



Helpline And Information Services
The Royal College Of Psychiatrists
17 Belgrave Square
London
SW1X 8PG
Tel. 0171 235 2351 Ext. 138/152

EDITORIAL

- 1 A symbiosis of paper and electronic publishing, serving the interests of the *Journal's* readers**
I. Chalmers

REVIEW ARTICLE

- 3 Psychiatry in the National Health Service 1948–1998**
H. Freeman

PAPERS

- 12 Venlafaxine and paroxetine in treatment-resistant depression. Double-blind, randomised comparison**
M.-F. Poirier and P. Boyer
- 17 Fluoxetine in post-traumatic stress disorder. Randomised, double-blind study**
K. M. Connor, S. M. Sutherland, L. A. Tupler, M. L. Malik and J. R. T. Davidson
- 23 Crisis telephone consultation for deliberate self-harm patients: effects on repetition**
M. O. Evans, H. G. Morgan, A. Hayward and D. J. Gunnell
- 28 First-contact incidence rate of schizophrenia on Barbados**
G. E. Mahy, R. Mallett, J. Leff and D. Bhugra
- 34 Ethnicity and outcome of psychosis**
N. Goater, M. King, E. Cole, G. Leavey, E. Johnson-Sabine, R. Blizard and A. Hoar
- 43 Outcome of psychosis in people of African–Caribbean family origin. Population-based first-episode study**
G. Harrison, S. Amin, S. P. Singh, T. Croudace and P. Jones
- 50 Suicide in prisons. Reflections on the communities served, or exacerbated risk?**
S. M. Gore
- 56 Burden experienced by care-givers of persons with bipolar affective disorder**
D. Perlick, J. F. Clarkin, J. Sirey, P. Raue, S. Greenfield, E. Struening and R. Rosenheck
- 63 Reduced *in vivo* binding to the serotonin transporter in the cerebral cortex of MDMA ('ecstasy') users**
D. M. Semple, K. P. Ebmeier, M. F. Glabus, R. E. O'Carroll and E. C. Johnstone
- 70 North Staffordshire Community Beds Study: longitudinal evaluation of psychiatric in-patient units attached to community mental health centres. 1: Methods, outcome and patient satisfaction**
A. P. Boardman, R. E. Hodgson, M. Lewis and K. Allen
- 79 North Staffordshire Community Beds Study: longitudinal evaluation of psychiatric in-patient units attached to community mental health centres. 2: Impact upon costs and resource use**
A. Haycox, L. Unsworth, K. Allen, R. Hodgson, M. Lewis and A. P. Boardman

COLUMNS

- 87 Correspondence**
92 One hundred years ago
94 Book reviews
101 Contents of *The American Journal of Psychiatry*

The difference is plain to see



Consider the plain facts

Cipramil:

- Proven efficacy in depression and panic disorder
- The most selective SSRI^{1,2}
- The least expensive branded SSRI³
- Faster onset of action than fluoxetine⁴ and sertraline⁵
- Clinical experience in over 12 million patients worldwide⁶

With differences like these, it's plain to see why Cipramil is the UK's fastest growing SSRI⁷.

Cipramil - makes a visible difference both to your patients and your prescribing costs.



Cipramil

citalopram
make a difference

Abbreviated prescribing information. Presentation: Cipramil tablets 10 mg, PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £10.09. Cipramil tablets 20 mg, PL 0458/0058, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets £16.79. Cipramil tablets 40 mg, PL 0458/0059, each containing 40 mg of citalopram as the hydrobromide. 28 (OP) 40 mg tablets £20.39. **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. Withdrawal symptoms have been reported with SSRIs, abrupt

withdrawal of citalopram should be avoided. **Overdosage:** Symptoms have included somnolence, coma, sinus bradycardia, 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 9LE. © Cipramil is a Registered Trade Mark. © 1999 Lundbeck Ltd. Date of preparation: May 1999. 0599/CIP/501/058.

References: 1. Hyttel J. XXIII Nordiske Psykiater Kongres, Reykjavik, 1988; 11-21. 2. Eison AS et al. Psychopharmacology Bull 1990; 26 (3) 311-315. 3. Based on 28 days' treatment, prices from MIMS, May 1999. 4. Parris M et al. Int Clin Psychopharmacol 1996; 11: 129-135. 5. Stahl SM. Citalopram vs sertraline vs placebo: preliminary efficacy results. Poster presented at the APA meeting, 1998. 6. Data on file, Lundbeck Limited, to December 1998. 7. Taylor Nelson 'Scriptorum' prescription audit data, 6 months to March 1999.



THE BRITISH JOURNAL OF PSYCHIATRY

JULY 1999 VOL. 175

EDITOR Greg Wilkinson LIVERPOOL

EDITORIAL BOARD

DEPUTY EDITOR

Alan Kerr
NEWCASTLE UPON TYNE

ASSOCIATE EDITORS

Sidney Crown
LONDON

Julian Leff
LONDON

Sir Martin Roth, FRS
CAMBRIDGE

Sir Michael Rutter, FRS
LONDON

Peter Tyrer
LONDON

EDITORIAL ADVISERS

Howard Croft
OXFORD

Tony Johnson
CAMBRIDGE

Kathleen Jones
YORK

Martin Knapp
LONDON

Herschel Prins
LEICESTER

John Wing
LONDON

Sir John Wood
SHEFFIELD

ASSISTANT EDITORS

Louis Appleby
MANCHESTER

Alistair Burns
MANCHESTER

Patricia Casey
DUBLIN

John Cookson
LONDON

Tom Fahy
LONDON

Anne Farmer
CARDIFF

Michael Farrell
LONDON

Nicol Ferrier
NEWCASTLE UPON TYNE

Richard Harrington
MANCHESTER

Sheila Hollins
LONDON

Jeremy Holmes
BARNSTAPLE

Michael King
LONDON

Michael Kopelman
LONDON

Alan Lee
NOTTINGHAM

Glyn Lewis
CARDIFF

Shôn Lewis
MANCHESTER

Robin McCreadie
DUMFRIES

Ian McKeith
NEWCASTLE UPON TYNE

J. Spencer Madden
UPTON-BY-CHESTER

David Owens
LEEDS

Ian Pullen
MELROSE

Henry Rollin
LONDON

Jan Scott
NEWCASTLE UPON TYNE

Andrew Sims
LEEDS

George Stein
LONDON

CORRESPONDING EDITORS

Andrew Cheng
TAIWAN

Kenneth Kendler
USA

Arthur Kleinman
USA

Paul Mullen
AUSTRALIA

Michele Tansella
ITALY

J. L. Vázquez-Barquero
SPAIN

STATISTICAL ADVISER

Pak Sham
LONDON

STAFF

PUBLICATIONS MANAGER

Dave Jago

MARKETING MANAGER

Lucy Alexander

SCIENTIFIC EDITOR

Andrew Morris

ASSISTANT SCIENTIFIC EDITORS

Lucretia King

Zoë Stagg

EDITORIAL ASSISTANTS

Eloise Glover

Sue Thakor

MARKETING ASSISTANT

Bryony Stuart

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 1999 (12 issues post free) are as follows:

	INSTITUTIONS	INDIVIDUALS
Europe (& UK)	£185	£157
US	\$375	\$270
Elsewhere	£220	£170

Full airmail is £36/
US\$64 extra.

Single copies of the
journal are £19, \$30
(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

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. Subscription price is \$375. Second class postage paid at Rathway, NJ. Postmaster send address corrections to the British Journal of Psychiatry, c/o Mercury Airfreight International Ltd Inc., 2323 Randolph Avenue, Avenel, New Jersey 07001.

TMThe paper used in this publication meets the minimum requirements of the American National Standard for Information Sciences - Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Typeset by Dobbie Typesetting Ltd, Tavistock.

Printed by Henry Ling Ltd, The Dorset Press, 23 High East Street, Dorchester, Dorset DT1 1HD.

Past Editors

Eliot Slater	1961-72	John L. Crammer	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.

©1999 The Royal College of Psychiatrists. Unless so stated, material in the *British Journal of Psychiatry* does not necessarily reflect the views of the Editor or the Royal College of Psychiatrists. The publishers are not responsible for any error of omission or fact.

