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Satellite symposia

SAT1 - Satellite symposium: TREATING SCHIZOPHRENIA WITHOUT SEDATING THE PATIENT: GOAL OR CHALLENGE

Sponsored by Bristol-Myers-Squibb

SAT1.01

What does agitation mean in the acute setting?

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Agitation is a frequent symptom associated with schizophrenia, mainly in the acute or impending relapse phases, and can be defined as any inappropriate, excessive motor or verbal activity. Manifestations of agitation may include excitement, hostility, aggressive and destructive behaviours, verbal abuse and extreme personal distress. Agitation has an adverse effect on many aspects of psychiatric disorders, negatively impacting patient care, caregiver experience and society as a whole. In terms of patient care, the symptoms of agitation can hinder diagnosis and treatment of the psychiatric disorder. Delayed diagnosis and treatment and its associated effects can increase the duration of hospitalization for a patient. Agitation symptoms can heighten caregiver distress, as agitated individuals are generally perceived to be acting inappropriately. Among inpatients, agitation is a common warning signal that frequently precedes an act of violence and, therefore, is among the most fear-provoking aspects for caregivers. Potentially, this can lead to increased need for institutionalization, leading to societal implications due to the increased need for emergency care and the associated costs. Also, increased hospitalization further influences the patient experience - adversely affecting patient quality of life. Thus, addressing agitation as a symptom of schizophrenia is an important therapeutic target. Given the seriousness of these symptoms and their effects, together with the fact that patients with agitation associated with psychiatric disorders frequently present in the emergency department experiencing an acute psychiatric episode, rapid, effective intervention is key. The initial treatment period is critical for optimal patient outcomes, and an ideal treatment for a patient presenting with acute agitation would: calm the patient quickly, without excessive sedation; decrease the likelihood of harm to self or others; attenuate psychosis and associated symptoms; allow initiation of a therapeutic relationship between patient and physician; be easily and effectively administered; decrease the use of seclusion and restraint; and consider both short- and long-term treatment goals and patient health.

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SAT1.02

Sedation is not the opposite of agitation

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The induction of sleep was originally considered to be a desirable therapeutic endpoint for the rapid control of agitation associated with psychotic disorders. However, it has become clear that sleep is not essential for a decrease in agitation or for the rapid improvement in core psychotic symptoms. Indeed, although the initial calming effects of treatment may be considered useful, excessive sedation or 'oversedation' is not a desirable effect, as it can interfere with both the physician's ability to interview/evaluate the patient and establish an effective therapeutic alliance with them, and with the patient's ability to participate in their treatment (e.g., answer questions, hydrate themselves). Furthermore, oversedation has the potential to mask illnesses that show central nervous system depression as a symptom, which could lead to further morbidity or mortality. Thus, although sleep may be advantageous in certain circumstances, achieving control of agitation via rapid calming rather than sedation is becoming an important therapeutic goal. Management of acute agitation has traditionally involved the use of benzodiazepines, such as lorazepam; however, problems with oversedation have led to the increased use of intramuscular antipsychotics in place of, or in combination with, benzodiazepines. Although combination treatment, for example, with intramuscular haloperidol plus intramuscular lorazepam, may provide superior efficacy to treatment with either agent alone, the sedative effects are at least as great as with the use of benzodiazepines as monotherapy. Specific calming without excessive sedation is emerging as a significant clinical advantage of intramuscular formulations of atypical antipsychotics versus conventional treatments.

SAT1.03

Appropriate treatments for agitation associated with schizophrenia: Control of acute agitation and maintenance of efficacy

A. Fagiolini. *Department of Psychiatry, University of Pittsburgh, Pittsburgh, PA, USA*

The first challenge in the treatment of acute agitation associated with schizophrenia is to control agitation without excessively sedating the patient, while also treating the symptoms of schizophrenia. Although oral formulations of antipsychotics have shown efficacy in the treatment of agitation, some agitated patients may not be able to take oral drugs and it may be necessary to use an intramuscular form of medication. Intramuscular formulations of benziodiazepines, typical antipsychotics and, more recently, atypical antipsychotics, have all

