THE BRITISH JOURNAL OF PSYCHIATRY

JUNE 1998 VOL. 172

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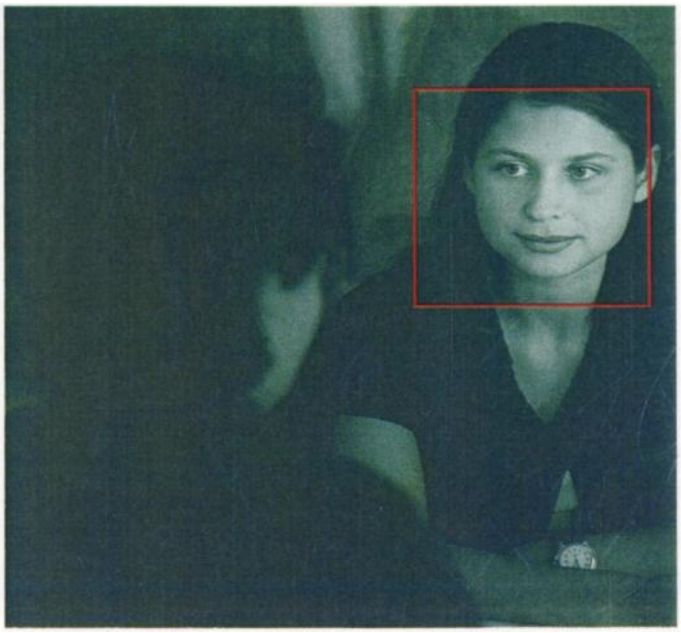
Debbie doesn't know that Cipramil is now indicated for panic disorder



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

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

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

Lundbeck

Cipramil
citalopram

now indicated for panic disorder

Presentation: 'Cipramil' tablets 10 mg: PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £12.77. 'Cipramil' tablets 20 mg: PL 0458/0058, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets £21.28. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/recurrence. Treatment of panic disorder, with or without agoraphobia. **Dosage:** ***Treating depression: Adults:*** 20 mg a day. Depending upon individual patient response, this may be increased in 20 mg increments to a maximum of 60 mg. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. Treatment for at least 6 months is usually necessary to provide adequate maintenance against the potential for relapse. ***Treating panic disorder:*** 10 mg daily for the first week, increasing to 20 mg daily. Depending upon individual patient response, dosage may be further increased to a maximum of 60 mg daily. Depending upon individual patient response, it may be necessary to continue treatment for several months. ***Elderly:*** 20 mg a day increasing to a maximum of 40 mg dependent upon individual patient response. ***Children:*** Not recommended. ***Reduced hepatic/renal function:*** Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance <20ml/min). **Contra-indications:** Combined use of 5-HT agonists. Hypersensitivity to citalopram. ***Pregnancy and Lactation:*** Safety during human pregnancy and lactation has not been established. Use only if potential benefit outweighs possible risk. **Precautions:** Driving and operating machinery. History of mania. Caution in patients at risk of cardiac arrhythmias. Do not use with or within 14 days of MAO inhibitors: leave a seven day gap before starting MAO inhibitor treatment. Use a low starting dose for panic disorder, to reduce the likelihood of an initial anxiogenic effect (experienced by some patients) when starting pharmacotherapy. **Drug Interactions:** MAO inhibitors (see Precautions). Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjusted. **Adverse Events:** Most commonly nausea, sweating, tremor, somnolence and dry mouth. With citalopram, adverse effects are in general mild and transient. When they occur, they are most prominent during the first two weeks of treatment and usually attenuate as the depressive state improves. **Overdosage:** Symptoms have included somnolence, coma, sinus tachycardia, occasional nodal rhythm, episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No specific antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon request. Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LF. ® 'Cipramil' is a Registered Trade Mark. © 1997 Lundbeck Ltd. Date of preparation: April 1997. 0897/CIP/501/04

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THE BRITISH JOURNAL OF PSYCHIATRY

JUNE 1998 VOL. 172

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Instructions to authors

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

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

Subscriptions

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

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

Full airmail is £36/US$64 extra

Single copies of the Journal are £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

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Past Editors

Eliot Slater	1961–72	John E. Cranswick	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.

College News

Issue 5
June
1998

Election results

Following a ballot of the Membership, Professor Cornelius Katona was elected Dean, to succeed Professor John Cox. He takes up office on 1 July.

Court of Appeal judgement

L. v. Bournewood Community and Mental Health NHS Trust

The Court of Appeal has ruled that the Trust was unlawful in keeping a man with autism and profound learning disabilities in hospital as a voluntary patient, as he was incapable of forming a judgement about whether or not he wished to be in hospital. This means that patients who lack capacity to consent to hospital admission cannot receive treatment for mental disorder as informal patients, but have to be admitted compulsorily under the provisions of the Mental Health Act 1983.

An appeal to the House of Lords against this decision has been set for 2–3 June. Until then, the ruling remains law in England and Wales, and it is the responsibility of individual trusts to advise their staff how to respond to its legal implications. The ruling does not affect Scotland or Northern Ireland.

The Mental Health Act Commission has produced a guidance note on the application of the judgement. It emphasises that, despite the pending appeal to the House of Lords, this judgement "represents an authoritative statement of the current state of the law and is binding on those with relevant responsibilities under the Act."

The College was invited by the NHS Executive to advise on the likely implications of the ruling, and a detailed response has been submitted, incorporating advice from the Faculties of Learning Disability Psychiatry and Old Age Psychiatry, and the Mental Health Law Sub-Committee.

Members should be assured that the College will do all in its power to influence the legal process in order to resolve this issue. If the judgement is not overruled or narrowly circumscribed in the House of Lords, the College will press for new legislation.

Dr Robert Kendell, President

Management of Imminent Violence

In this first product of the College's Clinical Practice Guidelines Programme, an extensive systematic review was used to evaluate quantitative evidence on the outcome of methods of coping with imminent violence in mental health settings.

A complimentary copy of the 'quick reference' guide to the report is included in the June issue of the *British Journal of Psychiatry*. The full report, containing the project's detailed methodology, is available from the College's Book Sales Office (ext. 146) at a reduced rate of £10.00 for College members.

Claire Palmer, Clinical Guidelines Facilitator (ext. 282, crulondon@compuserve.com).

MHO status

Part-time doctors

Recent legal judgements have concluded that the exclusion of part-time doctors from the pension benefits of mental health officer (MHO) status is discriminatory. In response to this, the British Medical Association (BMA) has argued that doctors who have worked part-time in mental health since 1976 should have MHO status and is seeking an urgent response from the Department of Health. In the meantime, advice is available from

every family in the land
changing minds

This five-year College campaign will be launched in October. It will aim to:

- increase public and professional undertanding of mental disorders;
- reduce the stigma and discrimination against people suffering from these disorders;
- close the gap between the different beliefs of health care professionals and the public about useful treatments and interventions.

The campaign will focus on public perceptions of: dangerousness; self-infliction of mental disorders; the bleak outlook for people suffering with mental health problems; and communication problems.

For further information, contact Liz Cowan, Campaign Administrator (ext. 122, lcowan@rcpsych.ac.uk)

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the BMA concerning what immediate legal action should be taken by doctors who have recently retired from part-time posts or who are currently in employment.

Andrea Woolf, Committees Officer (ext. 147, awoolf@rcpsych.ac.uk).

Forthcoming events

This year's Annual Meeting will be held at the Belfast Waterfront Centre, Belfast, 22–25 June. Members who have not yet registered but wish to attend should contact the Conference Unit by Monday 8 June.

Conference Unit (ext. 142, asummers@rcpsych.ac.uk).

A regional meeting of the College will be held in Abu Dhabi, United Arab Emirates, in November 1998.Further information is available from:

Overseas Desk, Postgraduate Educational Services Department (ext. 123, glodge@rcpsych.ac.uk).

HAS 2000, Young Minds, the Audit Commission and the College Research Unit's FOCUS project are planning a conference next February which will focus on the current state of Child and Adolescent Mental Health Services and the development of effective services and clinical practice.

To register your interest, please contact Sam Coombs (ext. 234, scoombs@rcpsych.ac.uk).

Job share register

Psychiatrists seeking to share a full-time hospital post may register their interest with the job share register maintained by the Women in Psychiatry Special Interest Group. Efforts will be made to match members who might be interested in sharing appointments. Application forms from: Sue Duncan, PA to the Secretary (ext. 130): sduncan@rcpsych.ac.uk

Dr Anne Cremona, Chair, Women in Psychiatry Special Interest Group.

Regional representatives

The College's Postgraduate Education Department maintains lists of regional representatives in each Faculty and Section.

