



## EDITORIALS

- I **The National Health Service celebrates its 50th birthday**

R. E. Kendell

- 4 **British psychiatric morbidity survey**

R. Jenkins, P. Bebbington, T. S. Brugha,  
M. Farrell, G. Lewis and H. Meltzer

- 8 **Severe personality disorder – whose responsibility?**

R. Cawthra and R. Gibb

## REVIEW ARTICLE

- II **Excess mortality of mental disorder**

E. Clare Harris and B. Barraclough

## PAPERS

- 54 **Sertraline in the treatment of panic disorder. A multi-site, double-blind, placebo-controlled, fixed-dose investigation**

P. D. Lundborg, R. Wolkow, W. T. Smith,  
E. DuBoff, D. England, J. Ferguson, M. Rosenthal  
and C. Weise

- 61 **London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis. III: Follow-up and economic evaluation at 18 months**

E. Kuipers, D. Fowler, P. Garety, D. Chisholm,  
D. Freeman, G. Dunn, P. Bebbington and C. Hadley

- 69 **SPET study of verbal fluency in schizophrenia and epilepsy**

J. D. C. Mellers, N. Adachi, N. Takei, A. Cluckie,  
B. K. Toone and W. A. Lishman

- 75 **Genetic epidemiology of bingeing and vomiting**

P. F. Sullivan, C. M. Bulik and K. S. Kendler

- 80 **Predictors of a healthy workplace for Swedish and English psychiatrists**

S. Thomsen, J. Dallender, J. Soares, P. Nolan  
and B. Arnetz

## COLUMNS

- 85 **Correspondence**  
89 **One hundred years ago**  
89 **Corrigenda**  
90 **Book reviews**  
96 **Contents of *The American Journal of Psychiatry***



# 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<sup>1,2</sup>, good tolerability<sup>3</sup>, and low risk of drug interactions<sup>4,5</sup>. She just recognises the difference that Cipramil makes to the stability and quality of her life.



## Cipramil<sup>▼</sup> 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

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. Sindrin SH et al. Ther Drug Monit 1993; 15:



**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

Tony Johnson  
CAMBRIDGE

Kathleen Jones  
YORK

Martin Knapp  
LONDON

Herschel Prins  
LEICESTER

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  
Dominic Bentham

### 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 annual is £36/  
US\$64 extra

Single copies of the  
journal are £14. \$25  
(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.

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](mailto: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>.



# Instructions to authors

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to The Editor, The British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG.

All published articles are peer reviewed. A decision will be made on a paper within three months of its receipt.

Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere. Authors submitting papers to the *BJP* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications, simultaneous submissions, and papers in preparation.

The *BJP* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *BJP* does not necessarily reflect the views of the Editor or the Royal College of Psychiatrists.

Published articles become the property of the *BJP* and can be published elsewhere, in full or in part, only with the Editor's written permission.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

We regret that manuscripts and figures unsuitable for publication will not normally be returned.

## MANUSCRIPTS

Three high-quality copies should be submitted and authors should keep one copy for reference. Articles should be 3000–5000 words long, must be typed on one side of the paper only, double-spaced throughout (including tables and references) and with wide margins (at least 4 cm); all the pages, including the title page, must be numbered.

## TITLE AND AUTHORS

The title should be brief and relevant. If necessary, a subtitle may be used to amplify the main title.

All authors must sign the covering letter; one of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress.

All authors should clearly state their involvement in the work presented, and any conflict of interest arising, in the accompanying letter.

If authors wish to have their work peer reviewed anonymously, they must submit their work without personal identification; names and addresses of all authors should be given in the covering letter. Otherwise, the names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out given at the end of the paper.

## STRUCTURE OF MANUSCRIPTS

A structured summary should be given at the beginning of the article, incorporating the following headings: Background; Method; Results; Conclusions. This should be up to 150 words long. Editorials do not require summaries.

Introductions should be no more than one paragraph (up to 150 words). Use of subheadings is encouraged, particularly in Discussion sections. Three clinical implications and three limitations of the study should be provided. A separate Conclusions section is not required.

## REFERENCES

References should be listed alphabetically at the end of the paper, the titles of journals being given in full.

Reference lists not in *BJP* style will be returned to the author for correction.

Authors should check that the text references and list are in agreement as regards dates and spelling of names. The text reference should be in the form '(Smith, 1971)' or 'Smith (1971) showed that . . .'. The reference list should follow the style example below (note that *et al* is used after three authors have been listed for a work by four or more).

Alderson, M. R. (1974) Self poisoning: what is the future? *Lancet*, *i*, 104–113.

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). Washington, DC: APA.

Aylard, P. R., Gooding, J. H., McKenna, P. S., et al (1987) A validation study of three anxiety and depression self assessment scales. *Psychosomatic Research*, *1*, 261–268.

De Rougemont, D. (1950) *Passion and Society* (trans. M. Bellion). London: Faber and Faber.

Fisher, M. (1990) *Personal Love*. London: Duckworth.

Flynn, C. H. (1987) Defoe's idea of conduct: ideological fictions and fictional reality in *Ideology of Conduct* (eds N. Armstrong & L. Tenenhouse), pp. 73–95. London: Methuen.

Jones, E. (1937) Jealousy. In *Papers on Psychoanalysis*, pp. 469–485. London: Baillière, Tindall.

Mullen, P. E. (1990a) Morbid jealousy and the delusion of infidelity. In *Principles and Practice of Forensic Psychiatry* (eds R. Buglass & P. Bowden), pp. 823–834. London: Churchill Livingstone.

— (1990b) A phenomenology of jealousy. *Australian and New Zealand Journal of Psychiatry*, *24*, 17–28.

Personal communications need written authorisation; they should not be included in the reference list. No other citation of unpublished work, including unpublished conference presentations, is permissible.

## TABLES

Each table should be submitted on a separate sheet. They should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information in the text. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

## FIGURES

Figures should be individual glossy photographs, or other camera-ready prints, or good-quality output from a computer, not photocopies, clearly numbered and captioned below. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity:unit (note: 'litre' should be spelled out in full unless modified to ml, dl, etc.).

Authors must obtain permission if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

Colour figures may be reproduced if authors are able to cover the costs.

## STATISTICS

Not all papers require statistical analysis. Case histories and studies with very small numbers are examples. In larger studies where statistical analyses are included it is necessary to describe these in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post-hoc* analyses carried out. The value of test statistics used (e.g.  $\chi^2$ , *t*, *F*-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as  $\pm$ , but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry*, *156*, 472–474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

## GENERAL

All abbreviations must be spelt out on first usage.

The generic names of drugs should be used, and the source of any compounds not yet available on general prescription should be indicated.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not g ml<sup>-1</sup>.

The use of notes separate to the text should generally be avoided, whether they be footnotes or a separate section at the end of a paper. A footnote to the first page may, however, be included to give some general information concerning the paper.

If an individual patient is described, his or her consent should be obtained and submitted with the manuscript. The patient should read the report before submission. Where the patient is not able to give informed consent, it should be obtained from an authorised person. Where the patient refuses to give consent, the case study can only be written up if personal details and dates and other information which identifies the patient is omitted to ensure that there is no breach of confidentiality. Contributors should be aware of the risk of complaint by patients in respect of defamation and breach of confidentiality, and where concerned should seek advice.

## PROOFS

A proof will be sent to the corresponding author of an article. Offprints, which are prepared at the same time as the *BJP*, should be ordered when the proof is returned to the Editor. Offprints are despatched up to six weeks after publication. The form assigning copy-right to the College must be returned with the proof.

## LETTERS TO THE EDITOR

Letters should not exceed 350 words. They will be edited for clarity and conformity with *BJP* style and may be shortened. There should be no more than five references. Proofs will not be sent to authors.

## Huntercombe Manor



### ADOLESCENT UNIT

The newly refurbished, 11 bedded Adolescent Unit provides an assessment and treatment service for young people between the ages of 13–19 years who are suffering from mental health problems which may include:

- Acute psychosis
- Major depressive disorder
- Aspergers syndrome
- Organic psycho-syndromes
- Severe somatoform disorder, conversion disorder and other psychosomatic disorders
- Acute manic and hypomanic episodes
- Obsessive-compulsive disorder
- Chronic fatigue syndrome
- Severe and socially incapacitating anxiety

### INTENSIVE CARE UNIT

The Intensive Care Unit is a high quality, purpose built, locked facility for the assessment and treatment of young people between the ages of 13–19 years, detained under the Mental Health Act 1983, diagnosed as, or suspected of, suffering from severe mental illness, which may include:

- Schizophrenia
- Drug induced psychosis
- Severe depressive episode

*These services are under the direction of:*

**DR MICK VENABLES**  
BA, MRCS, LRCP, MRCPsych  
Consultant Psychiatrist

*Medical Advisor:*

**PROFESSOR PETER HILL**  
MA, MB, BChir, FRCP, MRCP, FRCPsych  
Professor of Child & Adolescent Psychiatry, St George's Hospital, London

*For further information, please contact the Admissions Manager on 01628 607419 or 667881  
Huntercombe Manor, Huntercombe Lane South, Taplow, Maidenhead, Berkshire SL6 0PQ*



ROYAL COLLEGE OF PHYSICIANS  
OF LONDON

and

ROYAL COLLEGE OF PAEDIATRICS  
AND CHILD HEALTH



## ALCOHOL AND THE YOUNG Tuesday 27 October 1998

at the Royal College of Physicians  
11 St Andrews Place, Regent's Park, London NW1

This conference will include sessions on:

- **PARENTS:** Medium and long-term effects of fetal alcohol exposure; Impact of parental alcohol consumption on children and adolescents; Family support where parental drinking is problematic.
- **ADOLESCENTS:** When is adolescent drinking problematic? Perspective from an Accident and Emergency Department; Motivational interviewing; Services for young problem drinkers; Sensible drinking for young people: whose responsibility?

