THE BRITISH JOURNAL OF PSYCHIATRY

FEBRUARY 1999 VOL. 174

EDITORIALS

93 The demise of the published case report – is resuscitation necessary?
A. Farmer

95 Two-phase epidemiological surveys in psychiatric research
G. Dunn, A. Pickles, M. Tansella and J. L. Vázquez-Barquero

101 Lipids and schizophrenia
N. P. Walker, H. C. Fox and L. J. Whalley

REVIEW ARTICLE

105 Genetic basis of attention deficit and hyperactivity
A. Thapar, J. Holmes, K. Poulton and R. Harrington

PAPERS

112 Early life family disadvantages and major depression in adulthood
H. Sadowski, B. Ugarte, I. Kolvin, C. Kaplan and J. Barnes

121 Neurodevelopmental antecedents of early-onset bipolar affective disorder
E. Sigurdsson, E. Fombonne, K. Sayal and S. Checkley

128 Medication received by patients with depression following the acute episode: adequacy and relation to outcome
R. Ramana, E. S. Paykel, P. G. Surtees, D. Melzer and M. A. Mehta

135 Impact of pregnancy on bulimia nervosa
J. F. Morgan, J. H. Lacey and P. M. Sedgwick

141 Cantabria First-Episode Schizophrenia Study: three-year follow-up
J. L. Vázquez-Barquero, M. J. Cuesta, S. H. Castanedo, I. Lastra, A. Herrán and G. Dunn

150 Prevalence of substance misuse in first-episode psychosis
R. Cantwell, J. Brewin, C. Glazebrook, T. Dalkin, R. Fox, I. Medley and G. Harrison

154 Coping strategies in relatives of people with schizophrenia before and after psychiatric admission
M. Scazufca and E. Kuipers

159 Satisfaction with in-patient psychiatric services. Relationship to patient and treatment factors
N. Greenwood, A. Key, T. Burns, M. Bristow and P. Sedgwick

164 Limits to the value of mental health review tribunals for offender patients. Suggestions for reform
P. J. Taylor, E. Goldberg, M. Leese, M. Butwell and A. Reed

170 Stalking: false claims of victimisation
M. Pathé, P. E. Mullen and R. Purcell

173 Efficacy of bupropion for smoking cessation in smokers with a former history of major depression or alcoholism
K. E. Hayford, C. A. Patten, T. A. Rummans, D. R. Schroeder, K. P. Offord, I. T. Croghan, E. D. Glover, D. P. L. Sachs and R. D. Hurt

COLUMNS

179 Correspondence
181 One hundred years ago
183 Book reviews
185 Contents of *The American Journal of Psychiatry*

PUBLISHED BY THE ROYAL COLLEGE OF PSYCHIATRISTS ISSN 0007-1250

Their doctor knew that their symptoms were similar

Symptoms: Low mood, suicidal thoughts
Diagnosis: **Depression**

Symptoms: Palpitations, intense anxiety
Diagnosis: **Panic disorder**

Symptoms: Sleep disturbance, hopelessness
Diagnosis: **Depression**

Depression and panic disorder are seen across all age groups in both sexes. From the doctor's viewpoint, overlapping symptoms can make them appear similar. For the patients, the same effective treatment can make a real difference to their quality of life.

Cipramil combines proven efficacy with an established safety and tolerability profile, which makes it a logical first choice for patients suffering from depression or panic disorder. For effective relief from depression and panic disorder, prescribe Cipramil - the most selective SSRI - and make a real difference to your patients.

Cipramil
citalopram
make a difference in depression and panic disorder

They just know that Cipramil makes a real difference

Lundbeck

Abbreviated prescribing information: 'Cipramil' tablets 10 mg: PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £10.09. 'Cipramil' tablets 20 mg: PL 0458/0058, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets £16.79. 'Cipramil' tablets 40 mg: PL 0458/0059, each containing 40 mg of citalopram as the hydrobromide. 28 (OP) 40 mg tablets £28.38. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/ recurrence. Treatment of panic disorder, with or without agoraphobia. **Dosage:** *Treating depression: Adults:* 20 mg a day. Depending upon individual patient response, this may be increased in 20 mg increments to a maximum of 60 mg. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. Treatment for at least 6 months is usually necessary to provide adequate maintenance against the potential for relapse. *Treating panic disorder:* 10 mg daily for the first week, increasing to 20 mg daily. Depending upon individual patient response, dosage may be further increased to a maximum of 60 mg daily. Depending upon individual patient response, it may be necessary to continue treatment for several months. *Elderly:* 20 mg a day increasing to a maximum of 40 mg dependent upon individual patient response. *Children:* Not recommended. *Reduced hepatic/renal function:* Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance <20ml/min). **Contra-indications:** Combined use of 5-HT agonists. Hypersensitivity to citalopram. *Pregnancy and Lactation:* - Use only if potential benefit outweighs possible risk. **Precautions:** Driving and operating machinery. History of mania. Caution in patients at risk of cardiac arrhythmias. Do not use with or within 14 days of MAO inhibitors; leave a seven day gap before starting MAO inhibitor treatment. Use a low starting dose for panic disorder, to reduce the likelihood of an initial anxiogenic effect (experienced by some patients) when starting pharmacotherapy. **Drug Interactions:** MAO inhibitors (see Precautions). Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjusted. **Adverse Events:** Most commonly nausea, sweating, tremor, somnolence and dry mouth. With citalopram, adverse effects are in general mild and transient. When they occur, they are most prominent during the first two weeks of treatment and usually attenuate as the depressive state improves. Withdrawal symptoms have been reported with SSRIs. Abrupt withdrawal of citalopram should be avoided. **Overdosage:** Symptoms have included somnolence, coma, sinus tachycardia, occasional nodal rhythm, episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No specific antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon request. Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LF. ▲ 'Cipramil' is a Registered Trade Mark. © 1998 Lundbeck Ltd. Date of preparation: December 1998. 1298/CIP/501/056

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

THE BRITISH JOURNAL OF PSYCHIATRY

FEBRUARY 1999 VOL. 174

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists (a registered charity, registration number 228636). The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to the Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SWIX 8PG. Queries, letters to the Editor and book reviews may also be sent electronically to sthakor@rcpsych.ac.uk.

Instructions to authors

Full instructions to authors are given at the beginning of the January and July issues, and on the Web Site below. Copies are also available from the Journal Office.

Information about the College's publications is available on the World Wide Web at http://www.rcpsych.ac.uk.

Subscriptions

Non-members of the College should contact the Publications Subscription Department, Royal Society of Medicine Press Limited, PO Box 9002, London WIA 0ZA (tel. 0171 290 2928; fax 0171 290 2929). Annual subscription rates for 1999 (12 issues post free) are as follows:

	INSTITUTIONS	INDIVIDUALS
Europe (& UK)	£185	£157
US	$375	$270
Elsewhere	£220	£170

Full airmail is £36/ US$64 extra

Single copies of the Journal are £19, $30 (post free)

Queries from non-members about missing or faulty copies should be addressed within six months to the same address; similar queries from College members should be addressed to the Registration Subscription Department, The Royal College of Psychiatrists, 17 Belgrave Square, London SWIX 8PG.

Payment should be made out to the British Journal of Psychiatry.

Back issues

Back issues published before 1996 may be purchased from William Dawson & Sons Ltd, Cannon House, Folkestone, Kent (tel. 01303 850 101).

Advertising

Correspondence and copy should be addressed to Stephen H. P. Mell, Advertising Manager, PTM Publishers Ltd, 282 High Street, Sutton, Surrey SM1 1PQ (tel. 0181 642 0162; fax 0181 643 2275).

US Mailing Information

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. Subscription price is $375. Second class postage paid at Rathway, NJ. Postmaster send address corrections to the British Journal of Psychiatry, c/o Mercury Airfreight International Ltd Inc., 2323 Randolph Avenue, Avenel, New Jersey 07001.

™The paper used in this publication meets the minimum requirements of the American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Typeset by Dobbie Typesetting Ltd, Tavistock.