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists (a registered charity, registration number 228636). The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to the Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG. Queries, letters to the Editor and book reviews may also be sent electronically to sthakor@rcpsych.ac.uk.

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>.

Instructions to authors

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to The Editor, The British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG.

All published articles are peer reviewed. A decision will be made on a paper within three months of its receipt.

Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere. Authors submitting papers to the *BJP* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications, simultaneous submissions, and papers in preparation.

The *BJP* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *BJP* does not necessarily reflect the views of the Editor or the Royal College of Psychiatrists.

Published articles become the property of the *BJP* and can be published elsewhere, in full or in part, only with the Editor's written permission.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

We regret that manuscripts and figures unsuitable for publication will not normally be returned.

MANUSCRIPTS

Three high-quality manuscript copies together with an electronic copy on floppy disk (IBM formatted) should be submitted, and authors should keep one copy for reference. Articles should be 3000–5000 words long, must be typed on one side of the paper only, double-spaced throughout (including tables and references) and with wide margins (at least 4 cm); all the pages, including the title page, must be numbered.

TITLE AND AUTHORS

The title should be brief and relevant. If necessary, a subtitle may be used to amplify the main title.

All authors must sign the covering letter; one of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress.

All authors should clearly state their involvement in the work presented, and any conflict of interest arising, in the accompanying letter.

If authors wish to have their work peer reviewed anonymously, they must submit their work without personal identification; names and addresses of all authors should be given in the covering letter. Otherwise, the names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out given at the end of the paper.

STRUCTURE OF MANUSCRIPTS

A structured summary should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions; Declaration of interest. The latter should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, an organisation whose interests, financial or otherwise, may be affected by the publication of your paper. This pertains to all the authors of the study. The summary should be no more than 150 words. Editorials do not require summaries.

Introductions should be only one paragraph (up to 150 words). Use of sub-headings is encouraged, particularly in the Discussion. Three clinical implications and three limitations of the study should be provided. A separate Conclusions section is not required.

REFERENCES

References should be listed alphabetically at the end of the paper, the titles of journals being given in full. Reference lists not in *BJP* style will be returned to the author for correction.

Authors should check that the text references and list are in agreement as regards dates and spelling of names. The text reference should be in the form '(Smith, 1971)' or 'Smith (1971) showed that . . .'. The reference list should follow the style example below (note that *et al* is used after three authors have been listed for a work by four or more).

Alderson, M. R. (1974) Self poisoning: what is the future? *Lancet*, *i*, 104–113.

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM–III). Washington, DC: APA.

Aylard, P. R., Gooding, J. H., McKenna, P. S., et al (1987) A validation study of three anxiety and depression self assessment scales. *Psychosomatic Research*, *1*, 261–268.

De Rougemont, D. (1950) *Passion and Society* (trans. M. Beligon). London: Faber and Faber.

Fisher, M. (1990) *Personal Love*. London: Duckworth.

Flynn, C. H. (1987) Defoe's idea of conduct: ideological fictions and fictional reality. In *Ideology of Conduct* (eds N. Armstrong & L. Tenenhouse), pp. 73–95. London: Methuen.

Jones, E. (1937) Jealousy. In *Papers on Psychoanalysis*, pp. 469–485. London: Baillière, Tindall.

Mullen, P. E. (1990a) Morbid jealousy and the delusion of infidelity. In *Principles and Practice of Forensic Psychiatry* (eds R. Buglass & P. Bowden), pp. 823–834. London: Churchill Livingstone.

— (1990b) A phenomenology of jealousy. *Australian and New Zealand Journal of Psychiatry*, *24*, 17–28.

Personal communications need written authorisation; they should not be included in the reference list. No other citation of unpublished work, including unpublished conference presentations, is permissible.

TABLES

Each table should be submitted on a separate sheet. They should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information in the text. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

FIGURES

Figures should be individual glossy photographs, or other camera-ready prints, or good-quality output from a computer, not photocopies, clearly numbered and captioned below. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity:unit (note: 'litre' should be spelled out in full unless modified to ml, dl, etc.).

Authors must obtain permission if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

Colour figures may be reproduced if authors are able to cover the costs.

STATISTICS

Not all papers require statistical analysis. Case histories and studies with very small numbers are examples. In larger studies where statistical analyses are included it is necessary to describe these in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post-hoc* analyses carried out. The value of test statistics used (e.g. χ^2 , t , F -ratio) should be given as well as their significance levels

so that their derivation can be understood. Standard deviations and errors should not be reported as \pm , but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry*, 156, 472–474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

GENERAL

All abbreviations must be spelt out on first usage.

The generic names of drugs should be used, and the source of any compounds not yet available on general prescription should be indicated.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not g ml^{-1} .

The use of notes separate to the text should generally be avoided, whether they

be footnotes or a separate section at the end of a paper. A footnote to the first page may, however, be included to give some general information concerning the paper.

If an individual patient is described, his or her consent should be obtained and submitted with the manuscript. The patient should read the report before submission. Where the patient is not able to give informed consent, it should be obtained from an authorised person. Where the patient refuses to give consent, the case study can only be written up if personal details and dates and other information which identifies the patient is omitted to ensure that there is no breach of confidentiality. Contributors should be aware of the risk of complaint by patients in respect of defamation and breach of confidentiality, and where concerned should seek advice.

PROOFS

A proof will be sent to the corresponding author of an article. Offprints, which are prepared at the same time as the *BJP*, should be ordered when the proof is returned to the Editor. Offprints are despatched up to six weeks after publication. The form assigning copyright to the College must be returned with the proof.

LETTERS TO THE EDITOR

Letters must be double spaced and should not exceed 350 words. They will be edited for clarity and conformity with *BJP* style and may be shortened. There should be no more than five references. Proofs will not be sent to authors.



K E E L E
UNIVERSITY

SCHOOL OF POSTGRADUATE MEDICINE
DEPARTMENT OF PSYCHIATRY

DIPLOMA and MSc courses in General Psychiatry

Commencing September 1999

Part-time courses for registered medical practitioners offering an opportunity to update knowledge and skills in general psychiatry.

Diploma Suitable for affiliates of the College, GPs and all non-training grades, this one year course provides an overview of current research and practice based on MRCPsych Part 1 syllabus. Students attend one afternoon of lectures in term-time and work on clinical case studies under individual supervision.

MSc Students who achieve a pass with credit or above or who have gained part 1 MRCPsych may apply for the MSc. A two year course based on the MRCPsych Part 2 syllabus. Formal teaching takes place one afternoon per week. In addition students receive tutorials and seminars on critical reading, presentation skills, research methods and have the option of taking a specialist subject in which they undertake literature reviews and complete a dissertation:-

- Liaison Psychiatry
- Perinatal Psychiatry
- Social and Community Psychiatry
- Substance Abuse
- Transcultural Psychiatry

All students are allocated a personal academic supervisor.

For further details contact: Miss Tracy Brittain, Department of Psychiatry, School of Postgraduate Medicine, Thornburrow Drive, Hartshill, Stoke-on-Trent ST4 7QB. Tel: (01782) 554019, Fax: (01782) 747319. E-mail: pcao2@keele.ac.uk

Closing date: Friday 30 July 1999

BBR
MEDICAL
EDUCATION

Intensive weekend courses

MRCPsychiatry Parts I & II
Written and Clinical skills courses

MRCPsychiatry Part I written 11-12 September

MRCPsychiatry Part II written 11-12 September

Critical Appraisal - Four hour course
10 September 1999

MRCPsychiatry clinical 6-7 November

BBR Courses are
Stimulating, entertaining and successful.

Telephone or Fax 0181-959-7562

33 Flower Lane, Mill Hill, London NW7

RESEARCH FELLOWSHIP

National Institute of Mental Health
National Institutes of Health
Bethesda, Maryland

Starting July 2000, there is a 2-5 year post-doctoral Research Fellowship in the Child Psychiatry Branch, National Institute of Mental Health, involving clinical, pharmacologic genetic, and neuroimaging studies of childhood onset schizophrenia. Core training curriculum and other courses provided on an individual basis. Salary will be based on education and experience. Educational Commission for Foreign Medical Graduates (ECFMG) certification is required. Training in Child Psychiatry is desirable.

