/0317 £109.20. Starter packs containing 6 Risperdal 1 mg tablets are also available £4.15. Clear, colourless solution containing 1 mg risperidone per ml in bottles containing 100 ml. PL 0242/0199 £65.00. **FURTHER INFORMATION IS AVAILABLE FROM THE PRODUCT LICENCE HOLDER:** Janssen-Cilag Ltd, Saunderton, High Wycombe, Buckinghamshire HP14 4HJ. APIVER 140797. **References:**
1. Brecher M, Lemmens P, Van Baelen B. Presented at the Annual Meeting of the American College of Neuropsychiatry, December 9-13, 1996, San Juan, Puerto Rico. 2. Data on file, Janssen-Cilag Ltd. MJE 12/97.

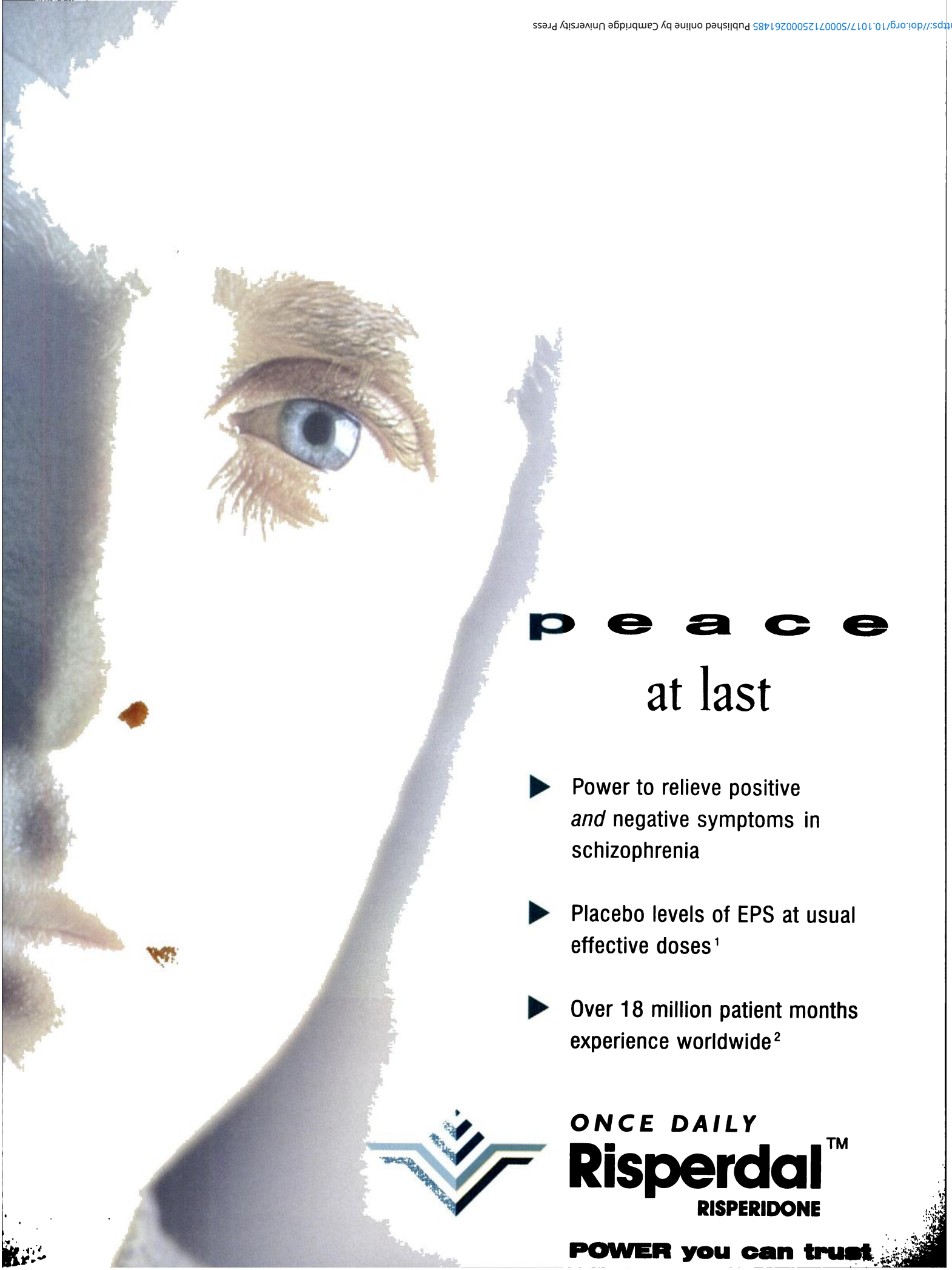
Date of preparation: December 1997

© Janssen-Cilag Ltd ™trademark

801905A

For the mind in turmoil

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press



https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

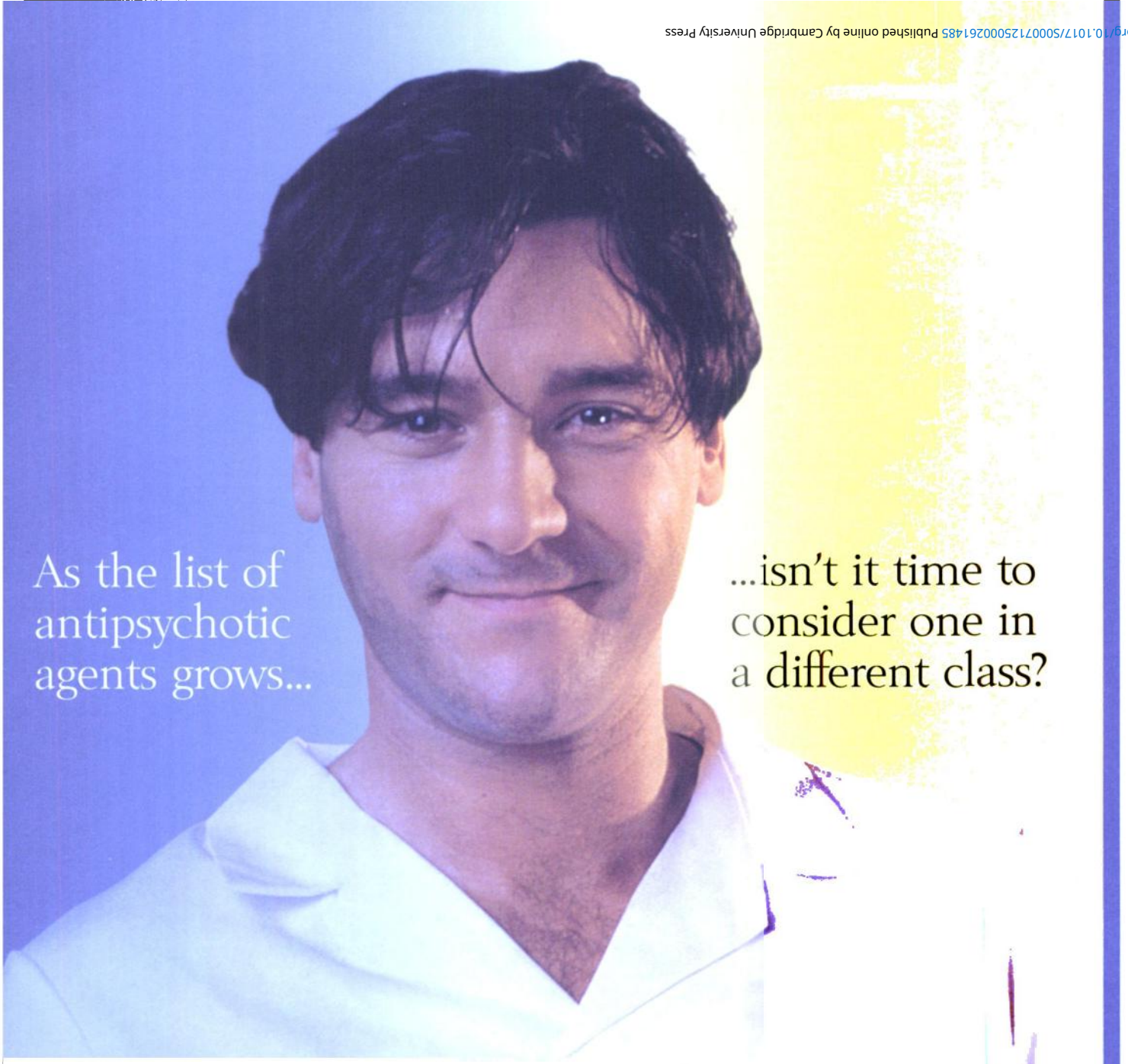
CLOZARIL®
clozapine

CLOZARIL ABBREVIATED PRESCRIBING INFORMATION. The use of CLOZARIL is restricted to patients registered with the CLOZARIL Patient Monitoring Service. Indication Treatment-resistant schizophrenia (patients non-responsive to, or intolerant of, conventional neuroleptics). **Presentations** 25mg and 100 mg clozapine tablets. **Dosage and Administration** Initiation must be in hospital in-patients and is restricted to patients with normal white blood cell and differential counts. Initially, 12.5 mg once or twice on the first day, followed by one or two 25 mg tablets on the second day. Increase dose slowly, by increments to reach a therapeutic dose within the range of 200 - 450mg daily (see data sheet). The total daily dose should be divided and a larger portion of the dose may be given at night. Once control is achieved a maintenance dose of 150 to 300 mg daily may suffice. At daily doses not exceeding 200mg, a single administration in the evening may be appropriate. Exceptionally, doses up to 900 mg daily may be used. Patients with a history of epilepsy should be closely monitored during CLOZARIL therapy since dose-related convulsions have been reported. Patients with a history of seizures, as well as those suffering from cardiovascular, renal or hepatic disorders, together with the elderly need lower doses (12.5 mg given once on the first day) and more gradual titration. **Contra-Indications** Allergy to any constituents of the formulation. History of drug-induced neutropenia/agranulocytosis, myeloproliferative disorders, uncontrolled epilepsy, alcoholic and toxic psychoses, drug intoxication, comatose conditions, circulatory collapse and/or CNS depression of any cause, severe renal or cardiac failure, active liver disease, progressive liver disease or hepatic failure. **Warning** CLOZARIL can cause agranulocytosis. A fatality rate of up to 1 in 300 has been estimated when CLOZARIL was used prior to recognition of this risk. Since that time strict haematological monitoring of patients has been demonstrated to be effective in markedly reducing the risk of fatality. Therefore, because of this risk its use is limited to treatment-resistant schizophrenic patients:- 1. who have normal leucocyte findings and 2. in whom regular leucocyte counts can be performed weekly during the first 18 weeks and at least every two weeks thereafter for the first year of therapy. After one year's treatment, monitoring may be changed to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue throughout treatment and for four weeks after complete discontinuation of CLOZARIL. Patients must be under specialist supervision and CLOZARIL supply is restricted to pharmacies registered with the CLOZARIL Patient Monitoring Service. Prescribing physicians must register themselves, their patients and a nominated pharmacist