Details are available from Marion Palmer Jones (ext. 276, mpalmerjones@rcpsych.ac.uk).

MRCPsych Clinical Examination centres

Appreciation is expressed to the following hospitals and NHS trusts for their assistance in hosting the MRCPsych clinical examinations.

Current Part I Clinical Centres

114 Beacon Park Road (Scott Hospital Site), Plymouth
Addenbrooke's Hospital, Cambridge
Barrow Hospital, Bristol
Bassetlaw District General Hospital, Worksop
Billinge Hospital, Wigan
Bushey Fields Hospital, Dudley
Crichton Royal Hospital, Dumfries
Derbyshire Royal Infirmary, Derby
Dykebar Hospital, Paisley
Fair Mile Hospital, Oxfordshire
Garlands Hospital, Cumbria
Hellesdon Hospital, Norwich
Invicta Community Care NHS Trust, Maidstone
Knockbracken Healthcare Park, Belfast
Leicester General Hospital, Leicester
Lyme Brook Mental Health Centre, Staffordshire
Murray Royal Hospital, Perth
New Cross Hospital, Wolverhampton
North Manchester General Hospital, Manchester
Princess of Wales Hospital, Cotty Clinic, Bridgend
Queen Elizabeth II Hospital, Welwyn Garden City
Royal Dundee Liff Hospital, Dundee
Royal South Hants Hospital, Southampton
Royal Victoria Infirmary, Newcastle
St Andrew's Hospital, Northampton
St Cadoc's Hospital, Gwent
St George's Day Hospital, Sheffield
St Vincent's Hospital, Dublin
Warlingham Park Hospital, Surrey
West Cheshire NHS Trust, Chester

Current Part II Clinical Centres

Abraham Cowley Unit, Surrey, Chertsey
Airedale General Hospital, West Yorkshire
Bangor District General Hospital, Bangor
Bethlem Royal Hospital, Kent
Caludon Centre, (Rear of Walsgrave Hospital), Coventry
Cherry Knowle Hospital, Sunderland
Chesterfield & North Derbyshire Royal Hospital, Chesterfield
Clarendon House, Surrey
Epsom General Hospital, Epsom
Fazakerley Hospital, Liverpool
Forston Clinic, Dorset
Guy's Hospital Medical School, London
Heatherwood Hospital, Ascot
Holywell Hospital, Antrim
Homerton Hospital, Homerton
King's Mill Hospital, Nottinghamshire
Lambeth Healthcare NHS Trust, London
Leverndale Hospital, Glasgow
Lewisham Hospital, Lewisham
Mental Health Services of Salford, Salford
Queen Elizabeth Psychiatric Hospital, Birmingham
Royal Cornhill Hospital, Aberdeen
Royal United Hospital, Bath
Sandbach Mental Health Resource Centre, Crewe
Springfield University Hospital, London
St George's Hospital, Link Centre, Essex
St James's University Hospital, Leeds
St John of God Hospital, Dublin
St Michael's Hospital, Warwick
St Tydfil's Hospital, Merthyr Tydfil
Stepping Stones House, Bromley
Stone House Hospital, Dartford
The Sunderland Centre, Stoke on Trent
University College Hospital, Galway
Worcester Royal Infirmary, Worcester.

There is an urgent need for more centres – if your hospital or trust is able to assist, please contact: Mary Ryan, Head of Examinations Services (ext. 253, mryan@rcpsych.ac.uk).

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Hospital Medicine is proud to announce

Eating Disorders 99

The Fourth London International Conference on Eating Disorders

PROGRAMME

Tues 27th to Thurs 29th April 1999

The New Connaught Rooms
Great Queen Street, London WC2B 5DA

Tuesday 27th April

08.00 - 09.30	**Registration and coffee**
09.30 - 09.45	**Opening remarks** **Bryan Lask,** University of London, UK **and Rachel Bryant Waugh,** Dorset HealthCare NHS Trust, UK
09.45 - 10.30	**KEYNOTE ADDRESS:** **Albert Stunkard,** University of Pennsylvania, USA **Changing views on weight and shape**
10.30 - 11.00	**Coffee and exhibition viewing**
11.00 - 13.00	**Plenary Session 1 : The environmental bases of eating disorders** **Chairperson: Melanie Katzman,** University of London, UK
Speaker 1	**Mervat Nasser** University of Leicester, UK
Speaker 2	**Guntner Rathner** University of Innsbruck, Austria
Speaker 3	**Alan Stein** University of London, UK
13.00 - 14.00	**Lunch and exhibition viewing**
14.00 - 15.30	**Concurrent Session 1**
15.30 - 16.00	**Tea and exhibition viewing**
16.00 - 17.30	**Concurrent Session 2**
17.30 - 18.30	**Drinks Reception and Poster viewing**
18.30 - 19.45	**Special Lecture presented by** **Joseph Silverman,** Columbia University, USA **& Gerald Russell,** University of London, UK

Wednesday 28th April

08.30 - 09.30	**Registration, coffee and exhibition viewing**
09.30 - 11.00	**Plenary Session 2: The biological bases of eating disorders** **Chairperson: Joseph Silverman,** Columbia University, USA
Speaker 1	**Kenneth Nunn** University of New South Wales, Australia
Speaker 2	**Janet Treasure** University of London, UK
Speaker 3	**Bryan Lask** University of London, UK
11.00 - 11.30	**Coffee and exhibition viewing**
11.30 - 13.00	**Short Paper Sessions**
13.00 - 14.00	**Lunch and exhibition viewing**
14.00 - 15.30	**Concurrent Session 3**
15.30 - 16.00	**Tea and exhibition viewing**
16.00 - 17.30	**Plenary Session 3: The relevance of personality to eating disorders** **Chairperson: Hubert Lacey,** University of London, UK
Speaker 1	**Bob Palmer** University of Leicester, UK
Speaker 2	**Pat Fallon** University of Washington, USA
Speaker 3	**Steve Wonderlich** University of North Dakota, USA
17.30	**Social Event: Scottish Malt Whisky Tasting**

Thursday 29th April

09.00 - 09.30	**Registration, coffee and exhibition viewing**
09.30 - 11.00	**Concurrent Session 4**
11.00 - 11.30	**Coffee and exhibition viewing**
11.30 - 13.00	**Concurrent Session 5**
13.00 - 14.15	**Lunch and exhibition viewing**
14.15 - 15.45	**Plenary Session 4: Integrating research and practice** **Chairperson: B Timothy Walsh,** Columbia University, USA
Speaker 1	**Rachel Bryant Waugh** Dorset HealthCare NHS Trust, UK
Speaker 2	**Christopher Fairburn** University of Oxford, UK
Speaker 3	**Tom Wadden** University of Pennsylvania, USA
15.45 - 16.00	**Closing remarks**
16.00	**Tea and conference ends**

For further details please complete box and return to:

Conference Manager, Eating Disorders'99,
Mark Allen International Communications Ltd,
Croxted Mews, 286A-288 Croxted Road,
London SE24 9BY
Tel: 0181-671 7521 Fax: 0181-674 4550

Title (Dr/Mr/Mrs etc).....

Surname:.....

Forenames: .....

Job Title: .....

Full Address: (Hospital/Practice).....

(Street).....

(Town).....

(County) .....

(Postcode).....

(Country) .....

Telephone:.....

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ADVANCE DIARY DATES

Thinking about management issues in schizophrenia?

As part of a comprehensive programme of initiatives open to psychiatrists, CPNs and pharmacists, we are organising a series of one day multi-disciplinary workshops under the general heading **"Therapy Management"**.

Presentations and discussion groups will focus on the following:

- Factors influencing concordance
- Wider therapeutic options in the management of schizophrenia

Meeting Dates

20 May	Zeneca HQ, Cheshire	18 June	Birmingham
21 May	Southampton	18 June	Essex
22 May	Aylesbury	22 June	Bristol
27 May	London	23 June	Cardiff
8 June	Newcastle	24 June	Wembley
10 June	Cambridge	26 June	Totnes
17 June	Wigan	1 July	Belfast
17 June	Ashford	3 July	Leeds
17 June	Glasgow		

For more information on these multi-disciplinary workshops please call Sally Heap at Zeneca on 01625 712412.

Granted To ICI Pharmaceuticals

ZENECA

THINKING AHEAD IN PSYCHIATRY

When you next see a depressed patient, ask her which shade of lipstick she wears.

Self pride is just part of how well a depressed patient re-adapts socially, and social interaction is an extremely valuable measure of successful treatment.