*For further information, please contact:*

Conference Office, Royal College of Physicians  
Tel: 0171 935 1174 ext. 252/300/436  
Fax: 0171 487 5218



## UNITED ARAB EMIRATES UNIVERSITY FACULTY OF MEDICINE AND HEALTH SCIENCES

### Assistant/Associate Professor of Psychiatry

Applications are sought for FMHS which was established by Royal Decree in 1986 to become an international center of excellence. Applicants must possess American Board Certification or be recognised by membership/fellowship of a Royal College of Psychiatry (Canada, United Kingdom, Ireland, Australia or New Zealand) or Board qualified psychiatrists from Nordic countries. There should be clear evidence of well supervised specialty training with increasing responsibilities and subsequent experience in the organization, development, and conduct of quality educational, research, and clinical care programs. Familiarity with the USMLE and programmatic psychiatric residencies is a distinct advantage. The language of instruction is English but the ability to speak Arabic is highly desirable.

Appointees receive a competitive tax-free salary, accommodation, annual air tickets, an award at the end of each year of service, and generous support for furniture and children's tuition fees. With all the amenities of any modern society, the Emirates has one of the most enviable lifestyles in all of the Middle East.

Further information may be obtained from the web site at <http://www.uaeu.ac.ae> or Dr Omer El-Rufaie, Acting Department Chair, +971 3 672000 (phone) or +971 3 672995 (fax). Applications including full curriculum vitae and publication list, name/tax/phone/address of five referees and accompanying letter outlining depth of interest, experience, and suitability for the post can be sent to:

Dr Omer El-Rufaie (C/o. Mr. CP Nair)  
Personnel Department  
Faculty of Medicine and Health Sciences  
UAE University  
P O Box 17666  
Al Ain, United Arab Emirates

Applications will be closed twelve weeks after the date of publication.

# LISTER

# O

*Psychiatrists  
Urgently Required*

*All Grades*

# C

*Immediate Bookings*

*Excellent Rates- (negotiable)*

*Prompt Weekly Payments*

# U

*"The friendly,  
personal  
approach to  
business"*

Please call  
Andy on:

Freephone

0800 298 1780

or fax CV

details to:

01253 730398

# M

# LTD



The Royal College of Psychiatrists'  
*Journal of Continuing Professional  
Development*

## Advances in Psychiatric Treatment

Editor: Andrew Sims, *Professor of Psychiatry,  
St James's University Hospital, Leeds*

Subscription rate for **Volume 4, 1998 (6 issues):**

Europe, including UK £73.00

USA US\$120.00 Elsewhere £73.00

Full airmail £6/\$10 extra

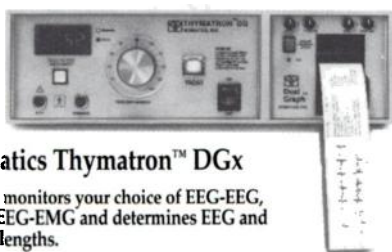
APT with CPD registration £85.00

*To enter your subscription or to obtain a sample copy of  
APT, contact: Publications Subscription Department,  
Royal Society of Medicine Press Limited, PO Box  
9002, London W1M 0ZA, UK. Tel: +44(0)171 290  
2927/8; Fax: +44(0)171 290 2929*

**Please note:** *College members wishing to receive APT and  
register for CPD should contact the Registration  
Department, Tel: +44(0)171 235 2351*



## 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

# 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.

INSTITUTE OF  
PSYCHIATRY

UNIVERSITY OF LONDON

## Skills Training Course and Diploma Course in Cognitive Behaviour Therapy

### Skills Training Course

There will be a skills training course in Cognitive Behaviour Therapy at the Institute of Psychiatry between January and November 1999. The course starts with a two day workshop and meets thereafter on Friday mornings 9.30am - 1.00pm over three academic terms, (January-March, April-June and September-November).

Participants will be expected to treat patients at their work place and attend the Institute for group supervision and a series of classes on the practical aspects of therapy.

### Diploma Course

In addition, there will be a Diploma course for those interested in reaching a higher level of competency. This will run on Friday afternoons in addition to the skills course (Friday mornings) and will consist of individual supervision and academic seminars. The Diploma will be examined by written assignments and the rating of therapy tapes.

Psychiatrists and post qualification psychologists may be particularly interested. Applications from other mental health professions are welcomed (please note that numbers will be limited).

**For further details and application form apply to: Mrs Geraldine Davies, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London SE5 8AF. Tel: 0171 919 3242.**

**The closing date for applications is Friday 14th August 1998.**

An Institute of King's College London



## CONSULTANTS



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

## 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

## NORDIC JOURNAL OF PSYCHIATRY

### NORDISK PSYKIATRISK TIDSSKRIFT

Nordic Journal of Psychiatry is published for the Nordic Psychiatric Associations in Denmark, Finland, Iceland, Norway and Sweden. The six issues per year are predominantly in English with some articles in a Scandinavian language with the abstract in English. Nordic Journal of Psychiatry is a main source for information about current Nordic psychiatry and related fields, addressing itself to researchers, clinical psychiatrists and their co-workers.



#### Editor-in-Chief:

Lars von Knorring,  
Professor,  
Dept of Psychiatry,  
University Hospital,  
S-751 85 Uppsala, Sweden.

Please enter my subscription to  
*Nordic Journal of Psychiatry*, starting with  
Vol. 52, No. 1, 1998. Six issues per year/volume.  
Postage included. Supplements are distributed  
free to subscribers. ISSN: 0803-9488.

- Institutions: US\$ 125 (In Scandinavia, NOK 620)  
 Individuals: US\$ 85 (In Scandinavia, NOK 375)  
 Please send a free sample copy  
 Please send invoice  Cheque enclosed  
Please charge my:  Visa  AmEx  Eurocard/Mastercard  
 Diners Club

Card No.

Exp. date:

8/223/ v w

Name (USE BLOCK LETTERS): \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Send to: Scandinavian University Press, Journals Customer Service, PO Box 2959 Tøyen,  
N-0608 Oslo, Norway. Fax: +47 22 57 53 3; E-mail: subscription@scup.no  
In U.S.: Scandinavian University Press North America, 875 Massachusetts Ave., Ste 84,  
Cambridge, MA 02139. Fax: (617) 354 6875





THE CHINESE UNIVERSITY OF HONG KONG  
Faculty of Medicine



The University (founded in 1963) offers comprehensive programmes up to PhD level, with student enrolment in 1997-98 standing over 12,000. The Faculty of Medicine offers undergraduate and postgraduate programmes in Medicine, Nursing and Pharmacy. The MBChB programme admits 160 students annually. Clinical courses are taught at the Faculty's 1,450-bed teaching hospital, the Prince of Wales Hospital (which is one of the regional hospitals in Hong Kong) and the Lek Yuen Health Centre.

Applications are invited for the following post:

**DEPARTMENT OF PSYCHIATRY**

**LECTURER** (carrying the academic title of Assistant Professor or Associate Professor, as appropriate)

(Ref: 98/046(173)/2) (closing date: 31 July 1998)

Applicants should have a medical qualification (preferably approved for full registration with the Hong Kong Medical Council), and be able to conduct clinical work in Cantonese. Possession of a higher medical qualification in the specialty will be an advantage. In addition to teaching duties, the appointee is expected to conduct research and is required to provide clinical service at the Prince of Wales Hospital. Appointment will initially be made on a three-year contract, renewable subject to mutual agreement. The appointee is expected to assume duty in January 1999 or as soon as possible thereafter.

**Annual Salary and Fringe Benefits**

Lecturer (Clinical): HK\$503,580 to 997,260 by 10 increments

(approx. exchange rate in May 1998: £1=HK\$12.92; US\$1=HK\$7.8)

Starting salary will be commensurate with qualifications and experience.

