We evaluated patients trough the following sequence: clinical interview in order to obtain clinical and social variables; Mini Mental State Examination (MMSE – M. Folstein,1975); Positive and Negative Syndrome Scale (PANSS - Kay SR, 1987),Assessment of Insight in Psychosis Scale (I. Marková, 2002) and Behavioral Assessment of Dysexecutive Syndrome (BADS- N. Alderman, 1996).

Results and Conclusions: The study is now under statistically evaluation.

P100

Number needed to treat (NNT) for all-cause medication discontinuation in catie compared to the schizophrenia outpatients health outcomes (SOHO) study

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Objective: To compare CATIE, a randomized double blind study, and SOHO, a 3-year prospective non-randomized observational European study of outpatients with schizophrenia, on the Number Needed to Treat (NNT) for all-cause medication discontinuation. NNTs place data into a clinically meaningful context - the number of patients needed to be treated with one antipsychotic instead of another to prevent one negative outcome, defined here as one additional medication discontinuation for any cause.

Method: Rate of medication discontinuation for any cause during the 18 months post initiation was calculated for patients newly initiated on olanzapine (N=4247), risperidone (N=1549), quetiapine (N=583), amisulpride (N=256), clozapine (N=274), oral typicals (N=471) or depot typicals (N=348). Cox models were employed to adjust for treatment group differences at baseline. NNTs with their 95% confidence intervals were calculated and compared with published NNTs for CATIE (Phase 1).

Results: The NNTs for all-cause discontinuation of olanzapine vs. each studied atypical antipsychotic during the 18 month following medication initiation in SOHO were comparable to CATIE: 4.3(95% CI: 3.6–5.3) for olanzapine vs. quetiapine (5.5 in CATIE); 16.1(11.0–28.1) for olanzapine vs. risperidone (10.1 in CATIE); 6.9(5.2–10.1) for olanzapine vs. oral typicals (9.0 in CATIE for olanzapine vs. perphenazine).

Conclusions: The NNTs for all-cause medication discontinuation based on CATIE appeared comparable to NNTs based on SOHO. The NNTs for olanzapine therapy were consistently better when compared to each studied atypical antipsychotic (except clozapine) and when compared to typical antipsychotics. Results should be interpreted conservatively, due to the observational design of SOHO.

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Aripiprazole in child and adolescent psychiatric disorders: Safety, tolerability, and pharmacokinetics

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Introduction: The primary objective of this FDA-requested study was to examine the tolerability, safety, and pharmacokinetics (PK) of 20, 25, and 30 mg/day of aripiprazole in children and adolescents, ages 10-17.

Methods: 21 patients were enrolled in this open-label, sequential cohort trial that employed a forced escalation paradigm. A 2 mg starting dose was increased to 5, 10, 15, 20, 25, or 30 mg (depending on the final dose) in 2-day, stepwise intervals. After this initial dose-escalation phase, subjects were maintained at their target dose for an additional 14 days. Study medication was given once daily. Preferential enrollment was given to patients with schizophrenia or bipolar illness. Blood samples were collected for aripiprazole concentrations.

Results: Using the described dose-escalation schedule, all 3 dose levels were well tolerated, in general. One subject discontinued treatment due to acute, moderate dystonia. Other adverse events were in the mild/moderate range and were transient in nature. Aripiprazole pharmacokinetics are linear across doses and similar to that observed in adult patients.

Conclusions:

- Doses of 20, 25 and 30 mg/day (following titration from a starting dose of 2 mg) are generally well tolerated in children and adolescents without regard to gender or psychiatric diagnosis.
- Aripiprazole pharmacokinetics are linear in child and adolescent patients.

P102

The "C.A.P. 13": A new clinical assesment of psychosis

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Measuring slow and little changes in schizophrenia is not easy. Authors have censed criterias of improvement in psychiatry, psycho-dynamic literature, and communautary mental health programs for severe mentally ill people. After being clasified following psycho-dynamic point of view, 24 items are defined, covering all the fields of clinical expresion of chronic psychotic states. Most of items have three levels of intensity, following a nearly quantitative manner. More than 100 patients were quotated by several clinicians. Statistic study show a good sensibility to usual changes obtained by five-years periods of treatment. Usually only 4 items among 25 change in five years. That explains under-estimation of improvement among psychotic chronic patients receiving long-term complex comunautary, psychotherapic and psychopharmacologic treatments. Reliability of quotation is tested by measuring Kappas, and appears rather good. Multi-dimensional analysis give an eight-dimensions model of description of schizophrenic chronic states. This confirms need of more complex models to describe slow and little changes in chronic states than to show improvement of acute psychosis. Authors compare their first clasification following psycho-pathological hypothesis of improvement criterias, the groups of criterias that change together with time, and the stucture by criterias of the eight axes.

Training for use appears rather easy for psychiatric teams because each three levels of the 25 items is generally defined by many features. Using this methodic description of chronic states help to perceive the homeostatic and balanced aspects of the clinic stability. So chronic states can be thinked otherwise than immobility.

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Long-term effect of olanzapine on caudate volume in schizophrenic patients

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