a forced-choice selection of factors that would persuade them to use depots more, the factor cited as most important was 'having more atypicals available in long-acting depot form' (43%). Most regarded depots as being associated with better compliance (89%) and reduced relapse rates (98%) compared to oral medication but only 62% agreed that depots can be used for those with first episode psychosis. A significant minority (33%) believed patients always prefer to have oral medication instead of a depot. 68% believed that patients taking medication of their own free choice is more likely for oral than depot.

Conclusions: During the last 5 years, overall depot prescribing rates have reduced. Most regarded depots as offering better adherence and reduced relapse rates but some remain concerned about the acceptability of depots to patients. These clinician concerns are important but, if extreme, could compromise medication choices offered to patients.

P0271

Audit of antipsychotic prescribing in adult services

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In the UK, several policies address the prescribing of psychotropic medication: the NSFs for mental health and for schizophrenia, and NICE guidance. The Trust has developed prescribing guidance and this audit aims to assess adherence to this and to assist in ensuring cost effective prescribing for the organisation. The general principles of the prescribing guidance are that patients requiring antipsychotic therapy should be receiving monotherapy treatment and all doses should be within the recommended maximum range.

An audit into the prescribing of all psychotropic medication prescribed by adult mental health services was undertaken. A total of 936 patients were included in the audit of which 643 (69%) were prescribed antipsychotics. At the time of the audit, 41% were inpatients and 59% community patients.

Most patients (65%) were receiving treatment with an oral atypical antipsychotic, the most common being olanzapine.

86.3% of patients were being treated with one antipsychotic and this is higher than figures quoted in national reports. When prescribed as monotherapy the doses are 99% within the therapeutic range. When polypharmacy occurs the doses are frequently above the recommended maximum range.

In line with the NSF for mental health and the NICE guidance for schizophrenia, it is recommended that prescribers review their prescribing. In particular, prescribers should review the treatment of patients prescribed more than one antipsychotic. As stated in the Trust prescribing guidance, prescribers should consider oral risperidone or amisulpride as first line atypical antipsychotics.

P0272

Olanzapine induced neutropenia : A case report

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Objective: Most of the reported Olanzapine induced leukocytopenia cases are generally associated with elderly or other metabolic diseases. We present a 23 years old female diagnosed as obsessive compulsive disorder (OCD) in whom neutropenia developed due to Olanzapine.

Case: The patient, who had diagnosis of OCD for three years and was treated with SSRIs previously, stopped drug intake few months ago. Symptoms of OCD exacerbated and additionally psychomotor agitation, irritability, rejection of treatment and persecutory thoughts started. She was hospitalized and Olanzapine 5 mg/d, Lorazepam 3mg/day were ordered. At the admission day the routine hematological and biochemical laboratory exams were in normal ranges. Olanzapine dosage was titrated up to 15mg/d in four days and psychotic features recovered on a large scale. Neutropenia was noticed at the sixth day of medication and Olanzapine was immediately stopped and Lorazepam was continued. No clinical signs of an infection occurred. After discontinuation of Olanzapine the blood cell counts started to increase at the first day and turned back to normal ranges at the sixth day. No special treatment was necessary. Psychiatric symptoms were remitted partially with Sertralin 200mg/g in 4 months.

Conclusion: Although the hematological effects of Olanzapine are still not clear exactly in this case the only probable agent to cause neutropenia is Olanzapine in young patient with no metabolic problems. Such a case would stress the importance of monitoring the patients while using antipsychotics whether they had a risk factor or not.

P0273

Can quetiapine induce delirium in bipolar disorder?

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Quetiapine is used in the treatment of delirium but recently there have been case reports of delirium associated with quetiapine especially with overdose. We present a case of delirium probably caused by quetiapine.

45 years-old male, with a diagnoses of Bipolar Disorder for 25 years and treated with lithuril 900mg/d, admitted to our outpatient clinic for starting insomnia during the last week. Quetiapine 100mg/d at night dosage added to medication but he ingested 200mg/d with the fear of that if he couldn't sleep. 2 hours later the symptoms of delirium started and continued for six hours and recovered with no treatment. The lithuril level was in normal ranges. Other psychotic and organic disorders were ruled out. It is learned that his brother had delirium with Quetiapine so he was thought to be a poor (deficient) metabolizer and Quetipine decreased to 25 mg/day in the night dosage but he had a delirium state with the same features again. Next morning he admitted to outpatient clinic only with hippomanic symptoms but no symptom of delirium. Quetiapine was discontinued and lithuril was combined with another atypical antipsychotic and symptoms were remitted.

To our knowledge this is the first case of delirium induced with low dosage of quetiapine. There were no organic risk factors or drug interactions. While a correlation of dosage and effect could be shown with Quetiapin, this case emphasizes that inter- and intraindividual differences could be observed probably due to genetical influence. Drug monitoring therefore seems useful in clinical setting.

P0274

Atypical antipsychotic agents in violent schizophrenic patients: Cholesterol, glucose and triglycerides levels

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Aims: To assess the effects of clozapine, olanzapine and haloperidol on cholesterol triglycerides and glucose levels in aggressive schizophrenic patients. To determine whether changes in cholesterol are related to aggression.