In addition to basic salary, the appointee will be entitled to a monthly cash allowance and other benefits including leave with full pay, medical and dental care, and where applicable a contract-end gratuity (up to 15% of basic salary).

Further information about the University and the general terms of service for teaching appointees is available on our World Wide Web homepage <<http://www.cuhk.edu.hk>>.

**Application Procedure**

Please send full resumé, copies of academic credentials, a publication list and/or abstracts of selected published papers, together with names and addresses (fax numbers/e-mail addresses as well, if available) of three referees to the **Personnel Office, The Chinese University of Hong Kong, Shatin, N.T., Hong Kong (Fax: (852)2603 6852)** on or before 31 July 1998. Please quote the reference number and mark "Application" on cover. [Note: The University reserves the right not to fill the post or to fill the post by invitation.]

		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](mailto:hannah@direct.medical.com)  
Call Julie (North): Tel. 01612 902020; Fax. 01612 903030; Email: [dms.north@virgin.net](mailto:dms.north@virgin.net)

# Life beyond Alzheimer's.



For people with mild to moderately severe Alzheimer's disease, new Exelon can not only delay the decline of cognition by 6 months or more,<sup>1,3</sup> but can also maintain their ability to carry out day-to-day activities that we take for granted.<sup>1-3</sup>

For carers and family, new Exelon could mean some relief from the demands for attention; for the sufferer, it could mean life beyond Alzheimer's.

NEW  
**EXELON**<sup>®</sup>  
(rivastigmine)

## Beyond cognition: prolonging functional ability.

**EXELON Prescribing Information.** **Indication:** Treatment of mild to moderately severe Alzheimer's dementia. **Presentation:** Capsules containing 1.5, 3, 4.5 or 6mg rivastigmine. **Dosage and Administration:** Effective dose is 3 to 6mg twice a day. Maintain patients on their highest well-tolerated dose. Maximum dose 6mg twice daily. Reassess patients regularly. Initial dose 1.5mg twice daily, then build up dose, at a minimum of two week intervals, to 3mg twice daily, 4.5mg twice daily then 6mg twice daily, if tolerated well. If adverse effects or weight decrease occur, these may respond to omitting one or more doses. If persistent, daily dose should be temporarily reduced to previous well tolerated dose. **Contraindications:** Known hypersensitivity to rivastigmine or excipients or any other carbamate derivatives; severe liver impairment. **Special Warning & Precautions:** Therapy should be initiated and supervised by a physician experienced in the diagnosis and treatment of Alzheimer's disease. A caregiver should be available to monitor compliance. There is no experience of use of EXELON in other types of dementia/memory impairment. Nausea and vomiting may occur, particularly when initiating and/or increasing dose. Monitor any weight loss. Use with care in patients with Sick Sinus Syndrome, conduction defects, active gastric or duodenal ulcers, or those predisposed to ulcerative conditions, history of asthma or obstructive pulmonary disease, those predisposed to urinary obstruction and seizures, in renal and mild to moderate hepatic impairment. Titrate dose individually. Safety in pregnancy not established; women should not breastfeed. Use in children not recommended. **Interactions:** May exaggerate effects of succinylcholine-type muscle relaxants during anaesthesia. Do not give with cholinergic drugs. May interfere with anticholinergic medications. No interactions were observed with digoxin, warfarin, clazepam, or fluoxetine (in healthy volunteers). Metabolic drug interactions unlikely, although it may inhibit butyrylcholinesterase mediated metabolism of other drugs. **Undesirable Effects:** Most commonly (≥5% and twice frequency of placebo): asthenia, anorexia, dizziness, nausea, somnolence,

vomiting. Female patients more susceptible to nausea, vomiting, appetite and weight loss. Other common effects (≥5% and ≥ placebo): abdominal pain, accidental trauma, agitation, confusion, depression, diarrhoea, dyspepsia, headache, insomnia, upper respiratory tract and urinary tract infections. Increased sweating, malaise, weight loss, tremor. Rarely, angina pectoris, gastrointestinal haemorrhage and syncope. No notable abnormalities in laboratory values observed. **Package Quantities and basic NHS Price:** 1.5mg x 28, £31.50; 1.5mg x 56, £63.00; 3mg x 28, £31.50; 3mg x 56, £63.00; 4.5mg x 28, £31.50; 4.5mg x 56, £63.00; 6mg x 28, £31.50; 6mg x 56, £63.00. **Legal Classification:** POM. **Marketing Authorisation Number:** 1.5mg, EU/1/98/066/001 - 2; 3mg, EU/1/98/066/004 - 5; 4.5mg, EU/1/98/066/007 - 8; 6mg, EU/1/98/066/010 - 11. Full prescribing information including Summary of Product Characteristics is available from: Novartis Pharmaceuticals UK Ltd, Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.

References: 1. Integrated Summary of Effectiveness 15/4/97 (B352). Data on file. 2. Integrated Summary of Effectiveness 15/4/97 (B303). Data on file. 3. Integrated Summary of Effectiveness 15/4/97 (pooled analysis). Data on file.

**Date of preparation:** May 1998.  
**Code No. EXE 98/23**

 NOVARTIS



- 18.00 PM Refreshments
- 18.15 PM **Welcome & Introduction**  
*Alistair Burns, MD, Chairman*  
*Manchester*  
*United Kingdom*
- 18.20 **Pediatric OCD:**  
*Characteristics and Treatment*  
*John March, MD*  
*Durham, North Carolina*  
*USA*
- 18.40 **The Prevalence and Treatment**  
**of Comorbid MDD and OCD**  
*Rudolf Hoehn-Saric, MD*  
*Baltimore, Maryland*  
*USA*
- 19.00 **Epidemiologic Perspectives:**  
*Comorbidity of Panic Disorder*  
*and Depression*  
*Borwin Bandelow, MD, PhD*  
*Göttingen*  
*Germany*
- 19.20 **Effective and Comprehensive**  
**Management of Patients**  
**with Panic Disorder**  
*Christer Allgulander, MD*  
*Huddinge*  
*Sweden*
- 19.40 **Late Life Depression:**  
*Improving Cognition, Anxiety,*  
*Energy, and Sleep*  
*Bernard Groulx, MD*  
*Ste-Anne de Bellevue, Quebec*  
*Canada*
- 20.00 **Question & Answer Session**  
*Faculty Panel*
- 20.15 **Reception**
- 20.45 **Adjournment**



*Depression, Panic, and OCD:*  
**Improving Patient Management** *Through the*  
*Life Cycle*

Argyll Suite  
 Moat House Hotel

Glasgow  
 Scotland

*XXIst Congress of the*  
*Collegium Internationale*  
*Neuro-Psychopharmacologicum*

To register for this program, please  
 call Pharmedica Communications, Inc.,  
 at 1-800-835-7633 USA  
 or E-mail [cinp@pharmedica.com](mailto:cinp@pharmedica.com)



*This program is made possible through*  
*an educational grant from Pfizer*  
*Pharmaceuticals Group.*



# Another seizure

Wasn't late for milking

Wasn't embarrassed at market

## A first choice add-on therapy

### Topamax Abbreviated Prescribing Information.

#### Please read Summary of Product Characteristics before prescribing.

**Presentation:** Tablets containing 25 mg, 50 mg, 100 mg, or 200 mg topiramate. **Uses:** Adjunctive therapy of inadequately controlled seizures: partial seizures; seizures associated with Lennox Gastaut Syndrome and primary generalised tonic/clonic seizures. **Dosage and Administration:** Oral administration. *Over 16 years of age:* Usual dose: 200-400 mg/day in two divided doses. Initiate at 50 mg daily then titrate to an effective dose. A lower dose may be used. Patients with significant renal disease may require a dose modification. See SmPC for additional information.

*Children age 2 to 16:* Usual dose: Approximately 5 to 9 mg/kg/day in two divided doses. Initiate at 25 mg nightly, and increase at 1 to 2 week intervals in 1 to 3 mg/kg increments, to an effective dose.