Please send resume, two letters of reference, and proof of medical degree (English translation required unless in Latin) to:

Dr Judith L. Rapoport, Chief, Child Psychiatry Branch, National Institute of Mental Health, Building 10, Room 3N202, 10 Center Drive, MSC 1600, Bethesda, Maryland 20892-1600.

NIH is an Equal Opportunity Employer

NB
MEDICAL EDUCATION

MRCPSYCH PART I
LONDON

Intensive exam-orientated weekend courses

- Theory for *new syllabus*.
- Technique and tactics.
- Over 2000 relevant MCQ's.
- Practice MCQ exams.
- HM67(27) approved for study leave.

London 28 and 29 August, 4 and 5 September
(4 day course).

Details: NB Medical Education, PO Box 767,
OXFORD OX1 1XD. Tel/fax. 01865 842206.

CONSULTANTS AND OTHER LEVELS NEEDED IN ALL SPECIALITIES OF PSYCHIATRY

Consultants require Section 12 or 20

Immediate Start

Short Term/Long Term
Assignments

Great on-call

£ £ Excellent £ £
£ £ Rates of £ £
£ £ Pay £ £



THROUGHOUT THE UK

Accommodation
Provided

Work Permits
Arranged

Contributions to
Travelling Expenses

Call Anna: Tel. 01703 393988; Fax. 01703 393908; Email anna@direct-medical.com

DIRECT

MEDICAL SERVICES

Academic Adolescent Psychiatry

The University of Calgary Department of Psychiatry and the Calgary Regional Health Authority invite applications for a full-time academic position in Adolescent Psychiatry. This position involves academic and regional administrative responsibilities, in addition to research, teaching and clinical service. The selected individual may be eligible to become Medical Clinical Director of Unit 26 at the Foothills Medical Centre.

Qualifications include a MD or equivalent, certification in Psychiatry, a proven record of teaching and research, and eligibility for licensure in the Province of Alberta. Previous administrative experience will be an asset.

In accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada. The University of Calgary respects, appreciates and encourages diversity.

Please submit curriculum vitae, a statement of research interests, and the names of three referees by September 15, 1999 to:

Dr. Donald Addington, Head
Department of Psychiatry
University of Calgary
1403 - 29 Street N.W.
Calgary, Alberta, Canada T2N 2T9



UNIVERSITY OF
CALGARY

www.ucalgary.ca

New from Gaskell



CAN: Camberwell Assessment of Need

Mike Slade, Graham Thornicroft, Linda Loftus, Michael Phelan & Til Wykes

The Camberwell Assessment of Need (CAN) is a tried and tested approach to assessing the needs of severely mentally ill. Rigorously developed by staff at the Section of Community Psychiatry (PRiSM), Institute of Psychiatry, it records both staff and patient assessments. Three versions are included, all designed to be photocopied. The full clinical research versions give a comprehensive assessment, and a short (one page) version (CANSAS) is suitable for routine clinical use. Also included are materials and instructions for a half-day CAN training workshop.

The CAN is suitable for use in primary care settings, specialist mental health teams, and social services. It will be of particular interest to care managers and mental health staff who wish to meet the legal requirement that the severely mentally ill receive a comprehensive needs assessment. Translations are available in 9 other languages.

**July 1999, £45.00, 144pp, Ringbound pack incl. photocopiable material,
ISBN 1 901242 25 0**

<http://www.rcpsych.ac.uk>

Available from the Book Sales Office, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.
Telephone +44 (0)171 235 2351 extension 146, fax +44 (0)171 245 1231.

MONEY! MONEY! MONEY!

Doctors wanted Nationwide

Abba had it right - imagine all the things you could do with the following rates:

SHO	£19.50 per hour
REG	£21.50 per hour
Staff Grade	£24.00 per hour

- Established over 8 years ago
- We are a specialist agency set up by a professional for professionals
- Nationwide opportunities
- Short and long term locums

Contact Sian Mathews today

Telephone: 01792 480297 Fax: 01707 263096

Email: taylor.anne@mailcity.com
Website: www.medicnet.co.uk



BJP33226



New from Gaskell

Promoting Mental Health Internationally

Editors

Giovanni de Girolamo, Leon Eisenberg, David Goldberg, and John Cooper

To mark the retirement of Dr Norman Sartorius in 1974 from his post as Director of the Division of Mental Health of the World Health Organisation, the editors (all long-standing advisors and collaborators with the WHO programme) have brought together contributions from a mixture of advisors, collaborators and WHO staff members. The chapters provide descriptions and commentaries on the main aspects of the last 30 years of the WHO programme in mental health. The major topics and issues include the cross-cultural epidemiology and outcome of persons with serious mental illnesses, cross-cultural aspects of problems related to the abuse and control of alcohol and drugs of dependency, the role of psychiatry in primary care, and the development of a 'common language' for psychiatrists and mental health workers.

June 1999, £25.00, 208pp, Hardback, ISBN 1 901242 37 4



Royal College of Psychiatrists
17 Belgrave Square, London, SW1X 8PG
Tel: 0171 235 2351
Fax: 0171 245 1231

SCHOOL OF PSYCHOLOGY, UNIVERSITY OF LEEDS in association with IMSCaR, University of Wales and the Linehan Training Group

DIALECTICAL BEHAVIOUR THERAPY:
A Cognitive Behavioural Treatment for Borderline Personality Disorder

TWO-DAY INTRODUCTORY WORKSHOP
Thursday 21 and Friday 22 October 1999 - to be conducted by

Heidi Heard and Michaela Swales
(members of Marsha Linehan's Training Team)

Hilton National, Leeds
£195 non-residential, including coffee, lunch and tea both days

This workshop will be of interest to all mental health professionals and managers involved in the provision of care to 'hard-to-help' clients presenting with deliberate self-harm, parasuicidal behaviour and other difficulties associated with a diagnosis of borderline personality disorder.

(Dependent on interest, this workshop may be followed by a UK intensive training seminar consisting of two 5-day events, and intervening development work. This will be offered to teams wishing to establish their own DBT services.)

For booking form and further information please contact:

Susan Alexander, PTRC, School of Psychology, University of Leeds, 17 Blenheim Terrace, Leeds LS2 9JT

Tel: 0113 233 5699/1957

Fax: 0113 233 6685



UNIVERSITY COLLEGE LONDON
ROYAL FREE AND UNIVERSITY
COLLEGE MEDICAL SCHOOL

Department of Psychiatry and
Behavioural Sciences

MSc in Psychiatric Theory
and Research 1999

A two year part-time course in research methodology

Applications are now invited for this two-year, part-time Masters course, starting 4 October 1999. The MSc is intended for SHO, Registrars and SpRs in Psychiatry and aims to provide a firm grounding in research methodology.

In the first year of the MSc, students need to attend for two half-days per week. One half-day involves seminars, tutorials and workshops on research methodology. The other half-day consists of lectures covering the MRCPsych Part II curriculum or an equivalent taught module. In the second year, students conduct a research project under supervision, and submit a dissertation.

The course is held in the Wolfson Building attached to the Middlesex Hospital which is close to the UCL main campus. Applications are welcome from 6 July to end of August 1999. The first interviews for short-listed candidates will be held at the end of July.

For an application form and prospectus contact the Course Administrator, Department of Psychiatry & Behavioural Sciences, Wolfson Building, 48 Riding House Street, London W1N 8AA, Tel: 0171 504 9475, Fax: 0171 323 1459 or email: rejujro@ucl.ac.uk

Working towards Equal Opportunities
Pursuing Excellence in Education and Research

REWARD

Are you a consultant?
Would you like to "get away from it all?"

Register now for our *summer promotion* to make your valuable free time work for you.

- ◆ Receive top hourly rates and holiday vouchers
- ◆ Exciting opportunities now available throughout the UK.
- ◆ Sub speciality Locums now free in general adult, child and family, rehab, learning disabilities.

