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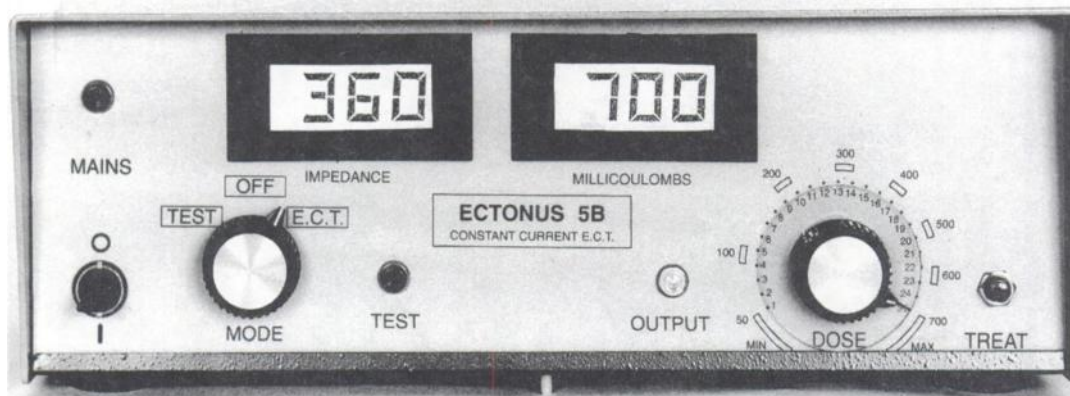
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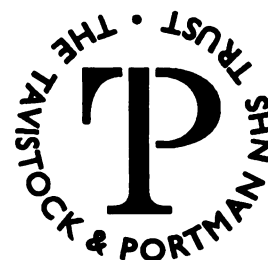
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if clearly needed. **Lactation:** Not recommended. **Precautions, warnings:** Renal insufficiency, unstable epilepsy, ECT, driving. LUSTRAL should be discontinued in a patient who develops seizures. LUSTRAL should not be administered to patients concurrently being treated with tranquillizers who drive or operate machinery. Do not use with, or within two weeks of ending treatment with, MAOIs. At least 14 days should elapse before starting any MAOI following discontinuation of LUSTRAL. Patients should be closely supervised for the possibility of suicide attempt or activation of mania/hypomania. **Drug interactions:** Administer with caution in combination with other centrally active medication. Serotonergic drugs including tryptophan, sumatriptan and fenfluramine should not be used with LUSTRAL. It is recommended that plasma lithium levels be monitored following initiation of LUSTRAL. Although LUSTRAL has been shown to have no adverse interaction with alcohol, concomitant use with alcohol is not recommended. The potential for LUSTRAL to interact with other highly protein bound drugs should be borne in mind. The potential of LUSTRAL to interact with a wide range of drugs, including and

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treatment as appropriate. Haemodialysis is effective in removing topiramate. Pharmaceutical Precautions: Store in a dry place at or below 25°C. Legal Category: POM. Package Quantities and Prices: Bottles of 60 tablets. 25mg (PL0242/0301) = £22.02; 50mg (PL0242/0302) = £36.17; 100mg (PL0242/0303) = £64.80; 200mg (PL0242/0304) = £125.83. Product Licence Holder: JANSSEN-CILAG LIMITED, SAUNDERTON, HIGH WYCOMBE, BUCKINGHAMSHIRE HP14 4HJ Further information is available on request from the Marketing Authorisation Holder: Janssen-Cilag Limited, Saunderton, High Wycombe, Buckinghamshire HP14 4HJ. © Registered Trademark © Janssen-Cilag Limited 1996 Date of Preparation Aug 1996