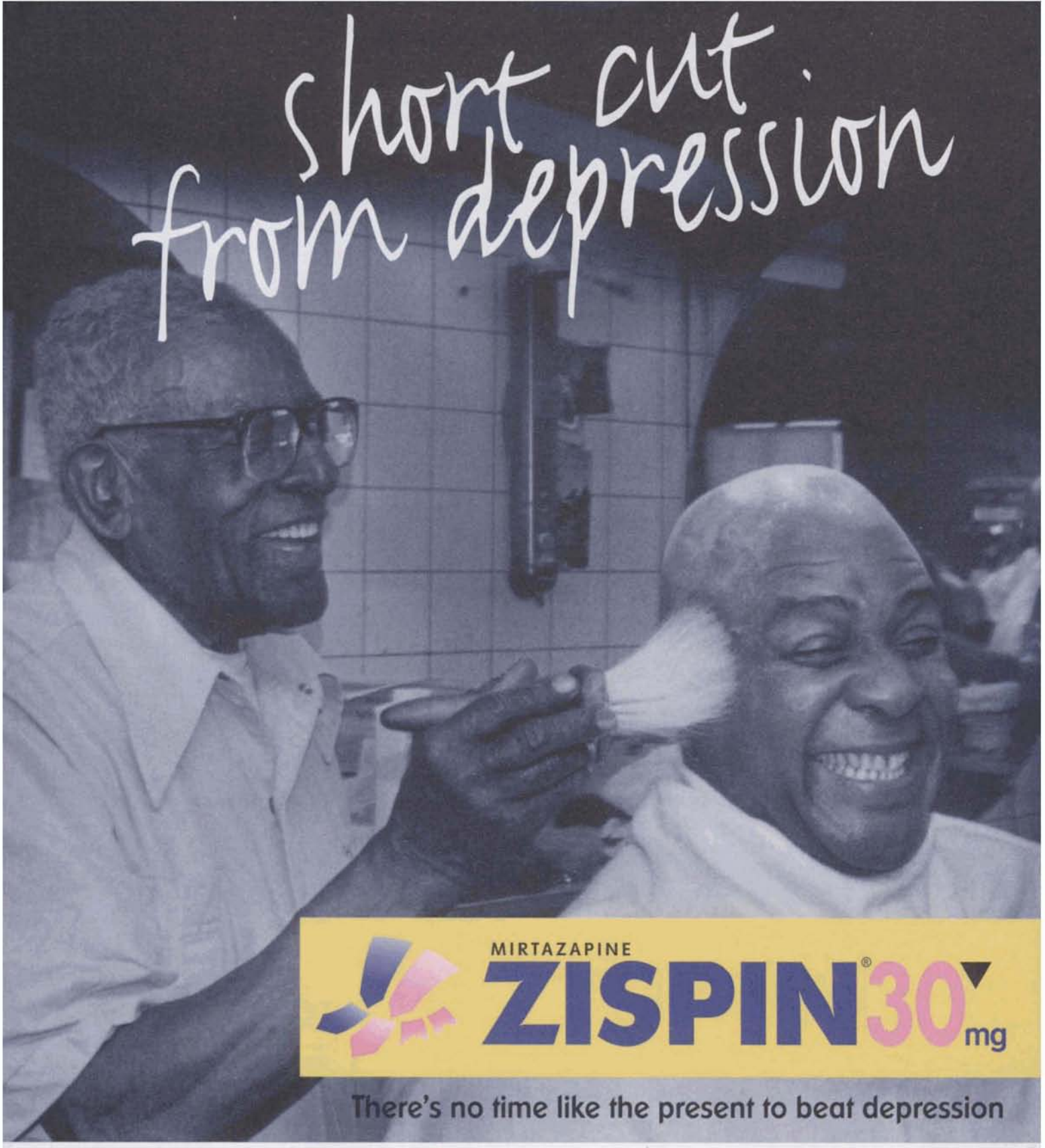
Printed by Henry Ling Ltd, The Dorset Press, 23 High East Street, Dorchester, Dorset DT1 1HD.

Past Editors

Eliot Slater	1961–72	John L. Crammer	1978–83
Edward H. Hare	1973–77	Hugh L. Freeman	1984–93

Founded by J. C. Bucknill in 1853 as the *Asylum Journal* and known as the *Journal of Mental Science* from 1858 to 1963.

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press



Prescribing Information

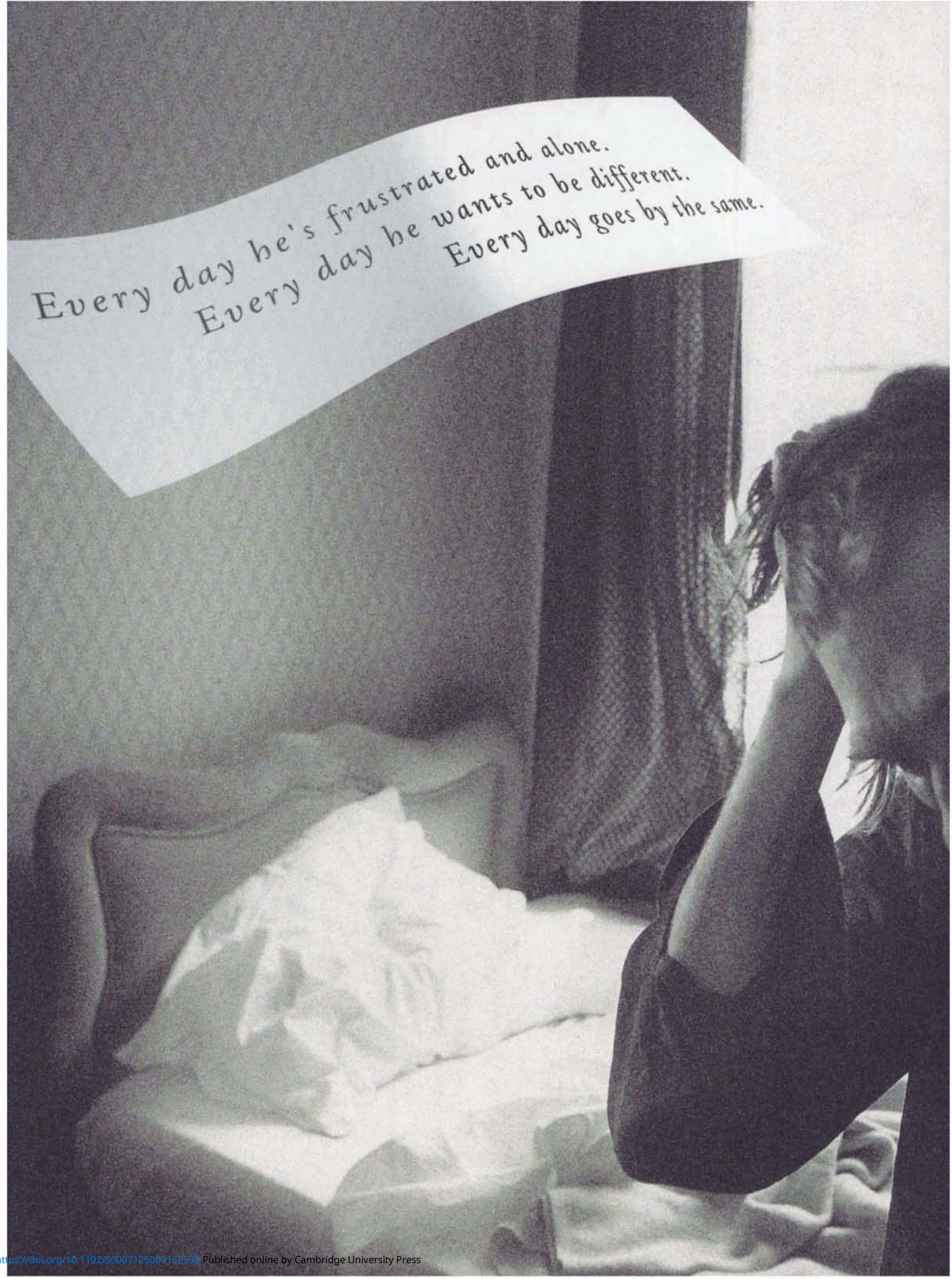
Presentation: Blister strips of 28 tablets each containing 30 mg of mirtazapine. **Uses:** Treatment of depressive illness. **Dosage and administration:** The tablets should be taken orally, if necessary with fluid, and swallowed without chewing. **Adults and elderly:** The effective daily dose is usually between 15 and 45 mg. **Children:** Not recommended. The clearance of mirtazapine may be decreased in patients with renal or hepatic insufficiency. Zispin is suitable for once-a-day administration, preferably as a single night-time dose. Treatment should be continued until the patient has been completely symptom-free for 4-6 months. **Contraindications:** Hypersensitivity to mirtazapine or any ingredients of Zispin. **Precautions and warnings:** Reversible white blood cell disorders including agranulocytosis, leukopenia and granulocytopenia have been reported with Zispin. The physician should be alert to symptoms such as fever, sore throat, stomatitis or other signs of infection; if these occur, treatment should be stopped and blood counts taken. Patients should also be advised of the importance of these symptoms. Careful dosing as well as regular and close [illegible] mellitus. Treatment should be discontinued if jaundice occurs. Moreover, as with other antidepressants, the following should be taken into account: worsening of psychotic symptoms can occur when antidepressants are administered to patients with schizophrenia or other psychotic disturbances; when the depressive phase of manic-depressive psychosis is being treated, it can transform into the manic phase. Zispin has sedative properties and may impair concentration and alertness. **Interactions:** Mirtazapine may potentiate the central nervous dampening action of alcohol; patients should therefore be advised to avoid alcohol during treatment with Zispin; Zispin should not be administered concomitantly with MAO inhibitors or within two weeks of cessation of therapy with these agents; Mirtazapine may potentiate the sedative effects of benzodiazepines; In vitro data suggest that clinically significant interactions are unlikely with mirtazapine. **Pregnancy and lactation:** The safety of Zispin in human pregnancy has not been established. Use during pregnancy is not recommended. Women of child bearing potential should employ an adequate method of contraception. Use in nursing mothers is not recommended. **Adverse** [illegible] adverse effects have been reported: **Common** (>1/100): Increase in appetite and weight gain. Drowsiness/sedation, levels. **Rare** (<1/1000): Oedema and accompanying weight gain. Reversible agranulocytosis has been reported as a rare occurrence. (Orthostatic) hypotension. Exanthema. Mania, convulsions, tremor, myoclonus. **Overdosage:** Toxicity studies in animals suggest that clinically relevant cardiotoxic effects will not occur after overdosing with Zispin. Experience in clinical trials and from the market has shown that no serious adverse effects have been associated with Zispin in overdose. Symptoms of acute overdosage are confined to prolonged sedation. Cases of overdose should be treated by gastric lavage with appropriate symptomatic and supportive therapy for vital functions. **Marketing authorization number:** PL 0065/0145 **Legal category:** POM **Basic NHS cost:** £24 for 28 tablets of 30 mg.