with the CLOZARIL Patient Monitoring Service. This service provides for the required leucocyte counts as well as a drug supply audit so that CLOZARIL treatment is promptly withdrawn from any patient who develops abnormal leucocyte findings. Each time CLOZARIL is prescribed, patients should be reminded to contact the treating physician immediately if any kind of infection begins to develop, especially any flu-like symptoms. **Precautions** CLOZARIL can cause agranulocytosis. Perform pre-treatment white blood cell count and differential count to ensure only patients with normal findings receive CLOZARIL. Monitor white blood cell count weekly for the first 18 weeks and at least two-weekly for the first year of therapy. After one year's treatment, monitoring may change to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue throughout treatment and for four weeks after complete discontinuation. If signs or symptoms of infection develop an immediate differential count is necessary. If the white blood count falls below 3.0 x 10^9/L and/or the absolute neutrophil count drops below 1.5 x 10^9/L, withdraw CLOZARIL immediately and monitor the patient closely, paying particular attention to symptoms suggestive of infection. Re-evaluate any patient developing an infection, or when a routine white blood count is between 3.0 and 3.5 x 10^9/L and/or a neutrophil count between 1.5 and 2.0 x 10^9/L, with a view to discontinuing CLOZARIL. Any further fall in white blood/neutrophil count below 1.0 x 10^9/L and/or 0.5 x 10^9/L respectively, after drug withdrawal requires immediate specialised care, where protective isolation and administration of GM-CSF or G-CSF and broad spectrum antibiotics may be indicated. Colony stimulating factor therapy should be discontinued when the neutrophil count returns above 1.0 x 10^9/L. CLOZARIL lowers the seizure threshold. Orthostatic hypotension can occur therefore close medical supervision is required during initial dose titration. Patients affected by the sedative action of CLOZARIL should not drive or operate machinery, administer with caution to patients who participate in activities requiring complete mental alertness. Monitor hepatic function regularly in liver disease. Investigate any signs of liver disease immediately with a view to drug discontinuation. Resume only if LFTs return to normal, then closely monitor patient. Use with care in prostatic enlargement, narrow-angle glaucoma and paralytic ileus. Patients with fever should be carefully evaluated to rule out the possibility of an underlying infection or the development of agranulocytosis. Avoid immobilisation of patients due to increased risk of thromboembolism. Do not give CLOZARIL with other drugs with a substantial potential to depress bone marrow function. CLOZARIL may enhance the effects of alcohol, MAO inhibitors, CNS depressants and drugs with anticholinergic, hypotensive or respiratory depressant effects. Caution is advised when CLOZARIL therapy is initiated in patients who are receiving (or have recently received) a benzodiazepine or any other psychotropic drug as these patients may have an increased risk of circulatory collapse, which, on rare occasions, can be profound and may lead to cardiac and/or respiratory arrest. Caution is advised with concomitant administration of therapeutic agents which are highly bound to plasma proteins. Clozapine binds to and is partially metabolised by the isoenzymes cytochrome P450 1A2 and P450 2D6. Caution is advised with drugs which posses affinity for these isoenzymes. Concomitant cimetidine and high dose CLOZARIL was associated with increased plasma clozapine levels and the occurrence of adverse effects. Concomitant fluoxetine and fluvoxamine