from paroxetine to placebo relapsed during RP, while only 5% (2/43) of patients continuing on paroxetine treatment relapsed ($p = 0.002$; Chi-square test). The median time to relapse after crossing over from paroxetine to placebo was 14 days and for the two patients in the paroxetine group was 14 and 28 days. Paroxetine treatment for up to 6 months demonstrated continuing therapeutic efficacy, and during MP was associated with a generally lower incidence of adverse events compared with the initial 10-week study. During RP the incidence of most common adverse events was not appreciably different between the placebo and combined paroxetine groups. In conclusion, therapeutic efficacy was maintained during long term paroxetine treatment for up to 6 months and importantly, paroxetine was effective in the prevention of relapse. Furthermore, good tolerability for paroxetine was evident with a lower incidence of adverse events compared with the short-term study.

[1] Dunbar G, et al. Eur Neuropsychopharmacol 1995; 5: 361.

ELECTROCONVULSIVE THERAPY AND DO NOT RESUSCITATE — A PARADOX

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Electroconvulsive therapy (ECT) is an effective treatment for affective and schizoaffective disorders. Legislated pre-ECT requirements include: indications consultation, explanation of procedures/alternatives/benefits/risks, minimum 24 hr delayed signed consent, and competency consultation. When does it become unethical to pursue ECT even though a consent has been obtained?

This 84yowmf presented with recurrent psychotic depression. The indications consultation concluded that ECT was merited in light of historical response but that the patient had clearly verbalized her desire to refuse such treatment. The competency consultant found the patient competent to refuse. When marked deterioration occurred within one week, this same consultant found the patient to be incompetent to consent or refuse. The court concurred and empowered the family to consent.

Medical decompensation required medical center transfer and the family/internist determined a Do Not Resuscitate (DNR) code status. Hospital policy necessitated complications that occur during surgery be resuscitated. The anaesthesiologist felt comfortable not resuscitating an ECT complication — the ECT treating physician did not. This impasse was reviewed with family members who desired both ECT and DNR. The paradox was cosmetically resolved by the family rescinding DNR status for the ECT procedure only. Ultimately after detailed discussions with family/internist/primary psychiatrist/anaesthesiologist, the ECT treating physician felt it unethical to proceed, especially since the patient's last competent desire was to refuse ECT.

LACK OF TYPICAL SSRI-RELATED ADVERSE EFFECTS AND SEXUAL DYSFUNCTION WITH MIRTAZAPINE IS RELATED TO SPECIFIC BLOCKADE OF 5-HT_2 AND 5-HT_3 RECEPTORS

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Mirtazapine, a noradrenergic and specific serotonergic antidepressant (NaSSA), potentiates noradrenergic neurotransmission directly via blockade of α_2-autoreceptors, and indirectly enhances 5-HT_1 -mediated serotonergic neurotransmission. Mirtazapine directly blocks the 5-HT_2 and 5-HT_3 receptors held responsible for development of typical SSRI-related side effects such as nausea, vomiting, diarrhea, insomnia, agitation and symptoms of sexual dysfunction. This novel pharmacological profile was expected to result in improved tolerability of the drug. We therefore analyzed the data of all patients (mirtazapine n = 359; placebo n = 328) who took at least one dose of study medication while participating in placebo-controlled studies of mirtazapine. Side effects where coded according to the WHO terminology. The data show that there are no statistically significant nor clinically relevant differences between mirtazapine and placebo regarding incidences of typical SSRI-related side effects. Only 2 symptoms typical of sexual dysfunction were registered during the use of mirtazapine: libido decreased (male), with incidence lower than in the placebo group (4% vs 7%), and libido decreased (female) with incidence equal to placebo group (4% vs 4%). Our analysis demonstrates that *in vitro* and *in vivo* data regarding mirtazapine's receptor binding profile can explain clinical data obtained during treatment of depressed patients. It may be concluded that the "designed" receptor binding profile of mirtazapine results in improved tolerability with respect to typical SSRI-related side effects.

CASE STUDY OF A PATIENT WITH DEPRESSIVE EPISODES WITHIN A COMPLEX BORDERLINE-, COMPULSORY- AND ANXIETY DISORDER. MEDICAL, PSYCHOTHERAPEUTIC AND REHABILITATION TREATMENT IN A COMMUNITY BASED PSYCHO-SOCIAL CENTRE

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The patient contacted the centre at the age of 23. Anxiety symptoms appeared when she was 8. At highschool loneliness, obsessive and compulsive disorders increased. A lack of sustaining power, the above mentioned problems and depressive episodes stopped her studies. She ceased all following jobs and the working time abridged from months to days. Diagnoses were based on phsychological testing and psychiatric interviews. The concept of therapy and care followed three main topics.

1.) Medical treatment: The maximum dosage she agreed to was 20 mg Fluoxetin per day. She complained of inner unrest several times. To prevent quitting all medication it was changed to Fluvoxamin 100 mg per day and after some months without side effects to 200 mg per day. This especially decreased the compulsory symptoms. The aggressive behavior relaxed and the anxiety descended a little, so that psychotherapy became possible. The patient tried to stop once, but the old symptoms appeared again, so she continued.

2.) Psychotherapeutic approach: Cognitive behavior therapeutic methods for anxiety and compulsary symptoms. Supporting her search for her place in a world which seems to be composed of extremities. Finding realistic goals by the patient and fixing small steps to reach them.

3.) Working rehabilitation: One attempt in a job finding course failed. Since August 1995 she has been working in a centre for work training up to this day.

Conclusion: For the treatment of complex disorders approaches from different sides are essential. The demanded flexibility is only possible in a multiprofessional team, which is very well embeded in and synergicing all possibilities attainable in the local area. Although only small improvements are reachable, they represent a big step in the quality of life to the patient.

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