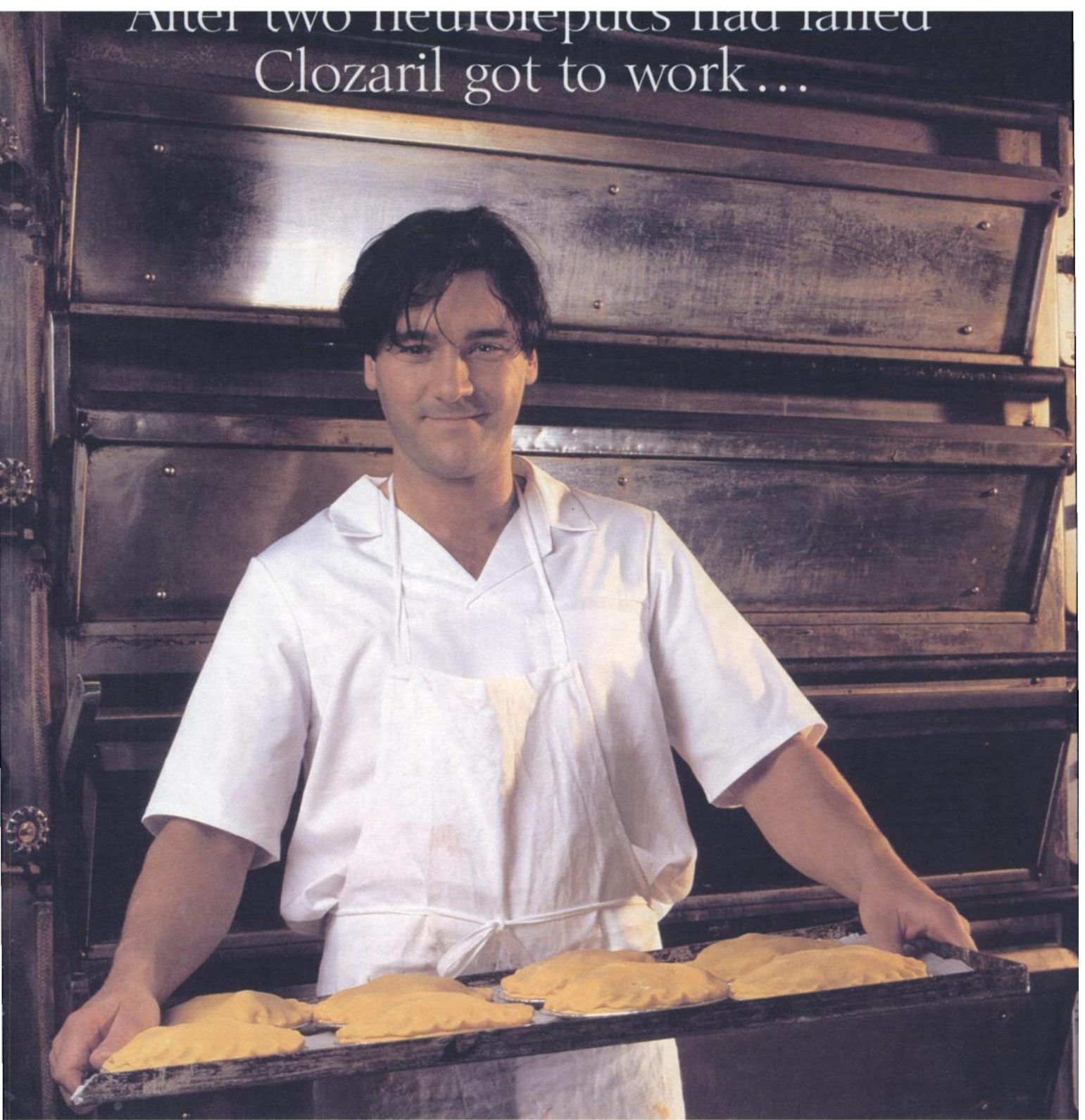
CLOZARIL ABBREVIATED PRESCRIBING INFORMATION. The use of CLOZARIL is restricted to patients registered with the CLOZARIL Patient Monitoring Service. Indication: Treatment-resistant schizophrenia (patients non-responsive to, or intolerant of, conventional neuroleptics). Presentations 25 mg and 100 mg clozapine tablets. **Dosage and Administration** Initiation of CLOZARIL treatment must be in hospital in-patients and is restricted to those patients with a normal white blood cell count and differential count. Initially, 12.5 mg once or twice on first day, followed by one or two 25 mg tablets on second day. Increase slowly, initially by daily increments of 25 to 50 mg, followed by increments of 50 to 100 mg to reach a therapeutic dose within the range of 200 to 450 mg daily. 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. Therefore, 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** Hypersensitivity to clozapine. 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 and severe hepatic, renal or cardiac 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. Because of the risk associated with CLOZARIL therapy its use is therefore limited to treatment-resistant schizophrenic patients: 1. who have normal leucocyte findings (white blood cell count and differential blood count), 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 treatment monitoring may be changed to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue as long as treatment continues. Patients must be under specialist supervision and CLOZARIL supply is restricted to hospital and community 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. Particular attention should be paid to flu-like complaints or other symptoms which might suggest infection, such as fever or sore throat. **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 treatment, monitoring may be changed to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue as long as treatment continues. If the white blood count falls below $3.0 \times 10^9/l$ and/or the absolute neutrophil count drops below $1.5 \times 10^9/l$, withdraw CLOZARIL immediately and monitor the patient closely, paying particular attention to symptoms suggestive of infection. Re-evaluate any patient developing an infection, or with a routine white blood count between 3.0 and $3.5 \times 10^9/l$ and/or a neutrophil count between 1.5 and $2.0 \times 10^9/l$, with a view to discontinuing CLOZARIL. Any further fall in white blood/neutrophil count below $1.0 \times 10^9/l$ and/or $0.5 \times 10^9/l$ respectively, after drug withdrawal requires immediate specialised care. Where protective isolation and administration of GM-CSF or G-CSF may be indicated. Colony stimulating factor therapy should be discontinued when the neutrophil count returns above $1.0 \times 10^9/l$. CLOZARIL lowers the seizure threshold. Orthostatic hypotension can occur therefore close medical supervision is required during initial dose titration.