have been associated with elevated clozapine levels. Discontinuation of concomitant carbamazepine resulted in increased clozapine levels. Phenytoin decreases clozapine levels resulting in reduced effectiveness of CLOZARIL. No clinically relevant interactions have been noted with antidepressants, phenothiazines and type lc antiarrhythmics, to date. Concomitant use of lithium or other CNS-active agents may increase the risk of neuroleptic malignant syndrome. The hypertensive effect of adrenaline and its derivatives may be reversed by CLOZARIL. Do not use in pregnant or nursing women. Use adequate contraceptive measures in women of child bearing potential. **Side-Effects** Neutropenia leading to agranulocytosis (See Warning and Precautions). Rare reports of leucocytosis including eosinophilia. Isolated cases of leukaemia and thrombocytopenia have been reported but there is no evidence to suggest a causal relationship with the drug. Most commonly fatigue, drowsiness, sedation. Dizziness or headache may also occur. CLOZARIL lowers the seizure threshold and may cause EEG changes and delirium. Myoclonic jerks or convulsions may be precipitated in individuals who have epileptogenic potential but no previous history of epilepsy. Rarely it may cause confusion, restlessness, agitation and delirium. Extrapyramidal symptoms are limited mainly to tremor, akathisia and rigidity. Tardive dyskinesia reported very rarely. Neuroleptic malignant syndrome has been reported. Transient autonomic effects eg dry mouth, disturbances of accommodation and disturbances in sweating and temperature regulation. Hypersalivation. Tachycardia and postural hypotension, with or without syncope, and less commonly hypertension may occur. In rare cases profound circulatory collapse has occurred. ECG changes, arrhythmias, pericarditis and myocarditis (with or without eosinophilia) have been reported, some of which have been fatal. Rare reports of thromboembolism. Isolated cases of respiratory depression or arrest, with or without circulatory collapse. Rarely aspiration may occur in patients presenting with dysphagia or as a consequence of acute overdosage. Nausea, vomiting and usually mild constipation have been reported. Occasionally obstipation and paralytic ileus have occurred. Asymptomatic elevations in liver enzymes occur commonly and usually resolve. Rarely hepatitis and cholestatic jaundice may occur. Very rarely fulminant hepatic necrosis reported. Discontinue CLOZARIL if jaundice develops. Rare cases of acute pancreatitis have been reported. Both urinary incontinence and retention and priapism have been reported. Isolated cases of interstitial nephritis have occurred. Benign hyperthermia may occur and isolated reports of skin reactions have been received. Rarely hyperglycaemia has been reported. Rarely increases in CPK values have occurred. With prolonged treatment considerable weight gain has been observed. Sudden unexplained deaths have been reported in patients receiving CLOZARIL. **Package Quantities and Price** Community pharmacies only 28 x 25mg tablets: £12.52 (Basic NHS) 28 x 100mg tablets: £50.05 (Basic NHS) Hospital pharmacies only 84 x 25 mg tablets: £37.54 (Basic NHS) 84 x 100 mg tablets: £150.15 (Basic NHS) Supply of CLOZARIL is restricted to pharmacies registered with the CLOZARIL Patient Monitoring Service. **Product Licence Numbers** 25 mg tablets: PL 0101/0228 100 mg tablets: PL 0101/0229 **Legal Category**: POM. CLOZARIL is a registered Trade Mark. Date of preparation, August 1997. Full prescribing information, including Product Data Sheet is available from Novartis Pharmaceuticals UK Ltd. Trading as: SANDOZ PHARMACEUTICALS, Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.