THE MORE YOU WORK -
THE MORE BONUS POINTS YOU EARN

i.e over 100 hours - £200 holiday vouchers
over 200 hours - £425 holiday vouchers

Contact Sian Mathews today
telephone - 01792 480297 fax: 01707 263096

email: taylor.anne@mailcity.com
website: www.medicnet.co.uk



Royal College of Psychiatrists



XI World Congress of Psychiatry

6 - 11 August 1999

Gaskell Press will be displaying and selling a wide selection of publications during the Congress. New publications to be launched at this congress include:

Promoting Mental Health Internationally

Giovanni de Girolamo, Leon Eisenberg, David Goldberg and John Cooper

Visit the stand for information about the full range of quality publications.

Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.
Telephone +44 (0)171 235 2351 extension 146, fax +44 (0)171 245 1231.

*The Specialists in
Mental Health and
Medical Conferences*



*CPD/CME and
PGEA approval
applied for*

Mole Conferences

24th September 1999 7.00pm: BEYOND THERAPY TOWARDS TRANSITIONAL RECONNECTION - 3rd Annual Henderson Hospital Maxwell Jones Lecture

Lecture given by: **Dr. Harold Bridger**
Respondent: **Dr. Jan Birtle**

Dr. Harold Bridger was a colleague of Dr. Maxwell Jones in the pioneering days of the Therapeutic Community movement in the 1940s and 1950s. He is a founder member of the Tavistock Institute where his early colleagues included Rickman, Bion, Trist and Bowlby.

7th October 1999; ASPERGERS' SYNDROME

A one day conference co-organised by Mole Conferences & Pavilion Publishing at Regent's College.

14th October 1999; ATTENTION DEFICIT/HYPERACTIVITY DISORDER

A one day conference organised by Mole Conferences at Regent's College.

22nd October 1999; PTSD in Clinical Practice

A one day Psychotrauma conference organised by the European Society for Traumatic Stress Studies (ESTSS) at Regent's College.

This one day conference will have two themes. In the morning, the focus will be on more complex trauma reactions - for example in children (Professor Bill Yule), following sexual or family violence or in refugees (Dr Stuart Turner). In the afternoon, there will be an emphasis on evidence-based treatments, both psychopharmacological and psychological (Professor David Clark, Dr Chris Freeman, Dr Ulrich Schnyder & Professor Nick Tarrier).

8th November 1999; Facing Death & grief
Dr. Lyn Franchino *Central London*

A one day Death & Dying course looking at death, loss and grief in an experiential rather than an academic way. Participants will be considering their own feelings about dying and their experiences around loss and grief.

12th November 1999; Setting Standards: Education, training and professional development for counsellors in primary care

A one day conference organised by Mole Conferences, Association for Counsellors and Psychotherapists in Primary Care, The Counselling in Primary Care Trust and Counselling in Medical Settings Division of the British Association for Counselling to be held at RIBA, London.

23rd November 1999; Mental health and social policy *Central London*

Conference convenor: Professor Hugh Freeman

A one day conference organised by Mole Conferences and Pavilion Publishing.

The topics to be covered include: social aspects of depression, social exclusion, social networks and support, the end of institutions, the balance of liberty and public safety, and the State's responsibility for mental disorder.

For further information & programmes please contact:
Mole Conferences, 26 Church Road, Portslade,
Brighton BN41 1LA

Telephone: 01273 242 634;

Fax: 01273 235 095;

Email: pweitz@compuserve.com

PSYCHIATRISTS

- Positions across the UK, Middle East & USA
- All Grades
- Quality locum positions
- Long & short term
- Excellent on-call
- Top rates paid

Apply on-line:
www.directmedical.co.uk

Call now for further details

Tel: 01792 472 525

Fax: 01792 472 535

e-mail: info@directmedical.co.uk

The Psychiatrists' Choice.

Direct Medical



Appointments



HARLEY STREET

OCCASIONAL AND SESSIONAL ROOMS

Open Monday–Friday, 9.00am–9.00pm
 Saturday and Sunday, 9.00am–5.30pm
 Early mornings by arrangement

FLEXIBLE, COST-EFFECTIVE
 CONSULTING OPTIONS
 PERSONALISED TELEPHONE ANSWERING
 AND FULL ADMINISTRATIVE SUPPORT

TELEPHONE 0171 467 8301

New Brief Pulse ECT with *Computer-Assisted* Easy Seizure Monitoring



Somatics Thymatron™ DGx

- Automatically monitors your choice of EEG-EEG, EEG-ECG, or EEG-EMG and determines EEG and motor seizure lengths.
- Computer-measured seizure quality, including postictal EEG suppression, seizure energy index.
- Up to 8 seconds stimulus duration; pulsewidth as short as 0.5 ms.
- Single dial sets stimulus charge by age; high-dose option available.
- FlexDial™ adjusts pulsewidth and frequency without altering dose.

Distributed in the U.K. by: DANTEC Electronics, Ltd. Garonor Way Royal Portbury Bristol BS20 9XE TEL (44) 1275-375333 FAX (44) 1275-375336	Distributed in Australia by: SONORAY Pty. Ltd. 32 Miamba Ave. Carlingford NSW 2118 TEL (61) 29-871-0804 FAX (61) 29-779-2110	Distributed in New Zealand by: MEDIC Healthcare Ltd. 20 Peterkin St. Wingate Lower Hutt TEL (64) 4-577-0000 FAX (64) 4-577-2000
Distributed in Ireland by: BRENNAN & CO. Dublin TEL (353) 1-295-2501 FAX (353) 1-295-2333	Distributed in India by: HOSPIMEDICA Pvt. Ltd. 58/10, 11d floor, Ashok Nagar New Delhi 110 018 TEL (91) 11-540-0984 FAX (91) 11-549-2977	Distributed in South Africa by: DELTA SURGICAL Craighall TEL (27) 11-792-6120 FAX (27) 11-792-6926

ASK ABOUT THE NEW 4-CHANNEL THYMATRON SYSTEM IV™

 SOMATICS, INC., 910 Sherwood Drive # 17, Lake Bluff, IL, 60044, U.S.A.
 Fax: (847) 234-6763; Tel: (847) 234-6761



PSYCHIATRISTS

England – Scotland – Wales
 all areas

Varied assignments
 Weekly Payments
 Expenses
 Professional and Friendly Service
 Also GP Locum Specialists

Call us today

Locums (UK)

Tel: 01489 788772 Fax: 01489 788771
 email: doctors@locums.co.uk



Spot the Edronax difference.



 Highly selective noradrenaline re-uptake inhibitor (NARI)¹

 **Edronax**[®]
reboxetine tablets 

Helps restore energy and motivation in tired depressed patients^{2,3}

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 Insufficiency** 2 mg b.i.d. which can be increased based on patient

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 medications and other forms of interaction:** Reboxetine should not be

used with 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, tachycardia, vertigo, urinary hesitancy (retention), headache, dizziness, drowsiness,

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 **References:** 1. Brunello N et al. *Human Psychopharmacology* 1998;13:S13-S19. 2. Dubini A et al. *J Psychopharmacol* 1997; 11(4):S17-S23. 3. Montgomery SA. *Prescriber* April 1998; 116-119. Further information is available from the Marketing Authorisation Holder: Pharmacia & Upjohn Limited, Davy Avenue, Knowlhill, Milton Keynes, MK5 8PH, UK. Telephone: 01908 661101. © Edronax is a registered trademark. Code No.P4008/12/98. Date of preparation: November 1998

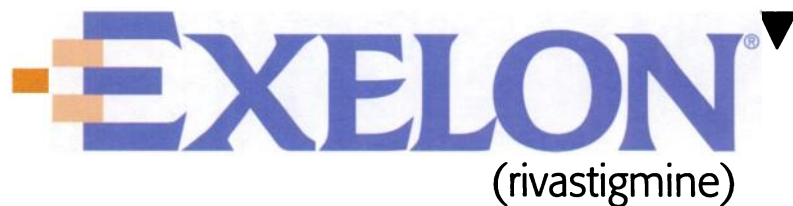
Life beyond Alzheimer's.



With Exelon, you can now help treat the symptoms of people with mild to moderately severe Alzheimer's disease.

