P0267

Atypical vs. Conventional antipsychotic drugs – effects on quality of life

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The study analyzes effects of using atypical antipsychotic drugs (risperidone and clozapine) as compared with effects of using conventional antipsychotic drugs (haloperidol) in treatment of schizophrenic and schizoaffective disorders. The analysis focuses on assessing quality of life and subjective association with applied treatment in examinees during the administration of a medicament therapy. Level and pace of reducing social dysfunction, as well as of improving quality of life, is measured by Heinrichs-Hanlon-Carpenter scale, while the subjective association with applied antipsychotic treatment in examinees is measured with a specifically designed scale. The study covers 160 examinees split into two groups of 80 - experimental and control. The experimental group's examinees are treated with atypical antipsychotic drugs, and the control groups examinees are treated with conventional antipsychotic drugs. The study encompasses one year of examinee observation with a following frequency: at a beginning of the analysis, after 2 weeks, after 4 weeks, after 8 weeks, after 3 months, after 6 months, after 9 months, and finally after 12 months. Statistical analysis and inter-group comparison of examinees treated with atypical antipsychotic drugs and those treated with conventional antipsychotic drugs followed the observation period.

Results: Indicate a significantly better social rehabilitation and subjective association with therapy in examinees treated with atypical antipsychotic drugs compared with those treated with conventional antipsychotic drugs.

P0268

Acute use of antipsychotics: The issue of dose

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Data on the use of antipsychotics in acute psychiatric patients are based almost entirely on RCT trials with fixed or flexible dosing inside registered dosing intervals. Usually antipsychotic monotherapy is used in such trials. Real-life clinical experience might differ from such data and put in question recommendations and guidelines.

Inpatients admitted to PICU at University Psychiatric Hospital in Ljubljana during one month in 1999 and in 2006 were compared by clinical variables using CGI and GAS and by the use of antipsychotics. The doses of used antipsychotics were calculated into CPZ equivalents and compared with recommended as well as registered doses.

Results showed that samples for 1999 and 2006 did not differ in major demographic data. Clinical data however showed that 2006 patients were admitted more ill and discharged less ill (1 point average difference in CGI). The average doses of antipsychotics rose from 383 mg/day in 1999 to 689 mg/day in 2006. Although the atypical/typical ratio changed 5-fold during observed time, change in the observed doses is attributed to atypicals only. The doses of typical antipsychotics did not change comparing 1999 and 2006 sample.

The study was able to show important changes in the acute use of antipsychotics during the era of atypical or newer antipsychotics. Our results put in question some of the recommended dosing for antipsychotics in the acute psychiatric patients and confirm the practice of off-label use of antipsychotics regarding the dose in acute psychiatric states.

P0269

Quetiapine reduces sib in non-psychotic BPD: A case report

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Self injurious behavior (SIB) is a core feature of borderline personality disorder (BPD). BPD is a potentially life threatening psychiatric disorder causing considerable intraindividual distress, impairment of psychosocial functioning, disturbed relationships and high rates of treatment utilization. The use of antipsychotics in BPD implies differential etiopathogenetic thinking in specialists who are convinced that BPD is a heterogen diagnosis representing "borderline schizophrenia" or bipolar disorder. Quetiapine decreases psychotic symptoms in hallucinating BPD and may be effective in "borderline schizophrenia" or "borderline bipolar patients". Several articles have speculated on the effectiveness of quetiapine in borderline symptoms as SIB targeting on reduction of causal pervasive affective dysregulation.

A 24 years old female patient was referred to a psychiatric inpatient unit due to an increase of SIB. Initial diagnostic process solidified diagnosis of BPD. Axis I diagnosis were alcohol abuse, recurrent major depression, eating disorder nos. A protocol on inner tension and frequency of SIB was introduced. HAM-D, CGI-S, CGI-I and Barrat-Impulsiveness-Scale were administered weekly respectively monthly for 3 month. After informed consent the initial polypharmacy excluding the antidepressant was terminated within the following 10 days and quetiapine was started with 25mg/day. The following days quetiapine dosage was titrated to 250mg/day with only mild sedation. There was a marked decrease of SIB over 3 month of treatment. All other measures improved over 3 month of observation time. Decrease of symptom pressure activated the patient to increase use of solving skills to reduce/control inner tension.

P0270

Psychiatrists' attitudes to antipsychotic depot injections (i): Preferences and choice

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Background: Antipsychotic depot injections can improve adherence compared to tablets. However, depot prescribing practices differ amongst psychiatrists. Previously, some clinicians perceived an ''image'' problem for typical antipsychotic depots. This study investigated psychiatrists' attitudes and knowledge concerning antipsychotic depots (typical and atypical) in an era when patient choice is a pertinent issue.

Method: Cross-sectional postal survey of consultant psychiatrists working in NorthWest England. A pre-existing questionnaire on clinicians' attitudes and knowledge regarding depots was updated.

Results: The sample comprised 102 consultant psychiatrists (response rate 102/143, 71%). Their use of depots over the past 5 years had: decreased (50%), not changed (27%), increased (23%). In

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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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