The aim of the study was to assess the possibility to predict violent events and efficaccy of preventive measures.

Methods: The study is prospective observational study at large 32-bed PICU in University Psychiatric Hospital, that covers 900.000 population with the average of 8 admissions per day. Recording of violent or other unexpected events is done routinelly. The risk for violent events was measured by BVC and by subjective assessment on a 7-point scale, both done three times daily. Using a special form, a number of prevented violent events is recorded with the same frequency. The results were compared with number of violent events before new assessments were introduced in everyday practice. Events were correlated with clinical assessments using CGI, GAS and BPRS.

Results: The number of actual violent incidents dropped significantly with new assessment methods. Subjective assessments of the risk for violent behavior showed superiority in the prediction of events then BVC. The majority of violent incidents were predictable and preventable, that reflected in low frequency of actual behaviors observed in the study.

Conclusions: Simple routine assessments done by educated stuff at PICU predict well unwanted and dangerous behaviors in acutelly ill psychiatric inpatients. Prevention strategies include known risk factors and give some new insights in the extent of the problem.

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Psychiatric diagnosis, clinical scales and impulsivity: a pilot study

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Background and aims: The value of psychiatric diagnosis is challenged by comorbidities and outcome prediction compared with symptom clusters and the role of common personality factors, such as impulsivity. The usuall clinical scales such as BPRS, HAM-D, YMRS or MMSE often mislead away from important symptoms or behaviors, since their validities are compared to valid classifications and diagnosis and do not include important coommon pathways to clinical manifestations and outcome.

Method: Using prospective design the study evaluates diagnosis, results of clinical scales (BPRS, HAM-D, YMRS and MMSE) and impulsivity (BIS) to retrospectivelly assessed course of illness and outcome of index episode in adult patients presenting with acute episode or worsening of schizophrenia, unipolar depression, bipolar disorder and dementia.

Results: 120 patients were included (30 in each diagnostic group) in the study, that is on-going at present. We found no correlation between past and present outcome and diagnosis, the corrleations were confirmed to clinical scales used, but the strongest corrleations were found between impulsivity and outcome in all four patient groups.

Conclusions: Current diagnostic systems are limited in longitudinal and outcome strenght. Other symptom clusters and impulsivity seem to predict outcome more consistently.

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Diagnostic, clinical magnificence of somatoform syndrome

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For existing classification in psychiatry (DSM-IV and ICD-10) in a foreseeable future syndromatic approach is more pragmatic and consequently demands searches of ways to its perfection. Most often in common medical networks they come out as a hyperventilation syndrome - 2,1%), - 4,7% and irritable colon syndrome 2,8% whereas the total share of other OS makes 1,8%; the similar data at general hospital make 1,8%, 0,6% and 1,0% against 0,5% accordingly, at a polyclinic - 7,3%, 15,6% and 9,7% against 6,1% accordingly. That reflects ambiguity of original attempts of reconciliation with nosologic classification system for studying a phenomenon of somatisation.

Somatoform syndrome within (OS) is presented within the limits of a continuum, where there is the mental pathology, including somatovegetative complex, at the one pole, and somatic infringements, amplificated by functional frustration at the other.

The central part of a continuum is formed actually with OS (functional frustration), on the one hand, masking, pushing aside on a level of facultative symptoms, psychopathological frustration, and on the other - duplicating (in the form of a cliche) symptom complex of somatic disease.

Accepting the increasing distribution the concept of comorbidity, should not simplify our activity, and opposite, definition types of comorbidity within somatoform syndrome, will allow to expand opportunities of studying pathogeny of somatisation. But absence the variants of personal reaction to frustration in ICD-10 complicates integration of psychiatry with internal medicine.

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Adjustment disorders as stress-related disorders: Prevalences from a representative community survey

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Stress-related disorders have been conceptualised as a nosological group comprising Adjustment Disorders (AJDs), Posttraumatic Stress Disorder (PTSD), and Complicated Grief Disorder(CGD). A used a recently proposed diagnostic model that describes AJDs as stress-related disorder (Maercker et al., Psychopathology, Vol. 40, No. 2).

A representative sample of a total of 712 elderly persons from Zurich aged 65-96 years were assessed by standardized interview or self-report questionnaires for occurrence of stressful index events and subsequent disorders: AJDs, PTSD, Major Depressive Disorder (MDD), and Recurrent Brief Depression (RBD). PTSD was assessed according to DSM-IV criteria, MDD was operationalised by CES-D criteria.

Index events for adjustment disorders were indicated by 52%, with 2.3% current adjustment disorder of any subtype. 36% of participants reported traumatic events meeting the DSM A1 criterion with 0.7% full and 4% subthreshold PTSD in the sample. CES-D depression prevalence was 6%, MDD 2.3%, and RBD 3%. Only AJDs and MDD were significantly associated with comorbid disorders. Health care utilisation (pharmacological or psychological treatment) were low for all diagnoses ($< 25\%$) with relatively more psychotherapy for PTSD and more pharmacotherapy for CG.

As this study was conducted in a sample of the elderly, further research should investigate syndrome criteria and prevalences in other age groups.

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Usefulness of the eeg investigation to diagnose TIC disorders in children and adolescents.

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Objective: The aim of the study was to analyse EEG investigation to diagnose the tic disorders in children and adolescents.