Drowsiness likely. Topamax may be sedating; therefore caution if driving or operating machinery. Do not use in pregnancy unless potential benefit outweighs risk. Woman of childbearing potential should use adequate contraception. Do not use if breastfeeding. **Interactions:** *Other Antiepileptic Drugs:* No clinically significant effect except in some patients on phenytoin where phenytoin plasma concentrations may increase. Phenytoin level monitoring is advised. *Effects of other antiepileptic drugs:* Phenytoin and carbamazepine decrease topiramate plasma concentration. *Digoxin:* A decrease in serum digoxin occurs. Monitor serum digoxin on addition or withdrawal of TOPAMAX®. *Oral Contraceptives:* Should contain not less than 50µg of oestrogen. Ask patients to report any change in bleeding patterns. *Others:* Avoid agents predisposing to nephrolithiasis. **Side Effects:** *Adults:* In 5% or more: abdominal pain, ataxia, anorexia, asthenia, confusion, difficulty with



# ure-free day

Didn't lose any sheep

Didn't have a seizure



**TOPAMAX**<sup>®</sup>  
topiramate

**At the end of the day, it works.**


a p y f o r m o s t s e i z u r e t y p e s

speech problems, abnormal vision and weight decrease. May cause agitation and emotional lability (mood problems and nervousness) and depression. Less common adverse effects include, gait abnormal, aggressive reaction, apathy, cognitive problems, coordination problems, leucopenia, psychotic symptoms (such as hallucinations), and taste perversion. Venous thromboembolic events reported - causal association not established. *Children:* In 5% or more: somnolence, anorexia, fatigue, insomnia, nervousness, personality disorder (behaviour problems), difficulty with concentration/attention, aggressive reaction, weight decrease, gait abnormal, mood problems, ataxia, saliva increased, nausea, difficulty with memory, hyperkinesia, dizziness, speech disorders/related speech problems and paraesthesia. Less frequently, but potentially relevant: emotional lability, agitation, apathy, cognitive problems, psychomotor slowing, confusion, hallucination, depression and leucopenia. Topiramate increases the risk of nephrolithiasis.

Supportive treatment as appropriate. Haemodialysis is effective in removing topiramate. **Pharmaceutical Precautions:** Store in a dry place at or below 25°C. **Legal Category:** POM. **Package Quantities and Prices:** Bottles of 60 tablets. 25 mg (PL0242/0301) = £22.02, 50 mg (PL0242/0302) = £36.17; 100 mg (PL0242/0303) = £64.80; 200 mg (PL0242/0304) = £125.83. **Product licence holder:** JANSSEN-CILAG LIMITED, SAUNDERTON, HIGH WYCOMBE, BUCKINGHAMSHIRE HP14 4HJ ENGLAND. APIVER200498. Further information is available on request from the Marketing Authorisation Holder: Janssen-Cilag Limited, Saunderton, High Wycombe, Buckinghamshire HP14 4HJ. © Registered Trademark © Janssen-Cilag Limited 1998

Date of Preparation April 1998





For the  
mind in  
turmoil

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 16 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.





**p e a c e**  
at last

- ▶ Power to relieve positive *and* negative symptoms in schizophrenia
- ▶ Placebo levels of EPS at usual effective doses<sup>1</sup>
- ▶ Over 18 million patient months experience worldwide<sup>2</sup>



**ONCE DAILY**  
**Risperdal**<sup>TM</sup>  
**RISPERIDONE**

**POWER you can trust**



**ZISPIN Prescribing Information**  
**Presentation:** Blister strips of 28 tablets each containing 30 mg of mirtazapine.  
**Uses:** Treatment of depressive illness.  
**Dosage and administration:** The tablets should be taken orally, if necessary with fluid, and swallowed without chewing.  
**Adults and elderly:** The effective daily dose is usually between 15 and 45 mg.  
**Children:** Not recommended. The clearance of mirtazapine may be decreased in patients with renal or hepatic insufficiency. Zispin is suitable for once-a-day administration, preferably as a single night-time dose. Treatment should be continued until the patient has been completely symptom-free for 4–6 months.  
**Contraindications:** Hypersensitivity to mirtazapine or any ingredients of Zispin.  
**Precautions and warnings:** Reversible white blood cell disorders including agranulocytosis, leukopenia and granulocytopenia have been reported with Zispin. The physician should be alert to symptoms such as fever, sore throat, stomatitis or other signs of infection; if these occur, treatment should be stopped and blood counts taken. Patients should also be advised of the importance of these symptoms. Careful dosing as well as regular and close monitoring is necessary in patients with: epilepsy and organic brain syndrome; hepatic or renal insufficiency; cardiac diseases; low blood pressure. As with other antidepressants care should be taken in patients with: micturition disturbances like prostate hypertrophy, acute narrow-angle glaucoma and increased intra-ocular pressure and diabetes mellitus. Treatment should be discontinued if jaundice occurs. Moreover, as with other antidepressants, the following should be taken into account: worsening of psychotic symptoms can occur when antidepressants are administered to patients with schizophrenia or other psychotic disturbances; when the depressive phase of manic-depressive psychosis is being treated, it can transform into the manic phase. Zispin has sedative properties and may impair concentration and alertness.  
**Interactions:** Mirtazapine may potentiate the central nervous dampening action of alcohol; patients should therefore be advised to avoid alcohol during treatment with Zispin; Zispin should not be administered concomitantly with MAO inhibitors or within two weeks of cessation of therapy with these agents; Mirtazapine may potentiate the sedative effects of benzodiazepines; In vitro data suggest that clinically significant interactions are unlikely with mirtazapine. **Pregnancy and lactation:** The safety of Zispin in human pregnancy has not been established. Use during pregnancy is not recommended. Women of child bearing potential should employ an adequate method of contraception. Use in nursing mothers is not recommended. **Adverse reactions:** The following adverse effects have been reported: **Common (>1/100):** Increase in appetite and weight gain. Drowsiness/sedation, generally occurring during the first few weeks of treatment. (NB, dose reduction generally does not lead to less sedation but can jeopardize antidepressant efficacy). **Less common:** Increases in liver enzyme levels. **Rare (<1/1000):** Oedema and accompanying weight gain. Reversible agranulocytosis has been reported as a rare occurrence. (Orthostatic) hypotension. Exanthema. Mania, convulsions, tremor, myoclonus. **Overdosage:** Toxicity studies in animals suggest that clinically relevant cardiotoxic effects will not occur after overdosing with Zispin. Experience in clinical trials and from the market has shown that no serious adverse effects have been associated with Zispin in overdose. Symptoms of acute overdosage are confined to prolonged sedation. Cases of overdose should be treated by gastric lavage with appropriate symptomatic and supportive therapy for vital functions. **Marketing authorization number:** PL 0065/0145 **Legal category:** POM **Basic NHS cost:** £24 for 28 tablets of 30 mg.



For further information, please contact:  
Organon Laboratories Limited,  
Cambridge Science Park, Milton Road,  
Cambridge CB4 4FL  
Telephone: 01223 423445.  
Fax: 01223 424368.  
Zispin is a registered trade mark.  
Date of Preparation: April 1998

MIRTAZAPINE  
**ZISPIN**<sup>®</sup> 30 mg  
The NaSSA

**Strong  
yet  
gentle  
in  
depression**







# "Now I can stay awake until bedtime"

**FOR MOST PATIENTS, SCHIZOPHRENIA IS A LIFELONG DISEASE REQUIRING LIFELONG MEDICATION. SEDATION IS THE MOST COMMON SINGLE SIDE-EFFECT OF ANTIPSYCHOTIC MEDICATIONS<sup>1</sup> AND ITS POTENTIAL IMPACT ON COMPLIANCE AND QUALITY OF DAILY LIFE IS THEREFORE AN IMPORTANT ISSUE TO CONSIDER.**

## **TRIALS WITH SERDOLECT HAVE DEMONSTRATED PLACEBO-LEVEL SEDATION<sup>2</sup>**

By separating efficacy from sedation, Serolect gives physicians greater flexibility in patient management - in acute psychotic disturbance, Serolect may be safely combined with a benzodiazepine<sup>2</sup>.

## **SERDOLECT ADDITIONALLY OFFERS**

- Efficacy against positive and negative symptoms of schizophrenia<sup>3,4</sup>
- EPS at placebo level<sup>1</sup>
- Prolactin levels maintained within normal limits<sup>2</sup>
- Once-daily dosage

## **REFERENCES**

1. American Psychiatric Association. Practice Guidelines for the treatment of patients with schizophrenia. Supplement to Am. J. Psychiatry 1997; 154(4)
2. Data on file, H. Lundbeck A/S
3. Zimbroff DL et al. Am. J. Psychiatry 1997;154:782-791
4. Hale A. et al. Poster presented at CINP meeting, June 1996, Melbourne



**Serolect**<sup>®</sup>

sertindole

*Success is a long-term achievement*

## **SERDOLECT: ABBREVIATED PRESCRIBING INFORMATION**

**Presentation:** Tablets of 4mg, 12mg, 16mg or 20mg sertindole. **Indications:** Treatment of schizophrenia. Not for urgent relief of symptoms in acutely disturbed patients. **Dosage and administration:** Tablets should be taken orally once daily without regard for food. Adults: All patients should be started on 4mg/day. The dose should be increased by 4mg increments after 4-5 days on each dose to the optimum daily maintenance dose range of 12-20mg. The dose may be increased to a maximum of 24mg. Re-titration is necessary if dosing is suspended for more than one week. Children: Not recommended. Mild to moderate hepatic impairment: Lower titration and lower maintenance dose. Elderly: Slower titration and lower maintenance doses may be required. **Contraindications:** Known prolongation of QT interval or combined use of drugs known to prolong QT interval. Clinically significant cardiac disease or uncorrected hypokalaemia. Combined use of drugs that may induce hypokalaemia. Diuretic therapy may Published online by Cambridge University Press. Combined use of agents known to inhibit hepatic isoenzymes may necessitate lower maintenance doses. Combined use of agents