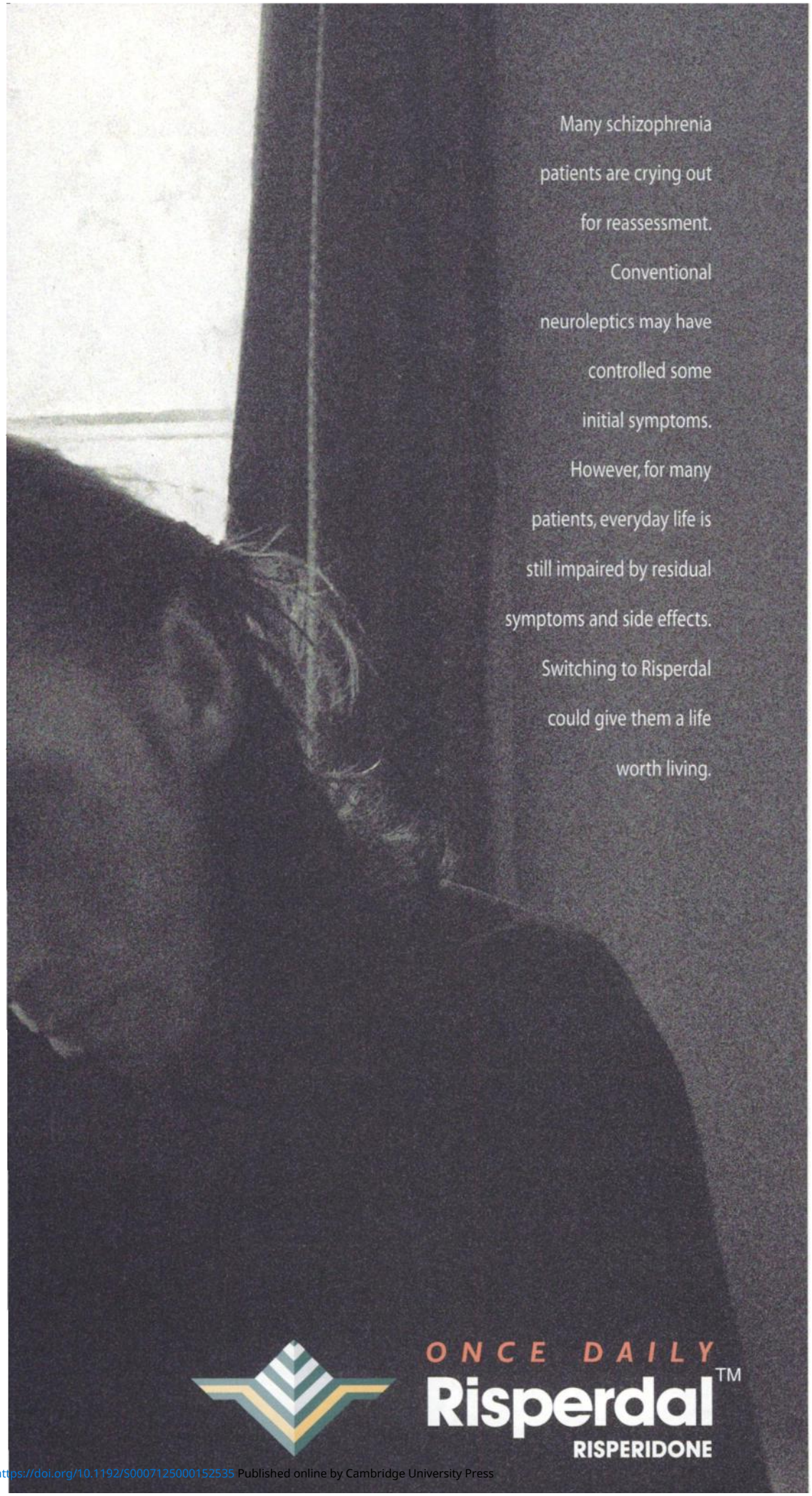
For further information, please contact:

Organon Nourypharma

Organon Laboratories Limited, Cambridge Science Park

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press





Please refer to Summary of Product Characteristics before prescribing Risperdal (risperidone). USES The treatment of acute and chronic schizophrenia, and other psychotic conditions, in which positive and/or negative symptoms are prominent. Risperdal also alleviates affective symptoms associated with schizophrenia. DOSAGE Where medically appropriate, gradual discontinuation of previous antipsychotic treatment while Risperdal therapy is initiated is recommended. Where medically appropriate, when switching patients from depot antipsychotics, consider initiating Risperdal therapy in place of the next scheduled injection. The need for continuing existing antiparkinson medication should be re-evaluated periodically. Adults. Risperdal may be given once or twice daily. All patients, whether acute or chronic, should start with 2 mg/day. This should be increased to 4 mg/day on the second day and 6 mg/day on the third day. However, some patients such as first-episode psychotic patients may benefit from a slower rate of titration. From then on the dosage can be maintained unchanged, or further individualised if needed. The usual effective dosage is 4 to 8 mg/day although in some patients an optimal response may be obtained at lower doses. Doses above 10 mg/day may increase the risk of extrapyramidal symptoms and should only be used if the benefit is considered to outweigh the risk. Doses above 16 mg/day should not be used. Elderly, renal and liver disease: A starting dose of 0.5 mg bd is recommended. This can be individually adjusted with 0.5 mg bd increments to 1 to 2 mg bd. Risperdal is well tolerated by the elderly. Use with caution in patients with renal and liver disease. Not recommended in children aged less than 15 years. CONTRA-INDICATIONS, WARNINGS, ETC. Contra-indications: Known hypersensitivity to Risperdal. Precautions: Orthostatic hypotension can occur (alpha-blocking effect). Use with caution in patients with known cardiovascular disease. Consider dose reduction if hypotension occurs. For further sedation, give an additional drug (such as a benzodiazepine) rather than increasing the dose of Risperdal. Drugs with dopamine antagonistic properties have been associated with tardive dyskinesia. If signs and symptoms of tardive dyskinesia appear, the discontinuation of all antipsychotic drugs should be considered. Caution should be exercised when treating patients with Parkinson's disease or epilepsy. Patients should be advised of the potential for weight gain. Risperdal may interfere with activities requiring mental alertness. Patients should be advised not to drive or operate machinery until their individual susceptibility is known. Pregnancy and lactation: Use during pregnancy only if the benefits outweigh the risks. Women receiving Risperdal should not breast feed. Interactions: Use with caution in combination with other centrally acting drugs. Risperdal may antagonise the effect of levodopa and other dopamine agonists. On initiation of carbamazepine or other hepatic enzyme-inducing drugs, the dosage of Risperdal should be re-evaluated and increased if necessary. On discontinuation of such drugs, the dosage of Risperdal should be re-evaluated and decreased if necessary. Side effects: Risperdal is generally well tolerated and in many instances it has been difficult to differentiate adverse events from symptoms of the underlying disease. Common adverse events include: insomnia, agitation, anxiety, headache. Less common adverse events include: somnolence, fatigue, dizziness, impaired concentration, constipation, dyspepsia, nausea/vomiting, abdominal pain, blurred vision, priapism, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, urinary incontinence, rhinitis, rash and other allergic reactions. The incidence and severity of extrapyramidal symptoms are significantly less than with haloperidol. However, the following may occur: tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. If acute, these symptoms are usually mild and reversible upon dose reduction and/or administration of antiparkinson medication. Rare cases of Neuroleptic Malignant Syndrome have been reported. In such an event, all antipsychotic drugs should be discontinued. Occasionally, orthostatic dizziness, hypotension (including orthostatic), tachycardia (including reflex) and hypertension have been observed. An increase in plasma prolactin concentration can occur which may be associated with galactorrhoea, gynaecomastia and disturbances of the menstrual cycle. Oedema and increased hepatic enzyme levels have been observed. A mild fall in neutrophil and/or thrombocyte count has been reported. Rare cases of water intoxication with hyponatraemia, tardive dystonesia, body temperature dysregulation and seizures have been reported. Overdosage: Reported signs and symptoms include drowsiness and sedation, tachycardia and hypotension, and extrapyramidal symptoms. A prolonged QT interval was reported in a patient with concomitant hypokalaemia who had ingested 360mg. Establish and maintain a clear airway, and ensure adequate oxygenation and ventilation. Gastric lavage and activated charcoal plus a laxative should be considered. Commence cardiovascular monitoring immediately, including continuous electrocardiographic monitoring to detect possible arrhythmias. There is no specific antidote, so institute appropriate supportive measures. Treat hypotension and circulatory collapse with appropriate measures. In case of severe extrapyramidal symptoms, give anti-cholinergic medication. Continue close medical supervision and monitoring until the patient recovers. PHARMACEUTICAL PRECAUTIONS Tablets: Store below 30°C. Liquid: Store below 30°C; protect from freezing. LEGAL CATEGORY POM. PRESENTATIONS, PACK SIZES, PRODUCT LICENCE NUMBERS & BASIC NHS COSTS White, oblong tablets containing 1 mg risperidone in packs of 20. PL 0242/0186 £13.45. Pale orange, oblong tablets containing 2 mg risperidone in packs of 60. PL 0242/0187 £79.56. Yellow, oblong tablets containing 3 mg risperidone in packs of 60. PL 0242/0188 £117.00. Green, oblong tablets containing 4 mg risperidone in packs of 60. PL 0242/0189 £154.44. Yellow circular tablets containing 6 mg risperidone in packs of 28. PL 0242/0317 £109.20. Starter packs containing 6 Risperdal 1 mg tablets are also available £4.15. Clear, colourless solution containing 1 mg risperidone per ml in bottles containing 100 ml. PL 0242/0199 £65.00. FURTHER INFORMATION IS AVAILABLE FROM THE PRODUCT LICENCE HOLDER. Janssen-Cilag Ltd, Saunderton, High Wycombe, Buckinghamshire HP14 4HJ. APIVER140797