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

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

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

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

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

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

Edronax® ▼
REBOXETINE

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

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

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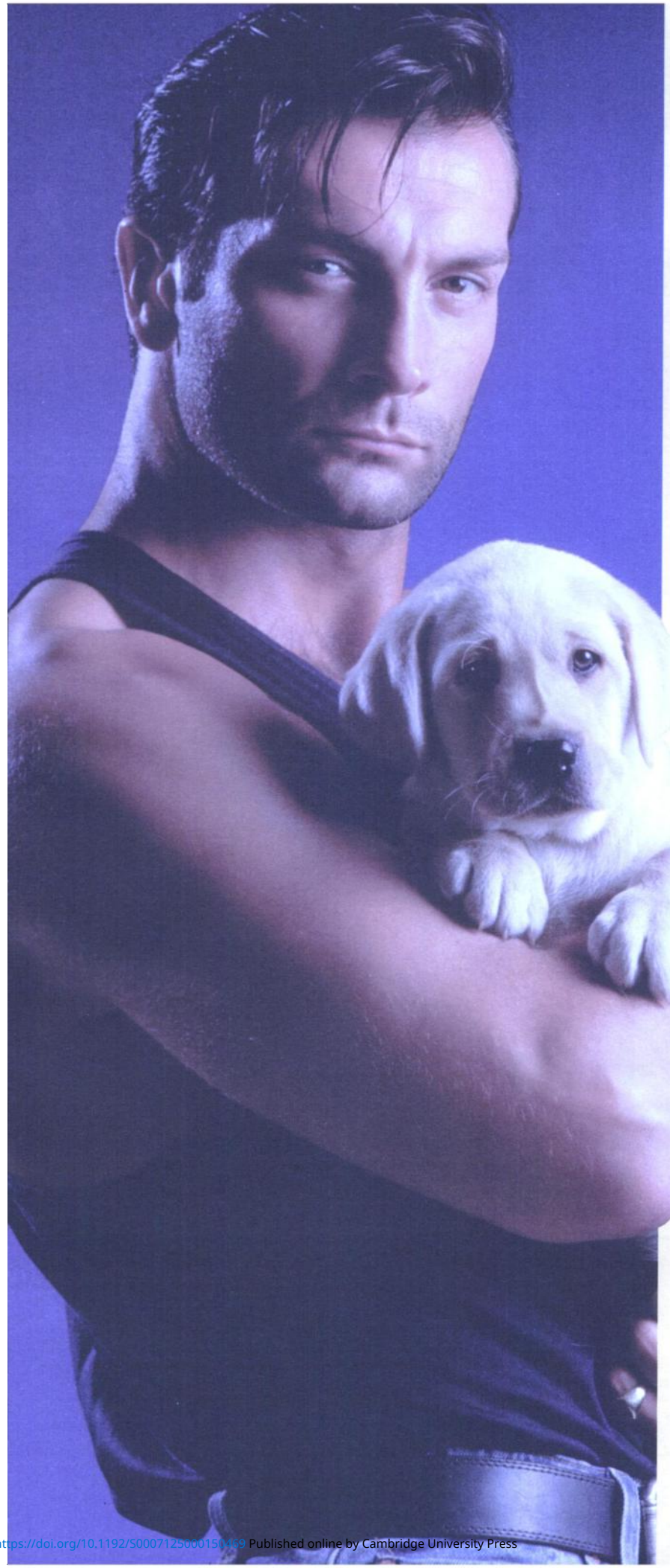

MIRTAZAPINE

ZISPIN SEBIN 30 mg

The NaSSA

Strong yet gentle in depression

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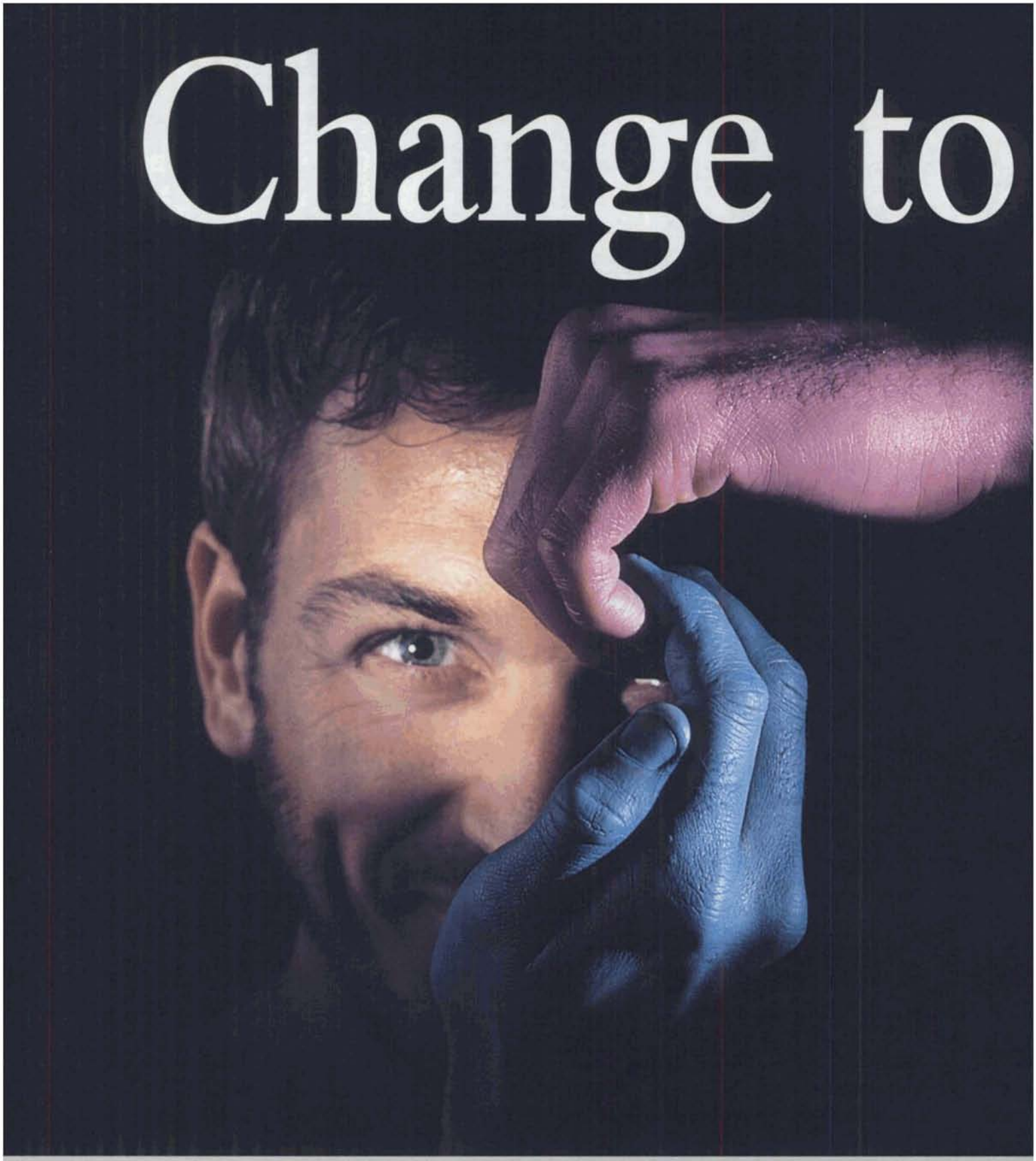

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2. Arvanitis LA *et al.* Biol Psychiatry 1997; **42**: 233-246.
3. Small JG, Hirsch SR, Arvanitis LA *et al.* Arch Gen Psychiatry 1997; **54**: 549-557.
4. Borison RL, Arvanitis LA, Miller MS *et al.* J Clin Psychopharmacol 1996; **16** (2):158-169.
5. Data on File, Zenaca Pharmaceuticals.
6. Data on File, Zeneca Pharmaceuticals.
7. 'Seroquel' Summary of Product Characteristics.