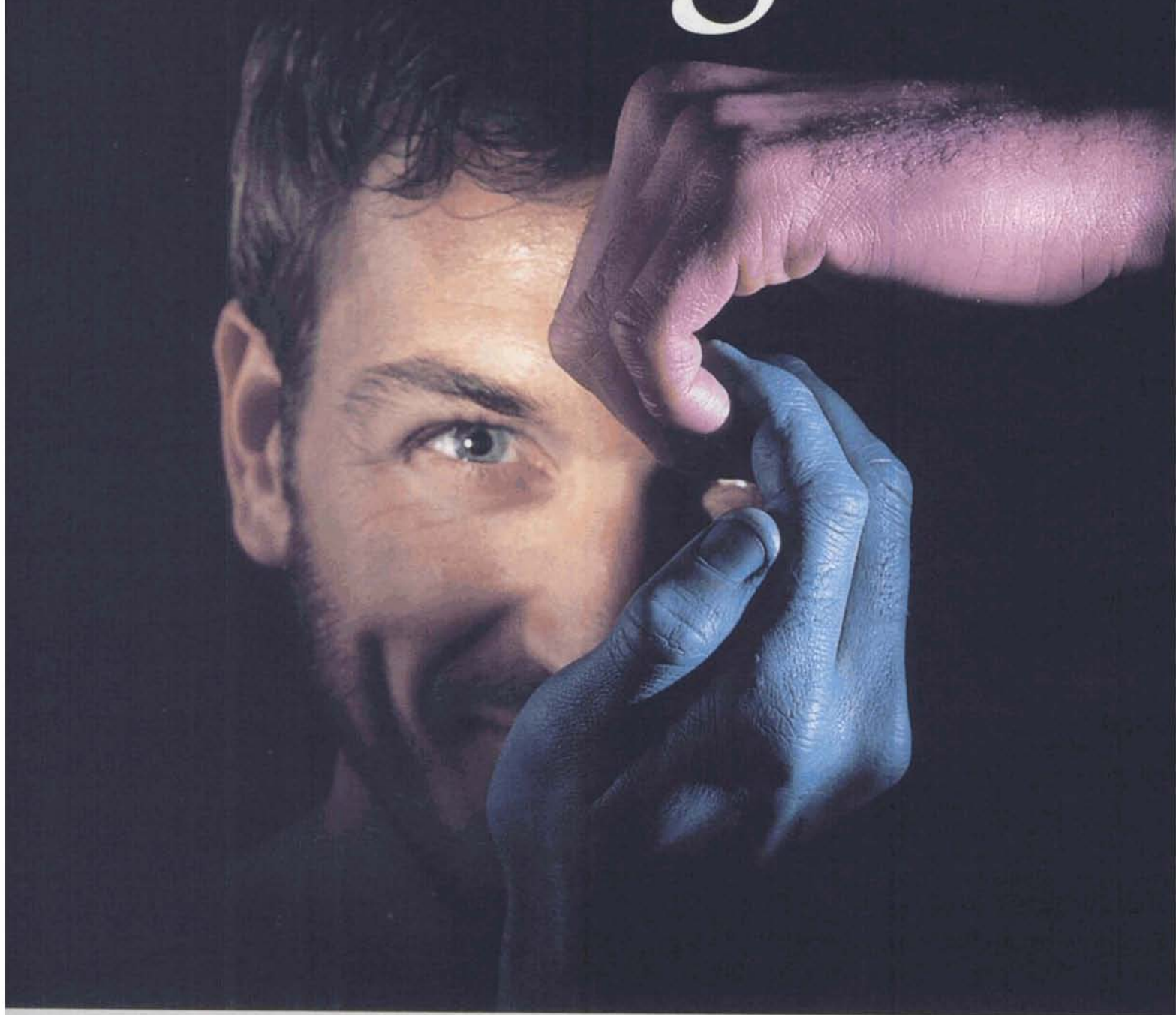
Serolect is not sedative, however, patients should be advised not to drive or operate machinery until their individual susceptibility is known. History of diabetes, seizures, Parkinson's disease. Symptoms of orthostatic hypotension may occur and blood pressure should be monitored during initial dose titration and in early maintenance phase. In common with other antipsychotic drugs, Serolect lengthens the QT interval in some patients (<1.7% of patients). Electrolyte imbalance or combined use of other drugs that inhibit Serolect metabolism can increase the risk of occurrence of prolonged QT interval. An ECG should be performed prior to use with periodic ECG monitoring during treatment. Serolect should not be initiated or should be discontinued if the QTc<sub>2</sub> interval exceeds 520 msec. Hypokalaemia and hypomagnesaemia should be corrected and maintained within normal limits during treatment. If signs and symptoms of tardive dyskinesia appear, consider dose reduction or discontinuation. **Drug interactions:** Combined use of agents known to inhibit hepatic isoenzymes may necessitate lower maintenance doses. Combined use of agents

prolonged QT interval. Incidence of EPS adverse events similar to placebo. **Overdosage:** Symptoms have included somnolence, slurred speech, tachycardia, hypotension and transient prolongation of QT interval. There is no specific antidote. Treatment is supportive and symptomatic. Epinephrine and dopamine should not be used (may exacerbate hypotension). Cardiovascular monitoring recommended. Administration of activated charcoal and laxative should be considered. **Package quantities and basic NHS price:** 4mg tablets, £36.63 for 30 tablet pack, 12mg tablets, £102.55 for 28 tablet calendar pack, 16mg tablets, £102.55 for 28 tablet calendar pack, 20mg tablets, £102.55 for 28 tablet calendar pack. Legal category: POM. **Product Licence numbers:** 4mg: 13761/0001, 12mg: 13761/0003, 16mg: 13761/0004, 20mg: 13761/0005. **Date of last review:** April 1997. Further information is available on request from Lundbeck Limited, Sunningdale House, Caldecotte Lake Business

Lundbeck



# Change to



## 'SEROQUEL' (quetiapine)

### Prescribing Notes.

Consult Summary of Product Characteristics before prescribing. Special reporting to the CSM required.

**Use:** Treatment of schizophrenia.

**Presentation:** Tablets containing 25 mg, 100 mg and 200 mg of quetiapine.

**Dosage and Administration:** 'Seroquel' should be administered twice daily. Adults: The total daily dose for the

Elderly patients: Use with caution, starting with 25 mg/day and increasing daily by 25 to 50 mg to an effective dose. Children and adolescents: Safety and efficacy not evaluated. Renal and hepatic impairment: Start with 25 mg/day increasing daily by 25 to 50 mg to an effective dose. Use with caution in patients with hepatic impairment.

**Contra-indications:** Hypersensitivity to any component of the product.

**Precautions:** Caution in patients with cardiovascular disease, cerebrovascular disease or other conditions predisposing to hypotension and patients with a history of seizures. Caution with drugs known to prolong the QTc interval, especially in the elderly. Caution in combination

systemic ketoconazole or erythromycin. If signs and symptoms of tardive dyskinesia appear, consider dosage reduction or discontinuation of 'Seroquel'. In cases of neuroleptic malignant syndrome, discontinue 'Seroquel' and give appropriate medical treatment. 'Seroquel' should only be used during pregnancy if benefits justify the potential risks. Avoid breastfeeding whilst taking 'Seroquel'. Patients should be cautioned about operating hazardous machines, including motor vehicles.

**Undesirable events:** Somnolence, dizziness, constipation, postural hypotension, dry mouth, asthenia, rhinitis, dyspepsia, limited weight gain, orthostatic hypotension (associated with dizziness), tachycardia and in some patients syncope. Occasional seizures and rarely possible neuroleptic malignant



NEW

# Seroquel

quetiapine

- Effective in positive and negative symptoms<sup>1-4</sup> and improving mood<sup>\*5</sup> in patients with schizophrenia
- Incidence of EPS no different from placebo across the full dose range<sup>1-4</sup>
- Rate of withdrawals due to adverse events no different from placebo<sup>6</sup>
- No requirement for routine blood, BP or ECG monitoring<sup>7</sup>



*Changing thinking in schizophrenia.*

\* Defined as the BPRS item scores of depressive mood, anxiety, guilt feelings and tension

Small elevations in non-fasting serum triglyceride levels and total cholesterol. Decreases in thyroid hormone levels, particularly total T4 and free T4 usually reversible on cessation. Prolongation of the QTc interval (in clinical trials this was not associated with a persistent increase).

**Legal category:** POM  
**Product licence numbers:**  
25 mg tablet: 12619/0112  
100 mg tablet: 12619/0113  
200 mg tablet: 12619/0114

Further information is available from:  
ZENECA Pharma on 0800 200 123 please ask for Medical Information, or write to King's Court, Water Lane, Wilmslow, Cheshire SK9 5AZ.

