graphic changes which have resulted in a "graying of the population", the number of older individuals with chronic psychiatric illnesses (eg. schizophrenia; bipolar mood disorder) is also increasing. The same demographic trends are causing a significant increase in the incidence of neurodegenerative disorders (eg. Alzheimer's Disease) which are frequently characterized by behavioural changes in addition to their cognitive stigmata. This presentation will describe the prevalence and phenomenology of psychiatric syndromes and neurodegenerative illnesses in the elderly population, and will detail the differential diagnosis which the psychiatrist must invoke in order to arrive at a satisfactory diagnosis in the individual patient.

CLINICO-PATHOLOGICAL CORRELATIONS OF THE COGNITIVE IMPAIRMENT IN SCHIZOPHRENIA, TREATMENT IMPLICATIONS

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The debate between the Kraepelinian pronouncement that outcome of schizophrenia is invariably bleak and the view that outcome of schizophrenia in old age is variable focuses on cognitive capacities in old age and not on psychosis, which for many patients ameliorates. In addressing this debate, we studied cognitive functions in 400 institutionalized schizophrenic patients, between the ages of 25 and 85. To investigate the biological substrate for the cognitive impairment in geriatric schizophrenics, some of them had been followed until death and autopsy. Results indicated that 2/3 of the institutionalized geriatric schizophrenic patients experienced severe cognitive impairment but less than 10% of cognitively impaired schizophrenic patients met definite neurohistological criteria for Alzheimer's Disease (AD) and non had cholinergic deficits. On the other hand abnormal distribution of neuropeptides and synaptopysin was detected in these patients. Attempts to treat cognitive impairment in schizophrenia with behavioral interventions or currently available antipsychotic drugs have yielded only limited success. A reconceptualization of the treatment of schizophrenia is needed in which cognitive impairment becomes a target for pharmacological treatment. This can be achieved by conducting trials with compounds that are not antipsychotic but are believed to improve cognition, and/or by searching for antipsychotic compounds with cognitive enhancing properties. It is also essential to determine which of the novel anti-psychotic drugs can be given to agitated, psychotic, demented patients without further worsening cognitive performance.

A very preliminary study in which risperidone was given to geriatric schizophrenics suggests improvements in CGI, digit span, and MMSE scores without producing EPS. These suggestions are now investigated in large, double blind, placebo (and/or active) controlled studies.

ANTIPSYCHOTIC DRUG TREATMENT OF LATE-LIFE PSYCHOSES

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Late-life psychoses include dementia with psychosis, psychotic depression, schizophrenia, delusional disorder, psychoses secondary to general medical conditions, and several other less common disorders with psychotic symptoms. Antipsychotics generally constitute the most effective treatment of late-onset psychoses. The risk of many adverse effects with antipsychotic drug treatment is, however, considerably higher in the aged. For example, we found the cumulative annual incidence of tardive dyskinesia with typical neuroleptics among patients over age 45 (mean age 66) to be 26%, which was five to six times greater than that reported in younger patients. Data concerning the use of the new serotonin-dopamine antagonists in elderly patients are relatively scanty. Initial studies suggest that clozapine in efficacious but its use in older patients is markedly limited by side effects such as anticholinergic toxicity. We recently examined the use of risperidone in 39 patients ranging in age from 45 to 100. Risperidone was clinically effective in a majority of these patients and was generally well-tolerated, but needed to be prescribed in lower dosages (3 mg/day or less) than those recommended for younger adults in order to reduce the incidence of adverse effects such as *postural* hypotension, sedation and extrapyramidal symptoms. Our preliminary data also suggested a mild but significant cognitive enhancing effect of low-dose risperidone in older psychotic patients. The mean Mini-Mental State Examination score increased from 24.2 to 28.2 after an average of 11 weeks of treatment ($p < 0.005$). We will discuss the risk: benefit ratio of the newer atypical antipsychotics in older patients.

PHARMACOLOGICAL MANAGEMENT OF PSYCHOSIS IN THE FACE OF DEMENTIA

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Psychosis (hallucinations and delusions) occurs in up to one third of patients with Alzheimer's disease (AD) and can be the presenting and most disturbing feature of Lewy Body dementia (LBD). Typical neuroleptics are frequently prescribed to this patient population but are ineffective in many, produce side effects in most, and can be associated with fatal neuroleptic sensitivity in LBD. It remains unclear whether the lack of efficacy of typical neuroleptics in dementia patients is due to intolerance of higher doses or to resistance of psychotic symptoms to dopamine blockade. The side effect profile of atypicals appears more promising although efficacy remains to be demonstrated. Non-neuroleptic treatments can be useful, particularly where there is agitation or sleep disturbance associated with psychotic symptoms. In spite of the drawbacks, judicious use of neuroleptics in selected patients can be extremely beneficial. The following guidelines for neuroleptic use in dementia patients are based on the available empirical data: (i) Neuroleptics should be avoided if possible in patients with a history of neuroleptic sensitivity or suspected LBD. (ii) There is no clear evidence that one neuroleptic is any better than another and the choice of drug therefore depends on the side effect profile and clinician preference. (iii) The starting dose should be low and titrated upwards gradually, but in most cases, treatment doses should be in the range of 0.25–3.0 mg of haloperidol equivalents. (v) Although the ideal minimum (or maximum) period of treatment is unknown at present, because behavioral disturbances tend to be episodic and neuroleptic exposure is frequently associated with treatment emergent side-effects, exposure to neuroleptic should be time-limited and reviewed on a regular basis.

