that psychostimulant use can be understood as the representation of and identification with the cultural messages and models (e.g. quality of life, consumption patterns, etc.) on microcultural and individual level.

P01.58

LACK OF EFFECT OF VITAMIN B_6 ON PSYCHOTIC SYMPTOMS IN CHRONIC SCHIZOPHRENIC AND SCHIZOAFFECTIVE PATIENTS: A DOUBLE-BLIND PLACEBO-CONTROLLED STUDY

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Deficiency of certain vitamins, and especially from the 'B' complex, can produce symptoms of psychiatric disorder. Vitamin B_6, or pyridoxine plays an intrinsic role in the synthesis of certain neurotransmitters which take part in development of psychotic states. There are a number reports that vitamin B_6 may be a factor in a number of psychiatric disorders, such as autism, Alzheimer's disease, hyperactivity, learning disability, anxiety disorder and depression. Moreover, there are anecdotal reports of a reduction in psychotic symptoms after vitamin B_6 supplementation of psychopharmacologic treatment of patients suffering from schizophrenia or organic mental disorder. The aim of this study was to systematically examine whether vitamin B_6 therapy influences psychotic symptoms in patients suffering from schizophrenia and schizoaffective disorder. The effect of the supplementation of vitamin B_6 to antipsychotic treatment on the positive and negative symptoms in 15 schizophrenic and schizoaffective patients were examined in a double-blind, placebo controlled, crossover study spanning 9 weeks. All patients had stable psychopathology for at least a month before entry into the study and were maintained on their pre-study psychoactive and antiparkinsonian medications throughout the study. All patients were assessed by Positive and Negative Syndrome Scale for Schizophrenia (PANSS) on weekly base. The patients randomly received increasing doses of vitamin B_6 or placebo at 100 mg/day for the first week, 200 mg/day for the second week, 300 mg/day for the third week and 400 mg/day for the fourth week. PANSS scores revealed no differences between vitamin B_6 and placebo-treated patients in amelioration of their mental state.

P01.59

IS PRESCRIPTION OF CYAMEMAZINE USEFUL TO FAVOR WITHDRAWAL OF BENZODIAZEPINES AFTER LONG TERM TREATMENT?

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Long term prescription of anxiolytic benzodiazepines (BZD) is frequently associated with dependence. The objective of our study was to evaluate the efficacy and tolerance of an anxiolytic neuroleptic: cyamemazine used at low doses to avoid anxiety rebound, withdrawal signs, reintroduction of BZD when a long term anxiolytic benzodiazepines prescription had to be stopped.

Method: A multicentric, double blind, randomised study was conducted in 168 patients taking BZD (5 to 20 mg equivalent diazepam) for anxiety since more than 3 months. The study compared two groups of treatment, one with a substitution from BZD initial to bromazepam during 14 days then prescription of half the dose of bromazepam during 14 days then prescription of placebo for 14 days, and the other group with a substitution from BZD initial to cyamemazien during 14 days then half the dose of cyamemazine during 14 days then placebo for 14 days. The doses of cyamemazine used were 12.5 mg to 50 mg and for bromazepam 1.5 mg to 6 mg. Six month-follow-up was carried out to collect data after a withdrawal period of 6 weeks.

Results: There was no significant difference between the two groups neither on maximal amplitude of anxiety rebound on HARS between DO and D42 (main criteria), nor on percentage of anxiety rebound on HARS or Zung anxiety scale, nor on number of new or worsened syptoms on Rickels withdrawal scale. After 6 months, the physician estimated that the rate of success was better in the cyamemazine group than in the bromazepam group ($p = 0.03$). Cyamemazine was well tolerated without extrapyramidal symptoms. Cyamemazine could be useful to favor long term maintenance of BZD withdrawal among patients supposed to be subject to relapse and reintroduce BZD.

P01.60

WHAT'S BENEATH THE SKIN?

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The relaTIONSHIP between the skin and the psychic system has been well-known for a long time.