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Material and Methods: The analysis was conducted on a group of 76 patients admitted to the Department of Developmental Neurology between 2000-2005 years to diagnose the tic disorders. The average of children's age was 11,4 +/- 3,7 years. In investigated group of patients there were 62 boys (81,6%) and 14 girls (18,4%). The video-EEGs were carried out at 7 patients (22,4%).

Results: There were recorded a single sharp waves in 37 patients (47,4%) and the groups of sharp waves in 21 cases (27,6%). Accordingly there were registered the spike and wave complexes in 7 cases (9,2%) and the sharp and wave complexes in 4 cases (5,3%) in EEG. The generalized paroxysmal activity was recorded in 7 patients (9,1%). The abnormal activity appeared in the temporal part of cerebral hemispheres in 41 children (53,9%). The hiperventilation activated EEG recording of 33 children (43,4%). In 18 cases (23,7%) the abnormal graphoelements didn't appeare in EEG recording. The video recording and the clinical observations during EEG invstigation didn't revealed any coincidence between changes in EEG recording and the involuntary movements presented by patients.

Conclusions: The resting, routine EEG revealed abnormalities in most cases. Therefore video-EEG recording enabled to differentiate tics from epileptic seizure by finding any corelation between the occurrence of involuntary movements and abnormal graphoelements recorded during in EEG investigation.

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Symptomatology of TIC disorder in children and adolescents.

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The aim of the study was to analyze the clinical symptoms of the tic disorder in children and adolescents and verify the diagnosis of the Tourette's syndrome.

The analysis was conducted on a group of 123 patients at the age of 11.1 +/- 3.2 years, admitted to the Chair and Department of Developmental Neurology to diagnose and treatment of the tic disorder.

Variable tics symptomatology were observed in 53 patients (43,1%). The simple motor tics occurred in 121 patients from the researched group (98,4%), the complex motor tics in 7 cases (5,7%) and the vocal tics in 55 cases (44,7%). The dominant symptoms of simple motor tics in the researched group included: blinking occurring in 67 patients (54,5%) and the head movements occurring in 62 children (50,4%). The complex motor tics were the most frequently manifested by jumping - 4 patients (3,3%). The vocal tics manifested as throat cleaning were observed in 40 patients (32,5%). Coprolalia was observed only in 4 children (3.3%). The obsessive – compulsive disorders occurred in 3 patients (2,4%). In 41 examined patients (33,3%) the co-existence of tics with ADHD symptoms was observed.

The diagnostic criteria of the Tourette's syndrome according to DSM-IV were met by 44 patients (35,8%).

The symptomatology of the tics in children and adolescents are exceptionally rich and the symptoms are highly variable. The Tourette's syndrome is still too seldom recognised as the reason of tics in children and teenagers, despite the patients meeting the diagnostic criteria.

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Psychiatric disorders in a palliative care unit

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Objective: To evaluated the frequency of psychiatric disorders in 50 subjects from Inpatients the Palliative Care Unit (HC-IV) of the National Cancer Institute (INCA).

Method: Psychiatric diagnoses were assessed with the Mini-International Neuropsychiatric Interview (MINI) Version 4.4.

Results: Thirty-eight cancer patients (46.0%) reported at the current psychiatric disorder. The frequency of major depressive disorder was 32.0%, manic episode 2.0%, panic disorder 6.0%, agoraphobia 6.0%, obsessive compulsive disorders 2.0%, generalized anxiety 14%; alcohol abuse 4%; bulimia 4%; suicidal ideation 4%; somatization 2%; psychotic syndromes 2%; 14% of patients fulfill more than one diagnosis.

Conclusion: Comorbid psychiatric disorders are clinically significant in advanced cancer patients and may alter symptom control strategies. Clinical staff should be prepared for psychiatric diagnosis in their daily practice, given that such comorbidity may significantly alter the patient's quality of life.

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Different cut-off points for different trimesters? the use of edinburgh postnatal depression scale and beck depression inventory to screen depression during pregnancy in Taiwan

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Background: Compared with postpartum depression, validating self-reported questionnaires to detect depression during pregnancy has gained much less attention. Furthermore, it is not known whether it is appropriate to use the same cut-off point to detect depression in different trimesters of pregnancy.

Methods: One hundred and eighty-five Taiwanese women during pregnancy who completed the EPDS-T and the BDI-II were interviewed by psychiatrists with the structural interview, Mini-International Neuropsychiatric Interview (MINI), to establish DSM-IV diagnosis of major depressed disorder. We analyzed and compared the sensitivity, specificity, and validity of EPDS-T and the BDI-II against the MINI diagnosis in the second and third trimesters.

Results: We identified 12/13 as the optimal cut-off of EPDS-T, at which the sensitivity of the scale was 83%, specificity 89%. The optimal cut-off of BDI-II was 11/12, at which the sensitivity of the scale was 74%, specificity 83%. The area under the curve (AUC) of the receiver-operating characteristic (ROC) analysis was 0.92 for EPDS-T and 0.84 for BDI. There were different optimal cut-off points of EPDS-T for detecting major depression during different trimesters: 13/14 for the second trimester and 12/13 for the third trimester. There was no different optimal cut-off point of BDI-II for different trimesters.

Conclusions: EPDS-T has a satisfactory sensitivity and specificity, and a better validity than BDI-II for detecting major depressive disorder during pregnancy in Taiwanese pregnant women. Although it is possible that different cut-off points should be used to detect depression in different trimesters.

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