studies also indicated it may be helpful to depression. Will it be helpful if treating the adolescent bipolar disorder?

Method: 76 patients were randomized into two groups, 37 treated with capsule Acanthopanax senticosus plus tablet lithium, 39 treated with capsule fluoxetine plus tablet lithium. Hamilton depression rating scale, 17 items (HAMD-17) was assessed during the trial.

Result: After 6 weeks treatment, There was a main effect for duration of treatment for Hamilton depression scale scores ($F=183.06$, $P<0.01$), but there was no group main effect($F=0.99$, $P=0.323$) or group-by-duration of treatment interaction($F=0.779$, $P=0.437$). The response rate and remission rate between the two group were similar. 3 patients suffered mood switching in fluoxetine treated group while no patients in Acanthopanax senticosus treated group.

Conclusion: This preliminary study suggested that lithium adding Acanthopanax senticosus was as effective as lithium adding fluoxetine for treating adolescent bipolar depression, and Acanthopanax senticosus may be more safer and less risk to mood switching.

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Response- and remission rates as efficacymarker of monotherapy with atypical neuroleptics in the treatment of acute mania

S. Eppendorfer, S. Wilhelm, C. Nicolay, H.P. Hundemer. *Medical Department, Lilly Deutschland GmbH, Bad Homburg, Germany*

Introduction: Numerous studies on the treatment of acute mania in bipolar patients have demonstrated the efficacy of atypical neuroleptics versus placebo or active comparator. However, there is a lack of direct comparative studies between atypicals. We present an overview on the efficacy (response and remission rates) of atypicals.

Methods: Using MEDLINE-analysis, all prospective double-blind studies of atypical neuroleptics in acute mania published until November 2006 were identified. Response was defined as 50% improvement and remission as an endpoint ? 12 in YMRS. The following parameters were calculated: response rates, remission rates, odds ratios, adjusted odds ratios.

Results and Discussion: Response rates in placebo controlled studies (duration 3-4 weeks) ranged from 18.9% to 42.9% (placebo) and from 39.8% (aripiprazol) to 72.9% (risperidone) for comparators. The adjusted odds ratios ranged from 1.946 (ziprasidone) to 2.727 (risperidone), all differences versus placebo were statistically significant in favor of the atypical. Remission rates ranged between 22.1% and 35.7% (placebo) and for comparators between 27.7% (quetiapine) and 61.1% (olanzapine). In comparator controlled studies (duration 3-12 weeks) response rates ranged between 42.3% and 74.2%. With odds ratios between 0.580 and 1.629, differences versus comparator were not statistically significant. Remission rates in these studies varied from 27,7% (quetiapine) to 49% (lithium). The observed trends for treatment effect differences between the atypicals are confounded by different study designs and patient characteristics. Thus, direct comparative studies between atypicals in acute mania are required to detect potential treatment effect differences, e.g. in special patient subgroups.

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Preventing bipolar relapse: Which factors are associated with different mood stabilizer therapy?

S. Wilhelm [1], A. Schacht [1], A. Minarzyk [1], A. Liebeskind [1], H. Grunze [2]. [1] *Lilly Deutschland GmbH, Medical Department, Bad Homburg, Germany* [2] *Department of Psychiatry, Ludwig-Maximilans-University, Munich, Germany*

Background: As bipolar disorder drastically afflicts the patient's family, social, and occupational life alongside with a high suicide rate, early initiation and maintenance of pharmacotherapy is crucial. However, bipolar relapse prevention including modern atypical antipsychotics still deserves research.

Methods: Targeting relapse prevention in a natural setting, this ongoing 18-months, prospective, multicenter, non-interventional study compares mood-stabilizing therapies in German outpatients with bipolar disorder.

Results: The present analysis of baseline-data reveals that of 761 adults included, 26.1% are receiving olanzapine monotherapy (OM), 21.2% lithium monotherapy (LM), 30.1% anticonvulsant monotherapy (AM), 6.4% olanzapine/lithium combination therapy (OLC), 9.5% olanzapine/anticonvulsant combination therapy (OAC), 6.7% other combinations of mood stabilizers (OC) and 5.8% no mood stabilizers (NO). A higher rate of females receive AM (32.5%, males 22.9%) while males are rather treated with OM (26.6%, females 23.0%). At baseline, 36.4% of the patients had been hospitalized within the last 12 months due to psychiatric disorder, 26.8% had a history of suicide attempts, 10.7% were considered rapid cyclers.