Monitor hepatic function in liver disease. Use with care in prostatic enlargement, narrow-angle glaucoma and paralytic ileus. Patients affected by the sedative action of CLOZARIL should not drive or operate machinery. CLOZARIL should be administered with caution to patients who participate in activities requiring complete mental alertness. Patients with fever should be carefully evaluated to rule out the possibility of an underlying infection or the development of agranulocytosis. 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 isoenzyme cytochrome P450 2D6. Caution is advised with drugs which possess affinity for the same isoenzyme. Concomitant cimetidine and high dose CLOZARIL was associated with increased plasma clozapine levels and the occurrence of adverse effects. Discontinuation of concomitant carbamazepine resulted in increased clozapine levels. Phenytoin decreases clozapine levels resulting in reduced effectiveness of CLOZARIL. No clinically relevant interactions noted with antidepressants, phenothiazines and type Ic antiarrhythmics observed, to date. Isolated reports of fluvoxamine increasing clozapine plasma levels by 5-10 fold. 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. 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. 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. Isolated cases of respiratory depression or arrest, with or without circulatory collapse. GI disturbances, increases in hepatic enzymes. In rare cases, cholestasis has been reported and very rarely ileus may occur. Rarely aspiration may occur in patients presenting with dysphagia or as a consequence of acute overdose. Both urinary incontinence and retention and priapism have been reported. 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 hospital and community 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** January 1996. Full prescribing information, including Product Data Sheet is available from SANDOZ PHARMACEUTICALS. Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.



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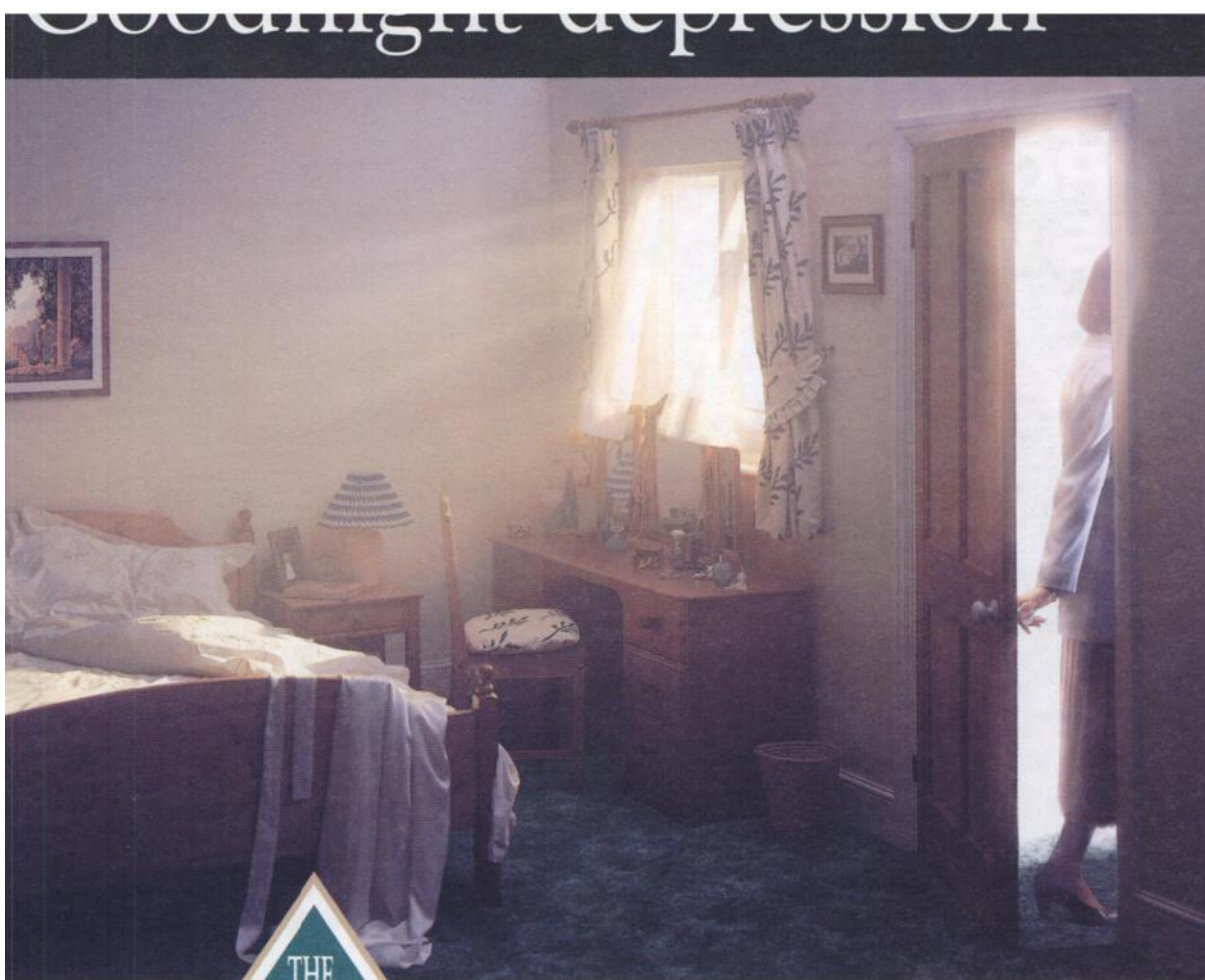
SEROTONIN NORADRENALINE REUPTAKE INHIBITOR