NOVARTIS

AUG'97 CLZ 97/13

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press



CLOZARIL®
clozapine

Proven efficacy in treatment resistant schizophrenia

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

United Kingdom Psychiatric Pharmacy Group

Psychiatric medication helpline for patients and carers.

0171 919 2999

Open 11.00am to 5.00pm. Weekdays only.

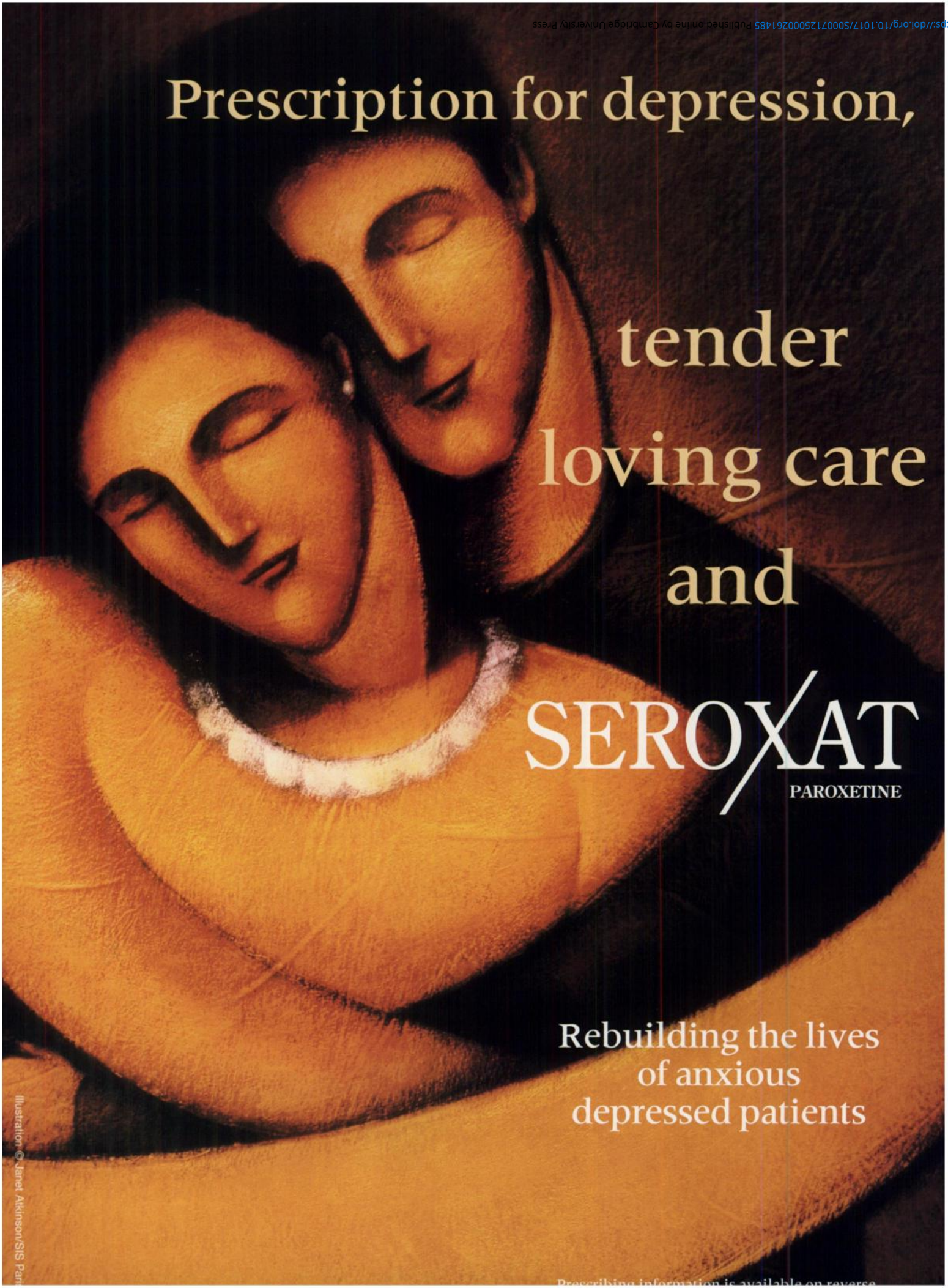
This helpline is staffed by experienced pharmac[illegible]

Patients and carers may telephone [illegible] any queries they have about medicines used in psychiatry.

United Kingdom Psychiatric Pharmacy Group

U.K.P.P.G.

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press



https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

PRESCRIBING INFORMATION

Presentation: 'Seroxat' Tablets, PL 10592/0001-2, each containing either 20 or 30 mg paroxetine as the hydrochloride. 30 (OP) 20 mg tablets, £20.77; 30 (OP) 30 mg tablets, £31.16. 'Seroxat' Liquid, PL 10592/0092, containing 20 mg paroxetine as the hydrochloride per 10 ml. 150 ml (OP), £20.77.

Indications: Treatment of symptoms of depressive illness of all types including depression accompanied by anxiety. Following satisfactory response, continuation is effective in preventing relapse. Treatment of symptoms and prevention of relapse of obsessive compulsive disorder (OCD). Treatment of symptoms and prevention of relapse of panic disorder with or without agoraphobia.

Dosage: *Adults: Depression:* 20 mg a day. Review response within two to three weeks and if necessary increase dose in 10 mg increments to a maximum of 50 mg according to response.

Obsessive compulsive disorder: 40 mg a day. Patients should be given 20 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 60 mg a day.

Panic disorder: 40 mg a day. Patients should be given 10 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 50 mg a day.

Give orally once a day in the morning with food. The tablets should not be chewed. Continue treatment for a sufficient period, which should be at least four to six months after recovery for depression and may be longer for OCD and panic disorder. As with many psychoactive medications abrupt discontinuation should be avoided – see Adverse reactions.

Elderly: Dosing should commence at the adult starting dose and may be increased in weekly 10 mg increments up to a maximum of 40 mg a day according to response.

Children: Not recommended.

Severe renal impairment (creatinine clearance <30 ml/min) or severe hepatic impairment: 20 mg a day. Restrict incremental dosage if required to lower end of range.

Contra-indication: Hypersensitivity to paroxetine.

Precautions: History of mania. Cardiac conditions: caution. Caution in patients with epilepsy; stop treatment if seizures develop. Driving and operating machinery.

Drug interactions: Do not use with or within two weeks after MAO inhibitors; leave a two-week gap before starting MAO inhibitor treatment. Possibility of interaction with tryptophan. Great caution with warfarin and other oral anticoagulants. Use lower doses if given with drug metabolising enzyme inhibitors; adjust dosage if necessary with drug metabolising enzyme inducers. Alcohol is not advised. Use lithium with caution and monitor lithium levels. Increased adverse effects with phenytoin; similar possibility with other anticonvulsants.

Pregnancy and lactation: Use only if potential benefit outweighs possible risk.

Adverse reactions: In controlled trials most commonly nausea, somnolence, sweating, tremor, asthenia, dry mouth, insomnia, sexual dysfunction (including impotence and ejaculation disorders), dizziness, constipation and decreased appetite.

Also spontaneous reports of dizziness, vomiting, diarrhoea, restlessness, hallucinations, hypomania, rash including urticaria with pruritus or angioedema, and symptoms suggestive of postural hypotension. Extrapyramidal reactions reported infrequently; usually reversible abnormalities of liver function tests and hyponatraemia described rarely. Symptoms including dizziness, sensory disturbance, anxiety, sleep disturbances, agitation, tremor, nausea, sweating and confusion have been reported following abrupt discontinuation of 'Seroxat'. It is recommended that when antidepressant treatment is no longer required, gradual discontinuation by dose-tapering or alternate day dosing be considered.

Overdosage: Margin of safety from available data is wide. Symptoms include nausea, vomiting, tremor, dilated pupils, dry mouth, irritability, sweating and somnolence. No specific antidote. General treatment as for overdosage with any antidepressant. Early use of activated charcoal suggested.

Legal category: POM. 7.4.98

SB SmithKline Beecham Pharmaceuticals

PARTNERS IN PSYCHIATRIC CARE

Welwyn Garden City, Hertfordshire AL7 1EY.

'Seroxat' is a trade mark.
© 1998 SmithKline Beecham Pharmaceuticals.