While Exelon has not been shown to affect the disease process, six-month trials have established its effectiveness on key areas that Alzheimer's disease attacks - cognition, global functioning and activities of daily living.¹

For carers and family, this could mean some relief from the demands for attention; for the sufferer, it could mean life beyond Alzheimer's.



Beyond cognition: improving functional ability.

EXELON Prescribing Information. Indication: Symptomatic treatment of mild to moderately severe Alzheimer's dementia. **Presentation:** Capsules containing 1.5, 3, 4.5 or 6mg rivastigmine. **Dosage and Administration:** Effective dose is 3 to 6mg twice a day. Maintain patients on their highest well-tolerated dose. Maximum dose 6mg twice daily. Reassess patients regularly. Initial dose 1.5mg twice daily, then build up dose, at a minimum of two week intervals, to 3mg twice daily, 4.5mg twice daily then 6mg twice daily, if tolerated well. If adverse effects or weight decrease occur, these may respond to omitting one or more doses. If persistent, daily dose should be temporarily reduced to previous well tolerated dose. **Contraindications:** Known hypersensitivity to rivastigmine or excipients or any other carbamate derivatives; severe liver impairment. **Special Warning & Precautions:** Therapy should be initiated and supervised by a physician experienced in the diagnosis and treatment of Alzheimer's disease. A caregiver should be available to monitor compliance. There is no experience of use of EXELON in other types of dementia/memory impairment. Nausea and vomiting may occur, particularly when initiating and/or increasing dose. Monitor any weight loss. Use with care in patients with Sick Sinus Syndrome, conduction defects, active gastric or duodenal ulcers, or those predisposed to ulcerative conditions, history of asthma or obstructive pulmonary disease, those predisposed to urinary obstruction and seizures. In renal and mild to moderate hepatic impairment, titrate dose individually. Safety in pregnancy not established; women should not breastfeed. Use in children not recommended. **Interactions:** May exaggerate effects of succinylcholine-type muscle relaxants during anaesthesia. Do not give with cholinomimetic drugs. May interfere with anticholinergic medications. No interactions were observed with digoxin, warfarin, diazepam, or fluoxetine (in healthy volunteers). Metabolic drug interactions unlikely, although it may inhibit butyrylcholinesterase mediated metabolism of other drugs. **Undesirable Effects:** Most commonly (>5% and twice frequency of placebo): asthenia, anorexia, dizziness, nausea, somnolence,

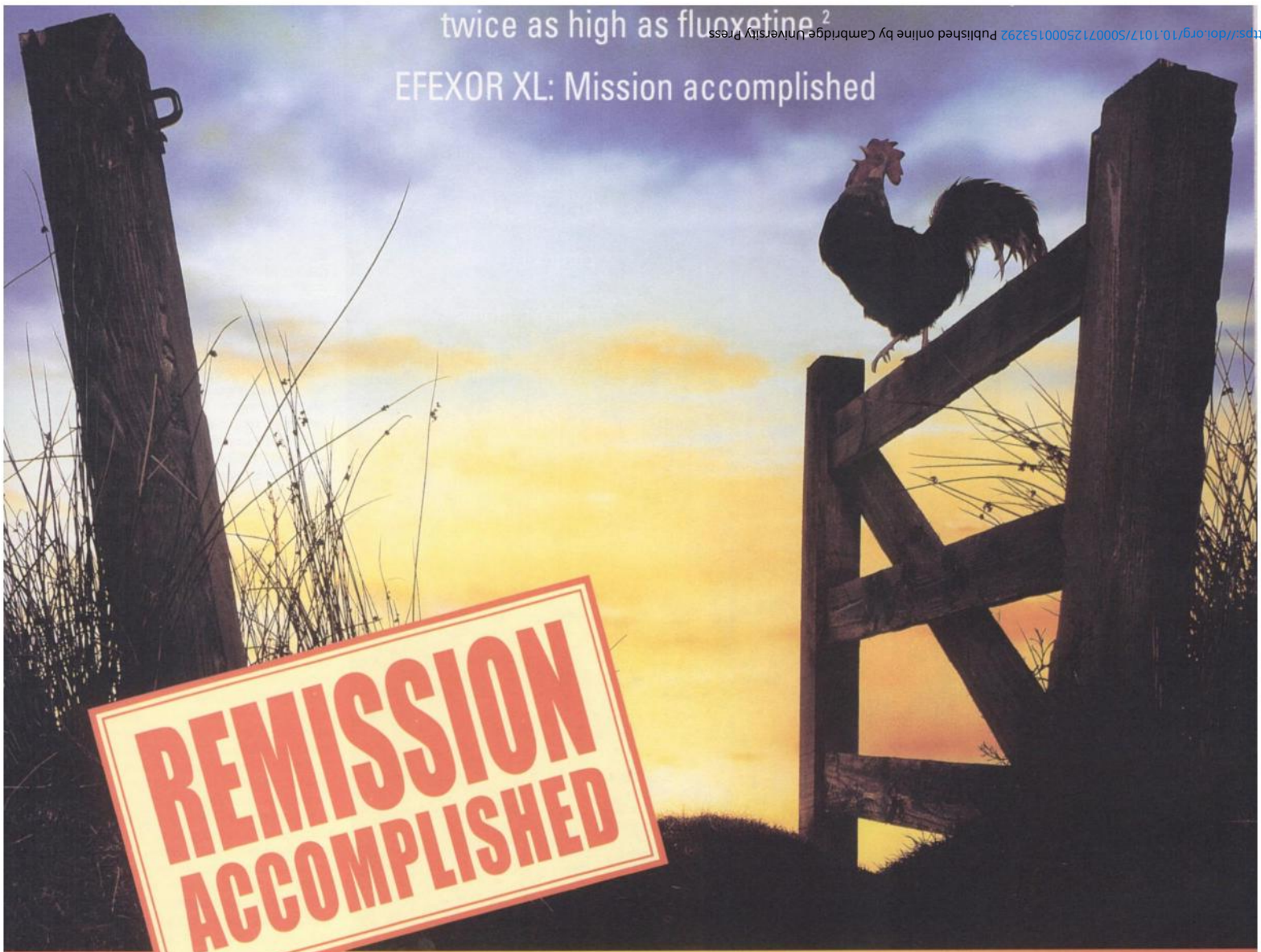
vomiting. Female patients more susceptible to nausea, vomiting, appetite and weight loss. Other common effects (>5% and ≥ placebo): abdominal pain, accidental trauma, agitation, confusion, depression, diarrhoea, dyspepsia, headache, insomnia, upper respiratory tract and urinary tract infections, increased sweating, malaise, weight loss, tremor. Rarely, angina pectoris, gastrointestinal haemorrhage and syncope. No notable abnormalities in laboratory values observed. **Package Quantities and basic NHS Price:** 1.5mg x 28, £31.50; 1.5mg x 56, £63.00; 3mg x 28, £31.50; 3mg x 56, £63.00; 4.5mg x 28, £31.50; 4.5mg x 56, £63.00; 6mg x 28, £31.50; 6mg x 56, £63.00. **Legal Classification:** POM. **Marketing Authorisation Number:** 1.5mg, EU/1/98/066/001 - 2; 3mg, EU/1/98/066/004 - 5; 4.5mg, EU/1/98/066/007 - 8; 6mg, EU/1/98/066/010 - 11. Full prescribing information including Summary of Product Characteristics is available from: Novartis Pharmaceuticals UK Ltd, Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.

Reference: 1. Corey-Bloom J, et al. *International Journal of Geriatric Psychopharmacology* 1998; 1: 55-65.

Date of preparation: May 1999.

Code No. EXE 99/20

EFEXOR XL: Mission accomplished




**REMISSION
ACCOMPLISHED**

EFEXOR XL
VENLAFAXINE 75 mg o.d.

Simply effective

AGENT OF REMISSION IN DEPRESSION

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 reduce the possibility of withdrawal reactions. *Children:* Contraindicated 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. Symptoms reported on discontinuation of venlafaxine were mostly non-serious and self-limiting and included dizziness, insomnia, nausea and nervousness. **Basic NHS price:** 75mg capsule (PL 00011/0223) – blister pack of 28 capsules: £23.97. 150 mg capsule (PL 00011/0224) – 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. References: 1. Ferrier N. Presentation at Wyeth Symposium, CINP, Glasgow, July 1998. 2. Rudolph R *et al.* Poster presented at ECNP, Vienna 1997. Date of preparation: March 1999. * trade mark. Code no: Z780580/0399



Life beyond Alzheimer's.