PRESCRIBING INFORMATION: PRESENTATION: Tablets containing 37.5mg, 50mg or 75mg venlafaxine (as hydrochloride). USE: Treatment of depressive illness. DOSAGE: Usually 75mg/day (37.5mg bd) with food, increasing to 150mg/day (75mg bd) if necessary. In more severely depressed patients, 150mg/day (75mg bd) increasing every 2 or 3 days in up to 75mg/day increments to a maximum of 375mg/day, then reducing to usual dose consistent with patient response. Discontinue gradually. Elderly: use normal adult dose. Children: contraindicated. Doses should be reduced by 50% for moderate renal or moderate 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. Use with caution in patients taking other CNS-active drugs or in the elderly or hepatically-impaired patients taking cimetidine. Patients with a history of drug abuse should be monitored carefully. Not recommended in severe renal or severe hepatic impairment. INTERACTIONS: MAOIs: do not use Efexor in combination with MAOIs or within 14 days of stopping MAOI treatment. Allow 7 days after stopping Efexor before starting a MAOI. SIDE-EFFECTS: Nausea, headache, insomnia, somnolence, dry mouth, dizziness, constipation, asthenia, sweating, nervousness, anorexia, dyspepsia, abdominal pain, anxiety, impotence, abnormality of accommodation, vasodilation, vomiting, tremor, paraesthesia, abnormal ejaculation/orgasm, chills, hypertension, palpitation, weight gain, agitation, decreased libido, rise in blood pressure, postural hypotension, reversible increases in liver enzymes, slight increase in serum cholesterol, hyponatraemia.

BASIC NHS PRICE: 37.5mg tablet (PL 0011/0199) – Calendar pack of 56 tablets: £23.97, 50mg tablet (PL 0011/0200) – Blister pack of 42 tablets: £23.97, 75mg tablet (PL 0011/0201) – Calendar pack of 56 tablets: £39.97. LEGAL CATEGORY: POM. Further information is available upon request. PRODUCT LICENCE HOLDER: Wyeth Laboratories (John Wyeth & Brother Limited), Taplow, Maidenhead, Berkshire, SL6 0PH. Space photography provided courtesy of National Aeronautics and Space Administration (NASA). References: 1. Muth EA *et al.* *Biochem Pharmacol* 1986; 35(24): 4493-4497. (EX00007). 2. Dierick M *et al.* *Prog Neuropsychopharmacol Biol Psychiat* 1996; 20: 57-71. 3. Clerc GE *et al.* *Int Clin Psychopharmacol* 1994; 9(3): 139-143. (EX00101). 4. Entsuah R *et al.* *Human Psychopharmacol* 1995; 10: 195-200. 5. Data on file, 635. 6. Troy SM *et al.* *J Clin Pharmacol* 1995; 35: 410-419. 7. Data on file, 20276. 8. Parker V *et al.* *J Clin Pharmacol* 1991; 3(9): 867 (Abstract 110). (EX00023). 9. Troy S *et al.* *Clin Neuropharm* 1992; 15(Suppl 1 pt.B): 324B. (EX00067). Date of preparation: September 1996. Code: Z776040/0996. *trade marks





THE
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ANTIDEPRESSANT
LICENSED FOR
PANIC
DISORDER†

Good morning world

Because most patients with depression suffer from insomnia and disturbed sleep,¹ an antidepressant should tackle this problem early on.