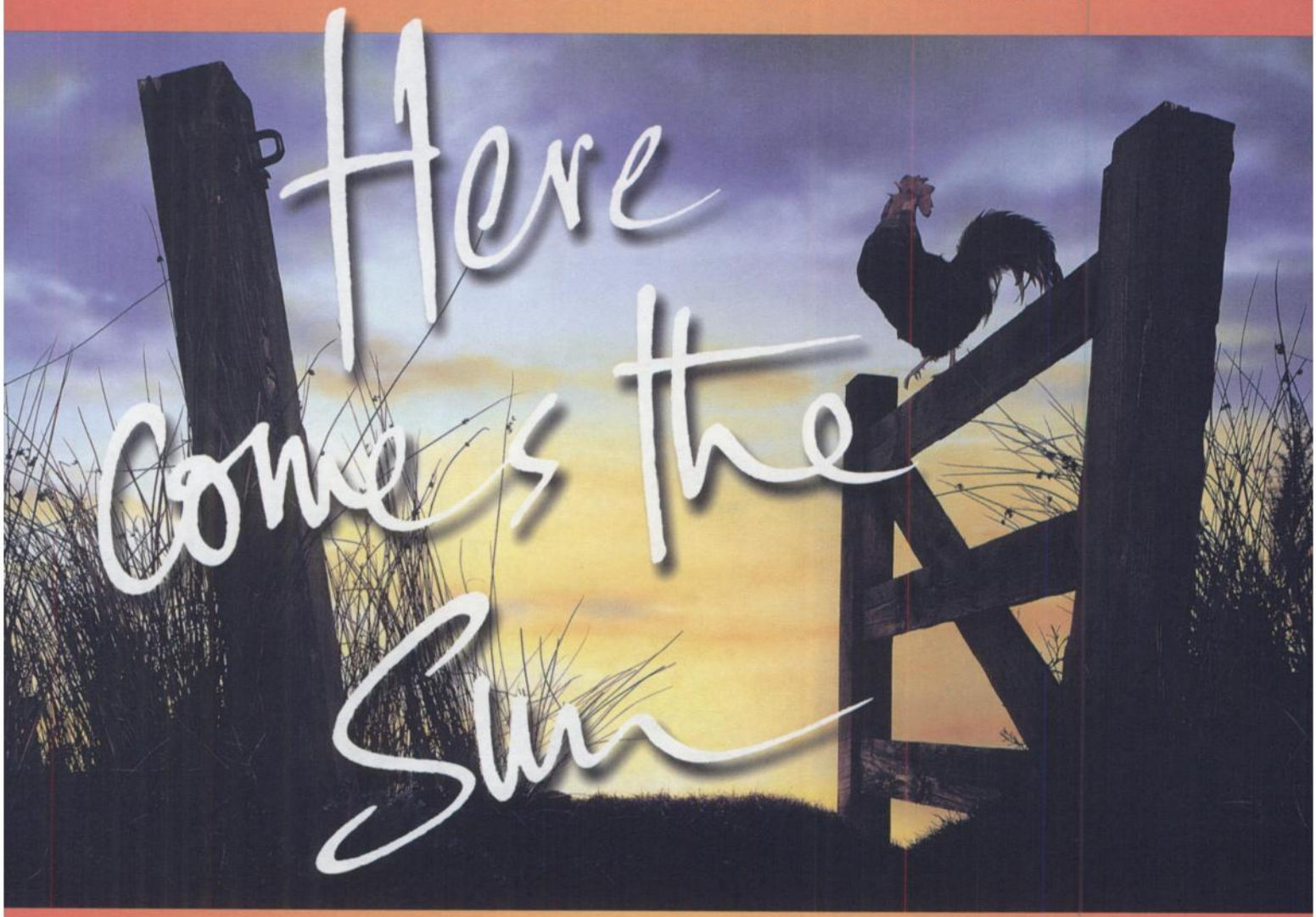
SEROXAT

Rebuilding the lives of anxious depressed patients

0598 ST:AD/8/037JP

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Efexor* XL venlafaxine - Prescribing information Presentation: Capsules containing 75mg or 150mg venlafaxine (as hydrochloride) in an extended release formulation. **Use:** Treatment of depressive illness. **Dosage:** *Adults (including the elderly):* Usually 75mg, given once daily with food, increasing to 150mg once daily if necessary. The dose can be increased further to 225mg once a day. Dose increments should be made at intervals of approximately 2 weeks or more, but not less than 4 days. Discontinue gradually to avoid possibility of discontinuation effects. *Children:* Contra-indicated below 18 years of age. *Moderate renal or moderate hepatic impairment:* Doses should be reduced by 50%. Not recommended in severe renal or severe hepatic impairment. **Contra-indications:** Pregnancy, lactation, concomitant use with MAOIs, hypersensitivity to venlafaxine or other components, patients aged below 18 years. **Precautions:** Use with caution in patients with myocardial infarction, unstable heart disease, renal or hepatic impairment, or a history of epilepsy (discontinue in event of seizure). Patients should not drive or operate machinery if their ability to do so is impaired. Possibility of postural hypotension (especially in the elderly). Women of child-bearing potential should use contraception. Prescribe smallest quantity of tablets according to good patient management. Monitor blood pressure with doses >200mg/day. Advise patients to notify their doctor should an allergy develop or if they become or intend to become pregnant. Patients with a history of drug abuse should be monitored carefully. **Interactions:** MAOIs: do not use Efexor XL in combination with MAOIs or within 14 days of stopping MAOI treatment. Allow 7 days after stopping Efexor XL before starting an MAOI. Use with caution in elderly or hepatically-impaired patients taking cimetidine, in patients taking other CNS-active drugs, and in patients taking drugs which inhibit *both* CYP2D6 and CYP3A4 hepatic enzymes. **Side-effects:** Nausea, insomnia, dry mouth, somnolence, dizziness, constipation, sweating, nervousness, asthenia, abnormal ejaculation/orgasm, anorexia, abnormal vision/accommodation, impotence, vomiting, tremor, abnormal dreams, vasodilatation, hypertension, rash, agitation, hypertonia, paraesthesia, postural hypotension, reversible increases in liver enzymes, slight increase in serum cholesterol, weight gain or loss, hyponatraemia. **Basic NHS price:** 75mg capsule (PL 00011/0223) - blister pack of 28 capsules: £23.97. 150 mg capsule (PL 00011/0224) - blister pack of 28 capsules: £39.97. **Legal category:** POM. Further information is available upon request from the Product Licence holder: Wyeth Laboratories, Taplow, Maidenhead, Berkshire, SL6 0PH. Date of preparation: August 1997. *trade mark Code no Z777440/0897. WEFX3-UK-JA. References: 1. Muth EA *et al.* Biochem Pharmacol 1986; 35(24): 4493-4497. 2. Muth EA *et al.* Drug Development Research 1991; 23: 191-199. 3. Rudolph R *et al.* Poster presented at the New Clinical Drug Evaluation Unit (National Institute of Mental Health). Boca Raton, Florida 1997. 4. McPartlin GM *et al.* Poster at the 10th European College of Neuropsychopharmacology meeting, Vienna, September 13th-17th, 1997. 5. Salinas E. Biol Psychiatry 1997; 42(Suppl. 1): 244S.