JANSSEN-CILAG Ltd

Organon

Date of preparation: August 1998

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

Please refer to summary of product characteristics before prescribing.
Presentation: White to off white tablets each containing modafinil 100 mg **Indication:** Narcolepsy. **Dosage:** *Adults* 200-400 mg daily either as two divided doses in the morning and at noon or as a single morning dose according to response. *Elderly* Treatment should start at 100 mg daily which may be increased subsequently to the maximum adult daily dose in the absence of renal or hepatic impairment. *Severe renal or hepatic impairment* Reduce dose by half (100-200 mg daily). *Children* See contra-indications. **Contra-indications:** Pregnancy, lactation, use in children, moderate to severe hypertension, arrhythmia, hypersensitivity to modafinil or any excipients used in Provigil. **Warnings and precautions:** Patients with major anxiety should only receive Provigil treatment in a specialist unit. Sexually active women of child bearing potential should be established on a contraceptive programme before starting treatment. Blood pressure and heart rate should be monitored in hypertensive patients. Provigil is not recommended in patients with a history of left ventricular hypertrophy or ischaemic ECG changes, chest pain, arrhythmia or other clinically significant manifestations of mitral valve prolapse in association with CNS stimulant use. Studies of modafinil have demonstrated a low potential for dependence although the possibility of this occurring with long term use cannot be entirely excluded. **Drug interactions:** Induction of cytochrome P 450 isoenzymes has been observed *in vitro*. Effectiveness of oral contraceptives containing at least 50 mcg ethinyloestradiol should be taken. Tricyclic antidepressants no clinically relevant interaction was seen in a single dose interaction study of Provigil and clomipramine. However, patients receiving such medication should be carefully monitored. Care should be observed with co-administration of anti-convulsant drugs. **Side effects:** Nervousness, excitation, aggressive tendencies, insomnia, personality disorder, anorexia, headache, CNS stimulation, euphoria, abdominal pain, dry mouth, palpitation, tachycardia, hypertension and tremor have been reported. Nausea and gastric discomfort may occur and may improve when tablets are taken with meals. Pruritis, skin rashes have been observed occasionally. Buccolacial dyskinesia has been reported very rarely. A dose related increase in alkaline phosphatase has been observed. **Basic NHS cost:** Packs of 30 blister packed 100 mg tablets £60.00. **Marketing authorisation number:** 16260/0001. **Marketing authorisation holder:** Cephalon UK Ltd, 11-13 Frederick Sanger Road, Surrey Research Park, Guildford, GU2 5YD. **Legal category:** POM. **Date of preparation:** January 1998. Provigil and Cephalon are registered trademarks. **References:** 1. Mitler MM. *Sleep* 1994; **17**: S103-S106. 2. Data on file, Cephalon. [3]. Lin JS. *et al. Proc. Natl. Acad. Sci. USA* 1996; **93**: 13-40-14128-14133. 4. Simon P. *et al.* Eur. Neuropsychopharmacol. 1995; **5**: 509-514.

WAKE UP LITTLE SUZIE, WAKE UP

Excessive sleepiness associated with narcolepsy frequently has a disastrous effect on patients' lives, by impairing their physical, social and emotional well being. Unfortunately, treatment with amphetamines is often associated with a high incidence of unpleasant side effects, which limit their overall benefit.[1]

Now Provigil (modafinil) – a novel wake promoting agent – offers new advantages in narcolepsy. The clinical efficacy of Provigil has been demonstrated in large controlled clinical studies. In one study,[2] one in five people with severe narcolepsy reached normal levels of daytime wakefulness while receiving Provigil.

Provigil selectively activates the hypothalamus[3] and differs greatly from amphetamines in its pharmacology.[4] Consequently the incidence of amphetamine

PROVIGIL®▼
MODAFINIL

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

Initiated under the auspices of the European Community.
Supported by Pfizer Pharmaceuticals Group.
Endorsed by the University of Maastricht and the Department of Medicine, Bristol University.

1989  **1999**

The European Certificate in Anxiety and Mood Disorders

This international post graduate programme provides an overview of the most recent scientific developments in the field of affective disorders. Lectures and Seminars are given by a panel of leading scientists during intensive residential sessions, with ample opportunity for informal exchanges.

The Board of Directors announces

THE XI-th CERTIFICATE

to take place in:

Bristol, UK, 3 - 7 July 1999

This 1999 course will be on mood disorders. Successful trainees are awarded the European Certificate in Anxiety and Mood Disorders, by the University of Maastricht, the Netherlands.
Full information and application forms (deadline **1 April 1999**):

Prof. D. Nutt,
Course Director
School of Medical Sciences
University Walk, Bristol
BS8 1TD, United Kingdom
Phone: +44 (0)1179-253066
Fax: +44 (0)1179-277057
E-mail: David.J.Nutt@bristol.ac.uk

or

Prof. E.J.L. Griez,
Chairman of the Board of Directors
University of Maastricht
P.O. Box 616
6200 MD Maastricht
Phone: +31 (0)43-3685 332
Fax: +31 (0)43-3685 331
Email: eric.griez@pn.unimaas.nl

Or one of the other directors:
Prof. C. Faravelli, Florence
fax: + 39 55 57 47 44

Prof. J. Zohar, Tel Aviv
fax: + 972 3 5352 788

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

Spot the Edronax difference.