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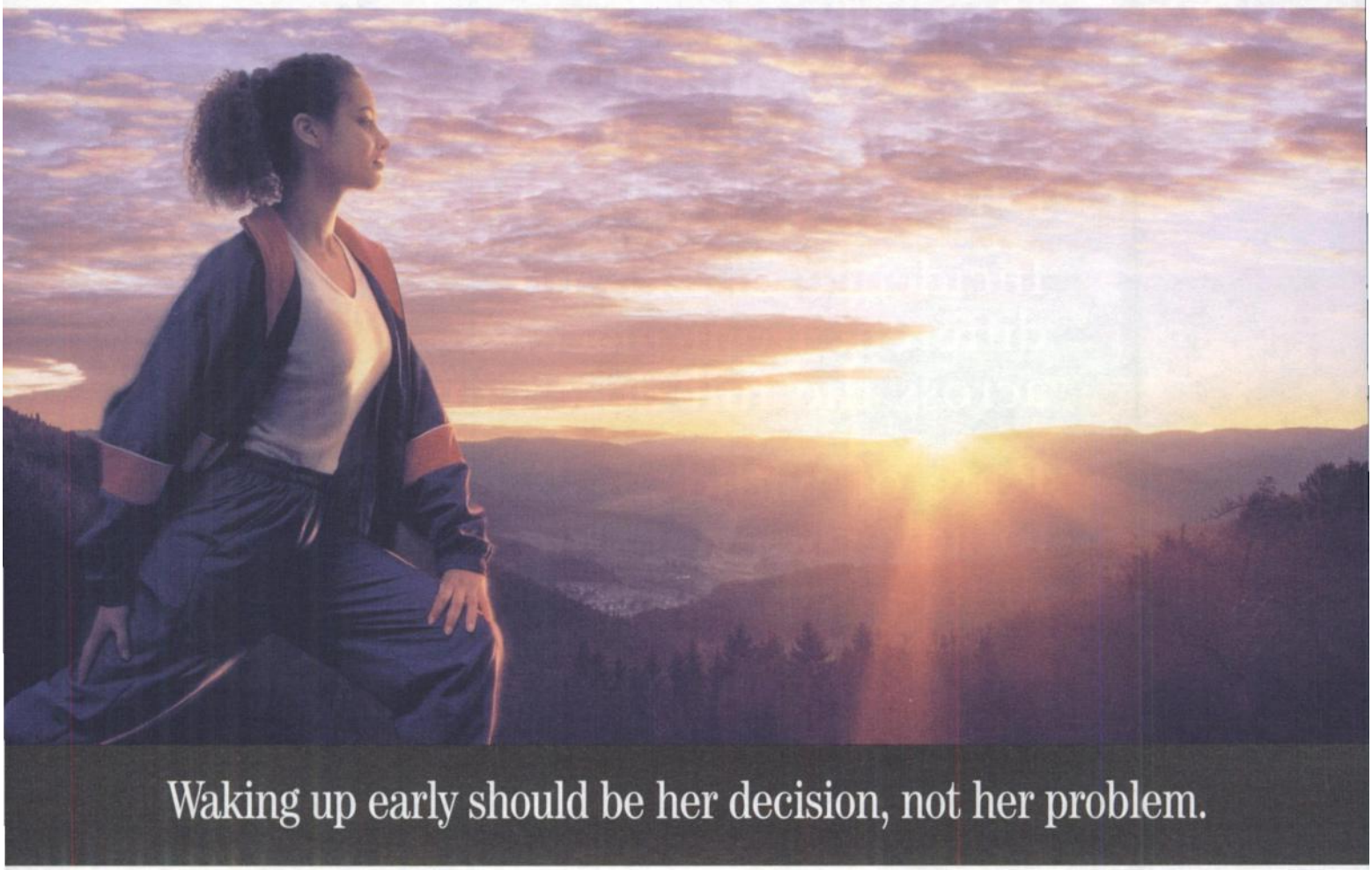
DUTONIN™▼ Abbreviated Prescribing Information PRESENTATION: Tablets containing 50mg, 100mg and 200mg nefazodone hydrochloride. INDICATIONS: Symptomatic treatment of all types of depressive illness, including depressive syndromes accompanied by anxiety or sleep disturbances. DOSAGE: Usual therapeutic 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. 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 $P_{450}III_{A4}$; see Summary of Product Characteristics. SIDE EFFECTS: Most frequently asthenia, dry mouth, nausea, constipation, somnolence, light-headedness and dizziness; see Summary of Product Characteristics. OVERDOSAGE: There is no specific antidote for nefazodone. Gastric lavage recommended for suspected overdose. Treatment should be symptomatic and supportive in the case of hypotension or excessive sedation. PRODUCT LICENCE NUMBERS: Dutonin Tablets 50mg PL 11184/0027; Dutonin Tablets 100mg PL 11184/0028; Dutonin Tablets 200mg 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.

Bristol-Myers Squibb Pharmaceuticals Limited



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

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

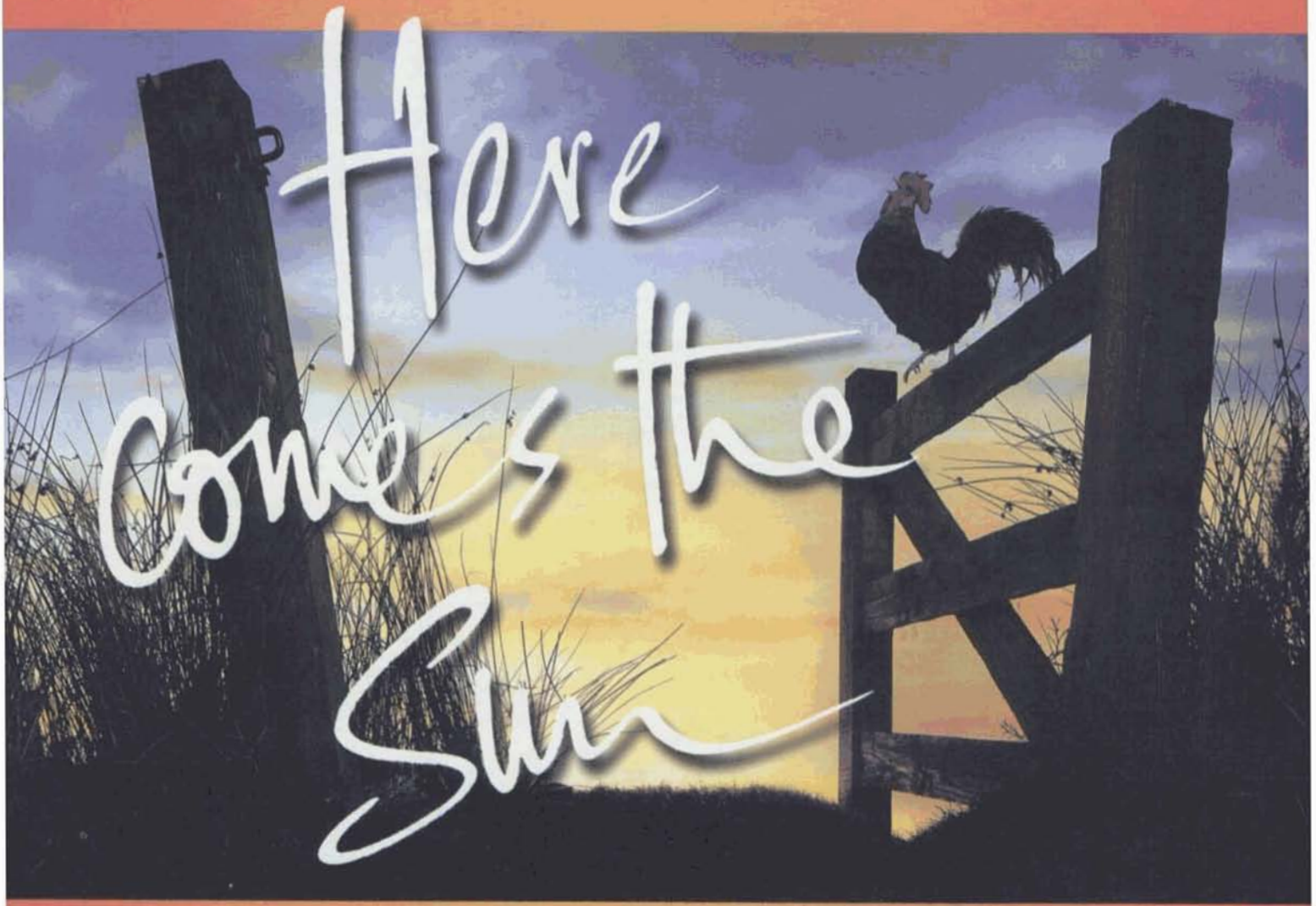
Moreover, Dutonin lifts anxiety symptoms within the first week of treatment.[5]