With Exelon, you can now help treat the symptoms of people with mild to moderately severe Alzheimer's disease.

While Exelon has not been shown to affect the disease process, six-month trials have established its effectiveness on key areas that Alzheimer's disease attacks - cognition, global functioning and activities of daily living.¹

For carers and family, this could mean some relief from the demands for attention; for the sufferer, it could mean life beyond Alzheimer's.



Beyond cognition: improving functional ability.

EXELON Prescribing Information. **Indication:** Symptomatic treatment of mild to moderately severe Alzheimer's dementia. **Presentation:** Capsules containing 1.5, 3, 4.5 or 6mg rivastigmine. **Dosage and Administration:** Effective dose is 3 to 6mg twice a day. Maintain patients on their highest well-tolerated dose. Maximum dose 6mg twice daily. Reassess patients regularly. Initial dose 1.5mg twice daily, then build up dose, at a minimum of two week intervals, to 3mg twice daily, 4.5mg twice daily then 6mg twice daily, if tolerated well. If adverse effects or weight decrease occur, these may respond to omitting one or more doses. If persistent, daily dose should be temporarily reduced to previous well tolerated dose. **Contraindications:** Known hypersensitivity to rivastigmine or excipients or any other carbamate derivatives; severe liver impairment. **Special Warning & Precautions:** Therapy should be initiated and supervised by a physician experienced in the diagnosis and treatment of Alzheimer's disease. A caregiver should be available to monitor compliance. There is no experience of use of EXELON in other types of dementia/memory impairment. Nausea and vomiting may occur, particularly when initiating and/or increasing dose. Monitor any weight loss. Use with care in patients with Sick Sinus Syndrome, conduction defects, active gastric or duodenal ulcers, or those predisposed to ulcerative conditions, history of asthma or obstructive pulmonary disease, those predisposed to urinary obstruction and seizures. In renal and mild to moderate hepatic impairment, titrate dose individually. Safety in pregnancy not established; women should not breastfeed. Use in children not recommended. **Interactions:** May exaggerate effects of succinylcholine-type muscle relaxants during anaesthesia. Do not give with cholinomimetic drugs. May interfere with anticholinergic medications. No interactions were observed with digoxin, warfarin, diazepam, or fluoxetine (in healthy volunteers). Metabolic drug interactions unlikely, although it may inhibit butyrylcholinesterase mediated metabolism of other drugs. **Undesirable Effects:** Most commonly (≥5% and twice frequency of placebo): asthenia, anorexia, dizziness, nausea, somnolence,

vomiting. Female patients more susceptible to nausea, vomiting, appetite and weight loss. Other common effects (≥5% and ≥ placebo): abdominal pain, accidental trauma, agitation, confusion, depression, diarrhoea, dyspepsia, headache, insomnia, upper respiratory tract and urinary tract infections. Increased sweating, malaise, weight loss, tremor. Rarely, angina pectoris, gastrointestinal haemorrhage and syncope. No notable abnormalities in laboratory values observed. **Package Quantities and basic NHS Price:** 1.5mg x 28, £31.50; 1.5mg x 56, £63.00; 3mg x 28, £31.50; 3mg x 56, £63.00; 4.5mg x 28, £31.50; 4.5mg x 56, £63.00; 6mg x 28, £31.50; 6mg x 56, £63.00. **Legal Classification:** POM. **Marketing Authorisation Number:** 1.5mg, EU/1/98/066/001 - 2; 3mg, EU/1/98/066/004 - 5; 4.5mg, EU/1/98/066/007 - 8; 6mg, EU/1/98/066/010 - 11. Full prescribing information including Summary of Product Characteristics is available from: Novartis Pharmaceuticals UK Ltd, Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.

Reference: 1. Corey-Bloom J. *et al. International Journal of Geriatric Psychopharmacology* 1998; 1: 55-65.

Date of preparation: May 1999.

Code No. EXE 99/20

Every day he's frustrated and alone.
Every day he wants to be different.
Every day goes by the same.



Many schizophrenia patients are crying out for reassessment. Conventional neuroleptics may have controlled some initial symptoms. However, for many patients, everyday life is still impaired by residual symptoms and side effects. Switching to Risperdal could give them a life worth living.



ONCE DAILY
RisperdalTM
 RISPERIDONE

Please refer to Summary of Product Characteristics describing Risperdal (risperidone) (HSE). 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 2 mg/day. This should be increased to 4 mg/day on the second day and 6 mg/day on the third day. However, some patients such as first-episode psychotic patients may benefit from a slower rate of titration. From then on the dosage can be maintained unchanged, or further individualised if needed. The usual effective dosage is 4 to 8 mg/day although in some patients an optimal response may be obtained at lower doses. Doses above 10 mg/day may increase the risk of extrapyramidal symptoms and should only be used if the benefit is considered to outweigh the risk. Doses above 16 mg/day should not be used. **Elderly, renal and liver disease:** A starting dose of 0.5 mg bd is recommended. This can be individually adjusted with 0.5 mg bd increments to 1 to 2 mg bd. Risperdal is well tolerated by the elderly. Use with caution in patients with renal and liver disease. Not recommended in children aged less than 15 years. **CONTRA-INDICATIONS, WARNINGS, ETC. Contra-indications:** 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 antagonistic 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, hypotension (including orthostatic), tachycardia (including reflex) and hypertension have been observed. 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 360mg. 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. **PHARMA: CRITICAL PRECAUTIONS:** Tablets: Store below 30°C. Liquid: Store below 30°C; protect from freezing. **LEGAL CATEGORY:** POM. **PRESENTATIONS, PACK SIZES, PRODUCT LICENCE NUMBERS & BASIC NHS COSTS:** White, oblong tablets containing 1 mg risperidone in packs of 20. PL 0242/0186 £13.45. Pale orange, oblong tablets containing 2 mg risperidone in packs of 60. PL 0242/0187 £79.56. Yellow, oblong tablets containing 3 mg risperidone in packs of 60. PL 0242/0188 £117.00. Green, oblong tablets containing 4 mg risperidone in packs of 60. PL 0242/0189 £154.44. Yellow, circular tablets containing 6 mg risperidone in packs of 28. PL 0242/0317 £109.20. Starter packs containing 6 Risperdal 1 mg tablets are also available £4.15. Clear, colourless solution containing 1 mg risperidone per ml in bottles containing 100 ml. PL 0242/0199 £65.00. **FURTHER INFORMATION IS AVAILABLE FROM THE PRODUCT LICENCE HOLDER, Janssen-Cilag Ltd, Saunderton, High Wycombe, Buckinghamshire HP14 4JU. APIVER140797**



Date of preparation: August 1998
 © Janssen-Cilag Ltd TM trademark



MISSION: To make depressed patients well again.¹

MEANS: The SNRI that achieves remission rates nearly twice as high as fluoxetine.²

EFEXOR XL: Mission accomplished

REMISSION
ACCOMPLISHED

EFEXOR XL
VENLAFAXINE 75 mg o.d.