Highly selective noradrenaline re-uptake inhibitor (NARI)[1]

Edronax®
reboxetine tablets

Helps restore energy and motivation in tired depressed patients[2,3]

EDRONAX ® ABBREVIATED PRESCRIBING INFORMATION
Presentation: Tablets containing 4mg reboxetine. **Indications:** Use in the acute treatment of depressive illness, and maintenance of clinical benefit in patients responsive to treatment. **Posology and method of administration:** ***Adults*** 4 mg b.i.d. (8 mg/day) administered orally. After 3-4 weeks, can increase to 10 mg/day. ***Elderly and children*** Elderly patients have been studied in comparative clinical trials at doses of 2 mg b.i.d., although not in placebo controlled conditions. There is no experience in children and therefore reboxetine cannot be recommended in either of these groups. ***Renal/Hepatic insufficiency*** Dose should be reduced in patients with renal and/or hepatic impairment which can be increased based on patient **precautions for use:** Close supervision is required for subjects with a history of convulsive disorders and must be discontinued if the patient develops seizures. Avoid concomitant use with MAO-inhibitors. Close supervision of bipolar patients is recommended. Close supervision should be applied in patients with current evidence of urinary retention, glaucoma, prostatic hypertrophy and cardiac disease. At doses higher than the maximum recommended, orthostatic hypotension has been observed with greater frequency. Particular attention should be paid when administering reboxetine with other drugs known to lower blood pressure. **Interactions with other medicaments and other forms of interaction:** Reboxetine should not be co-administered with MAOIs. Reboxetine should not be co-administered with drugs that have a narrow therapeutic margin and are metabolised by CYP3A4 or CYP2D6 e.g. anti-arrhythmics (flecainide), anti-psychotic drugs and tricyclic anti-depressants. No pharmacokinetic interaction with lorazepam. Reboxetine does not appear to potentiate the effect of alcohol. **Pregnancy and lactation:** Reboxetine is contraindicated in pregnancy and lactation. **Effects on ability to drive and use machines:** Reboxetine is not sedative per se. However, as with all psychoactive drugs, caution patients about operating machinery and driving. **Undesirable effects:** Adverse events occurring more frequently than placebo are: dry mouth, constipation, insomnia, paraesthesia, increased sweating, tachycardia, vertigo, urinary hesitancy (retention, impotence. **Overdose:** Monitor **NHS Price:** Pack of 60 tablets in blisters £19.80. **Legal Category:** POM **Marketing Authorisation Holder:** Pharmacia & Upjohn Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. **Marketing Authorisation Number:** PL 0032/0216 **References: 1.** Brunello N et al. *Human Psychopharmacology* 1998;**13**:S13-S19. **2.** Dubini A et al. *J Psychopharmacol* 1997; 11(4):S17-S23. **3.** Montgomery SA. *Prescriber* April 1998; 116-119. Further information is available from the Marketing Authorisation Holder: Pharmacia & Upjohn Limited, Davy Avenue, Knowlhill, Milton Keynes, MK5 8PH, UK. Telephone: 01908 661101. ® Edronax is a registered trademark. Code No.P4008/12/98.
Date of preparation:

TURNING POINT IN SCHIZOPHRENIA?

Prescribing Information appears overleaf

As a modern antipsychotic, it is no surprise that Zeleptil offers effective control of positive symptoms of schizophrenia as well as a significant reduction in SANS total score. But what may come as a surprise is the fact that over 2 million patients have already been treated with Zeleptil.

A SURPRISING ANTIPSYCHOTIC

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

A SURPRISING ANTIPSYCHOTIC

Zoleptil Brief Prescribing Information
Indication: Treatment of schizophrenia. **Dosage and Administration:** Zoleptil is given orally in divided doses with or without food. **Adults:** The effective adult dose is 75 to 300mg daily. The recommended starting dose is 25mg taken three times daily. The dose may be adjusted according to clinical response up to a maximum of 100mg three times daily. Dosage adjustments should be made at intervals of four days. Doses above 300mg per day may increase the risk of seizures. **Elderly patients and patients with established hepatic and/or renal impairment:** A starting dose of 25mg twice daily is recommended. Titration should be gradual, based on efficacy and tolerability, up to a maximum of 75mg twice daily. Zoleptil is not recommended for use in children under 18 years of age. **Contra-indications:** Known hypersensitivity to Zoleptil or any of its excipients. Patients suffering from acute intoxication with CNS depressants including alcohol. As with other uricosuric agents, Zoleptil should not be used in patients with acute gout or a history of nephrolithiasis though in practice the risk of increased urate renal stone formation appears to be low. **Precautions:** Zoleptil should not be used to treat patients with a history of epilepsy unless the benefit outweighs the risk. Caution is advised when using Zoleptil in patients at risk of arrhythmias or in combination with drugs known to cause prolongation of the QTc interval. When treating patients from these groups it is recommended that an ECG is performed before starting treatment. Caution is advised in patients with known severe cardiovascular disease including severe hypertension or severely restricted cardiac output. Zoleptil is associated with an increase in heart rate and should therefore be used with caution in patients suffering from angina pectoris. Zoleptil may cause orthostatic hypotension and a dose reduction or more gradual titration should be considered if this occurs. Isolated cases of neuroleptic malignant syndrome have been reported. In this event all antipsychotic drugs including Zoleptil should be discontinued. If a reduction in white cell count is suspected a white cell count should be performed. A lower starting dose, gradual titration and a reduced maximum daily dose should be used in the elderly, and in renally or hepatically impaired patients. Monitoring of liver function tests is recommended in patients with hepatic impairment. Patients should be advised of the possibility for weight gain. Isolated cases of tardive dyskinesia have occurred. In this case the discontinuation or reduction in dose of all antipsychotics should be considered. Zoleptil should be used with caution in patients with prostatic hypertrophy, retention of urine, narrow angle glaucoma and paralytic ileus. Zoleptil has uricosuric properties and should be used with caution in patients with gout or hyperuricaemia. Patients should be advised not to drive or operate machinery until their susceptibility has been established. **Pregnancy and Lactation:** Zoleptil should not be used during pregnancy unless the benefits to the mother outweigh the potential risks to the baby. Nursing mothers taking Zoleptil should not breast-feed. **Interactions:** Zoleptil should be used with caution in combination with other centrally acting drugs, in particular high doses of other antipsychotics which may further lower the seizure threshold, as well as fluoxetine and diazepam which may lead to increased plasma concentrations of zotepine. Caution should be exercised when Zoleptil is co-prescribed with hypotensive agents, including some anaesthetic agents. **Side Effects and Adverse Reactions:** The following adverse events have been reported in association with Zoleptil therapy in clinical trials and spontaneously during clinical usage (approximately 1.98 million patients treated). Most commonly reported adverse events include: asthenia, chills, headache, infection, pain, hypotension, tachycardia, constipation, dyspepsia, elevated liver function tests, changes in ESR, leucocytosis and leucopenia, weight increase, agitation, anxiety, depression, dizziness, dry mouth, EEG abnormal, extrapyramidal syndrome, insomnia, salivation increased, somnolence, rhinitis, sweating, blurred vision. Occasionally reported were: abdominal pain, chest pain, fever, flu syndrome, malaise, arrhythmia, ECG abnormality, hypertension, postural hypotension, syncope, anorexia, appetite increased, diarrhoea, nausea, vomiting, prolactin increased, abnormal blood cells, anaemia, thrombocythaemia, creatinine increased, hyperglycaemia, hypoglycaemia, hyperlipidaemia, hypouricaemia, oedema, thirst, weight loss, arthralgia, joint disease, myalgia, confusion, convulsions, dysautonomia, hostility, libido decreased, nervousness, speech disorder, vertigo, cough increase, dyspnoea, acne, dry skin, rash, conjunctivitis, impotence, urinary incontinence. **Overdosage:** May result in exaggerated pharmacological effects which include hypotension, tachycardia, arrhythmias, agitation, pronounced extrapyramidal effects, hypo- or hyperthermia, seizures, respiratory depression, stupor or coma. There is no specific antidote, therefore appropriate supportive measures should be instituted. A clear airway should be established and maintained, and adequate oxygenation and ventilation ensured. Gastric lavage and administration of activated charcoal together with a laxative should be considered. Cardiovascular monitoring should commence immediately and should include continuous ECG monitoring to detect possible arrhythmias. Hypotension and circulatory collapse should be treated by plasma volume expansion and other appropriate measures. If sympathomimetic agents are used for vascular support, adrenaline and dopamine should not be used as this may worsen hypotension. In the case of severe extrapyramidal symptoms, anticholinergic medication should be administered. Seizures may be treated with intravenous diazepam. Close medical supervision and monitoring should continue until the patient recovers. **Legal Category:** POM. **Product Licence Numbers:** 25mg tablets: PL00169/0110; 50mg tablets: PL00169/0111; 100mg tablets: PL00169/0112. **Presentations, Nature and Content of Containers, Basic NHS Cost:** Zoleptil 25: white sugar-coated tablets containing 25mg zotepine provided in blister strip packs of 30 £15.00 and 90 £45.00. Zoleptil 50: yellow sugar-coated tablets containing 50mg zotepine provided in blister strip packs of 30 £20.00 and 90 £60.00. Zoleptil 100mg: pink sugar-coated tablets containing 100mg zotepine provided in blister strip packs of 30 £33.00 and 90 £99.00. **Marketing Authorisation Holder:** Knoll Ltd. 9 Castle Quay. Castle Boulevard. Nottingham NG7 1FW. England. Full prescribing information is available on request from Orion Pharma (UK) Ltd. 1st floor, Leat House, Overbridge Square, Hambridge Lane, Newbury, Berkshire, RG14 5UX. Zoleptil is a registered trade mark. **Date of Preparation:** October 1998.

Orion Pharma (UK) Ltd, 1st Floor, Leat House, Overbridge Square,
Hambridge Lane, Newbury, BERKS RG14 5UX

ORION PHARMA

Licensed from Fujisawa Pharmaceutical Co. Ltd., Japan

ZOL0220

Add life to living with schizophrenia

Solian is a new benzamide antipsychotic, with the ability to treat both the positive[1] and negative[2] symptoms of schizophrenia.