'Seroxat' has a difference, now well documented in major trials. It has the ability to match tricyclic efficacy in improving sleep by night, without the likelihood of sedation by day.^{2,3}

With 'Seroxat', you can give your patients much needed sleep as early as week one.⁴ You can lift both depression⁵ and anxiety² and reduce rather than increase agitation.⁶

It's a real difference for people needing the strength to face reality again, and a real reason to prescribe this SSRI, which is now also indicated for Panic Disorder and Obsessive Compulsive Disorder.

SEROXAT
PAROXETINE

20 mg tablets, £20.77; 30 (OP) 30 mg tablets, £31.16. **Indications:** Treatment of symptoms of depressive illness of all types including depression accompanied by anxiety. Treatment of symptoms 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 increments; 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, hyponaemia, rash including urticaria with pruritus or angioedema and symptoms suggestive of postural hypotension. Extrapyramidal reactions reported infrequently; usually reversible abnormality of liver function tests and hyponatraemia described rarely. Symptoms including dizziness, sensory disturbance, anxiety, sleep disturbance, agitation, tremor, nausea, sweating, 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. 1.7.96. † In the UK. **Reference:** 1. Fleming J. *Prog Neuro-Psychopharmacol, Biol Psychiatr* 1989;13:419-29. 2. Hutchinson D et al. *Br J Clin Res* 1991;2:43-57. 3. Hindmarch J. *Int Clin Psychopharmacol* 1992;6(Suppl 4):65-7. 4. Dunbar GC et al. *Acta Psychiatr Scand* 1993;87:302-5. 5. Medicines Resource Centre. *Int Pharm J* 1992;6:6-9. 6. Dunbar GC, Fux DL. *Int Clin Psychopharmacol* 1992;6(Suppl 4):81-9. 7. Dorman T. *Int Clin Psychopharmacol* 1992;6(Suppl 4):53.

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Pharmaceuticals

SmithKline Beecham Pharmaceuticals,
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AL7 1EY.

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THE WORLD**



REXAMAN

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. 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. **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.

 **PSYCHIATRY**
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**HELP HIM
IN IT**

promise to put patients' lives back the way they were. But the right choice of medication may help them find a place in their community.

Zyprexa demonstrated improvement in the negative as well as the positive symptoms of schizophrenia (in four out of five controlled trials in patients presenting with both positive and negative symptoms).¹⁻³

With a simple once-daily dosage and no requirement for routine blood or ECG monitoring,⁴ Zyprexa may offer a step towards community re-integration.

Antipsychotic Efficacy for First-line Use

ZYPREXA
Olanzapine



Making Community Re-integration the Goal

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 indirect dopamine agonists. Postural hypotension was infrequently observed in the 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 effect on the foetus in rats. 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 placebo. 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/1/96/022/009 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 per pack of 56 x 7.5mg tablets. £210.93 per pack of 56 x 10mg tablets. Date of Preparation: August 1996. Full Prescribing Information is Available From: Lilly Industries Limited, Dextra Court, Chapel Hill, Basingstoke, Hampshire RG21 5SY. Telephone: Basingstoke (01256) 315000. 'ZYPREXA' is a Lilly trademark. References: 1. Data on file, Lilly Industries. 2. Data on file, Lilly Industries. 3. Zyprexa Summary of Product Characteristics, Section 5.1: Pharmacodynamic Properties. 4. Zyprexa Summary of Product Characteristics.**

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MENTAL HEALTH "A POSITIVE FUTURE?"

A major Conference, suitable for innovative professionals with an interest in the future of Mental Health, jointly organised by Northallerton Health Services (NHS) Trust and Craegmorr Healthcare.

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CPD accreditation for Psychiatrists had been applied for; One full day PGEA accreditation for GPs has already been granted.