Simply effective

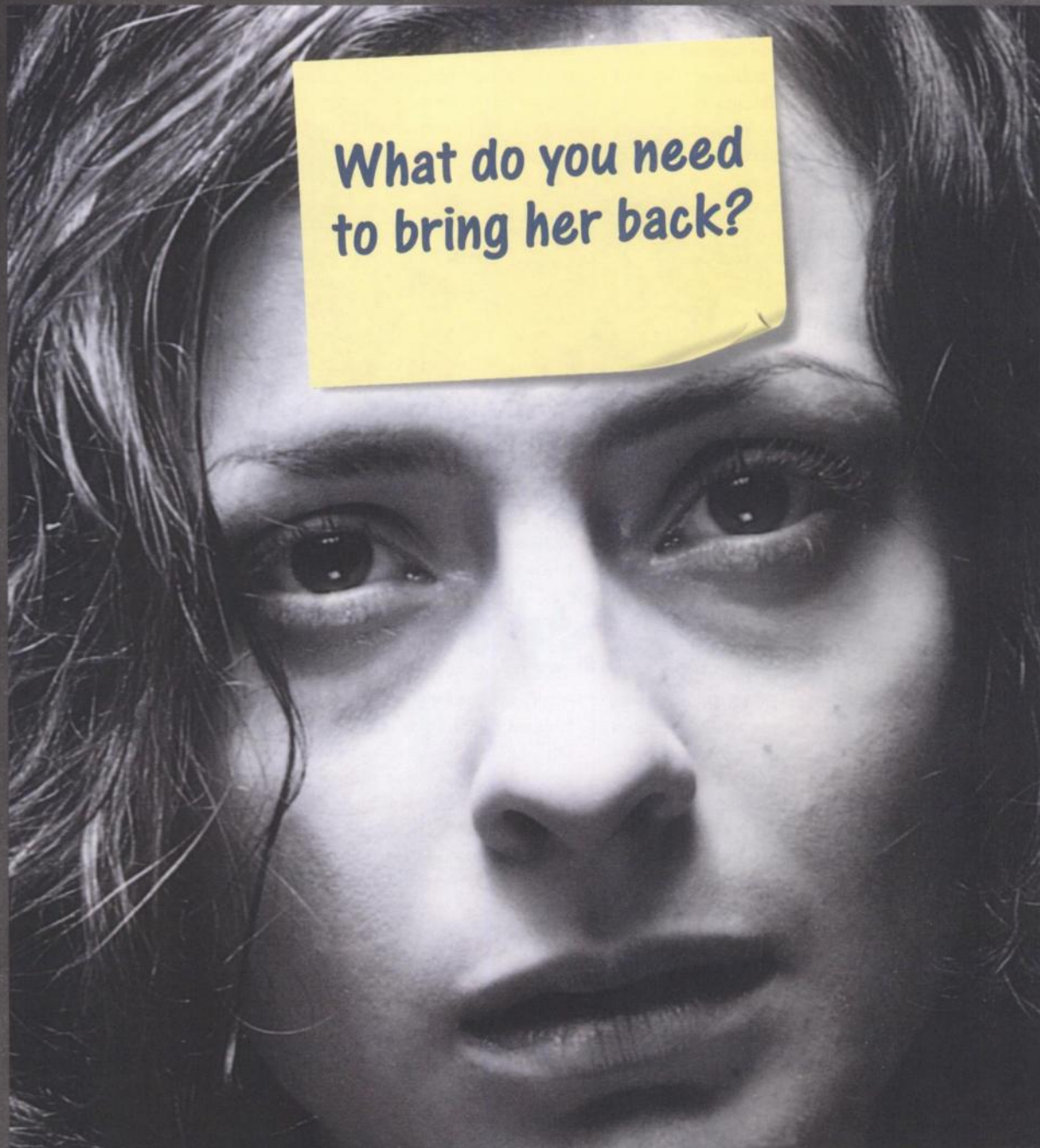
AGENT OF REMISSION IN DEPRESSION

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 reduce the possibility of withdrawal reactions. **Children:** Contraindicated 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:** **Wyeth[®]** Use with caution in patients with myocardial infarction,

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,

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. Symptoms reported on discontinuation of venlafaxine were mostly non-serious and self-limiting and included dizziness, insomnia, nausea and nervousness. **Basic NHS price:** 75mg capsule (PL 00011/0223) – blister pack of 28 capsules: £23.97. 150 mg capsule (PL 00011/0224) – 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. References: 1. Ferrier N. Presentation at Wyeth Symposium, CINP, Glasgow, July 1998. 2. Rudolph R *et al.* Poster presented at ECNP, Vienna 1997. Date



What do you need
to bring her back?

Prescribing Information - Solian 200 and Solian 50 Presentation: Solian 200 tablets contain 200mg amisulpride and Solian 50 tablets contain 50mg amisulpride. **Indication:** Acute and chronic schizophrenia including predominant negative symptoms. **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; pheochromocytoma; children under 15 years;

occur (discontinue Solian). Caution in patients with a history of epilepsy and Parkinson's disease. **Interactions:** Caution in concomitant administration of CNS depressants (including alcohol), antihypertensives and other 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 Synthelabo UK & Ireland Ltd, Foundation Park, Brookwood Way, Maidenhead, Berkshire, SL6 3HD.

Action in Alzheimer's



real lives - realistic expectations



Aricept[®]



donepezil hydrochloride



Once daily in Alzheimer's

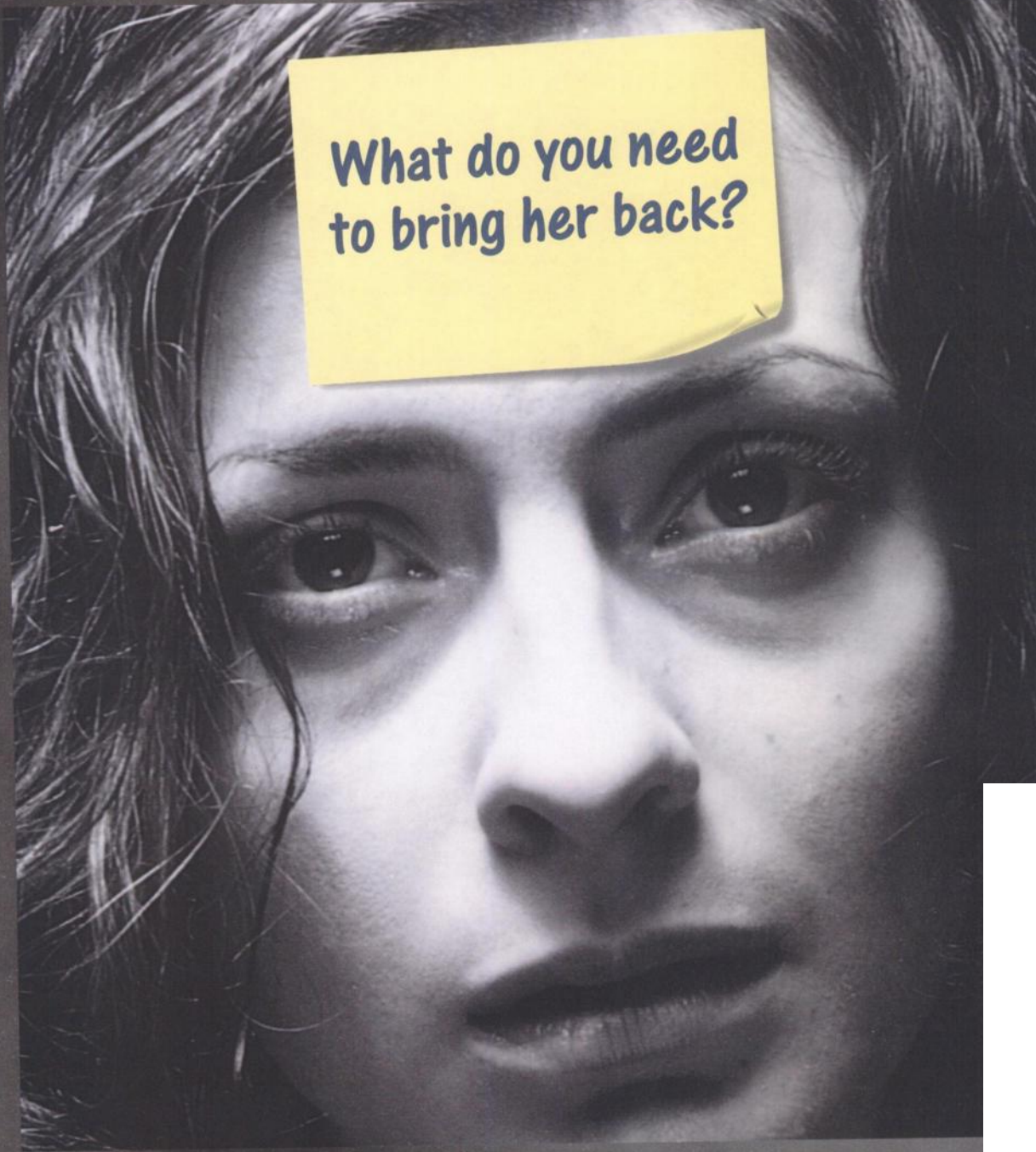
BRIEF PRESCRIBING INFORMATION

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 a therapeutic effect ceases. **Side effects:** Most commonly diarrhoea, muscle cramps, nausea, vomiting, and insomnia. Other common effects in clinical trials (≥5%, and ≥placebo) headache, pain, accident, common cold, abdominal disturbance and dizziness. Rare cases of syncope, bradycardia, heart block. Psychiatric disturbances, including hallucinations, agitation and aggressive behaviour have been reported; these resolved on dose reduction or discontinuation. Minor increases in muscle creatine kinase. **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 5mg; 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:**  