Methods: 100 physically aggressive schizophrenics were assigned to a randomized, double-blinded, parallel-group, 12-week treatment. There were 33, 34, and 33 subjects in the clozapine, olanzapine, and haloperidol groups, respectively. Fasting cholesterol, triglycerides and glucose were collected at baseline and at end of study. All aggressive events were recorded.

Results: 95 patients provided blood samples. There were differences among the three medications in weight change (F=7.6, df=2,93; p<.001), with greater weight gain for clozapine and olanzapine than haloperidol. There were significant differences among the 3 groups in changes in cholesterol (F=4.5, df=2,93; p=.01; greater increase for clozapine than for haloperidol, p <.01), triglycerides (F=5.5, df=2,93; p<.01; greater increase in clozapine than haloperidol, p <.01 and olanzapine p=.01) and glucose (F=3.9, df=2,93; p=.02; greater increase for clozapine than for haloperidol, p <.01 and than olanzapine, p=.05). We investigated the relationship to aggression, by dividing patients into high and low cholesterol groups through a median split. Patients in the low cholesterol group were more physically aggressive during the study than those in the high group (F=4.94, df=2,92, p=.03). A significantly higher percentage of the patients in the haloperidol group than in the clozapine group had values below the median.

Conclusions: Clozapine treatment is associated with increases in serum glucose, triglycerides and cholesterol. This increase in cholesterol may explain in part its antiaggressive effect.

P0275

Tardive dystonia in neuroleptic treated bipolar disorder and treated with clozapine - a case report and review of the literature

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Tardive dystonia is an extrapyramidal adverse effect that can arise after prolonged use of dopamine receptor antagonists and is characterized by sustained involuntary muscle contractions frequently causing twisting and repetitive movements or abnormal postures. This occurs most commonly in the head and neck region and can begin as a focal dystonia, which then progresses to a segmental form. The prevalence of tardive dystonia in neuroleptic treated individuals ranges from 0.4% to 4%. Up to half of the patients who develop tardive dystonia tend to do so in the first 5 years of neuroleptic exposure, with onset earlier in males than females. Tardive dystonia tends to be persistent with a low remission rate of 10 percent in 6.6 years. Previous cases of tardive dystonia were mainly reported in patients with schizophrenia spectrum disorders. We report a case of tardive dystonia in a neuroleptic treated bipolar disorder and was treated with clozapine.

Tardive dystonia has been associated with both typical and atypical neuroleptic exposure, such as clozapine, olanzapine, risperidone and ziprasidone. Several authors have suggested the use of clozapine in the treatment of tardive dystonia. The ability of clozapine to treat tardive dystonia may be related to D1 receptor antagonism. There have also been case reports of tardive dystonia treated by olanzapine and quetiapine. Botulinum toxin and dopamine-depleting drugs may also be effective. More recent reports suggested the use of deep brain stimulation of regions such as globus pallidus and subthalamic nucleus in the treatment of tardive dystonia.

P0276

Remission in patients with schizophrenia treated with risperidone long-acting injection: Results from the e-STAR project in Czech Republic and Slovakia

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Objective: Assess illness remission in patients with schizophrenia enrolled in the electronic-Schizophrenia Treatment Adherence Registry (e-STAR) in Czech Republic and Slovakia.

Methods: e-STAR is a secure web-based, ongoing, international, long-term observational study of patients with schizophrenia who initiate RLAI during routine clinical management. Data is collected retrospectively (1 year) and prospectively (2 years). Prospectively patients are evaluated for the following symptoms: delusions, conceptual disorganization, hallucinatory behaviour, mannerisms and posturing, unusual thought content, blunted affect, passive/apathetic social withdrawal, and lack of spontaneity and flow of conversation. Patients in whom all of these symptoms are absent, minimal or mild and within normal boundaries, stable, and do not interfere with thinking, social relations, and behaviour or functioning, were considered to be in cross-sectional remission and if this persisted for at least 6 months, they were considered to be in remission.

Results: 1,068 patients have been enrolled into e-STAR in Czech Republic and Slovakia; 280 patients have been followed for at least 12-months and were included. The majority were male (57.9%) with a diagnosis of schizophrenia or schizoaffective disorder (85.7%, 14.3% respectively) with a mean age of 37±12.1 years and a mean time since diagnosis of 9.2±9 years. The proportion of patients who met the criteria for cross-sectional remission increased from 2.4% at baseline to 37.9% at 12 months. After 12-months, 20.6% of patients met the criteria for illness remission.

Conclusions: Based on 12-month interim results, the proportion of patients who met the criteria for illness remission increased after initiating RLAI.

P0277

Improvements in illness severity and functioning in patients with schizophrenia treated with risperidone long-acting injection in The Netherlands

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Objectives: To assess changes in illness severity (Clinical Global Impression-Severity scale, CGI-S) and functioning (Global Assessment of Functioning, GAF) in patients initiated on risperidone long-acting injection (RLAI) during routine clinical practice and followed up for at least 12 months in the Netherlands.

Methods: e-STAR is an international, prospective, observational study of patients with schizophrenia who have been initiated with RLAI. Data are collected both retrospectively (1 year) and

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