- EFEXOR XL ACTS DIRECTLY ON BOTH SEROTONIN AND NORADRENALINE[1,2]
- PROVEN EFFICACY VS LEADING SSRIs[3,4]
- TOLERABILITY[3,4,5] AND CONVENIENCE YOU EXPECT FROM A FIRST-LINE THERAPY

NEW ONCE DAILY

EFEXOR XL®

VENLAFAXINE 75 mg o.d.

Simply effective

Wyeth®

PRESENTATION: Tablets containing 50mg, 100mg and 200mg nefazodone hydrochloride. INDICATIONS: Symptomatic treatment of all types of depressive illness, including depressive syndromes accompanied by anxiety or sleep disturbances. DOSAGE: Usual therapeutic dose 200mg twice daily. Range – 100mg - 600mg daily, see Summary of Product Characteristics. Elderly: Usual therapeutic dose 50 - 200mg twice daily. Renal and Hepatic Impairment: Lower end of dose range. Children: Not recommended below the age of 18 years. CONTRA-INDICATIONS: Hypersensitivity to nefazodone hydrochloride, tablet excipients or phenylpiperazine antidepressants.

Bristol-Myers Squibb Pharmaceuticals Limited

WARNINGS/ PRECAUTIONS: Hepatic or renal impairment. Patients at high risk of self harm should be kept under close supervision during function tests but no impairment of cognitive function. Not recommended in pregnancy and lactation. Use with caution in epilepsy, history of mania/hypomania, recent M.I., unstable heart disease. No clinical studies available on concurrent use of ECT and nefazodone. DRUG INTERACTIONS: Caution is advised when combining with other CNS medication, digoxin, products metabolised by Cytochrome $P_{450}III_{A4}$; see Summary of Product Characteristics. SIDE EFFECTS: Most frequently asthenia, dry mouth, nausea, constipation, somnolence, light-headedness and dizziness; see Summary of Product Characteristics. OVERDOSAGE: There is no specific antidote for nefazodone. Gastric lavage recommended for suspected overdose. Treatment should be symptomatic and supportive in the case of hypotension or excessive sedation. PRODUCT LICENCE NUMBERS: Dutonin Tablets 50mg PL 11184/0027; Dutonin Tablets 100mg PL 11184/0028; Dutonin Tablets 200mg Squibb Pharmaceuticals Ltd. BASIC NHS PRICE: Treatment initiation pack containing 50mg tablets 14, 100mg tablets 14, 200mg tablets 28 – £16.80; 100mg tablets 56 – £16.80; 200mg tablets 56 – £16.80. LEGAL CATEGORY: POM. Further information from: Medical Information, Bristol-Myers Squibb House, 141-149 Staines Road, Hounslow, Middlesex, TW3 3JA. Telephone: 0181-754-3740. Date of preparation: July 1997.

REFERENCES: 1. Armitage R. Journal of Psychopharmacology 1996; 10(suppl1): 22-25. 2. Sharpley AL *et al.* Psychopharmacology 1996; 126: 50-54. 3. Armitage R *et al.* J Clin Psychopharmacol 1997; 17(3): 161-168. 4. Armitage R *et al.* Presented at the European College of Neuropsychopharmacology (ECNP), 30 September - 4 October 1995, Venice, Italy. 5. Fontaine R *et al.* J Clin Psychiatry 1994; 55(6): 234-241. 6. Gillin JC *et al.* J Clin Psychiatry 1997; 58: 185-192.

Waking up early should be her decision, not her problem.

It's not only depression that wakes patients up early. Sleep can also be disturbed by many SSRIs.[1-4]

Dutonin is an excellent choice. Not only does Dutonin effectively relieve depression,[5] it also normalises sleep patterns.[3,4,6]

Moreover, Dutonin lifts anxiety symptoms within the first week of treatment.[5]

Waking up early should always be your patient's choice, not their problem.

Makes the difference in depression

DUTONIN™▼

NEFAZODONE

Presentation: White to off white tablets each containing modafinil 100 mg **Indication:** Narcolepsy **Dosage:** *Adults* 200-400 mg daily either as two divided doses in the morning and at noon or as a single morning dose according to response. *Elderly* Treatment should start at 100 mg daily which may be increased subsequently to the maximum adult daily dose in the absence of renal or hepatic impairment. *Severe renal or hepatic impairment* Reduce dose by half (100-200 mg daily) *Children* See contra indications **Contra indications:** Pregnancy, lactation, use in children, moderate to severe hypertension, arrhythmia, hypersensitivity to modafinil or any excipients used in Provigil **Warnings and precautions:** Patients with major anxiety should only receive Provigil treatment in a specialist unit. Sexually active women of child bearing potential should be established on a contraceptive programme before starting treatment. Blood pressure and heart rate should be monitored in hypertensive patients. Provigil is not recommended in patients with a history of left ventricular hypertrophy or ischaemic ECG changes, chest pain, arrhythmia or other clinically significant manifestations of mitral valve prolapse in association with CNS stimulant use. Studies of modafinil have demonstrated a low potential for dependence although the possibility of this occurring with long term use cannot be entirely excluded. **Drug interactions:** Induction of cytochrome P-450 isoenzymes has been observed *in vitro*. Effectiveness of oral no clinically relevant interaction was seen in a single dose interaction study of Provigil and clomipramine. However, patients receiving such medication should be carefully monitored. Care should be observed with co-administration of anti-convulsant drugs. **Side effects:** Nervousness, excitation, aggressive tendencies, insomnia, personality disorder, anorexia, headache, CNS stimulation, euphoria, abdominal pain, dry mouth, palpitation, tachycardia, hypertension and tremor have been reported. Nausea and gastric discomfort may occur and may improve when tablets are taken with meals. Pruritic skin rashes have been observed occasionally. Buccofacial dyskinesia has been reported very rarely. A dose related increase in alkaline phosphatase has been observed. **Basic NHS cost:** Packs of 30 blister packed 100 mg tablets: £60.00. **Marketing authorisation number:** 16260/0001. **Marketing authorisation holder:** Cephalon UK Ltd., 11/13 Frederick Sanger Road, Surrey Research Park, Guildford, GU2 5YD. **Legal category:** POM. **Date of preparation:** January 1998. Provigil and Cephalon are registered trademarks. **References:** **1.** Mitler MM. Sleep 1994; **17**: S103-S106. **2.** Data on file, Cephalon [3]. **3.** Lin JS *et al.* *Proc Natl Acad Sci USA* 1996; **93** (24): 14128-14133. **4.** Simon P *et al.* Eur Neuropsychopharmacol 1995; **5**: 509-514.