relaxation. Avoid concurrent use of anticholinesterases, cholinergic agonists, cholinergic antagonists. Possibility of vagotonic effect on the heart which 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, nausea, vomiting, and insomnia. Other common effects in clinical trials (≥5%, and ≥placebo) headache, pain, accident, common cold, abdominal disturbance and dizziness. Rare cases of syncope, bradycardia, heart block. Psychiatric disturbances, including hallucinations, agitation and aggressive behaviour have been reported; these resolved on dose reduction or discontinuation. Minor increases in muscle creatine kinase. **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 5mg; 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:**  

vomiting, and insomnia. Other common effects in clinical trials (≥5%, and ≥placebo) headache, pain, accident, common cold, abdominal disturbance and dizziness. Rare cases of syncope, bradycardia, heart block. Psychiatric disturbances, including hallucinations, agitation and aggressive behaviour have been reported; these resolved on dose reduction or discontinuation. Minor increases in muscle creatine kinase. **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 5mg; 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:**  



What do you need
to bring her back?

Prescribing Information - Solian 200 and Solian 50 Presentation: Solian 200 tablets contain 200mg amisulpride and Solian 50 tablets contain 50mg amisulpride. **Indication:** Acute and chronic schizophrenia including predominant negative symptoms. **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 tumours, prolactinomas and breast cancer; pheochromocytoma; children under 15 years;

occur (discontinue Solian). Caution in patients with a history of epilepsy and Parkinson's disease. **Interactions:** Caution in concomitant administration of CNS depressants (alcohol), antihypertensives and other hypotensive medications, and dopamine agonists. **Effects:** Insomnia, anxiety, agitation. Less commonly somnolence and GI disturbances. Solian may also cause weight gain, acute dystonia, extrapyramidal symptoms, dyskinesia, hypotension and bradycardia. Rarely, allergic reactions, seizures and malignant syndrome have been reported. **Basic NHS Cost:** Blister packs of: 20 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 Synthelabo, 100, The Parkway, Welwyn Garden City, Herts, SG13 7NF.

She's frightened, disturbed, disoriented - even disruptive. But behind her screams and tears, she's crying out to you - to bring her back from her terror of acute phase schizophrenia.

A rapid response

You can rely on Solian (amisulpride) in this critical acute phase. A significantly greater number of patients responded to Solian 800mg than haloperidol 20mg (62% vs 44% $p = 0.014$)¹ and Solian controls key symptoms - activation, thought disturbance and hostility - just as effectively.²

You can rely on Solian to start working quickly - with over 50% more patients responding to Solian therapy than to haloperidol within the first 2 weeks.³

Finally, because Solian is an atypical, it won't just bring her back - it'll keep her back in the community. So you can rely on it, just as your patients rely on you.



RELIABLE CONTROL OF ACUTE PHASE SCHIZOPHRENIA

Pharmacopsychiatry 1990; **23**: 125 - 130. **3**.
Turjanski S *et al.* Presented at ECNP Congress,
Paris, France, 1998, November.

Further information is available on request.
Lorex Synthelabo UK & Ireland Ltd, Foundation
Park, Roxborough Way, Maidenhead, Berks,
SL6 3UD.

Date of preparation: April 1999

Solian is a trademark

SOL.84

SYNTHELABO



New Books from Gaskell

Ethnicity: An Agenda for Mental Health

Edited by Dinesh Bhugra & Veena Bahl

This book sets the scene for identifying and meeting the mental health needs of black and minority ethnic groups. Clinicians, researchers, academics, hospital managers, commissioners and voluntary organisation workers come together to discuss the problems in health care delivery and the way of moving the agenda forward. In addition to multi-disciplinary working, the key emphasis here is involving commissioners and voluntary organisations in deciding how best to meet the needs of the communities.

This book will provide a useful agenda for mental health professionals, e.g. psychiatrists, trainees, nurses, OTs, psychologists, social workers and health care managers.

*May 1999, Paperback, ISBN 1 901242 15 3,
£25.00*

Evidence-Base Briefing: Dementia

Claire Palmer

The number of published papers on the subject of dementia is constantly rising and its virtually impossible for clinicians to read everything available, let alone to appraise it properly.

Evidence-Base Briefings (EBBs) are summarised collections of synthesised 'evidence' in a given topic area. This document on dementia attempts to encapsulate the best available evidence into a format which is quick and easy to use.

Its main aim is to provide a checklist of appraised evidence from which a clinician can easily obtain original documents. These documents can then be appraised (using the tool provided) and interpreted for the clinician's own practice. The evidence sources on which the EBB is based include research, guidelines and national guidance. The EBB includes full references to its source documents and details of further information resources to support evidence-based practice.

*July 1999, Paperback, ISBN 1 901242 35 8,
£15.00*

Mental Health of Ethnic Minorities: an annotated bibliography

Edited by Dinesh Bhugra

This book will be an invaluable and useful source for mental health professionals who have dealings with minority ethnic groups in their clinical and research practice. It provides an annotated bibliography of recent papers which describe research on mental health of minority ethnic groups in the UK. Collected from a number of resources these papers highlight the current status of the research and will also be useful for researcher and practitioner alike. Clinicians and researchers will find this book useful in informing their clinical practice and help formulate research ideas. This volume will be of use to mental health professionals as well as those who are interested in the field of cross-cultural psychiatry.

*July 1999, Paperback, ISBN 1 901242 31 5,
£10.00*

Getting the Message Across

Claire Palmer and Julie Fenner

An essential requirement of effective clinical practice is the rapid dissemination of research findings and their incorporation into practice. The usual dissemination method for NHS-generated research is publication in a professional journal and presentation at conferences. Occasionally educational strategies might be applied. There is increasing evidence that these strategies are often ineffective and that much of this new information is not adopted in to practice for many years, if at all.

This book is aimed at all those in the long chain between the source of new information in the NHS (be it policy, research or managerial innovations) and its intended target audience. The book includes overviews of relevant research and theory to support the development of more effective dissemination strategies in the NHS.

*July 1999, Paperback, ISBN 1 901242 36 6
£10.00*

Gaskell is the imprint of the Royal College of Psychiatrists. Gaskell books are available from good bookshops and from the Book Sales Department, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Telephone +44 (0)171 235 2351 extension 146, fax +44 (0)171 245 1231. Credit card orders can be taken over the telephone. The latest information on College publications can be seen on the Internet at www.rcpsych.ac.uk

Prescription for depression,

tender

loving care

and

SEROXAT
PAROXETINE

Now indicated for Social Phobia

Rebuilding the lives
of more anxious
depressed patients than any
other antidepressant¹

PRESCRIBING INFORMATION

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. Treatment of symptoms of social anxiety disorder/social phobia.

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. Social anxiety disorder/social phobia: 20 mg a day. Patients should start on 20 mg and if no improvement after at least two weeks they may benefit from weekly 10 mg dose increases up to a maximum of 50 mg/day according to response. 'Seroxat' has been shown to be effective in 12 week placebo-controlled trials. There is only limited evidence of efficacy after 12 weeks' treatment.

Give orally once a day in the morning with food. The tablets should not be chewed. Continue treatment for a sufficient period, which should be at least four to six months after recovery for depression and may be 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. 10.9.98



Welwyn Garden City, Hertfordshire AL7 1EY.

'Seroxat' is a trade mark.

© 1998 SmithKline Beecham Pharmaceuticals.

Reference: 1. Data on file.

0998/ST:AD/8/039BJ