**References**

1. Fabre LF, Arvanitis L, Pultz J *et al.* Clin Ther 1995; **17** (No.3): 366-378.
2. Arvanitis LA *et al.* Biol Psychiatry 1997; **42**: 233-246.
3. Small JG, Hirsch SR, Arvanitis LA *et al.* Arch Gen Psychiatry 1997; **54**: 549-557.
4. Borison RL, Arvanitis LA, Miller MS *et al.* J Clin Psychopharmacol 1996; **16** (2):158-169.
5. Data on File, Zeneca Pharmaceuticals.
6. Data on File, Zeneca Pharmaceuticals.
7. 'Seroquel' Summary of Product Characteristics.

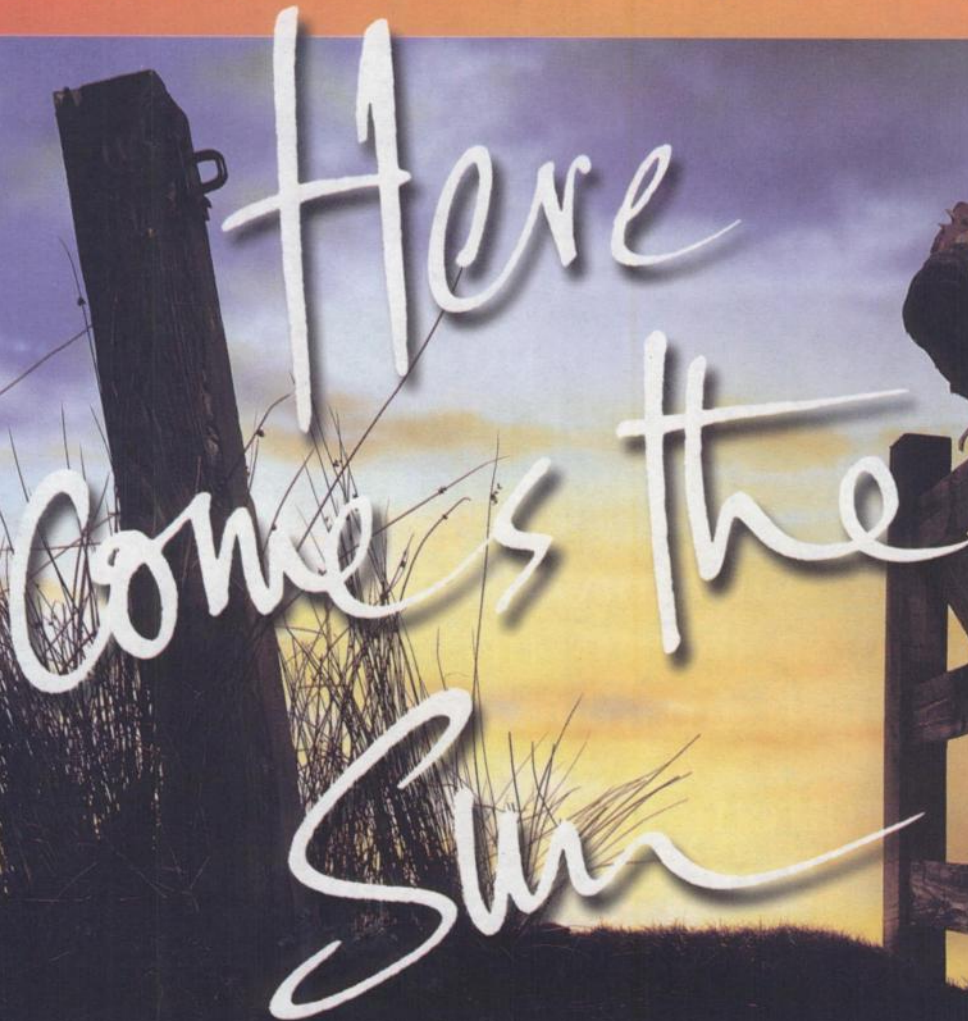




**Efexor<sup>®</sup> XL venlafaxine - Prescribing information Presentation:** Capsules containing 75mg or 150mg venlafaxine (as hydrochloride) in an extended release formulation. **Use:** Treatment of depressive illness. **Dosage: Adults (including the elderly):** Usually 75mg, given once daily with 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:** Contraindicated 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.



Here  
comes the  
Sun

◆ EFEXOR XL ACTS DIRECTLY ON BOTH SEROTONIN AND NORADRENALINE<sup>1,2</sup>

◆ PROVEN EFFICACY VS LEADING SSRIs<sup>3,4</sup>

◆ TOLERABILITY<sup>3,4,5</sup> AND CONVENIENCE YOU EXPECT FROM A FIRST-LINE THERAPY

NEW ONCE DAILY

**EFEXOR XL<sup>®</sup>**  
VENLAFAXINE 75 mg o.d.

Simply effective



**DUTONIN™** Abbreviated Prescribing Information  
**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

initial treatment phase. Modest decrease in some psychomotor 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<sub>450</sub>III<sub>4A</sub>; 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

PL 11184/0029, **PRODUCT LICENCE HOLDER:** Bristol-Myers 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.<sup>1,4</sup>

Dutonin is an excellent choice. Not only does Dutonin effectively relieve depression,<sup>5</sup> it also normalises sleep patterns.<sup>3,4,6</sup>

Moreover, Dutonin lifts anxiety symptoms within the first week of treatment.<sup>5</sup>

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



**DUTONIN™**

*Makes the difference in depression*





1 9 9 8  
THE LILLY  
SCHIZOPHRENIA  
REINTEGRATION  
AWARDS

**For further information  
please contact:**

Awards Secretariat,  
Schizophrenia Reintegration Awards,  
Third Floor,  
Communications Building,  
48 Leicester Square,  
London, WC2H 7LJ, UK  
Telephone: +44 171 331 5300  
Facsimile: +44 171 331 9083

**The Lilly Schizophrenia Reintegration Awards are designed to recognize and reward outstanding achievement by care givers in helping patients with schizophrenia reintegrate back into society.**

Schizophrenia is a frightening disease; it instils fear and dread in the minds of most people. The disease is equally frightening for the sufferers – it can affect anyone, particularly younger people. With the development of newer treatment options the symptoms of schizophrenia can be controlled, offering the chance for people who suffer to live more normal lives again.

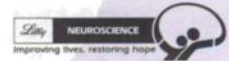
The Awards Scheme is conducted in three regions: Eastern Mediterranean, Latin America and Europe. Entries are invited in the following categories:

- Professional/Public  
*(including clinical medicine, nursing, social work and community action)*
- Journalism  
*(including print and broadcast)*

Award winners will receive a certificate of excellence, a commemorative trophy and an educational grant to include travel, hotel and congress registration expenses for one person to attend the relevant WPA regional meeting to accept their award. Winners of the Clinical Medicine and Community Action category will also be awarded a donation to a charity or not-for-profit institution of the winner's choice.

The winners selected from each category in each region will be invited to one of this year's WPA meetings.

- Eastern Mediterranean – Kaslik, Lebanon  
*(14th - 17th April 1998)*
- Europe – Geneva, Switzerland  
*(7th - 10th October 1998)*
- Latin America – Guadalajara, Mexico  
*(28th - 30th October 1998)*



## New Council Reports

**CR62** *'Not Just Bricks and Mortar': Report of the Working Group on the size, staffing, structure, siting and security of new acute adult psychiatric in-patient units, £7.50, April 1998*

To inform the planning of new acute in-patient units for adult mental health

**CR63** *Gender Identity Disorders in Children and Adolescents: Guidance for Management, £5.00, April 1998*

Offers guidance in the management and therapeutic interventions with children and adolescents and their families.

**CR64** *Managing Deliberate Self-Harm in Young People, £5.00, April 1998*

Provides guidance on managing young people up to the age of 16 (including young people with learning disabilities) who deliberately harm themselves.

**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](http://www.rcpsych.ac.uk)**



**CAMPRAL EC PRESCRIBING INFORMATION**

**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  $\geq$  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

does not constitute treatment during the withdrawal period. **Interactions:** None observed in studies with diazepam, disulfiram or imipramine. The 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, Liphos 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.