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ABBREVIATED PRESCRIBING INFORMATION

Please refer to summary of product characteristics before prescribing

Risperdal (risperidone)

USES The treatment of acute and chronic schizophrenia, and other psychotic conditions, in which positive and/or negative symptoms are prominent. Risperdal also alleviates affective symptoms associated with schizophrenia. **DOSAGE** Where medically appropriate, gradual discontinuation of previous antipsychotic treatment while Risperdal therapy is initiated is recommended. Where medically appropriate, when switching patients from depot antipsychotics, consider initiating Risperdal therapy in place of the next scheduled injection. The need for continuing existing antiparkinson medication should be re-evaluated periodically. **Adults:** Risperdal may be given once or twice daily. All patients, whether acute or chronic, should start with 2mg/day. This should be increased to 4mg/day on the second day and 6mg/day on the third day. From then on the dosage can be maintained unchanged, or further individualised if needed. The usual optimal dosage is 4 to 8 mg/day. Doses above 10mg/day may increase the risk of extrapyramidal symptoms and should only be used if the benefit is considered to outweigh the risk. Doses above 16mg/day should not be used. **Elderly, renal and liver disease:** A starting dose of 0.5mg b.d. is recommended. This can be individually adjusted with 0.5mg b.d. increments to 1 to 2mg b.d. Use with caution in these patients. Not recommended in children aged less than 15 years. **CONTRAINDICATIONS, WARNINGS ETC.** **Contraindications:** Known hypersensitivity to Risperdal. **Precautions:** Orthostatic hypotension can occur (alpha-blocking effect). Use with caution in patients with known cardiovascular disease. Consider dose reduction if hypotension occurs. For further sedation, give an additional drug (such as a benzodiazepine) rather than increasing the dose of Risperdal. Drugs with dopamine antagonist properties have been associated with tardive dyskinesia. If signs and symptoms of tardive dyskinesia appear, the discontinuation of all antipsychotic drugs should be considered. Caution should be exercised when treating patients with Parkinson's disease or epilepsy. Patients should be advised of the potential for weight gain. Risperdal may interfere with activities requiring mental alertness. Patients should be advised not to drive or operate machinery until their individual susceptibility is known. **Pregnancy and lactation:** Use during pregnancy only if the benefits outweigh the risks. Women receiving Risperdal should not breast feed. **Interactions:** Use with caution in combination with other centrally acting drugs. Risperdal may antagonise the effect of levodopa and other dopamine agonists. On initiation of carbamazepine or other hepatic enzyme-inducing drugs, the dosage of Risperdal should be re-evaluated and increased if necessary. On discontinuation of such drugs, the dosage of Risperdal should be re-evaluated and decreased if necessary. **Side effects:** Risperdal is generally well tolerated and in many instances it has been difficult to differentiate adverse events from symptoms of the underlying disease. Common adverse events include: insomnia, agitation, anxiety, headache. Less common adverse events include: somnolence, fatigue, dizziness, impaired concentration, constipation, dyspepsia, nausea/vomiting, abdominal pain, blurred vision, priapism, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, urinary incontinence, rhinitis, rash and other allergic reactions. The incidence and severity of extrapyramidal symptoms are significantly less than with haloperidol. However, the following may occur: tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. If acute, these symptoms are usually mild and reversible upon dose reduction and/or administration of antiparkinson medication. Rare cases of Neuroleptic Malignant Syndrome have been reported. In such an event, all antipsychotic drugs should be discontinued. Occasionally, orthostatic dizziness, orthostatic hypotension and reflex tachycardia have been observed, particularly with higher initial doses. An increase in plasma prolactin concentration can occur which may be associated with galactorrhoea, gynaecomastia and disturbances of the menstrual cycle. Oedema and increased hepatic enzyme levels have been observed. A mild fall in neutrophil and/or thrombocyte count has been reported. Rare cases of water intoxication with hyponatraemia, tardive dyskinesia, body temperature dysregulation and seizures have been reported. **Overdosage:** Reported signs and symptoms include drowsiness and sedation, tachycardia and hypotension, and extrapyramidal symptoms. A prolonged QT interval was reported in a patient with concomitant hypokalaemia who had ingested 360 mg. Establish and maintain a clear airway, and ensure adequate oxygenation and ventilation. Gastric lavage and activated charcoal plus a laxative should be considered. Commence cardiovascular monitoring immediately, including continuous electrocardiographic monitoring to detect possible arrhythmias. There is no specific antidote, so institute appropriate supportive measures. Treat hypotension and circulatory collapse with appropriate measures. In case of severe extrapyramidal symptoms, give anticholinergic medication. Continue close medical supervision and monitoring until the patient recovers. **PHARMACEUTICAL PRECAUTIONS** **Tablets:** Store between 15°C and 30°C, in a dry place and protected from light. **Liquid:** Store between 15°C and 30°C and protect from freezing. **LEGAL CATEGORY** POM. **PRESENTATIONS, PACK SIZES, PRODUCT LICENCE NUMBERS & BASIC NHS COSTS** White, oblong tablets containing 1mg risperidone in packs of 20. PL 0242/0186 £13.45. Pale orange, oblong tablets containing 2mg risperidone in packs of 60. PL 0242/0187 £79.56. Yellow, oblong tablets containing 3mg risperidone in packs of 60. PL 0242/0188 £117.00. Green, oblong tablets containing 4mg risperidone in packs of 60. PL 0242/0189 £154.44. Starter packs containing 6 Risperdal 1mg tablets are also available £4.15. Clear, colourless solution containing 1mg risperidone per ml in bottles containing 100ml. PL 0242/0199 £65.00. **FURTHER INFORMATION IS AVAILABLE FROM THE PRODUCT LICENCE HOLDER:** Janssen-Cilag Ltd, Sandertown, High Wycombe, Buckinghamshire, HP14 4HJ. References: Ereshefsky L, Lancombe S. Can J Psychiatry 1993; 38(suppl 3): S80-S88. Saller CF et al. J Pharmacol Exp Ther 1990; 253: 1162-1170. Data on file, Janssen-Cilag Ltd. Peuskens J. et al. BJ Psych 1995; 166: 712-726. Marder SR. & Meibach RC. Am J Psych 1994; 151: 825-835. Emsley RA. et al. NR465 [N11877] Klieser E. et al. J Clin Psychopharmacol 1995; 15 (Suppl 1):455-515. Lindstrom E. et al. Clin Ther 1995; 17 (No.3). (Reprint)