Solian offers a lower incidence of EPS than standard neuroleptics such as haloperidol,[3] as well as avoiding some of the drawbacks of certain atypicals: it does not require routine cardiovascular[4,5] or haematological[4,6] monitoring and patients gain significantly less weight than those treated with risperidone.[2]

So when patients need the ability to cope with their condition, Solian has the power to treat their positive[1] *and* their negative[2] symptoms whilst still allowing them to do the everyday things that the rest of us take for granted.

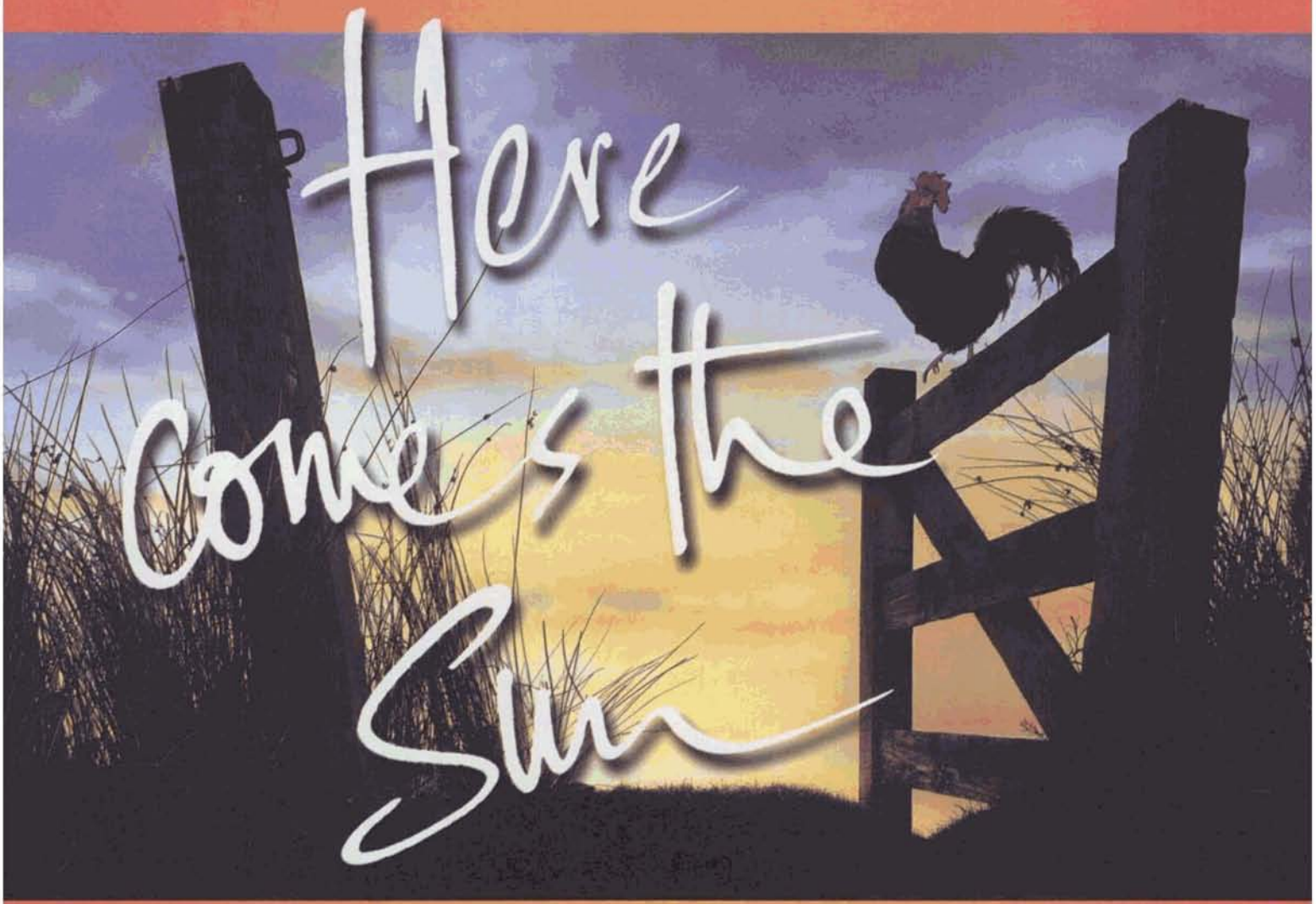
Solian®
AMISULPRIDE

Efficacy that patients can live with

Prescribing Information - Solian 200 and Solian 50 ▼ Presentation: Solian 200mg tablets contain 200mg amisulpride and Solian 50mg tablets contain 50mg amisulpride. **Indication:** Acute and chronic schizophrenia in which positive and/or negative symptoms are prominent. **Dosage:** Acute psychotic episodes: 400-800mg/day, increasing up to 1200mg/day according to individual response (dose titration not required), in divided doses. Predominantly negative symptoms: 50-300mg once daily adjusted according to individual response. Elderly: administer with caution due to the risk of hypotension or sedation. Renal insufficiency: reduce dose and consider intermittent therapy. Hepatic insufficiency: no dosage adjustment necessary. Children: contraindicated in children under 15 years (safety not established). **Contraindications:** Hypersensitivity; concomitant prolactin-dependent tumours e.g. pituitary gland prolactinaemias and breast cancer; phaeochromocytoma; children under 15 years; pregnancy; lactation; women of child-bearing potential unless using adequate contraception. **Warning and Precautions:** As with all neuroleptics, [illegible]. Caution in patients with a history of epilepsy and Parkinson's disease. **Interactions:** Caution in hypotensive medications, and dopamine agonists. **Side Effects:** Insomnia, anxiety, agitation. Less commonly somnolence and GI disorders. In common with other neuroleptics: Solian causes a reversible increase in plasma prolactin levels; Solian may also cause weight gain, acute dystonia, extrapyramidal symptoms, tardive dyskinesia, hypotension and bradycardia; rarely, allergic reactions, seizures and neuroleptic malignant syndrome have been reported. **Basic NHS Cost:** Blister packs of: 200mg x 60 tablets - £60.00; 200mg x 90 tablets - £90.00; 50mg x 60 tablets - £16.45; 50mg x 90 tablets - £24.69. **Legal Category:** POM. **Product Licence Numbers:** Solian 200 - PL 15819/0002, Solian 50 - PL 15819/0001. **Product Licence Holder:** Lorex Synthélabo UK and Ireland Ltd, Foundation Park, Roxborough Way, Maidenhead, Berks, SL6 3UD. **References:** 1. Freeman HL. Int Clin Psychopharmacol 1997;12(Suppl 2):S11-S17. 2. Möller HJ. 6th World Congress of Biological Psychiatry, Nice, France, June 22-27 1997. 3. Coukell AJ, Spencer CM, Benfield P. CNS Drugs (Adis) 1996 Sep 6 (3):237-256. 4. Solian SPC. Lorex Synthélabo. 5. Sertindole SPC. Lundbeck Ltd. 6. Clozapine SPC.

SYNTHELABO
CNS DIVISION

Efexor® XL venlafaxine - Prescribing information Presentation: Capsules containing 75mg or 150mg venlafaxine (as hydrochloride) in an extended release formulation. **Use:** Treatment of depressive illness. **Dosage:** *Adults (including the elderly):* Usually 75mg, given once daily with food, increasing to 150mg once daily if necessary. The dose can be increased further to 225mg once a day. Dose increments should be made at intervals of approximately 2 weeks or more, but not less than 4 days. Discontinue gradually to avoid possibility of discontinuation effects. *Children:* Contra-indicated below 18 years of age. *Moderate renal or moderate hepatic impairment.* Doses should be reduced by 50%. Not recommended in severe renal or severe hepatic impairment. **Contra-indications:** Pregnancy, lactation, concomitant use with MAOIs, hypersensitivity to venlafaxine or other components, patients aged below 18 years. **Precautions:** Use with caution in patients with myocardial infarction, unstable heart disease, renal or hepatic impairment, or a history of epilepsy (discontinue in event of seizure). Patients should not drive or operate machinery if their ability to do so is impaired. Possibility of postural hypotension (especially in the elderly). Women of child-bearing potential should use contraception. Prescribe smallest quantity of tablets according to good patient management. Monitor blood pressure with doses >200mg/day. Advise patients to notify their doctor should an allergy develop or if they become or intend to become pregnant. Patients with a history of drug abuse should be monitored carefully. **Interactions:** MAOIs: do not use Efexor XL in combination with MAOIs or within 14 days of stopping MAOI treatment. Allow 7 days after stopping Efexor XL before starting an MAOI. Use with caution in elderly or hepatically-impaired patients taking cimetidine, in patients taking other CNS-active drugs, and in patients taking drugs which inhibit *both* CYP2D6 and CYP3A4 hepatic enzymes. **Side-effects:** Nausea, insomnia, dry mouth, somnolence, dizziness, constipation, sweating, nervousness, asthenia, abnormal ejaculation/orgasm, anorexia, abnormal vision/accommodation, impotence, vomiting, tremor, abnormal dreams, vasodilatation, hypertension, rash, agitation, hypertonia, paraesthesia, postural hypotension, reversible increases in liver enzymes, slight increase in serum cholesterol, weight gain or loss, hyponatraemia. **Basic NHS price:** 75mg capsule (PL 00011/0223) - blister pack of 28 capsules: £23.97. 150 mg capsule (PL 00011/0224) - blister pack of 28 capsules: £39.97. **Legal category:** POM. Further information is available upon request from the Product Licence holder: Wyeth Laboratories, Taplow, Maidenhead, Berkshire, SL6 0PH. Date of preparation: August 1997. ® trade mark Code no Z777440/0897. WEFX3-UK-JA. References: 1. Muth EA *et al.* Biochem Pharmacol 1986; 35(24): 4493-4497. 2. Muth EA *et al.* Drug Development Research 1991; 23: 191-199. 3. Rudolph R *et al.* Poster presented at the New Clinical Drug Evaluation Unit (National Institute of Mental Health). Boca Raton, Florida 1997. 4. McPartlin GM *et al.* Poster at the 10th European College of Neuropsychopharmacology meeting, Vienna, September 13th-17th, 1997. 5. Salinas E. Biol Psychiatry 1997; 42(Suppl. 1): 244S.