**PRIX GALIEN AWARD  
FOR INNOVATIVE  
PHARMACEUTICAL  
PRODUCTS**

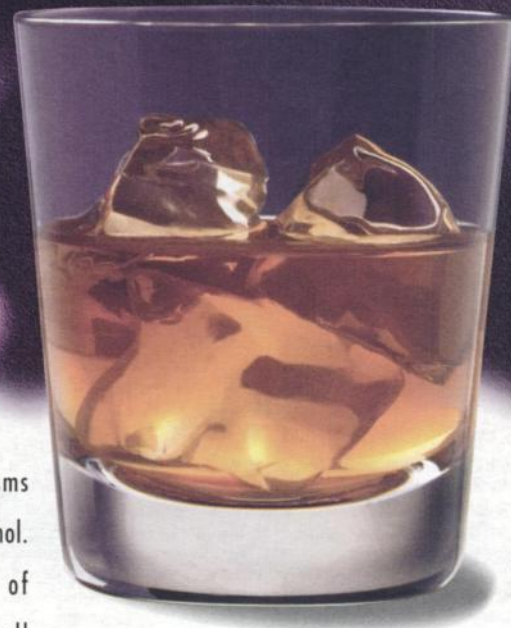


Commended 1998

**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

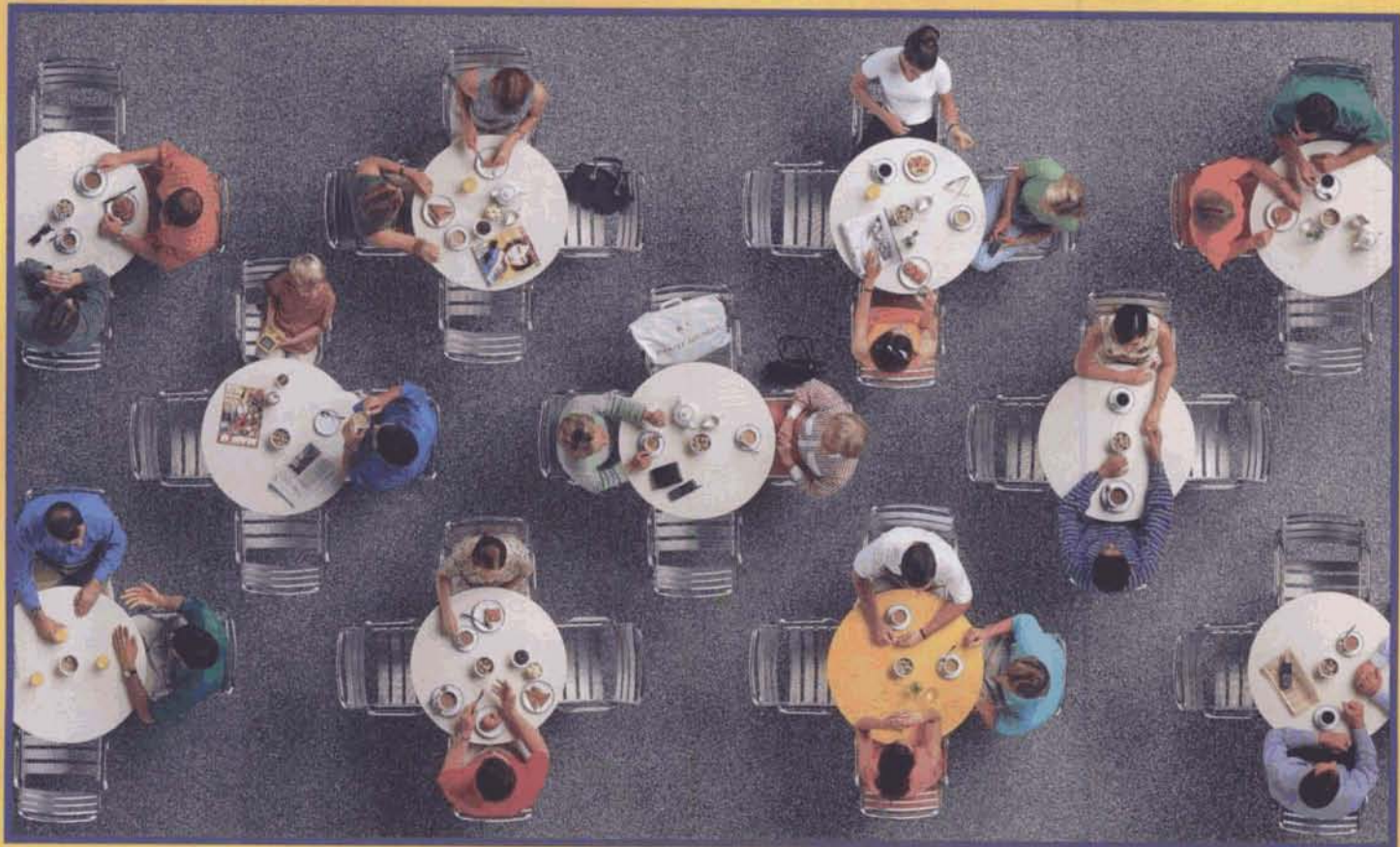


**0800 9807055**

Merck  
Pharmaceuticals  
Ltd  
Harrier House  
High Street  
West Drayton  
Middlesex  
UB7 7QG

**Campral EC**





# Add life to living with schizophrenia

Solian is a new benzamide antipsychotic, with the ability to treat both the positive<sup>1</sup> and negative<sup>2</sup> symptoms of schizophrenia.

Solian offers a lower incidence of EPS than standard neuroleptics such as haloperidol,<sup>3</sup> as well as avoiding some of the drawbacks of certain atypicals: it does not require routine cardiovascular<sup>4,5</sup> or haematological<sup>4,6</sup>

monitoring and patients gain significantly less weight than those treated with risperidone.<sup>2</sup>

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

**Solian**<sup>®</sup>  
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; pheochromocytoma; 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 (see caution Solian). Caution in patients with a history of epilepsy and Parkinson's disease. **Interactions:** Caution in

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 Synthelabo 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 Synthelabo. 5. Sotiledala SPC. Lundbeck Ltd. 6. Zimmaro SPC.

SYNTHELABO



# True leadership has to be earned.

## ASSOCIATED ANXIETY

Prozac has a proven record of efficacy in depression,<sup>1,2,3</sup> with a confirmed indication in depression with or without associated anxiety symptoms.<sup>4</sup>

A possible reason why Prozac has earned its status around the world.

# PROZAC

*fluoxetine*

The World's No.1 prescribed antidepressant brand.<sup>1</sup>

### 'PROZAC' ABBREVIATED PRESCRIBING INFORMATION (FLUOXETINE HYDROCHLORIDE)

**Presentation** Capsules containing 20mg or 60mg fluoxetine, as the hydrochloride. Liquid containing 20mg fluoxetine, as the hydrochloride, per 5ml syrup. **USES** Depression: TREATMENT OF THE SYMPTOMS OF DEPRESSIVE ILLNESS, WITH OR WITHOUT ASSOCIATED ANXIETY SYMPTOMS. **Obsessive-compulsive disorder. Bulimia nervosa:** For the reduction of binge-eating and purging activity. **Dosage and Administration** (For full information, see data sheet.) For oral administration to adults only. **Depression, with or without associated anxiety symptoms - adults and the elderly:** A dose of 20mg/day is recommended. **Obsessive-compulsive disorder:** 20mg/day to 60mg/day. A dose of 20mg/day is recommended as the initial dose. **Bulimia - adults and the elderly:** A dose of 60mg/day is recommended. Because of the long elimination half-lives of the parent drug (1-3 days after acute administration; may be prolonged to 4-6 days after chronic administration) and its major metabolite (average 9.3 days), active drug substance will persist in the body for several weeks after dosing is stopped. The capsule and liquid dosage forms are bioequivalent. **Children:** Not recommended. **Patients with renal and/or hepatic dysfunction:** See 'Contra-indications' and 'Precautions' sections. **Contra-Indications** Hypersensitivity to fluoxetine. Prozac should not be administered to patients with severe renal failure (GFR <10ml/min). **Usage in nursing mothers:** Prozac should not be prescribed to nursing mothers. **Monamine oxidase inhibitors:** At

initiation of therapy with an MAOI. Serious, sometimes fatal reactions (including hyperthermia, rigidity, myoclonus, autonomic instability and mental status changes that include extreme agitation, progressing to delirium and coma) have been reported with concomitant use or when fluoxetine had been recently discontinued and an MAOI started. Some cases presented with features resembling neuroleptic malignant syndrome. **Warnings** **Rash and allergic reactions:** Angioneurotic oedema, urticaria and other allergic reactions have been reported. Upon appearance of rash, or of other allergic phenomena for which an alternative aetiology cannot be identified, Prozac should be discontinued. **Pregnancy:** Use of Prozac should be avoided unless there is no safer alternative. **Precautions** Prozac should be discontinued in any patient who develops seizures. Prozac should be avoided in patients with unstable epilepsy; patients with controlled epilepsy should be carefully monitored. There have been rare reports of prolonged seizures in patients on fluoxetine receiving ECT treatment. A lower dose of Prozac, eg, alternate day dosing, is recommended in patients with significant hepatic dysfunction or mild to moderate renal failure (GFR 10-50ml/min). Caution is advisable when Prozac is used in patients with acute cardiac disease. Prozac may cause weight loss which may be undesirable in underweight depressed patients. In diabetics, fluoxetine may alter glycaemic control. There have been reports of abnormal bleeding by severe patients. The exact relationship to fluoxetine and clinical importance are unclear. **Drug interactions:**