Within the last 12 months 66.5% of the patients experienced manic episodes, 88.6% depressive episodes and 43.1% mixed episodes. The highest rates of prevalent diabetes mellitus (12.6%) and lipid disorders (17.5%) and second highest of cardiovascular disease (20.4%) was found in Patients receiving LM. Employment rate at baseline was highest in the AM-group (39.6%) and lowest with OC (29.2%).

Conclusion: The present data show that these patients in whom maintenance therapy was initiated, form an exceedingly heterogeneous population, suggesting a strong demand for individually customized therapies.

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Preventing bipolar relapse: In which way do patients with mixed episodes differ?

S. Wilhelm [1], A. Schacht [1], A. Minarzyk [1], A. Liebeskind [1], H. Grunze [2]. [1] *Lilly Deutschland GmbH, Medical Department, Bad Homburg, Germany* [2] *Department of Psychiatry, Ludwig-Maximilans-University, Munich, Germany*

Introduction: Treating bipolar disorder, patients with mixed episodes are considered the most problematic subgroup as they do not respond easily, which makes the choice and dosage of the respective pharmacotherapy difficult. One objective of this ongoing 18-months, prospective multicenter, non-interventional study on mood-stabilizing therapies is to find out what specific patient features are associated with mixed episodes.

Methods: Observational data from 761 outpatients are collected by 150 office or hospital based psychiatrists throughout Germany in the course of standard treatment for bipolar disorder. A baseline analysis was run and patients without mixed episodes (0-MX) were compared to those with one (1-MX) and more (>1-MX) mixed episodes.

Results: 30.9% patients experienced mixed episodes within the last 12 months, with a hospitalization rate of 33.2% for the 0-MX, 36.5% for the 1-MX and 43.4% for the >1-MX group. The 0-MX group had 5.6% rapid cyclers, while it was 11.0% for the 1-MX and 32.8% for the >1-MX group. Regarding treatment, 0-MX mostly receive anticonvulsive monotherapy (31.1%), 1-MX olanzapine monotherapy (31.8%) and >1-MX anticonvulsive monotherapy (35.3%). A higher psycho-education rate appeared with the 1-MX (19.0%) and >1-MX (28.8%) than with the 0-MX group (14.8%).

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Further psychotic diseases were associated with less mixed episodes (0-MX: 71.3%, 1-MX: 69.2%, >1-MX: 57.5%).

Conclusion: The high hospitalization rate suggests the need for a careful medical monitoring and optimized pharmacotherapy to prevent bipolar relapse in patients with mixed episodes. The present data reveal a want for more detailed analysis.

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Attention deficit hyperactivity disorder and bipolar disorder: comorbidities and psychosocial impairment

D. Bicer [1], C. Dedeoglu [2], K. Kora [1], Y. Yazgan [1]. [1] *Marmara University Faculty of Medicine, Marmara University Hospital ADHD Clinic for Adults (Presently Guzel Gunler Health Service Ltd), Istanbul, Turkey* [2] *Guzel Gunler Health Service Ltd., Istanbul, Turkey*

Background and aims: This study aims to compare ADHD and Bipolar Disorder(BPD) regarding comorbid axis I psychiatric disorders, personality disorders, existence of general psychopathology as measured on SCL-90-R and in areas of educational attainment and psychosocial adjustment.

Method: 38 patients who were diagnosed with ADHD in Marmara University Hospital, Psychiatry Department Adult ADHD Outpatient Clinic and 38 patients receiving treatment for Bipolar Disorder in Mood Disorders outpatient clinic during the same period, have been included in the study. The socio-demographic characterization was done using a semi-structured interview. To evaluate the presence of psychiatric comorbidity, structured clinical interviews (SCID-I and II) were conducted by two general psychiatrists experienced in ADHD and trained in SCID administration. All groups were given SCL-90-R for general psychopathology assessment and BDI for depression assessment.

Results: The ADHD and BPD patients did not differ in terms of marital status, the number of suicide attempts and family psychiatric history. However, ADHD patients had significantly greater scores on SCL-90 general psychopathology scale ($F(1,66)=27.303$, $p<.001$) and higher scores on depressive symptomatology ($F(1,63)= 10.988$, $p<.005$). ADHD patients had comparable frequency of comorbid axis I disorder and significantly higher frequency of comorbid axis II personality disorders ($F(1,64)= 24.438$, $p<.001$). Besides, repeating educational years ($F(1,66)=7.447$, $p<.005$) were more likely to be seen in ADHD patients in contrast to BPD patients.