THE MANAGEMENT OF PSYCHOTIC SYMPTOMS IN DEMENTIA WITH LEWY BODIES (DLB)

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DLB patients have higher rates of psychosis than in other dementia subtypes. Visual hallucinations (VH) occur in 80% of our autopsy confirmed DLB cases vs 19% of Alzheimer's disease (AD) and 0% of

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vascular dementia (VaD) cases. ($p < 0.001$). Not only are psychotic symptoms more frequent, they are also more persistent over time. Hallucinating DLB cases have reductions in choline acetyltransferase in temporal and parietal cortex, to 20% or less of age matched controls, with relatively preserved indices of monoaminergic function. Promising pharmacological strategies in DLB should therefore include cholinergic enhancement and serotoninergic/dopaminergic antagonism.

Severe adverse reactions occur in 50% of DLB patients prescribed standard doses of typical neuroleptics. This has generated a "neuroleptic sensitivity" hypothesis, which is supported by a review of the clinical literature. We have postmortem evidence of a critical vulnerability to striatal D2 receptor blockade in neuroleptic sensitive DLB patients, associated with a 40–50% loss of dopaminergic neurones in the substantia nigra.

The first step in managing psychosis in DLB should be a reduction in any anti-Parkinsonian agents, the preferred order being L-deprenyl, anticholinergics, followed by direct, then indirect, dopamine agonists. If psychosis persists despite withdrawal of anti-Parkinsonians to a point where further motor impairment becomes unacceptable, an antipsychotic agent should be cautiously prescribed during inpatient admission, observing carefully for serious adverse effects. Atypical neuroleptics, particularly those with neither D2 or muscarinic receptor antagonism, should be particularly suited to the neurochemical profile of patients with DLB.

S40. Physician assisted suicide

Chairmen: P Cosyns, F Beyaert

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DEBATE

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In this paper some arguments against physician assisted suicide in case of mental suffering will be evaluated.

A first argument contends that physician assisted suicide violates the moral integrity of medicine, psychiatry and the physician-patient relationship. Physician assisted suicide would undermine trust in the physician and undermines the goals of medicine and psychiatry. Elements of this argument are:

- the inalienability of life
- the sanctity of life
- the absolute prohibition against killing, and
- healing as the single goal of medicine

A second argument against physician assisted suicide in mental health care is that it inevitably leads to the so-called "slippery slope". By some it is even claimed that "the Dutch experience" — i.e. the legal ruling in the Chabot case — already shows that slippery slope effects in fact are taking place in the Netherlands.

The third claim that will be evaluated concerns the argument that if a person wants to die (i.e. to commit suicide) he can do it himself. Upon this claim there is no justified reason why a third person/physician ought to provide assistance.

Critical normative and empirical evaluation of these three arguments leads to the conclusion that they do not justify an absolute prohibition against physician-assisted suicide in case of mental suffering.

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DISCUSSION

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The main responsibility of physicians is to use medical expertise to respond to the patient's need for help in order to improve his health or functional status. Psychiatrists are sometimes, as any other physician, confronted with the limits of their scientific knowledge. What can a psychiatrist do when he no longer can meet the medical needs of his patient, requesting physician assisted suicide, when medical treatment is futile and has nothing to offer to improve the quality of life? There is a difference between the medical needs of a patient, his wishes and desires.

The current societal emphasis in our culture of the principle of autonomy means a shift of the responsibility of health from the physician to the patient. This principle of autonomy is not absolute and has also limitations. Respect for patients as autonomous persons is distinct from complying with their individual choices concerning life and death.

Physicians have a specific role in society, but should assisting suicide be a part of that role? Is assisting suicide a true medical act? Exceptional cases do indeed exist in medical practice, but they must remain exceptional, so not put forward as exemplary for a larger group of more common cases. Negative changes would enter into the relationship of the physician with the public and his patients, should the practice of physician assisted suicide become common. Moreover every one of us has the factual possibility to commit suicide without physicians help. In some individual cases nonintervention may be appropriate and characterize "allowed" suicide rather than "assisted" suicide, which implies aid in implementing a decision.

We take notice of a still expanding intrusion of the legal model and thinking in the field of medicine. Is it opportune or beneficial for society to make laws or official regulations on physician assisted suicide? The question is if such laws improve the quality of care provided by psychiatrists.

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DISCUSSION

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Suicide may be active or passive, voluntary or involuntary. Suicide and attempted suicide were decriminalised in France at the Revolution, in the U.K. in 1961 and in Ireland in 1993. Britain and Ireland regard assisted suicide as a crime. Physician assisted suicide carries the further penalty of erasure from the medical register. In euthanasia, the patient is passive and the doctor is the active agent. In assisted suicide, these roles are reversed with the doctor providing the drugs, instruments or necessary advice. In some European countries and, in most states in the U.S., the physician may give advice or drugs but cannot be present at the death. If he was, he would have a professional responsibility to resuscitate. A distinction must be made between assisted suicide and fatal terminal illness and assisted suicide in functional illness. Pre-emptive suicide, i.e. suicide in anticipation of illness, must also be distinguished.

The "slippery slope" appellation is usually used in a pejorative sense. Society is fragile however and intended restrictive practices may easily become general rules. Hard cases make bad law. Dissonants in Nero's day were asked had they considered suicide. If not, of if they hesitated, the Emperor was wont to send his physician to call.

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