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proved effective first-line therapies for the rapid control of agitation associated with psychotic disorders. Although widely used, intramuscular benzodiazepines have been associated with excessive sedation, and typical antipsychotics, such as intramuscular haloperidol, have a high propensity for causing acute extrapyramidal symptoms. Distressing side effects may adversely impact on patient acceptance of, and adherence to, future antipsychotic therapy. Intramuscular atypical antipsychotics may provide superior alternative treatments owing to improved safety and tolerability versus typical agents. Clinical studies have demonstrated the safety and efficacy of intramuscular formulations of aripiprazole, olanzapine and ziprasidone for the treatment of agitation associated with schizophrenia, and these agents have been approved for use in the USA and some European countries. Although rapid control of agitation is the primary goal, the longer-term effects of antipsychotic therapy also require consideration. Patients initially treated with an intramuscular antipsychotic will typically transition to oral therapy for the long-term management of their disorder. Therefore, the long-term safety and tolerability of oral therapy is important. For example, treatment-associated sedation can adversely affect patient quality of life and social integration during longer-term treatment, whereas treatment with antipsychotics that are associated with significant risk of weight gain, glucose dysregulation and dyslipidaemia may have serious implications for long-term patient health. Transferring from an intramuscular to an oral antipsychotic may impose a risk of the emergence of adverse effects, breakthrough symptoms and loss of therapeutic advantage, particularly if transitioning between intramuscular and oral formulations of different antipsychotics; ideally, continuation with the same agent would minimise this risk.

SAT2 - Lunch Satellite symposium: SEROTONIN, NORADRENALINE, DUAL - WHAT IS STATE OF THE ART? *Sponsored by Lundbeck*

SAT2.01

Pharmacological treatment of anxiety disorders - is there a state of the art?

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Selection of appropriate treatment for anxiety disorders is influenced by several considerations, including psychiatric comorbidity. Emerging data suggest that anxiety disorders have a chronic course and a high comorbidity with depression. Successful treatment can be facilitated by first establishing treatment goals, which include managing acute anxiety and following through to remission. Prevention of recurrence of anxiety disorders should be the ultimate objective.

Various treatment options exist for the treatment of anxiety disorders, including selective serotonin reuptake inhibitors (SSRIs), serotonin-noradrenaline reuptake inhibitors (SNRIs), tricyclic antidepressants, pregabalin, benzodiazepines, buspirone, and reversible and irreversible MAO inhibitors. Some SSRIs have been demonstrated efficacy in both acute and long-term trials. Regarding their risk-benefit ratio, they are established as first-line therapies. The combination of drug treatment with cognitive behaviour therapy (CBT) is also recommended.

The chronic nature of anxiety disorders, different treatment response among different anxiety disorders and the recognition of their frequent comorbidity with depression requires an informed and evidence based choice of the best pharmacological approach to the individual patient. The presentation will present the most recent data from randomised clinical trials of newer generation agents and put them into perspective, to help the physicians to appropriately diagnose anxiety disorders and achieve the goal of bringing patients to full remission.

SAT2.02

Requires severe depression a specific treatment?

S.H. Kennedy. *University Health Network, Toronto, ON, Canada*

Depression is a disabling disorder associated with considerable comorbidity, risk of suicide and social consequences. Although antidepressants are among the most prescribed therapeutic agents, recent reviews highlight the significant percentage of depressed patients who fail to achieve a response or remission.

Although epidemiological and clinical data do not support severe depression as a separate illness category, and there is no consensus on the definition of "severe depression" regarding diagnostic scales, evidence suggest that the severity of depressive symptomatology may be associated with a worse prognosis and an increased mortality. Furthermore is there a perception that specific subpopulations of depressed patients e.g. melancholic patients or treatment resistant patients suffer of more severe forms of depression. The treatment of severely depressed patients is thus of major concern in view of the debilitating course of the disease.

Some early studies suggested that tricyclic antidepressants (TCAs) like clomipramine were more effective that selective serotonin reuptake inhibitors (SSRIs) paroxetine or citalopram in "endogenously" depressed patients. Other reviews report comparable efficacy of TCAs and SSRIs in patients with severe or melancholic depression, with SSRIs being better tolerated.

Recent data suggesting a surprisingly better differentiation of escitalopram, the active enantiomer of racemic citalopram, regarding effeicacy in more severely depressed patients (MADRS $>$ 30 or $>$ 35) versus SSRIs such as paroxetine and citalopram as well as versus the SNRI venlafaxine argue for a differentiated treatment approach, based on severity of symptoms.

SAT2.03

OCD quo vadis? The Cape Town consensus statement

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The perception of Obsessive Compulsive Disorder (OCD), once seen as a rare refractory condition, has changed significantly over the past two decades. Neuroimaging and genetic findings have advanced the understanding of the neurobiology of OCD and new treatment options have improved the outlook for patients.

A consensus group at the International Anxiety Disorders Conference in Cape Town, South Africa in February 2006, felt it was timely and appropriate to revisit OCD, to identify key developments in the field of OCD and to examine how they might be translated into clinical practice.

The group reviewed the currently available data on symptomatology, diagnosis, assessment, psychobiology and treatment of OCD in order to provide an up-to-data summary of the literature and recommendations for the treating physician. Special attention was paid to the current controversies about the relationship of OCD to OCD

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