cytochrome P450IID6 isoenzyme system, concomitant therapy with other drugs also metabolised by this system, and which have a narrow therapeutic index (eg, carbamazepine, tricyclic antidepressants), should be initiated at or adjusted to the low end of their dose range. Greater than 2-fold increases of previously stable plasma levels of cyclic antidepressants have been observed when Prozac has been administered in combination. Agitation, restlessness and gastro-intestinal symptoms have been reported in a small number of patients receiving fluoxetine in combination with tryptophan. Patients on stable phenytoin doses have developed elevated plasma concentrations and clinical phenytoin toxicity after starting fluoxetine. **For further information, see data sheet. Adverse Effects** Asthenia, fever, nausea, diarrhoea, dry mouth, appetite loss, dyspepsia, vomiting, rarely abnormal LFTs, headache, nervousness, insomnia, drowsiness, anxiety, tremor, dizziness, fatigue, decreased libido, seizures, hypomania or mania, dyskinesia, movement disorders, neuroleptic malignant syndrome-like events, pharyngitis, dyspnoea, pulmonary events (including inflammatory processes and/or fibrosis), rash, urticaria, vasculitis, excessive sweating, arthralgia, myalgia, serum sickness, anaphylactoid reactions, hair loss, sexual dysfunction. The following have been reported in association with fluoxetine but no causal relationship has been established: aplastic anaemia, cerebral vascular accident, confusion, ecchymoses, eosinophilic pneumonia, gastro-intestinal haemorrhage, hyperprolactinaemia, immune-related

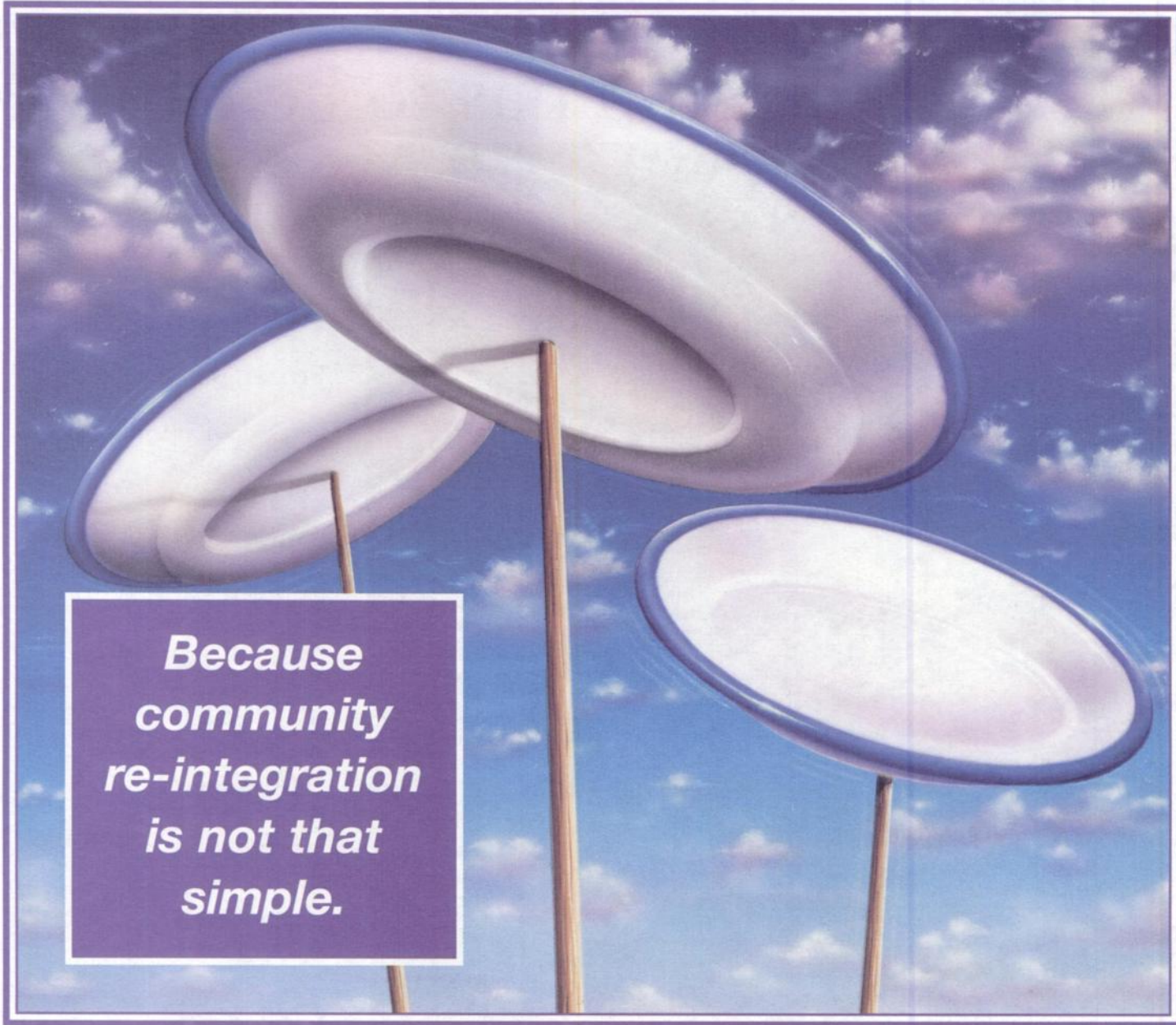
Hyponaatraemia (including serum sodium below 110mmol/l) has been rarely reported. This appears to be reversible upon discontinuation. **Overdosage** On the evidence available, fluoxetine has a wide margin of safety in overdose. Since introduction, reports of death, attributed to overdosage of fluoxetine alone, have been extremely rare. One patient who reportedly took 3000mg of fluoxetine experienced 2 grand mal seizures that remitted spontaneously. **Legal Category** POM **Product Licence Numbers** 0006/0195 0006/0198 0006/0272 **Basic NHS Cost** £20.77 per pack of 30 capsules (20mg), £67.85 per pack of 98 capsules (20mg), £62.31 per pack of 30 capsules (60mg), £19.39 per 70ml bottle. **Date of Preparation or Last Review** October 1996. **Full Prescribing Information is Available From** Dista Products Limited, Dexta Court, Chapel Hill, Basingstoke, Hampshire, RG21 5SY. Telephone: Basingstoke (01256) 52011 **'PROZAC'** is a Dista trademark

References: 1. Data on file, Dista Products Ltd. 2. Tignol J. *J Clin Psychopharm* 1993; 13 (6, suppl. 2): 18S-22S. 3. Bennie EH, Mullin JM, Martindale JJ. *J Clin Psychiatry* 1995; 56: 229-237. 4. Prozac Data Sheet 24M.

Date of preparation: May 1997

PZ 906





Because  
community  
re-integration  
is not that  
simple.

**ABBREVIATED PRESCRIBING INFORMATION:**

**Presentation:** Coated tablets containing 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. **Hepatic and/or renal impairment:** A lower starting dose (5mg) may be considered. 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 for 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 hyper eosinophilic conditions or with myeloproliferative disease. Thirty-two patients with clozapine-related neutropenia or agranulocytosis histories received olanzapine without decreases in baseline neutrophil counts. Although, in clinical trials, there were no reported cases of NMS in patients receiving olanzapine, if such an event occurs, or if there is unexplained high fever, 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 enhance the effects of direct and

**Antipsychotic Efficacy for First-line Use**

**Zyprexa**  
**Olanzapine**



**Making Community Re-integration the Goal**

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 foetus. 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 or high creatinine phosphokinase were reported rarely. Plasma prolactin levels were sometimes elevated, but associated clinical manifestations were rare. Asymptomatic haematological variations were occasionally seen in trials. **For further information see summary of product characteristics.** **Legal Category:** POM. **Marketing Authorisation Numbers:** EU/1/96/022/004 EU/1/96/022/006 EU/1/96/022/008 EU/1/96/022/009 EU/1/96/022/010. **Basic NHS Cost:** £52.73 per pack of 28 x 5mg tablets. £105.47 per pack of 28 x 10mg tablets. £158.20 perpack of 56 x 7.5mg tablets. £210.93 per pack of 56 x 10mg tablets. **Date of Preparation or Last Review:** April 1997. **Full Prescribing Information is Available From:** Eli Lilly and Company Limited, Dextra Court, Chapel Hill, Basingstoke, Hampshire RG21 5SY. Telephone: Basingstoke (01256) 315000.







Prescription for depression,

tender

loving care

and

**SEROXAT**  
PAROXETINE

Rebuilding the lives  
of anxious  
depressed patients



## 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. Extrapramidal 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



Welwyn Garden City, Hertfordshire AL7 1EY.

'Seroxat' is a trade mark.

© 1998 SmithKline Beecham Pharmaceuticals.