The skin is a surface for the projection of physical processes and changes-the explanation of the psychosomatic dermatological symptoms are based on the dysfunction of the emotional and autonomic nervous system. Behind the non-improving, itching and scratched ekzema we sometimes find either Ekbom-syndrome/ often diagnosed AS gerontological delusions of parasitosis,/ or therapy-resistent allergy/which conceals depression.

The authors present condensed case-stories about delusions of parasitosis and allergic syndromes-proving the excellent results achieved using risperidone-therapy and citalopram.

P01.61

STUDY OF CONVERSION FACTOR BETWEEN ZUCLOPENTHIXOL (ZCP) ACETATE AND ZCP DECANOATE IN PATIENTS RECEIVING HIGH DOSES OF ZCP ACETATE

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More and more consideration has been given to the high doses often used in the treatment of the schizophrenic patients presenting acute psychotic symptomatology. Zuclopenthixol has been found to be efficacious in the treatment of schizophrenia either with its depot (decanoate:AP) an semi prolongated (acetate:ASP) formulations. Recommandations for the transfer from ASP to AP treatment are used on the estimated daily dose of ASP. The objective of this multicentric study is to determine a conversion factor (CF) between ASP an AP in psychotic patients receiving high doses of ASP (mean dose $\geq$ 150 mg/day). The CF is bound to establish the minimal antipsychotic efficacy dose of AP. The determination of CF is based on both clinical (CGI, item 2) and pharmacokinetic (serum dosage of zuclopenthixol) assessment, the AP dosage used is then linked to the ASP posology. 48 patients were included in this open-label pilot study that comprises. 2 periods: I (acute treatment): ASP treatment until stabilisation/improvement assessed on the CGI item 2; II (maintenance treatment): switch to AP/14 days. Duration of period I must not be less than 4 days and total duration of period II is 80 days. Blood samples will be taken 7 days after each AP injection. The first AP/14 days dose was 3 fold the mean value of the last two ASP injections (dose A). The next AP doses (dose A $\times$ 2 or 3 or 4) were decided upon the results of the clinical response

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to treatment and the zuclopenthixol serum level. 32 patients (67%) were included at least during 28 days and 19 (40%) during 80 days. Mean doses of ASP was 220 mg/injection, of AP/14 days at D 28 = 669 mg and at D 80: 555 mg. At D 28, 25 patients (78%) have been improved and 17 (89%) at D 80. The mean CF used by the improved patients was 3 at D 28 and 2.7 at D 80. It seems justified to use a CF of 3 to determine the maintenance AP dose injected each 14 days, from the mean ASP dose used during the acute phase of psychotic symptoms.

P01.62

EFFICACY OF VENLAFAXINE ER IN GAD PATIENTS WITH PREDOMINANTLY SOMATIC SYMPTOMATOLOGY

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Venlafaxine extended-release (ER) is a selective serotonin and noradrenaline reuptake inhibitor, which has been recently approved for the treatment of generalized anxiety disorder (GAD). In order to validate the efficacy of venlafaxine ER for the somatic symptoms of GAD, we examined venlafaxine efficacy on the somatic and psychic factors of the HAM-A scale[1] in patients with mainly somatic symptoms at baseline. The relative importance of somatic and psychic HAM-A factors was examined in 1841 patients from 5 double-blind, multicentre, placebo-controlled studies of venlafaxine ER efficacy in GAD, two of which had long-term extensions. At baseline, 83.6% of the 1841 patients had a ratio between the somatic and psychic factor scores lower or equal to 1. Patients with mainly somatic symptoms (somatic/psychic factors > 1; "somatizers") did not show any difference in response rates (50% decrease or greater from baseline values) to venlafaxine ER on the somatic or psychic factors after 8 weeks of treatment (54% and 63% somatic factor responders and 58% and 58% psychic factor responders for non-somatizers and somatizers respectively). Analysis of patients (767) that took part in the two 6-month study extensions revealed a trend towards an increase in both somatic and psychic response rates to venlafaxine ER in patients with mainly somatic symptoms (65% and 77% somatic factor responders and 64% and 75% psychic factor responders for non-somatizers and somatizers respectively). Venlafaxine ER induced a significantly higher percentage of somatic and psychic factors responders versus placebo at both time points.

