

amenorrhea ($p < .001$), physical activity ($p < .001$), calcium intake ($p < .001$) and body mass index ($p < .001$). At follow-up, subjects with good outcome had a higher percentage of bone mass increase than normal adolescents, whereas patients with poor outcome had a bone mass loss. Conclusions: 35–44 % of patients had osteopenia and related variables were body mass index, duration of illness, calcium intake and physical activity. Patients with good outcome had a high bone mass increase.

S10.4

Genes, environment, and eating disorders: twin study findings

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Eating disorders are highly heritable conditions. Body dissatisfaction and dieting-oriented behavior are common in young people and often predispose vulnerable individuals to eating disorders.

We assessed pairwise twin correlations and heritability estimates of dieting frequency and Eating Disorder Inventory subscales body dissatisfaction and drive for thinness in a population sample of 936 female and 811 male Finnish twins aged 24–25. Body dissatisfaction was much influenced by genes, with different sets of genes operating in females and males, and with possible genetic dominance in males. Drive for thinness and dieting frequency had a moderate heritability in females and a lower heritability in males. Individual-specific environmental factors were relatively important for body dissatisfaction, drive for thinness, and dieting frequency in both males and females, but environmental factors shared by the twin pair were of negligible importance.

The genetic factors influencing body dissatisfaction and dieting-oriented behavior may constitute a part of the genetic vulnerability to eating disorders. These influences are likely to be age-specific and sex-specific.

S10.5

Somatic consequences of eating disorders

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More than other psychiatric disorders eating disorders are conditions in which a disturbed psyche directly contributes to a disturbed soma.

This study aims to assess the status at admission and course of the somatic consequences and laboratory findings in a sample of patients with serious and long lasting eating disorders.

Data were analysed per diagnostic group. Associations with ED-symptom severity were examined. Survival analyses were conducted to examine whether the physical status at admission could predict treatment outcome.

The sample consisted of 167 DSM-IV ED patients (mean age 28 years, mean duration of illness 11 years) referred to a tertiary care centre for inpatient treatment or day care. A physical examination and an extensive laboratory investigation were carried out.

Abnormal findings included anaemia, leucopenia and disturbed liver and renal function tests especially for the AN-group and electrolyte disturbances especially for the AN B/P type patients and BN patients. Most abnormal findings improved during treatment.

Empirically based guidelines for routine laboratory investigations are presented.

S11. Reforming psychiatry in Eastern Europe

Chairs: W. Rutz (WHO, Europe), L. Jacobsson (S)

S11.1

Swedish support to the restructuration of psychiatry in Eastern Europe

L. Jacobsson. Department of Psychiatry, Umeå, Sweden

The Swedish government has supported the restructuration of mental health services in North-western Russia, the Baltic countries and Bosnia Herzegovina since the early 1990'ies. This support has been channeled through the East Europe Committee of the Swedish Health Care Community, which is a joint body of all major actors in the Swedish health care community e.g. all professional organizations and the major care providers. Since 1995 more than 70 million Swedish crowns (6 million dollars) have been spent on hundreds of collaborative projects in which Swedish clinics and university institutions have been engaged in teaching and training of staff, study visits and supervision activities. Several thousands of professionals have been engaged in these activities. Some of these will be presented. Some evaluations of these projects have also been done and will be described.

S11.2

Reforming psychiatry in Eastern Europe – the WHO perspective

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Since 1999 the mental health program of the WHO Regional Office for Europe has been intensively involved in supporting necessary mental health reforms in the countries of transition in eastern, central and southeastern Europe. Focus of the work of the mental health program have been:

- Suicidality and other premature mortality, related to transitional stress and mental ill health.
- National mental health audits and planning.
- Restructuring, modernizing and humanizing services, leading to de-hospitalization, decentralization and community-based mental health services.
- And finally, counteracting taboo and discrimination.

This work is made possible with the help of WHO collaborating organizations, WHO task forces and WHO networks this work is made possible and it will be described. Outcomes as well as possible shortcomings will be analyzed.

S11.3

Reforming psychiatric services in Bosnia Hercegovina after the war

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Before the war in Bosnia (1992–1995) the organization of psychiatric service was on a relatively high level and not different from the other republics in former Yugoslavia. During the beginning of the war, most of the psychiatric institutions were closed, damaged or devastated. In spite of this psychiatric services continued to work, very often in improvised and poor conditions with the help of WHO and some NGO:s. After the war, in 1996, Federation of BiH government made an agreement with the World Bank on building

38 Mental health centers (MHC). At the same time an Expert Group for Mental health was formed, which made short- term and mid-term plans for the development. Now six years after the war and the realization of the expert group program with international support, there is a decentralized community based mental health service working and there are no traditional mental hospital beds in the Federation.

