selection criteria and the list of independent variables used in the models.

Results: Unadjusted TTAD (in days) for typical antipsychotics, olanzapine, risperidone and quetiapine were 92, 175, 182 and 177, respectively. TTAD achieved by patients using conventional antipsychotics was consistently shorter than TTAD achieved with atypical antipsychotics, but estimates varied from -96 days to -44 days depending on selection criteria and model specification ($p<0.0001$ relative to olanzapine). TTAD using risperidone or quetiapine appeared to be superior to olanzapine in simple models (+11 to +13 days, $p<0.000$), while virtually no differences across atypical antipsychotics were found when the analysis was restricted to patients with schizophrenia and more complete model specifications were employed. Specifically, screening for schizophrenia reversed risperidone's advantage over olanzapine from +6 days ($p<0.0001$) to -1.4 days ($p>0.05$). TTAD results favoring quetiapine over olanzapine were reversed from +7 days ($p<0.0001$) to − 0.4 days ($p>0.05$) when covariates for episode type were included in the model.

Conclusions: Differences in duration of antipsychotic therapy exist across diagnostic groups and episode type. Differences also exist in the diagnostic and episode mix across drugs. Therefore, disaggregated patient samples and expanded model specifications provide more accurate estimates of differences in TTAD.

P0174

Once-daily extended release quetiapine fumarate (quetiapine xr): Pooled safety data from 3 placebo-controlled monotherapy studies in acute schizophrenia

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Objective: To assess the safety and tolerability of quetiapine XR using pooled data from 3 studies (5077IL/0041, D1444C00132, D1444C00133).

Methods: Quetiapine XR (300mg [1 study], 400mg [2 studies], 600mg or 800mg once daily) was evaluated in 3 similarly designed, 6-week, placebo-controlled, double-blind, randomised studies in patients with acute schizophrenia. Matched dose quetiapine IR was included to demonstrate assay sensitivity. Safety assessments included AEs and vital signs.

Results: The pooled safety population included 1684 patients (951, quetiapine XR; 414, quetiapine IR; 319, placebo). Mean (SD) duration of exposure to quetiapine XR, quetiapine IR and placebo was 31.8 (14.9), 29.4 (15.9) and 30.6 (15.6) days, respectively.

The percentage of patients reporting an AE was similar for quetiapine XR (69.5%), quetiapine IR (72.5%) and placebo (61.4%). Serious AE incidence was similar for quetiapine XR (4.4%), quetiapine IR (3.9%) and placebo (4.4%). 6.4%, 7.7% and 7.5% of patients receiving quetiapine XR, quetiapine IR and placebo discontinued owing to AEs, respectively.

The five most common drug-related AEs (≥5%) were: sedation (11.5%, 14.0%, 5.0%), somnolence (10.6%, 11.4%, 3.1%), dry mouth (10.4%, 8.0%, 1.3%), dizziness (7.5%, 6.8%, 3.1%) and orthostatic hypertension (5.8%, 7.5%, 3.8%), for quetiapine XR, quetiapine IR and placebo, respectively. There was no dose relationship with any common AE for quetiapine XR. For completers, mean weight increases were: quetiapine XR (n=555), 1.77kg; quetiapine IR (n=215), 2.19kg; placebo (n=163), 0.26kg.

Conclusions: Once-daily quetiapine XR (300-800mg/day) was well tolerated in patients with acute schizophrenia. The tolerability profile was consistent with the known safety profile for quetiapine IR.

P0175

Identifying schizophrenic psychoses with psychological scales - the northern Finland 1966 birth cohort

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Background and Aims: We study the predictive power and associations of several psychological scales with respect to hospitalisations due to schizophrenic psychoses.

Methods: Temperament and Character Inventory, Physical Anhedonia Scale, Social Anhedonia Scale, Perceptual Aberration Scale, Hypomanic Personality Scale, Bipolar II Scale, and Schizoidia Scale were included in the 31-year follow-up survey of the prospective Northern Finland 1966 Birth Cohort (N=4,926). We compared subjects without any previous hospitalisations to those with previous hospital diagnoses (concurrent validity) and to those who in the eight year long follow-up were hospitalised due to schizophrenic psychosis (predictive validity). We also compared the subjects with schizophrenic psychoses and subjects with other psychiatric disorders (discriminant validity).

Results: In most scales, subjects with schizophrenic psychoses differed from healthy subjects. The Perceptual Aberration Scale was the best scales for concurrent (Effect Size, $d = 1.89$) and discriminant validity ($d = 0.64$). Subjects having a high score in Hypomanic Personality Scale were in the highest risk for schizophrenic psychoses (OR 10.72; 95% CI 2.87-40.06).

Conclusions: Subjects with schizophrenic psychoses differed in most of the scales from healthy controls and from subjects with other psychiatric disorders. Many of the scales were useful predictors for future hospitalisations due to schizophrenic psychoses; however scales were not very diagnosis specific. The predictive power of the scales is limited, these scales are probably not useful as screening instruments but can be used in several ways when studying e.g. risk factors or genetics of schizophrenic psychoses.

P0176

Prevalence of psychotic symptoms in the general population of the Czech Republic

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