The present study supports the efficacy of venlafaxine ER in patients with GAD, including the minority with predominantly somatic symptomatology.

(1) Hamilton, M. (1959) Br. J. Med. Psychol. 32, 50–55.

P01.63

VENLAFAXINE ER ACTION ON GENERALIZED ANXIETY DISORDER (GAD)-SPECIFIC ANXIETY SYMPTOMS

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In the DSM-IV definition[1], GAD is defined by the presence of excessive worry for a period of at least six months and the presence of 3 out of a list of six symptoms including restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and disturbed sleep. Changes in the Hamilton anxiety rating scale (HAM-A) score are commonly used as an indicator of the efficacy of therapeutic interventions in GAD. Venlafaxine extended-release (ER) was proven effective on this scale in patients with GAD[2]. Using effect size (ES)[3] analysis we examined venlafaxine ER efficacy on HAM-A items most closely corresponding to DSM-IV diagnostic symptoms for GAD (1, 2, 4, 5, 7 and 14). ES was evaluated from data obtained from 5 double-blind, 8-week placebo-controlled studies of similar design, comparing venlafaxine ER (n = 1297) with placebo (n = 544). Two of these studies had long-term (6-month) extensions. An ES cut-off of 1 (difference between pre- and post-treatment greater or equal to the standard deviation of that difference) was used to characterize items with the largest changes. After 8 weeks of treatment, venlafaxine ER produced an ES $\geq$ 1 in item 1 (anxious mood, including worry), 2 (tension) and 14 (behavior at interview). By the end of long-term treatment, an ES $\geq$ 1 was observed in items 1, 2, 5 (intellectual), 7 (somatic muscular) and 14. After both short and long-term treatment with venlafaxine ER, the largest effect sizes were observed on HAM-A items 1 and 2.

Venlafaxine ER induced large effect sizes on 5 out of the 6 HAM-A items related to GAD diagnostic symptoms. In GAD patients, venlafaxine ER appeared to be acting on the specific symptoms of this disorder.

(1) American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, (A.P.A., Washington D.C., 1994).
(2) Hackett D et al. *Eur. Psychopharm.* 9 (Suppl. 5), S315. 1999.
(3) Leon, A.C., et al. *Psychopharmacol. Bull.* **29**, 163–167 (1993).

P01.64

QUALITY OF RESPONSE IN GAD: IS RESPONSE TO PLACEBO THE SAME AS RESPONSE TO ACTIVE TREATMENT?

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Response (defined as a 50% or greater decrease from baseline severity) is often used in anxiety and depression studies as a clinically relevant criterion to determine the proportion of patients benefiting from pharmacological treatment. However, studies designed to test the efficacy of active treatments are frequently compromised by a high placebo response. The present analysis will examine the response characteristics in patients from a pool of two 6-month double-blind multicentre studies in patients suffering from generalized anxiety disorder (GAD). The response shown by GAD patients after placebo or the specific noradrenaline and serotonin reuptake inhibitor venlafaxine ER (extended release) treatment will be characterized in terms of sustainability, loss of response, fluctuations between response and non-response and relapse to baseline severity.

After 6 months of treatment, venlafaxine ER induced response in 66% of patients ($p < 0.001$ versus 39% in placebo group). More responders in the venlafaxine ER group were shown to sustain their response until the end of the study than responders in the placebo group ($p < 0.001$, 43% versus 22% of responders respectively). This difference was paralleled by a lower percentage of loss of response and fluctuations in venlafaxine ER responders. Responders in the venlafaxine ER group also showed a lower occurrence of relapse (6% and 15% in venlafaxine ER and placebo group respectively, $p = 0.003$).

Results from this study suggest that response to venlafaxine ER is qualitatively different from the response observed in the placebo-treated population. Response to venlafaxine ER is characterised by a higher stability. The superior stability of response observed in patients responding to venlafaxine ER is probably related to the lower intensity of residual symptoms in this population, and further supports the efficacy of venlafaxine ER in GAD.

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