S11.4

The role of NGOs in mental health reform example – Romania

B. Tudorache. *Romania*

The author describes the difficult and specific conditions, characteristic of new democratic countries – like Romania- regarding the planning and implementation of a mental health reform. These conditions depend not only on the executive and legislative power, but also on a series of factors (professional, political, social, cultural or religious) linked by the quality of the mental health professionals, by the structure of some NGOs or by some groups of users, ex-users or users' families, by the existence of the civil society. The author presents the importance and the role of the NGOs as one of the factors interested and involved in mental health problems.

Showing that at present, in Romania there are favourable auspices for a mental health reform (e.g. the support from the Romanian Ministry of Health and Family and the International Institutions), the author presents the steps that are made by the Romanian NGOs for the implementation of the mental health reform, and the principal key points absolutely necessary for the elaboration and implementation of a coherent mental health policy.

S11.5

Analysis of obstacles for effective mental health reform in Lithuania

D. Puras. *Vilnius University, Lithuania*

The first years of democracy and independence in Lithuania in the early 90's of 20th century have been full of new approaches in the field of psychiatry and mental health services. Reform minded professionals and NGO's were rather successfully introducing psychosocial community based interventions and other approaches which had been ignored by totalitarian system. However, in the end of 90's it appeared that the way to the liberation of mental health from traditional system of stigmatizing institutions and paternalistic approaches in post-communist countries is likely to be long and full of obstacles. One of the ways of facilitating basic changes in the mental health system is through qualitative and quantitative mental health services and policy research, which could analyze the hidden obstacles existing in the current system. The findings from research made in Vilnius University will be presented and preliminary recommendations for implementation of effective changes will be suggested.

S12. Subcortical vascular dementia – a new disorder?

Chairs: A. Wallin (S), L. Pantoni (I)

S12.1

Subcortical vascular dementia: introduction and clinical picture/diagnosis

A. Wallin*, M. Jonsson, M. Sjögren. *Göteborg University, Institute of Clinical Neuroscience, Mölndal, Sweden*

Vascular dementia (VaD), the second most common type of dementia, accounts for 10–50% of all dementia cases. With the variation in prevalence figures, diagnostic criteria and pathophysiological mechanisms, VaD must be considered a heterogeneous concept. In subcortical vascular dementia (SVD), the primary types of brain lesions are lacunar infarcts and ischaemic white matter lesions, with demyelination and loss of axons, the primary lesion site is the subcortical region. SVD fulfils what can be referred to as the basic criteria for a disease: the presence of a pattern of clinical features, i.e., frontosubcortical symptoms, that matches a pathological picture. The opposite seems to be true in post-stroke dementia, which has symptomatological variation and relatively heterogeneous aetiology, i.e., thromboembolism or haemorrhage. AD + VaD is also heterogeneous with regard to both clinical picture and (by definition) aetiology. The large clinicopathological spectrum of VaD has again become a focus of attention. International acceptance of the currently suggested criteria for SVD would provide a good starting-point for comparisons of manifestations and treatment responses across studies worldwide.

S12.2

Subcortical vascular dementia: neuropathological findings

D.G. Munoz*. *Universidad Autonoma de Madrid, Spain*

Three distinct, but often associated histological tissue lesions constitute the structural substrate of subcortical vascular dementia: Lacunes, perivascular atrophy, and leukoariosis. These lesions and possibly additional functional alterations are presumed caused by various anomalies of small cerebral blood vessels.

Lacunes are small (0.5 to 1.5 mm) trabeculated cavities with ragged margins, located in the hemispheric white matter, the basal ganglia, the thalami, the brain stem or the cerebellum. Infarcts are the most common cause, but some represent re-absorbed small hemorrhages.

Dilated perivascular spaces may result from elongation and spiralling of small arteries. They are often accompanied by rarefaction of the surrounding brain parenchyma.

Grossly visible extensive areas of demyelination sparing the subcortical U-fibers have been traditionally designated Binswanger's disease. There is not a commonly accepted term for the extensive white matter lesions observed on brain imaging and as pallor on histological sections, but the term leukoariosis could encompass all these alterations. Two competing theories for the mechanism of leukoariosis have been proposed: incomplete infarction, and edema.

The small cerebral blood vessels can be affected by at least 7 different pathological processes: atherosclerosis, lipohyalinosis, venous collagenosis, amyloid angiopathy, CADASIL, diverse inflammatory angiopathies, and a miscellaneous category which includes non-CADASIL Binswanger-like syndromes.