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

Makes the difference in depression

DUTONIN™▼

Efexor® XL venlafaxine - Prescribing information Presentation: Capsules containing 75mg or 150mg venlafaxine (as hydrochloride) in an extended release formulation. **Use:** Treatment of depressive illness. **Dosage:** *Adults (including the elderly):* Usually 75mg, given once daily with food, increasing to 150mg once daily if necessary. The dose can be increased further to 225mg once a day. Dose increments should be made at intervals of approximately 2 weeks or more, but not less than 4 days. Discontinue gradually to avoid possibility of discontinuation effects. *Children:* Contra-indicated below 18 years of age. *Moderate renal or moderate hepatic impairment:* Doses should be reduced by 50%. Not recommended in severe renal or severe hepatic impairment. **Contra-indications:** Pregnancy, lactation, concomitant use with MAOIs, hypersensitivity to venlafaxine or other components, patients aged below 18 years. **Precautions:** Use with caution in patients with myocardial infarction, unstable heart disease, renal or hepatic impairment, or a history of epilepsy (discontinue in event of seizure). Patients should not drive or operate machinery if their ability to do so is impaired. Possibility of postural hypotension (especially in the elderly). Women of child-bearing potential should use contraception. Prescribe smallest quantity of tablets according to good patient management. Monitor blood pressure with doses >200mg/day. Advise patients to notify their doctor should an allergy develop or if they become or intend to become pregnant. Patients with a history of drug abuse should be monitored carefully. **Interactions:** MAOIs: do not use Efexor XL in combination with MAOIs or within 14 days of stopping MAOI treatment. Allow 7 days after stopping Efexor XL before starting an MAOI. Use with caution in elderly or hepatically-impaired patients taking cimetidine, in patients taking other CNS-active drugs, and in patients taking drugs which inhibit *both* CYP2D6 and CYP3A4 hepatic enzymes. **Side-effects:** Nausea, insomnia, dry mouth, somnolence, dizziness, constipation, sweating, nervousness, asthenia, abnormal ejaculation/orgasm, anorexia, abnormal vision/accommodation, impotence, vomiting, tremor, abnormal dreams, vasodilatation, hypertension, rash, agitation, hypertonia, paraesthesia, postural hypotension, reversible increases in liver enzymes, slight increase in serum cholesterol, weight gain or loss, hyponatraemia. **Basic NHS price:** 75mg capsule (PL 0011/0223) - blister pack of 28 capsules: £23.97. 150 mg capsule (PL 0011/0224) - blister pack of 28 capsules: £39.97. **Legal category:** POM. Further information is available upon request from the Product Licence holder: Wyeth Laboratories, Taplow, Maidenhead, Berkshire, SL6 0PH. Date of preparation: August 1997. *trade mark Code no Z777440/0897. WEFX3-UK-JA. References: 1. Muth EA *et al.* Biochem Pharmacol 1986; 35(24): 4493-4497. 2. Muth EA *et al.* Drug Development Research 1991; 23: 191-199. 3. Rudolph R *et al.* Poster presented at the New Clinical Drug Evaluation Unit (National Institute of Mental Health). Boca Raton, Florida 1997. 4. McPartlin GM *et al.* Poster at the 10th European College of Neuropsychopharmacology meeting, Vienna, September 13th-17th, 1997. 5. Salinas E. Biol Psychiatry 1997; 42(Suppl. 1): 244S.



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

NEW ONCE DAILY

EFEXOR XL

VENLAFAXINE 75 mg o.d.

Simply effective

CLOZARIL®
clozapine

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

NOVARTIS

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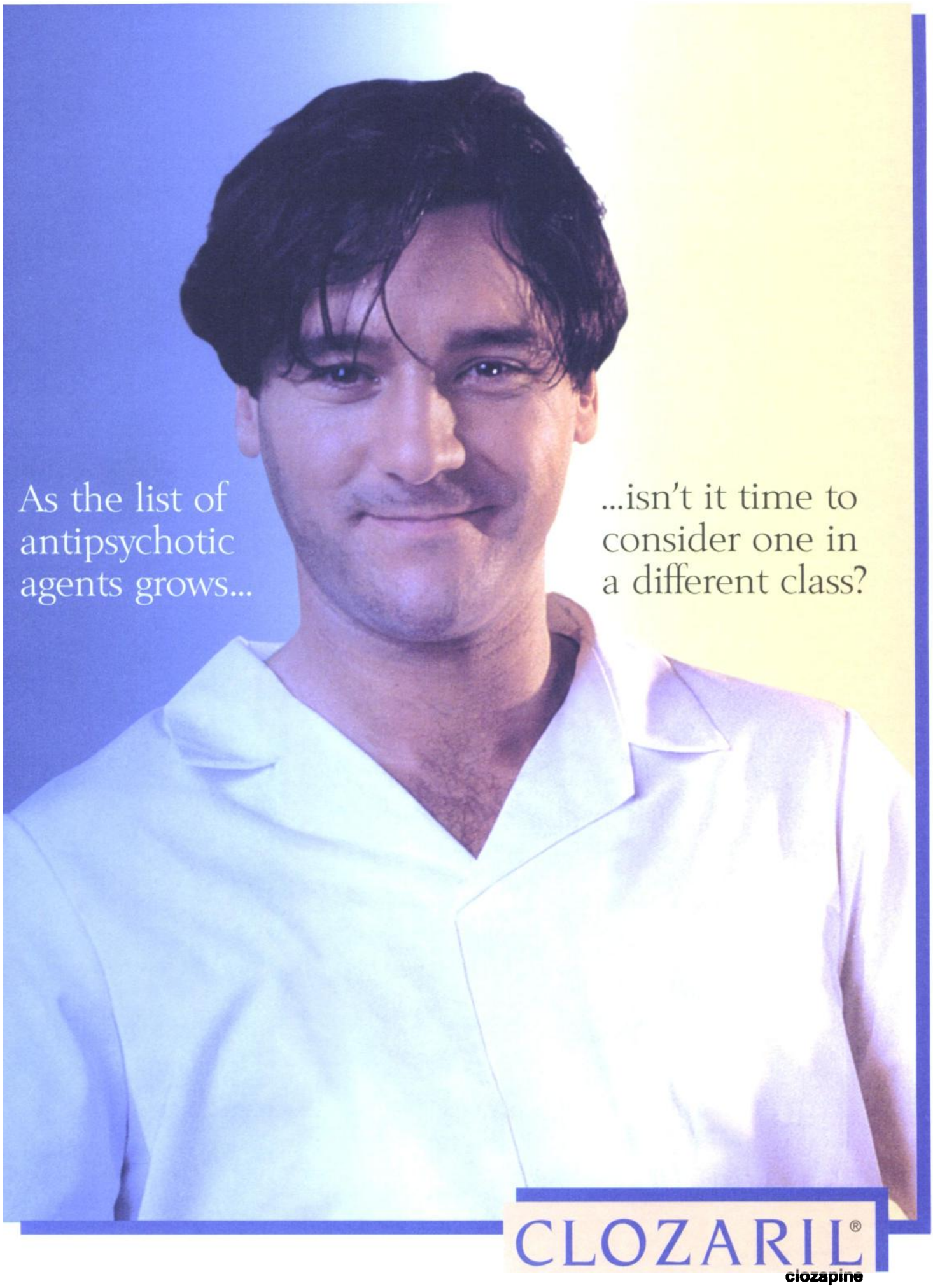