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

WAKE UP LITTLE SUZIE, WAKE UP

Excessive sleepiness associated with narcolepsy frequently has a disastrous effect on patients' lives, by impairing their physical, social and emotional well being. Unfortunately, treatment with amphetamines is often associated with a high incidence of unpleasant side effects, which limit their overall benefit.[1]

Now Provigil (modafinil) – a novel wake promoting agent – offers new advantages in narcolepsy. The clinical efficacy of Provigil has been demonstrated in large controlled clinical studies. In one study,[2] one in five people with severe narcolepsy reached normal levels of daytime wakefulness while receiving Provigil.

Provigil selectively activates the hypothalamus[3] and differs greatly from amphetamines in its pharmacology.[4] Consequently the incidence of amphetamine like side effects is very low.

PROVIGIL®▼
MODAFINIL

A NOVEL, NON-AMPHETAMINE

https://doi.org/10.1017/S0007125000078498 Published online by Cambridge University Press

Campral EC acamprosate

Presentation: Off-white round enteric-coated tablets, containing 333mg acamprosate calcium. Printed on one side with 333. **Properties:** Acamprosate may act by stimulating GABAergic inhibitory neurotransmission and antagonising excitatory amino acids, particularly glutamic acid. **Indication:** Maintenance of abstinence in alcohol dependent patients. It should be combined with counselling. **Dosage and Administration:** *Adults ≥ 60kg:* 6 tablets per day (2 tablets taken three times daily with meals) *Adults < 60kg:* 4 tablets per day (2 tablets in the morning, 1 at noon and 1 at night with meals). Recommended treatment period one year, starting as soon as possible after the withdrawal period. Treatment should be maintained if the patient relapses. *Elderly:* Not recommended. *Children:* Not recommended. **Contraindications:** Known hypersensitivity to the drug, renal insufficiency (serum creatinine > 120 micromol/L), severe hepatic failure (Childs-Pugh classification C), pregnancy, lactation. **Precautions and Warnings:** Campral EC concomitant intake of alcohol and acamprosate does not affect the pharmacokinetics of either alcohol or acamprosate. **Side Effects:** Diarrhoea, and less frequently nausea, vomiting and abdominal pain; pruritus. These are usually mild and transient. An occasional maculopapular rash and rare cases of bullous skin reactions have been reported. Fluctuations in libido have been reported. Campral EC should not impair the patient's ability to drive or operate machinery. **Overdose:** Gastric lavage; should hypercalcaemia occur, treat patient for acute hypercalcaemia. **Legal Category:** POM. **Pharmaceutical Precautions:** None. **Package Quantities and Basic NHS Price:** 84 blister packed tablets £24.95. **Marketing Authorisation Number/Holder:** 13466/0001, Lipha SA, Lyon, France. **Date of Preparation:** August 1997. Further information is available on request from Merck Pharmaceuticals, Harrier House, High Street, West Drayton, Middlesex, UB7 7QG. **Date of Preparation:** March 1998.

None observed in studies with diazepam, disulfiram or imipramine. The

FOR INNOVATIVE PHARMACEUTICAL PRODUCTS

Commended 1998

BRAIN BIOCHEMISTRY ADAPTS TO
LIFE WITH ALCOHOL

CAMPRAL EC HELPS BRAIN BIOCHEMISTRY ADAPT TO
LIFE WITHOUT IT

Non-aversive **Campral EC** modifies the biochemical mechanisms that cause craving in patients who are adapting to a life without alcohol. To find out how **Campral EC** can support the vital role of counselling in helping to prevent relapse simply call

0800 980 7055

A UNIQUE WAY TO COUNTERBALANCE THE BIOCHEMISTRY OF RELAPSE

Campral EC

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

There's a depressed patient sitting in front of you. Ask them if it's good to talk.

Communicating confidently, whether it's at work or with friends and family, is just one sign of how well a depressed patient is re-adapting socially. And social interaction is an extremely valuable measure of successful treatment.

Edronax is a selective NorAdrenaline Re-uptake Inhibitor (NARI). It not only lifts depressed mood,[1] but also significantly improves social interaction.[2]

These improvements in social functioning have been trial-proven by using the innovative SASS questionnaire (Social Adaptation Self-evaluation Scale).[3]

Edronax improves mood one week earlier than fluoxetine.[1] Additionally, when compared to fluoxetine, Edronax shows a significantly better outcome in terms of social functioning.[2]

Edronax helps restore patients' appreciation of friends, family, work and hobbies, and improves their self-perception.

Prescribe 4mg b.d. then make your usual assessments, to see the Edronax difference. The SASS questionnaire, which patients can complete in their own time, may also help.

For free copies of the SASS questionnaire, please telephone 01908 603083.

Edronax® ▼
REBOXETINE

A SELECTIVE NARI. LIFTS DEPRESSION.
HELPS RESTORE SOCIAL INTERACTION.

EDRONAX ®
ABBREVIATED PRESCRIBING INFORMATION
Presentation: Tablets containing 4mg reboxetine. **Indications:** Use in the acute treatment of depressive illness, and maintenance of clinical benefit in patients responsive to treatment. **Posology and method of administration:** *Adults* 4 mg b.i.d. (8 mg/day) administered orally. After 3-4 weeks, can increase to 10 mg/day. *Elderly and children* Elderly patients have been studied in comparative clinical trials at doses of 2 mg b.i.d., although not in placebo controlled conditions. There is no experience in children and therefore reboxetine cannot be recommended in either of these groups. *Renal/Hepatic Insufficiency* 2 mg b.i.d. which can be increased based on **Special warnings and precautions for use:** Close supervision is required for subjects with a history of convulsive disorders and must be discontinued if the patient develops seizures. Avoid concomitant use with MAO-inhibitors. Close supervision of bipolar patients is recommended. Close supervision should be applied in patients with current evidence of urinary retention, glaucoma, prostatic hypertrophy and cardiac disease. At doses higher than the maximum recommended, orthostatic hypotension has been observed with greater frequency. Particular attention should be paid when administering reboxetine with other drugs known to lower blood pressure. **Interactions with other medicaments and other forms of interaction:** Reboxetine should not be that have a narrow therapeutic margin and are metabolised by CYP3A4 or CYP2D6 e.g. anti-arrhythmics (flecainide), anti-psychotic drugs and tricyclic anti-depressants. No pharmacokinetic interaction with lorazepam. Reboxetine does not appear to potentiate the effect of alcohol. **Pregnancy and lactation:** Reboxetine is contraindicated in pregnancy and lactation. **Effects on ability to drive and use machines:** Reboxetine is not sedative per se. However, as with all psychoactive drugs, caution patients about operating machinery and driving. **Undesirable effects:** Adverse events occurring more frequently than placebo are: dry mouth, constipation, insomnia, paraesthesia, increased sweating, tachycardia, vertigo, urinary hesitancy/retention, impotence. required. **Package and NHS Price:** Pack of 60 tablets in blisters £19.80. **Legal Category:** POM **Marketing Authorisation Holder:** Pharmacia & Upjohn Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. **Marketing Authorisation Number:** PL 0032/0216, **Date of Preparation:** June 1998. **References: 1.** Montgomery SA. *Journal of Psychopharmacology* 1997 (in press). **2.** Dubini A. et al. *European Neuropsychopharmacol.* 1997; **7** (Suppl 1): S57-S70. **3.** Bosc M. et al. *European Neuropsychopharmacol.* 1997; **7** (Suppl 1): S57-S70. Further information is available from Pharmacia & Upjohn Limited, Davy Avenue, Knowlhill, Milton Keynes, MK5 8PH, UK.