- EFEXOR XL ACTS DIRECTLY ON BOTH SEROTONIN AND NORADRENALINE[1,2]
- PROVEN EFFICACY VS LEADING SSRIs[3,4]
- TOLERABILITY[3,4,5] AND CONVENIENCE YOU EXPECT FROM A FIRST-LINE THERAPY

NEW ONCE DAILY

EFEXOR XL®

VENLAFAXINE 75 mg o.d.

Simply effective

Wyeth

'PROZAC' ABBREVIATED PRESCRIBING INFORMATION (FLUOXETINE HYDROCHLORIDE)

Presentation Capsules containing 20mg or 60mg fluoxetine, as the hydrochloride. Liquid containing 20mg fluoxetine, as the hydrochloride, per 5ml syrup. **Uses** *Depression:* TREATMENT OF THE SYMPTOMS OF DEPRESSIVE ILLNESS, WITH OR WITHOUT ASSOCIATED ANXIETY SYMPTOMS. *Obsessive-compulsive disorder. Bulimia nervosa:* For the reduction of binge-eating and purging activity. **Dosage and Administration** (For full information, see data sheet.) For oral administration toadults only. *Depression, with or without associated anxiety symptoms - adults and the elderly:* A dose of 20mg/day is recommended. *Obsessive-compulsive disorder:* 20mg/day to 60mg/day. A dose of 20mg/day is recommended as the initial dose. *Bulimia - adults and the elderly:* A dose of 60mg/day is recommended. Because of the long elimination half-lives of the parent drug (1-3 days after acute administration; may be prolonged to 4-6 days after chronic administration) and its major metabolite (average 9.3 days), active drug substance will persist in the body for several weeks after dosing is stopped. The capsule and liquid dosage forms are bioequivalent. *Children:* Not recommended. *Patients with renal and/or hepatic dysfunction:* See 'Contraindications' and 'Precautions' sections. **Contraindications** Hypersensitivity to fluoxetine. Prozac should not be administered to patients with severe renal failure (GFR <10ml/min). *Usage in nursing mothers:* Prozac should not be prescribed to nursing mothers. *Monoamine oxidase inhibitors:* At least 14 days should elapse between discontinuation of an MAOI and initiation of treatment with Prozac. At least five weeks should elapse between discontinuation of Prozac and initiation of therapy with an MAOI. Serious, sometimes fatal reactions (including hyperthermia, rigidity, myoclonus, autonomic instability and mental status changes that include extreme agitation, progressing to delirium and coma) have been reported with concomitant use or when fluoxetine had been recently discontinued and an MAOI started. Some cases presented with features resembling neuroleptic malignant syndrome. **Warnings** *Rash and allergic reactions:* Angioneurotic oedema, urticaria and other allergic reactions have been reported. Upon appearance of rash, or of other allergic phenomena for which an alternative aetiology cannot be identified, Prozac should be discontinued. *Pregnancy:* Use of Prozac should be avoided unless there is no safer alternative. **Precautions** Prozac should be discontinued in any patient who develops seizures. Prozac should be avoided in patients with unstable epilepsy; patients with controlled epilepsy should be carefully monitored. There have been rare reports of prolonged seizures in patients on fluoxetine receiving ECT treatment. A lower dose of Prozac, eg, alternate day dosing, is recommended in patients with significant hepatic dysfunction or mild to moderate renal failure (GFR 10-50ml/min). Caution is advisable when Prozac is used in patients with acute cardiac disease. Prozac may cause weight loss which may be undesirable in underweight depressed patients. In diabetics, fluoxetine may alter glycaemic control. There have been reports of abnormal bleeding in several patients, but causal relationship to fluoxetine and clinical importance are unclear. *Drug interactions:* Increased (with lithium toxicity) or decreased lithium levels have been reported. Lithium levels should be monitored. Because fluoxetine's metabolism involves the hepatic cytochrome P450IID6 isoenzyme system, concomitant therapy with other drugs also metabolised by this system, and which have a narrow therapeutic index (eg, carbamazepine, tricyclic antidepressants), should be initiated at or adjusted to the low end of their dose range. Greater than 2-fold increases of previously stable plasma levels of cyclic antidepressants have been observed when Prozac has been administered in combination. Agitation, restlessness and gastro-intestinal symptoms have been reported in a small number of patients receiving fluoxetine in combination with tryptophan. Patients on stable phenytoin doses have developed elevated plasma concentrations and clinical phenytoin toxicity after starting fluoxetine. *For further information, see data sheet.* **Adverse Effects** Asthenia, fever, nausea, diarrhoea, dry mouth, appetite loss, dyspepsia, vomiting, rarely abnormal LFTs, headache, nervousness, insomnia, drowsiness, anxiety, tremor, dizziness, fatigue, decreased libido, seizures, hypomania or mania, dyskinesia, movement disorders, neuroleptic malignant syndrome-like events, pharyngitis, dyspnoea, pulmonary events (including inflammatory processes and/or fibrosis), rash, urticaria, vasculitis, excessive sweating, arthralgia, myalgia, serum sickness, anaphylactoid reactions, hair loss, sexual dysfunction. The following have been reported in association with fluoxetine but no causal relationship has been established: aplastic anaemia, cerebral vascular accident, confusion, ecchymoses, eosinophilic pneumonia, gastro-intestinal haemorrhage, hyperprolactinaemia, immune-related haemolytic anaemia, pancreatitis, pancytopenia, suicidal ideation, thrombocytopenia, thrombocytopenic purpura, vaginal bleeding after drug withdrawal and violent behaviour. Hyponatraemia (including serum sodium below 110mmol/l) has been rarely reported. This appears to be reversible upon discontinuation. **Overdosage** On the evidence available, fluoxetine has a wide margin of safety in overdose. Since introduction, reports of death, attributed to overdosage of fluoxetine alone, have been extremely rare. One patient who reportedly took 3000mg of fluoxetine experienced 2 grand mal seizures that remitted spontaneously. **Legal Category** POM **Product Licence Numbers** 0006/0195, 0006/0198, 0006/0272. **Basic NHS Cost** £20.77 per pack of 30 capsules (20mg). £67.85 per pack of 98 capsules (20mg). £62.31 per pack of 30 capsules (60mg). £19.39 per 70ml bottle. **Date of Preparation or Last Review** October 1996 (internal review June 1998). **Full Prescribing Information is Available From** Dista Products Limited, Dextra Court, Chapel Hill, Basingstoke, Hampshire, RG21 5SY. Telephone: Basingstoke (01256) 352011.