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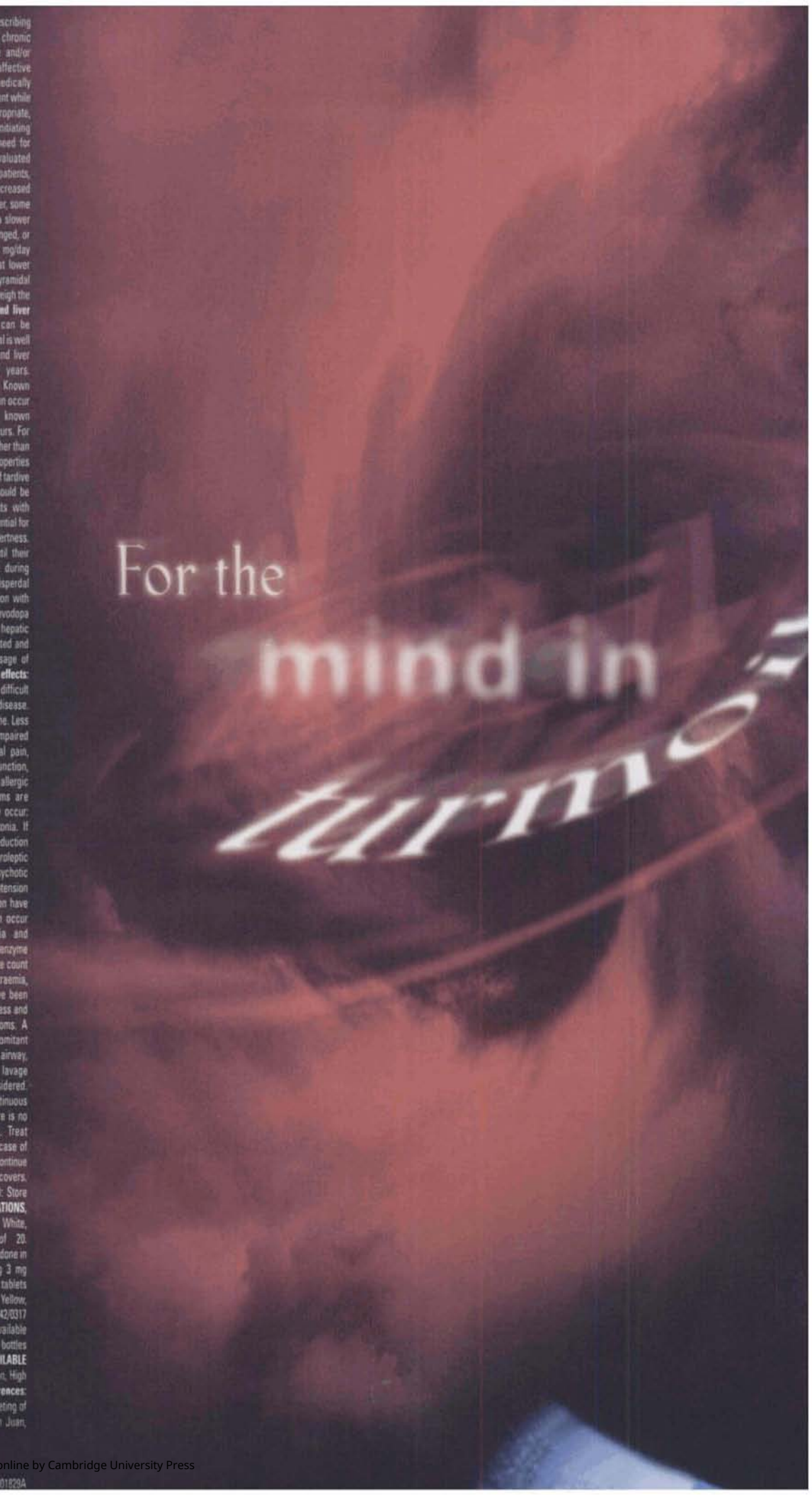

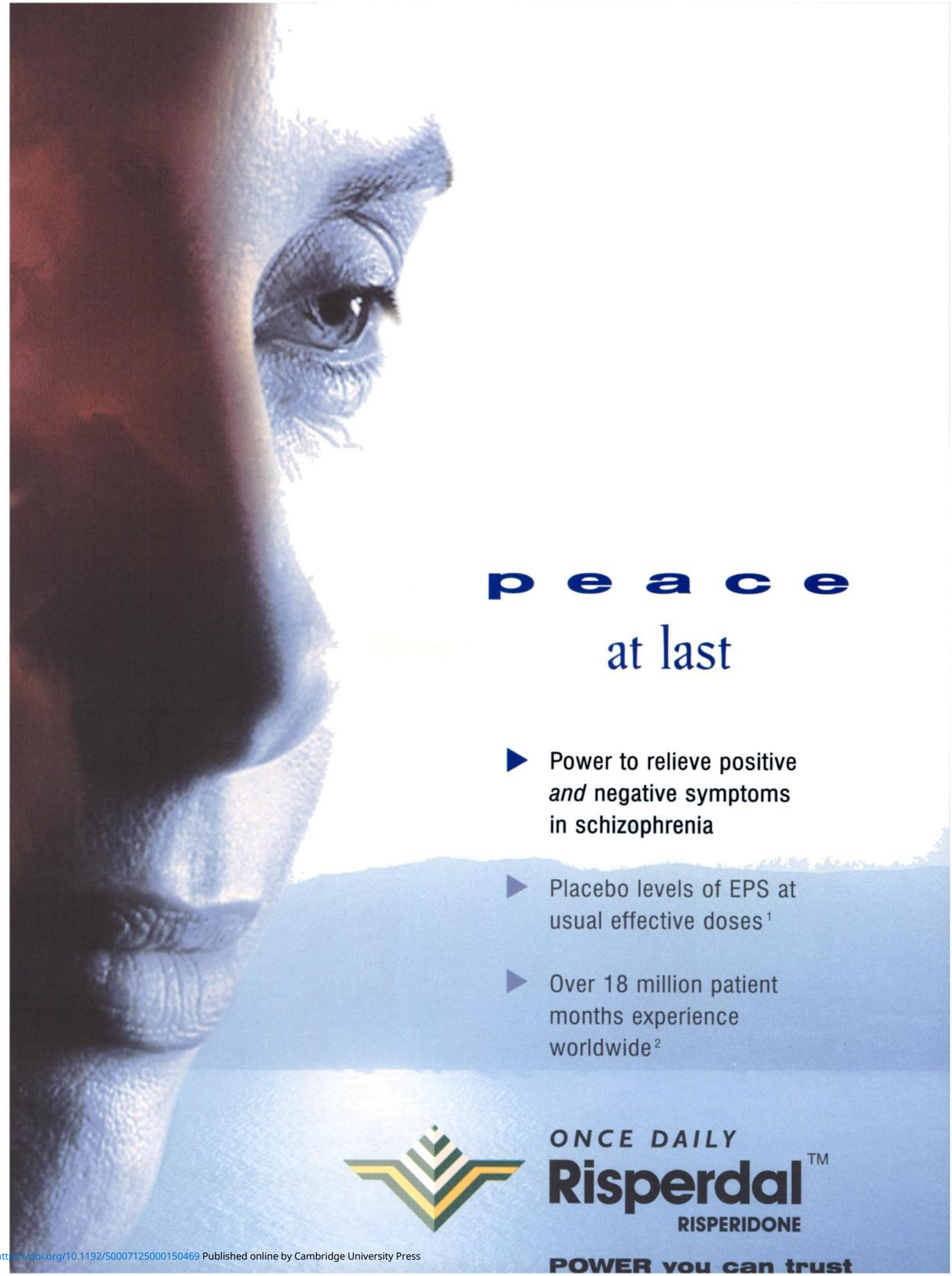

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Campral EC acamprosate

Presentation: Off-white round enteric-coated tablets, containing 333mg acamprosate calcium. Printed on one side with 333. **Properties:** Acamprosate may act by stimulating GABAergic inhibitory neurotransmission and antagonising excitatory amino acids, particularly glutamic acid. **Indication:** Maintenance of abstinence in alcohol dependent patients. It should be combined with counselling. **Dosage and Administration:** *Adults ≥ 60kg:* 6 tablets per day (2 tablets taken three times daily with meals) *Adults < 60kg:* 4 tablets per day (2 tablets in the morning, 1 at noon and 1 at night with meals). Recommended treatment period one year, starting as soon as possible after the withdrawal period. Treatment should be maintained if the patient relapses. *Elderly:* Not recommended. *Children:* Not recommended. **Contraindications:** Known hypersensitivity to the drug, renal insufficiency (serum creatinine > 120 micromol/L), severe hepatic failure (Childs-Pugh classification C), pregnancy, lactation. **Precautions and Warnings:** Campral EC 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. Campral EC should not impair the patient's ability to drive or operate machinery. **Overdose:** Gastric lavage; should hypercalcaemia occur, treat patient for acute hypercalcaemia. **Legal Category:** POM. **Pharmaceutical Precautions:** None. **Package Quantities and Basic NHS Price:** 84 blister packed tablets £24.95. **Marketing Authorisation Number/Holder:** 13466/0001, Lipha SA, Lyon, France. **Date of Preparation:** August 1997. Further information is available on request from Merck Pharmaceuticals, Harrier House, High Street, West Drayton, Middlesex, UB7 7QG. **Date of Preparation:** March 1998.
March 1998.ZZ10104