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Patient with schizophrenia exercises *self* control by shouting at people



The SDA effect of Risperdal can mean a huge difference to the lives of patients with schizophrenia.

Because SDA is the action of Serotonin and Dopamine Antagonism in a single drug. In positive and negative symptoms. In first episode and acute presentations, and in chronic patients. Risperdal continues to provide this SDA effect to give high efficacy, with low levels of extrapyramidal side effects, to more and more patients.

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Surely this is the ultimate goal.



Risperdal[™]
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New Zimovane™ LS.

Half the strength for added flexibility in the elderly.




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A non-benzodiazepine that's just right for the elderly.

Presentation: Zimovane™: white film coated tablets containing 7.5mg zopiclone. Zimovane™ LS: blue film coated tablets containing 3.75mg zopiclone. The tablets also contain lactose, cellulose and sodium. **Pharmacology:** Zopiclone is a non-benzodiazepine hypnotic, a member of the cyclopyrrolone group of compounds which is structurally unrelated to existing hypnotics and tranquillisers. **Indications:** Short term treatment of insomnia which is debilitating or causing severe distress for the patient. A course of treatment should not be longer than 4 weeks. **Dosage and Administration:** Adults: One 7.5mg tablet shortly before retiring. Elderly and renally impaired: A lower dose of 3.75mg zopiclone is recommended initially. The dosage subsequently may be increased to 7.5mg if clinically necessary. Hepatic insufficiency: A lower dose of 3.75mg is recommended. **Contra-indications:** Myasthenia gravis, respiratory failure, severe sleep apnoea syndrome, severe hepatic insufficiency, hypersensitivity to zopiclone. As with all hypnotics zopiclone should not be used in children. **Precautions:** Zopiclone is not a treatment for depression. Hepatic or renal insufficiency: A lower dose of 3.75mg zopiclone is recommended. **Pregnancy and lactation:** Use of zopiclone is not recommended. **Risk of dependence:** Minimal risk if treatment limited to not more than 4 weeks. Risk may be increased in those

who abuse drugs or alcohol, or who have marked personality disorders. **Withdrawal:** Withdrawal effects are unlikely although all patients should be monitored. **Interactions:** Alcohol, CNS depressant, tricyclic antidepressants. **Adverse Effects:** Most frequently, mild bitter or metallic after-taste, mild gastrointestinal disturbances. Occasionally drowsiness on waking, dizziness, light-headedness and incoordination. Although residual effects are rare, patients should not drive or operate machinery until it is established that performance is unimpaired. Psychological and behavioural disturbances and allergic manifestations such as urticaria or rash have been reported. Rebound insomnia on discontinuation of treatment and anterograde amnesia should not be excluded. **Legal Category:** POM. **Pharmaceutical Precautions:** Protect from light. Store in a dry place below 30°C. **Presentation and Basic NHS Cost:** Zimovane™ tablets: PL12/0259; 28 x 7.5mg tablets Basic NHS cost: £4.48. Zimovane™ LS: PL12/0260; 28 x 3.75mg tablets Basic NHS cost: £3.08. **Date of Preparation:** July 1996. Further information is available on request from Rhône-Poulenc Rorer, RPR House, St Leonards Road, Eastbourne, East Sussex BN21 3YG. ZIM 9896

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The facts about xerostomia

and how extra saliva can help.