Pharmacia

https://doi.org/10.1017/S0007125000261485 Published online by Cambridge University Press

Antipsychotic Efficacy for First-line Use

ZYPREXA
Olanzapine

Making Community Re-integration the Goal

ABBREVIATED PRESCRIBING INFORMATION: **Presentation:** Coated tablets containing 2.5mg, 5mg, 7.5mg or 10mg of olanzapine. The tablets also contain lactose. **Uses:** Schizophrenia, both as initial therapy and for maintenance of response. **Further Information:** In studies of patients with schizophrenia and associated depressive symptoms, mood score improved significantly more with olanzapine than with haloperidol. **Pharmacodynamics:** Olanzapine was associated with significantly greater improvements in both negative and positive schizophrenic symptoms than placebo or comparator in most studies. **Dosage and Administration:** 10mg/day orally, as a single dose without regard to meals. Dosage may subsequently be adjusted within the range of 5-20mg daily. An increase to a dose greater than the routine therapeutic dose of 10mg/day is recommended only after clinical assessment. *Children:* Not recommended under 18 years of age. *The elderly:* A lower starting dose (5mg/day) is not routinely indicated but should be considered when clinical factors warrant. *Renal and/or hepatic impairment:* A lower starting dose (5mg) should be considered. In moderate hepatic insufficiency, the starting dose should be 5mg, and only increased with caution. When more than one factor is present which might result in slower metabolism (female gender, elderly age, non-smoking status), consideration should be given to decreasing the starting dose. Dose escalation should be conservative in such patients. **Contra-indications:** Known hypersensitivity to any ingredient of the product. Known risk of narrow-angle glaucoma. **Warnings and Special Precautions:** Caution in patients with prostatic hypertrophy, or paralytic ileus and related conditions. Caution in patients with elevated ALT and/or AST, signs and symptoms of hepatic impairment, pre-existing conditions associated with limited hepatic functional reserve, and in patients who are being treated with potentially hepatotoxic drugs. As with other neuroleptic drugs, caution in patients with low leucocyte and/or neutrophil counts for any reason, a history of drug-induced bone marrow depression/toxicity, bone marrow depression caused by concomitant illness, radiation therapy or chemotherapy and in patients with hypereosinophilic conditions or with myeloproliferative disease. Thirty-two patients with clozapine-related neutropenia or agranulocytosis histories received olanzapine without decreases in baseline neutrophil counts. Rare cases reported as NMS have been received in association with olanzapine. If a patient develops signs and symptoms indicative of NMS, or presents with unexplained high fever without additional clinical manifestations of NMS, all antipsychotic drugs, including olanzapine, must be discontinued. Caution in patients who have a history of seizures or have conditions associated with seizures. If signs or symptoms of tardive dyskinesia appear a dose reduction or drug discontinuation should be considered. Caution when taken in combination with other centrally acting drugs and alcohol. Olanzapine may antagonise the effects of direct and indirect dopamine agonists. Postural hypotension was infrequently observed in the elderly. However, blood pressure should be measured periodically in patients over 65 years, as with other antipsychotics. As with other antipsychotics, caution when prescribed with drugs known to increase QTc interval, especially in the elderly. In clinical trials, olanzapine was not associated with a persistent increase in absolute QT intervals. **Interactions:** Metabolism may be induced by concomitant smoking or carbamazepine therapy. **Pregnancy and Lactation:** Olanzapine had no teratogenic effects in animals. Because human experience is limited, olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus. Olanzapine was excreted in the milk of treated rats but it is not known if it is excreted in human milk. Patients should be advised not to breast feed an infant if they are taking olanzapine. **Driving, etc:** Because olanzapine may cause somnolence, patients should be cautioned about operating hazardous machinery, including motor vehicles. **Undesirable Effects:** The only frequent (>10%) undesirable effects associated with the use of olanzapine in clinical trials were somnolence and weight gain. Occasional undesirable effects included dizziness, increased appetite, peripheral oedema, orthostatic hypotension, and mild, transient anticholinergic effects, including constipation and dry mouth. Transient, asymptomatic elevations of hepatic transaminases, ALT, AST have been seen occasionally. Olanzapine-treated patients had a lower incidence of parkinsonism, akathisia and dystonia in trials compared with titrated doses of haloperidol. Photosensitivity reaction, rash or high creatine phosphokinase were reported rarely. Rare cases reported as NMS have been received in association with olanzapine. Plasma prolactin levels were sometimes elevated, but associated clinical manifestations were rare. Haematological variations, such as leucopenia and thrombocytopenia, have been reported occasionally. *For further information see summary of product characteristics.* **Legal Category:** POM. **Marketing Authorisation Numbers:** EU/1/96/022/002 EU/1/96/022/004 EU/1/96/022/006 EU/1/96/022/009 EU/1/96/022/010. **Basic NHS Cost:** £34.27 per pack of 28 2.5mg tablets. £52.73 per pack of 28 5mg tablets. £158.20 per pack of 56 7.5mg tablets. £105.47 per pack of 28 10mg tablets. £210.93 per pack of 56 10mg tablets. **Date of Preparation or Last Review:** March 1998. **Full Prescribing Information is Available From:** Eli Lilly and Company Limited, Dextra Court, Chapel Hill, Basingstoke, Hampshire, RG21 5SY. Telephone: Basingstoke (01256) 315000. 'ZYPREXA' is an Eli Lilly and Company Limited trademark.

Lilly PHARMA
Improving lives, restoring hope