https://doi.org/10.1192/S0007125000150469

Add life to living with schizophrenia

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

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

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

Solian®
AMISULPRIDE

Efficacy that patients can live with

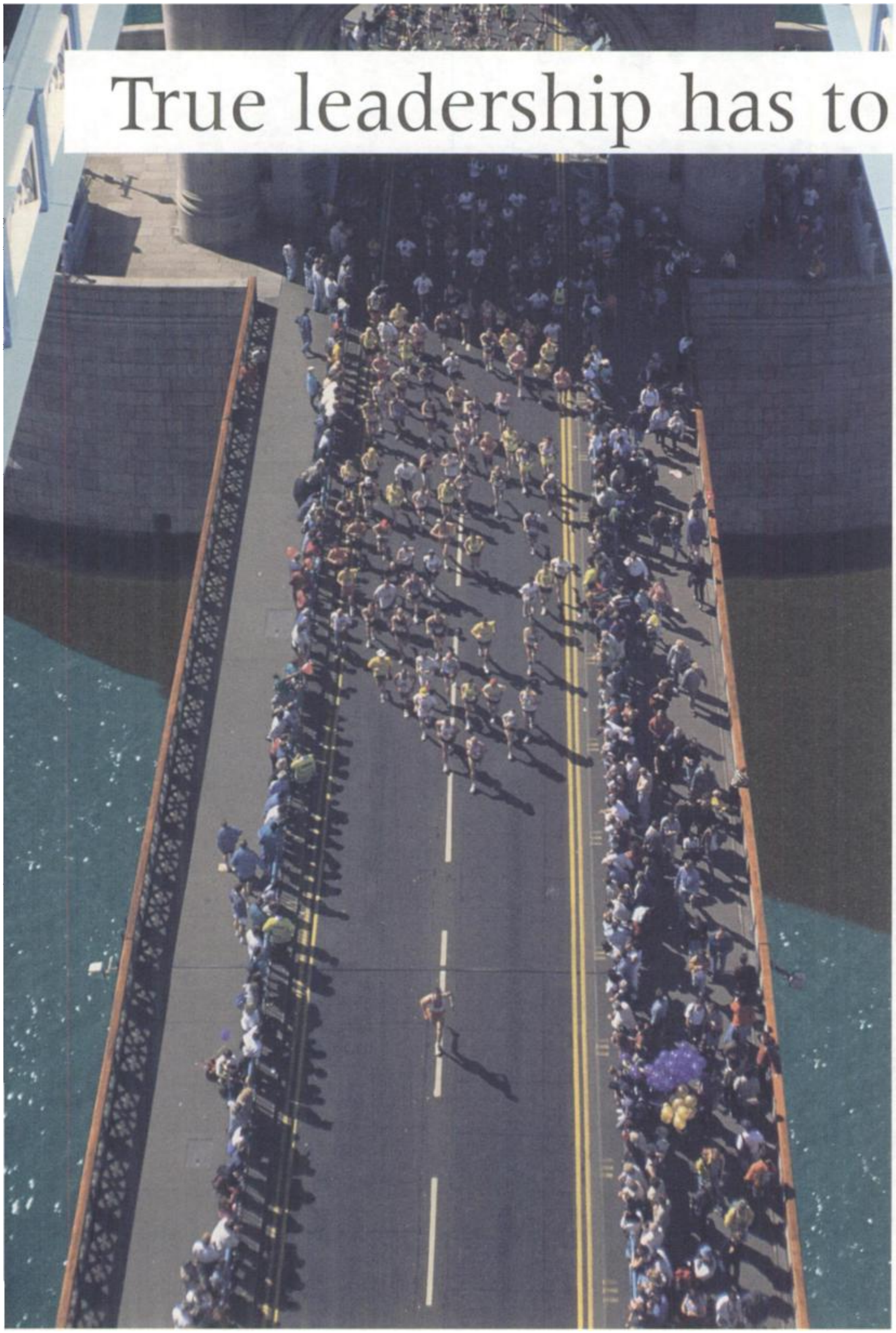
Prescribing Information - Solian 200 and Solian 50 ▼ Presentation: Solian 200mg tablets contain 200mg amisulpride and Solian 50mg tablets contain 50mg amisulpride. **Indication:** Acute and chronic schizophrenia in which positive and/or negative symptoms are prominent. **Dosage:** Acute psychotic episodes: 400-800mg/day, increasing up to 1200mg/day according to individual response (dose titration not required), in divided doses. Predominantly negative symptoms: 50-300mg once daily adjusted according to individual response. Elderly: administer with caution due to the risk of hypotension or sedation. Renal insufficiency: reduce dose and consider intermittent therapy. Hepatic insufficiency: no dosage adjustment necessary. Children: contraindicated in children under 15 years (safety not established). **Contraindications:** Hypersensitivity; concomitant prolactin-dependent tumours e.g. pituitary gland prolactinaemias and breast cancer; phaeochromocytoma; children under 15 years; pregnancy; lactation; women [illegible] **Precautions:** As with all neuroleptics, neuroleptic malignant syndrome may occur (discontinue Solian). Caution [illegible] **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 Synthélabo UK and Ireland Ltd, Foundation Park, Roxborough Way, Maidenhead, Berks, SL6 3UD. **References:** 1. Freeman HL. Int Clin Psychopharmacol 1997;12(Suppl 2):S11-S17. 2. Möller HJ. 6th World Congress of Biological Psychiatry, Nice, France, June 22-27 1997. 3. Coukell AJ, Spencer CM, Benfield P. CNS Drugs (Adis) 1996 Sep 6 (3):237-256. 4. Solian SPC. Lorex Synthélabo. 5. Sertindole SPC. Lundbeck Ltd. 6. Clozapine SPC.

SYNTHELABO
CNS DIVISION

A first choice add-on ther

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 mgs/kg/day in two divided doses. Initiate at 25 mg nightly and increase at 1 to 2 week intervals by 1 to 3 mg/kg/day to effective dose. **Contraindications:** Hypersensitivity to any component. **Precautions and Warnings:** Withdraw all 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 concentration/attention, difficulty with memory, diplopia, dizziness, fatigue, language problems,

True leadership has to be earned.



ASSOCIATED ANXIETY

Prozac has a proven record of efficacy in depression,[1,2,3] with a confirmed indication in depression with or without associated anxiety symptoms.[4]

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

PROZAC
fluoxetine

The World's No.1 prescribed antidepressant brand.[1]

'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. *Monoamine oxidase inhibitors:* At [illegible] 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 in several patients but their relationship to fluoxetine and clinical importance are unclear. *Drug interactions:* [illegible] 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 [illegible] Hyponatraemia (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** £20.77per 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, Dextra 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

https://doi.org/10.1192/S0007125000150469 Published online by Cambridge University Press

PRESCRIBING INFORMATION

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

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

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

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

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

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

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

Children: Not recommended.

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

Contra-indication: Hypersensitivity to paroxetine.