Conclusion: ADHD is a disorder that affects, no less significantly than BPD, educational achievement, and psychiatric comorbidity, especially in terms of increased presence of axis II disorders and psychiatric symptoms.

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The effect of quetiapine monotherapy on subjective estimates of sleep in acute mania

B.H. Yoon [1], W.M. Bahk [2], D.I. Jon [3], K.J. Min [4], A. Bae [1], Y.H. Sea [1], K.J. Kim [1,5]. [1] *Department of Psychiatry, Naju National Hospital, Naju, Jeonnam, South Korea* [2] *Department of Psychiatry, School of Medicine, The Catholic University of Korea, Seoul, South Korea* [3] *Department of Psychiatry, Hallym University, Sacred Heart Hospital, Anyang, South Korea* [4] *Department of Psychiatry, Chung-Ang University Hospital, Seoul, South Korea* [5] *Department of Psychiatry, College of Medicine, Sungkyun-Kwan University, Seoul, South Korea*

Objective: This study aimed to investigate the effect of quetiapine monotherapy on subjective feelings of sleep in patients with acute mania.

Method: In a Korean multicenter, open-label, 6-week study, patients with a DSM-IV diagnosis of bipolar I disorder (manic or mixed episodes) were included to treatment with quetiapine (flexibly dosed up to 800mg/day). Clinical Improvement was evaluated using Young Mania Rating Scale (YMRS). Side effects were measured by Simpson-Angus Rating Scale (SARS) and Barnes Akathisia Rating Scale (BARS). Modified version of Leeds Sleep Evaluation Questionnaire (LSEQ) was used to assess the subjective measures of sleep, which included the factors covering four areas: i) getting to sleep (GTS), ii) quality of sleep (QOS), iii) awakening from sleep (AFS), and iv) behavior following wakefulness (BFW). All assessments were done at baseline and days 7, 14, 21 and 42 after treatment with quetiapine.

Results: Fifty-six of 79 patients were completed the all assessments. Mean changes of YMRS from baseline were significant at days 7, 14, 21 and 42. There were no significant differences in SARS and BARS at any assessment. While mean changes of GTS, QOS and AFS from baseline were significantly improved at days 7, 14, 21 and 42, BFW was not differed between baseline and post-treatment assessments.

Conclusion: Quetiapine monotherapy showed improvements of self-perceived sleep without any impairment following sleep in acute manic patients.

Poster Session 2: ECT

P148

Are the ect machines with high dosage (>576mc) advantageous? A preliminary study

A.A. Alabi [1], G. Kungiri [2]. [1] *Leicester Frith Hospital, Leicester, Leicestershire, United Kingdom* [2] *Bradgate Mental Health Unit, Leicester, Leicestershire, United Kingdom*

Background: Missed seizure (motor seizure duration <15 seconds and/or EEG seizure duration <20 seconds) in ECT even with the maximum stimulus dose delivered by the machine is clinically challenging. The maximum deliverable dose in many countries is up to 576mC, although in UK and some parts of Europe this is nearly double.

Objective: This study examined the incidence of missed seizures at the standard dose of 500mC set on the ECT machine. The effect of using higher stimulus intensity in in-patient with missed seizure was evaluated.

Methodology: All patients who were initiated a course of ECT over one year period formed the sample (n=70; F=52, M=18). The tool used in data collation included demographic, clinical and ECT parameters. The ECT parameters included stimulus laterality, dosage administered, motor and EEG seizure duration of the last ECT treatment.

Results: Six (8.5%) patients had missed seizures at 500mC. Two of them had adequate seizures at a higher stimulus dose (706 and 760mC each).The remaining four failed to have adequate seizures even when the stimulus dose was set at 1000mC. Of the six patients four were females, five received bilateral ECT and three each were on mood stabilizers and benzodiazepines. The average age and number of ECT treatment were 63.3 years and 12 respectively. All had moderate to severe depression except one (bipolar depression).

Conclusion: In a proportion of patients with missed seizures higher stimulus (>576mC) produces adequate seizures. The effect of this on cognition need to be further studied.

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