How big a problem is xerostomia? Over 10 million people in the UK suffer from a sensation of dry mouth (xerostomia),¹ the subjective report of oral dryness.

The use of medications is one of the most common causes of xerostomia.² Over 400 commonly used drugs have been implicated in its aetiology.² These include antidepressants, antihistamines, antihypertensives, antipsychotics, antiemetics, anticholinergics, decongestants, diuretics and other blood pressure drugs.²

Dry mouth is also associated with Rheumatoid Arthritis, Systemic Lupus Erythematosus, Diabetes, Sjögren's Syndrome, Parkinson's Disease and HIV/AIDS.²

Oral dryness and quality of life Xerostomias commonly suffer from caries and oral soft tissue irritation, resulting in soreness and painful inflammation within the oral cavity.³ Dry mouth sufferers are more susceptible to bacteria and yeast infections (candidiasis).² Diminished salivary flow results in problems with tasting, chewing and swallowing food.² Mouth malodour (halitosis) is a common symptom. Speaking is also uncomfortable and inhibited.² Individuals who suffer with dry mouth experience both psychological distress and social embarrassment.

What to look out for: clinical signs and symptoms

- Cracked and fissured tongue.
- Frothy saliva and oral mucosa appears pale, thin and has lost its shine.
- A sudden increase in dental caries.
- No pooling of saliva in the floor of the mouth.
- Recurrent oral candida infections.
- A tongue blade or instrument sticking to soft tissues.
- Angular cheilosis.

Use of sugarfree gum to stimulate saliva Saliva is a protectant against plaque acid attack,⁴ tooth demineralisation,⁵ periodontal gingival disease and oral infections.⁶

Recently, considerable success has been achieved in the use of sugarfree gum to relieve the symptoms of xerostomia by stimulating salivary flow.^{3,7,8} Research among xerostomia patients has shown chewing gum stimulates saliva by up to 7 times its normal flow rate relative to resting saliva, providing immediate relief.⁹ Several studies have also shown that frequent chewing of sugarfree gum has a residual effect on salivary flow even when gum is no longer chewed.³

Sugarfree gum for symptomatic relief Xerostomia is likely to become more widespread and take on increasing significance as our population becomes older and more reliant on medications. Sugarfree gum provides simple and effective relief from this common and often debilitating condition.

Please send me more information about the diagnosis and relief of xerostomia.

Name: _____ Title: _____

Address: _____

Professional Speciality: _____

Please return this coupon to The Wrigley Company Limited,
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BJP

1. Data on file. The Wrigley Company Ltd. 2. FDI Working Group 10, International Dental Journal 1992; 42(4) Suppl. 2:296. 3. Whelton H *et al.* Data on file, The Wrigley Company Limited. 4. Manning RH *et al.* Caries Res 1991; 25(3): Abstract #78. 5. Leach SA *et al.* J Dent Res 1988;67: Abstract #647. 6. Council on Dental Therapeutics. JADA 1988; 116: 757. 7. Odulosa F. NYSDJ April 1991; 28-31. 8. Markovic N *et al.* Gerontology 1988; 7(2): 71-75. 9. Abelson DC *et al.* J Clin Dent 1990; 2(1): 3-5. 10. Edgar WM *et al.* J Dent Res 1981; 60 Sp.iss. 1137.



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The pictures and text in this book are intended to show the likely events when someone with learning disabilities or mental health needs comes into contact with the criminal justice system. The intended readership is people with learning disabilities or difficulties or mental health needs. The 'story' is told in pictures without any words although there is a text at the back of the book which may be useful too. You can make any story you like from the book as it will fit any crime and any verdict.

This book is a joint publication between the Royal College of Psychiatrists and St. George's Hospital Medical School. The authors all work with people with learning disabilities.

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You're under Arrest

Sheila Hollins, Isabel Clare
and Glynis Murphy,
illustrated by Beth Webb

The pictures and text in this book are intended to reflect the procedures used by the police when an adult with learning difficulties or mental health needs is under arrest. The intended readership is people with learning disabilities or difficulties or mental health needs. The 'story' is told in pictures without any words although there is a text at the back of the book which may be useful too. You can make any story you like from the book as it will fit any crime.

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