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

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

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

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

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

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

Legal category: POM. 16.2.98

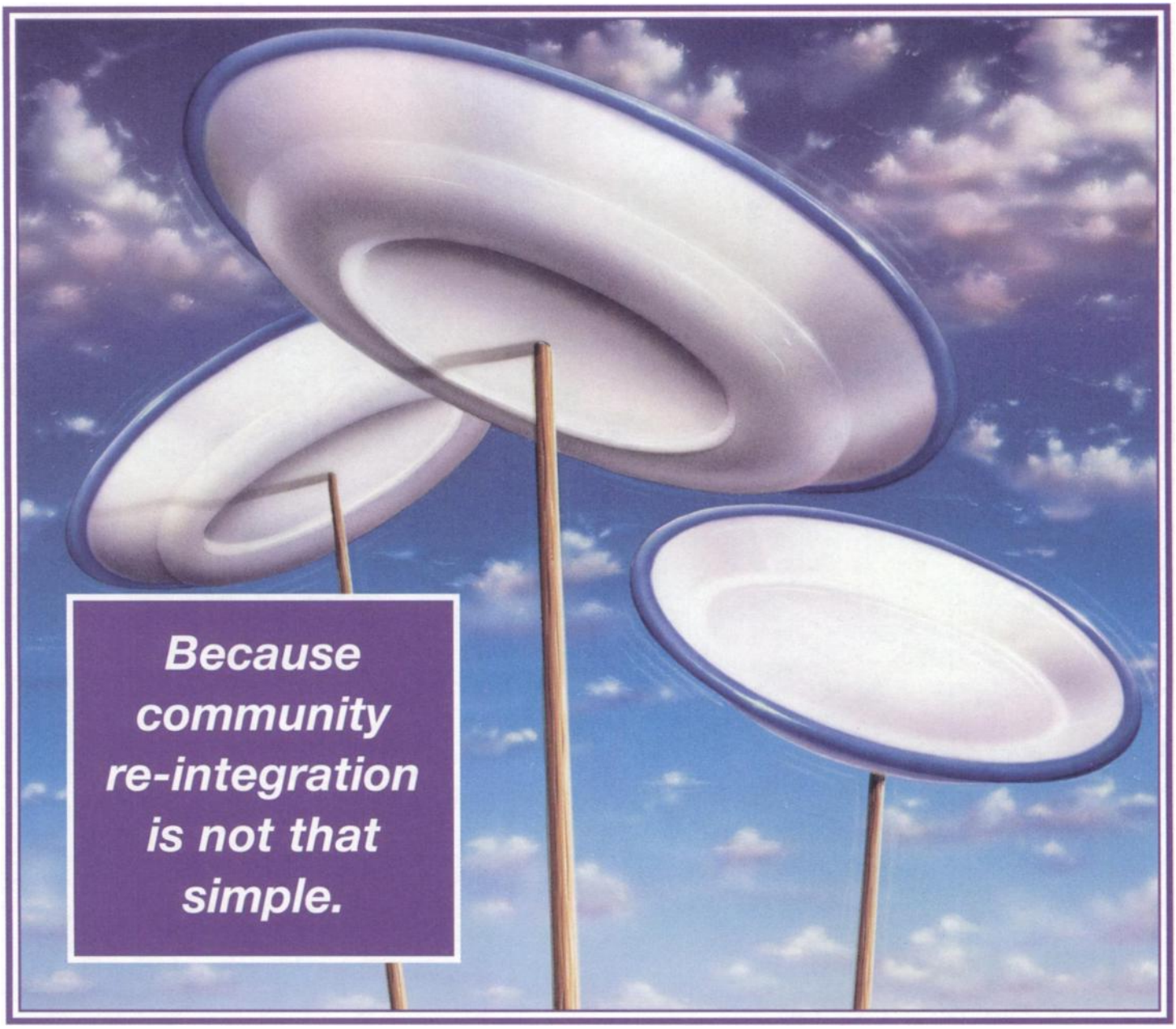
SB SmithKline Beecham Pharmaceuticals

Welwyn Garden City, Hertfordshire AL7 1EY.

SEROXAT

Rebuilding the lives of anxious depressed patients

https://doi.org/10.1192/S0007125000150469 Published online by Cambridge University Press



Antipsychotic Efficacy for First-line Use

Zyprexa Olanzapine

Making Community Re-integration the Goal

ABBREVIATED PRESCRIBING INFORMATION: **Presentation:** Coated tablets containing 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 hypereosinophilic 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 antagonise the effects of direct and 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.

Lilly PSYCHIATRY

Agenda

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**

13 July 1998

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

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Please refer to summary of product characteristics before prescribing
Presentation: White to off white tablets each containing modafinil 100 mg **Indication:** Narcolepsy **Dosage:** *Adults* 200 400 mg daily either as two divided doses in the morning and at noon or as a single morning dose according to response *Elderly* Treatment should start at 100 mg daily which may be increased subsequently to the maximum adult daily dose in the absence of renal or hepatic impairment. *Severe renal or hepatic impairment* Reduce dose by half (100 200 mg daily) *Children* See contra indications. **Contra indications:** Pregnancy, lactation use in children moderate to severe hypertension, arrhythmia, hypersensitivity to modafinil or any excipients used in Provigil **Warnings and precautions:** Patients with major anxiety should only receive Provigil treatment in a specialist unit Sexually active women of child bearing potential should be established on a contraceptive programme before starting treatment Blood pressure and heart rate should be monitored in hypertensive patients Provigil is not recommended in patients with a history of left ventricular hypertrophy or ischaemic ECG changes chest pain, arrhythmia or other clinically significant manifestations of mitral valve prolapse in association with CNS stimulant use Studies of modafinil have demonstrated a low potential for dependence although the possibility of this occurring with long term use cannot be entirely excluded **Drug interactions:** Induction of cytochrome P 450 isoenzymes has been observed *in vitro* Effectiveness of oral contraceptives containing at least 50 mcg ethinyloestradiol should be taken Tricyclic antidepressants no clinically relevant interaction was seen in a single dose interaction study of Provigil and clomipramine However, patients receiving such medication should be carefully monitored Care should be observed with co administration of anti convulsant drugs **Side effects:** Nervousness, excitation, aggressive tendencies, insomnia, personality disorder, anorexia, headache, CNS stimulation, euphoria, abdominal pain, dry mouth, palpitation tachycardia, hypertension and tremor have been reported Nausea and gastric discomfort may occur and may improve when tablets are taken with meals Pruritic skin rashes have been observed occasionally Buccofacial dyskinesia has been reported very rarely A dose related increase in alkaline phosphatase has been observed **Basic NHS cost:** Packs of 30 blister packed 100 mg tablets £60 00 **Marketing authorisation number:** 16260 0001 **Marketing authorisation holder:** Cephalon UK Ltd 11 13 Frederick Sanger Road Surrey Research Park Guildford GU2 5YD **Legal category:** POM **Date of preparation:** January 1998 Provigil and Cephalon are registered trademarks **References:** 1. Mitler MM Sleep 1994 **17** S103 S106 **2.** Data on file Cephalon [3] **3.** Lin JS *et al Proc Natl Acad Sci USA* 1996 **93** (24), 14128 14133 **4.** Simon P *et al* Eur Neuropsychopharmacol 1995, **5** 509 514

WAKE UP LITTLE SUZIE, WAKE UP

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

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

Provigil selectively activates the hypothalamus[3] and differs greatly from amphetamines in its pharmacology.[4] Consequently the incidence of amphetamine

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MODAFINIL

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Mum has Alzheimer's

- The only once daily treatment in Alzheimer's disease
- Effective in mild to moderately severe stages [1-4]
- Improves cognitive symptoms and maintains global function [1-4]
- Well tolerated 5mg and 10mg once daily doses. [1-5]

but she knew I was calling today

Aricept®

donepezil hydrochloride

Once daily in Alzheimer's

BRIEF PRESCRIBING INFORMATION

ARICEPT® (donepezil hydrochloride). Please refer to the SmPC before prescribing ARICEPT 5mg or ARICEPT 10mg. **Indication:** Symptomatic treatment of mild to moderately severe Alzheimer's dementia. **Dose and administration:** ***Adults/elderly;*** 5mg daily which may be increased to 10mg once daily after at least one month. No dose adjustment necessary for patients with renal or mild-moderate hepatic impairment. ***Children;*** Not recommended. **Contra-Indications:** Pregnancy. Hypersensitivity to donepezil, piperidine derivatives or any excipients used in ARICEPT. **Lactation:** Excretion into breast milk unknown. Women on donepezil should not breast feed. **Warnings and Precautions:** Initiation and supervision by a physician with experience of Alzheimer's dementia. A caregiver should be available to monitor compliance. Regular monitoring to ensure continued therapeutic benefit, consider discontinuation when evidence of therapeutic effect ceases. Exaggeration of succinylcholine-type muscle relaxation. Avoid concurrent use of may be particularly important with "sick sinus syndrome" and supraventricular conduction conditions. Careful monitoring of patients at risk of ulcer disease including those receiving NSAIDs. Cholinomimetics may cause bladder outflow obstruction. Seizures occur in Alzheimer's disease and cholinomimetics have the potential to cause seizures. Care in patients suffering asthma and obstructive pulmonary disease. As with all Alzheimer's patients, routine evaluation of ability to drive/operate machinery. **Drug Interactions:** Experience of use with concomitant medications is limited, consider possibility of as yet unknown interactions. Interaction possible with inhibitors or inducers of Cytochrome P450: use such combinations with care. Possible synergistic activity with succinylcholine-type muscle relaxants, beta-blockers, cholinergic or anticholinergic agents. **Side effects:** Most commonly diarrhoea, muscle cramps, fatigue, nausea, vomiting and insomnia. Other common effects in clinical trials (≥5% and ≥placebo) headache, pain, accident, common cold, abdominal **Presentation and basic NHS cost:** Blister packed in strips of 14. ARICEPT 5mg; white, film coated tablets marked 5 and ARICEPT, packs of 28 £68.32. ARICEPT 10mg; yellow, film coated tablets marked 10 and ARICEPT, packs of 28 £95.76. **Marketing authorisation numbers:** ARICEPT 5 mg; PL 10555/0006. ARICEPT 10mg; PL 10555/0007. **Marketing authorisation holder:** Eisai Ltd. **Further information from/Marketed by:** Eisai Ltd, Hammersmith International Centre, 3 Shortlands, London, W6 8EE and Pfizer Ltd, Sandwich, Kent, CT13 9NJ. **Legal category:** POM **Date of preparation:** January 1998. **References: 1.** Rogers SL et al. Neurology 1998; 50: 136-145. **2.** Study 301 (accepted for publication, Arch Int Med). **3.** Rogers SL, Friedhoff LT. Eur Neuropsychopharmacol 1998; 8 (1): 67-75. **4.** Rogers SL et al. Dementia 1996; 7: 293-303. **5.** Rogers SL & Friedhoff LT. Eur Neuropsychopharmacol 1997; 7 (suppl. 2): S251.

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