PROZAC is a Dista trademark

PROZAC DELIVERS

PROZAC
fluoxetine

TREATING DEPRESSION

CAMPRAL EC PRESCRIBING INFORMATION

Campral EC acamprosate

Presentation: Off-white round enteric-coated tablets, containing 333mg acamprosate calcium. Printed on one side with 333. **Properties:** Acamprosate may act by stimulating GABAergic inhibitory neurotransmission and antagonising excitatory amino acids, particularly glutamic acid. **Indication:** Maintenance of abstinence in alcohol dependent patients. It should be combined with counselling. **Dosage and Administration:** *Adults ≥ 60kg:* 6 tablets per day (2 tablets taken three times daily with meals) *Adults < 60kg:* 4 tablets per day (2 tablets in the morning, 1 at noon and 1 at night with meals). Recommended treatment period one year, starting as soon as possible after the withdrawal period. Treatment should be maintained if the patient relapses. *Elderly:* Not recommended. *Children:* Not recommended. **Contraindications:** Known hypersensitivity to the drug, renal insufficiency (serum creatinine > 120 micromol/L), severe hepatic failure (Childs-Pugh classification C), pregnancy, lactation. **Precautions and Warnings:** Campral EC does not constitute treatment during the withdrawal period. **Interactions:** None observed in studies with diazepam, disulfiram or imipramine. The concomitant intake of alcohol and acamprosate does not affect the pharmacokinetics of either alcohol or acamprosate. **Side Effects:** Diarrhoea, and less frequently nausea, vomiting and abdominal pain; pruritus. These are usually mild and transient. An occasional maculopapular rash and rare cases of bullous skin reactions have been reported. Fluctuations in libido have been reported. Campral EC should not impair the patient's ability to drive or operate machinery. **Overdose:** Gastric lavage; should hypercalcaemia occur, treat patient for acute hypercalcaemia. **Legal Category:** POM. **Pharmaceutical Precautions:** None. **Package Quantities and Basic NHS Price:** 84 blister packed tablets £24.95. **Marketing Authorisation Number/Holder:** 13466/0001, Lipha SA, Lyon, France. **Date of Preparation:** August 1997. Further information is available on request from Merck Pharmaceuticals, Harrier House, High Street, West Drayton, Middlesex, UB7 7QG.

SPECIAL COMMENDATION
AWARDED 1998
PRIX GALIEN AWARD
FOR INNOVATIVE
PHARMACEUTICAL PRODUCTS

BRAIN BIOCHEMISTRY ADAPTS TO
LIFE WITH ALCOHOL

CAMPRAL EC HELPS PATIENTS ADAPT TO
LIFE WITHOUT ALCOHOL

Non-aversive **Campral EC** can help reduce the craving in patients who are adapting to a life without alcohol.

EFFECTIVE IN MAINTAINING ABSTINENCE

Campral EC

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

PRESCRIBING INFORMATION

Prescribing information

Presentation: 'Seroxat' Tablets, PL 10592/0001-2, each containing either 20 or 30 mg paroxetine as the hydrochloride. 30 (OP) 20 mg tablets, £20.77; 30 (OP) 30 mg tablets, £31.16.

'Seroxat' Liquid, PL 10592/0092, containing 20 mg paroxetine as the hydrochloride per 10 ml. 150 ml (OP), £20.77.

Indications: Treatment of symptoms of depressive illness of all types including depression accompanied by anxiety. Following satisfactory response, continuation is effective in preventing relapse. Treatment of symptoms and prevention of relapse of obsessive compulsive disorder (OCD). Treatment of symptoms and prevention of relapse of panic disorder with or without agoraphobia. Treatment of symptoms of social anxiety disorder/social phobia.

Dosage: Adults: Depression: 20 mg a day. Review response within two to three weeks and if necessary increase dose in 10 mg increments to a maximum of 50 mg according to response.

Obsessive compulsive disorder: 40 mg a day. Patients should be given 20 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 60 mg a day.

Panic disorder: 40 mg a day. Patients should be given 10 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 50 mg a day.

Social anxiety disorder/social phobia: 20 mg a day. Patients should start on 20 mg and if no improvement after at least two weeks they may benefit from weekly 10 mg dose increases up to a maximum of 50 mg/day according to response. 'Seroxat' has been shown to be effective in 12 week placebo-controlled trials. There is only limited evidence of efficacy after 12 weeks' treatment.

Give orally once a day in the morning with food. The tablets should not be chewed. Continue treatment for a sufficient period, which should be at least four to six months after recovery for depression and may be longer for OCD and panic disorder. As with many psychoactive medications abrupt discontinuation should be avoided – see **Adverse reactions.**

Elderly: Dosing should commence at the adult starting dose and may be increased in weekly 10 mg increments up to a maximum of 40 mg a day according to response.

Children: Not recommended.

Severe renal impairment (creatinine clearance <30 ml/min) or severe hepatic impairment: 20 mg a day. Restrict incremental dosage if required to lower end of range.

Contra-indication: Hypersensitivity to paroxetine.

Precautions: History of mania. Cardiac conditions: caution. Caution in patients with epilepsy; stop treatment if seizures develop. Driving and operating machinery.

Drug interactions: Do not use with or within two weeks after MAO inhibitors; leave a two-week gap before starting MAO inhibitor treatment. Possibility of interaction with tryptophan. Great caution with warfarin and other oral anticoagulants. Use lower doses if given with drug metabolising enzyme inhibitors; adjust dosage if necessary with drug metabolising enzyme inducers. Alcohol is not advised. Use lithium with caution and monitor lithium levels. Increased adverse effects with phenytoin; similar possibility with other anticonvulsants.

Pregnancy and lactation: Use only if potential benefit outweighs possible risk.

Adverse reactions: In controlled trials most commonly nausea, somnolence, sweating, tremor, asthenia, dry mouth, insomnia, sexual dysfunction (including impotence and ejaculation disorders), dizziness, constipation and decreased appetite.

Also spontaneous reports of dizziness, vomiting, diarrhoea, restlessness, hallucinations, hypomania, rash including urticaria with pruritus or angioedema, and symptoms suggestive of postural hypotension. Extrapyramidal reactions reported infrequently; usually reversible abnormalities of liver function tests and hyponatraemia described rarely. Symptoms including dizziness, sensory disturbance, anxiety, sleep disturbances, agitation, tremor, nausea, sweating and confusion have been reported following abrupt discontinuation of 'Seroxat'. It is recommended that when antidepressant treatment is no longer required, gradual discontinuation by dose-tapering or alternate day dosing be considered.

Overdosage: Margin of safety from available data is wide. Symptoms include nausea, vomiting, tremor, dilated pupils, dry mouth, irritability, sweating and somnolence. No specific antidote. General treatment as for overdosage with any antidepressant. Early use of activated charcoal suggested.

Legal category: POM. 10.9.98

SmithKline Beecham Pharmaceuticals

PARTNERS IN PSYCHIATRIC CARE

Welwyn Garden City, Hertfordshire AL7 1EY.

Reference: 1. Data on file.

0998/ST:AD/8/039BJ

SEROXAT

Rebuilding the lives of anxious depressed patients

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

British Indian Psychiatric Association

The meeting will comprise of lectures on Advances in Schizophrenia, Psychopharmacology-making Choices, Advances in Affective Disorders and Clinical Risk Management. In addition, there will be a choice of workshops on mental health issues affecting Asians in the UK and a social cultural evening.

All BIPA members are welcome and anyone interested in becoming one.

For details contact:
Dr Thakor Mistry, Organising Secretary, All Saints Hospital, Lodge Road, Birmingham, B18 5SD
Tel.: 0121 685 6430
Fax.: 0121 685 6206

The meeting has been supported by an Educational Grant from Zeneca.

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press

Evaluating treatments for schizophrenia - time for a change.

For fifty years, the trials which inform the care of those with schizophrenia have often been **small**, of **short duration** and employ outcome scales of **limited relevance** to clinical practice. The Schizophrenia Trials Meeting is for those with a practical interest in evaluative research. It will focus on learning from past trials, the practical use of current studies and setting a research agenda for schizophrenia trials in the future.

Schizophrenia Trials Meeting

Stratford-upon-Avon

5th-7th May 1999

Speakers include: Clive Adams-*Coordinating Editor, Cochrane Schizophrenia Group* * **Richard Ashcroft**-*Lecturer of Ethics in Medicine, University of Bristol* * **Barbara Farrell**-*Trial manager, Institute of Health Sciences, Oxford* * **Philippa Garety**-*Professor of Clinical Psychology, St. Thomas's Hospital* * **John Geddes**-*Director, Centre for Evidence Based Mental Health, Oxford* * **Richard Gray**-*Director, Clinical Trials Unit, Birmingham* * **Richard Lilford**-*Regional Director, NHS National & Clinical Trials, West Midlands* * **Angus MacKay**-*Clinical Director, Argyle & Bute Hospital* * **Liam O'Toole**-*MRC Trials Manager, London*

Accredited with 10 CME points

The meeting will comprise didactic sessions interspersed with workshops and debate. It will be held in The Alveston Manor, a 15th Century hotel situated in the centre of Stratford-upon-Avon, which will also provide full accommodation for delegates. All fees are solely to cover costs.

Registration: **£195**

Two nights full board at The Alveston Manor: **£200**

For further details please contact:

Leanne Roberts, Conference Organiser, Cochrane Schizophrenia Group, Summertown Pavilion, Middle Way, Oxford, OX2 7LG, UK.

Tel:+44 (0)1865 316776 Fax:+44 (0)1865 316023 E-mail: leanne.roberts@psych.ox.ac.uk

NHS Executive
R&D Directorate
West Midlands

Cochrane Schizophrenia Group

IN MENTAL HEALTH NEW HORIZONS
South Warwickshire Mental Health Services

POWIC
Prince of Wales International Centre

https://doi.org/10.1192/S0007125000152535 Published online by Cambridge University Press