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The physical well-being of people with schizophrenia is remarkably neglected. Physical illnesses in these people are underdiagnosed and undertreated. A recent study in Australia showed that, although people with schizophrenia suffer more frequently from cardiovascular problems than the general population, they receive catheter much more rarely. People with schizophrenia have been also reported to be less likely than the general population to receive HbA1c and cholesterol monitoring, to receive a retinal examination for diabetes screening, and to be treated for osteoporosis. They have been also found to be more likely to be treated for physical illnesses only when the latter become life threatening. Among the factors contributing to this underdiagnosis and undertreatment of physical illnesses in people with schizophrenia are a low motivation of patients and their relatives to access medical services, the isolation of psychiatric services from other medical facilities, and a tendency of psychiatrists to overlook physical health problems in their patients. However, the most important factor is likely to be the stigma surrounding schizophrenia. The neglect of physical health in people with schizophrenia should be regarded as an expression of discrimination and disregard for their dignity and their rights as human beings and citizens. Due to the lack of prevention and intervention strategies, people with schizophrenia and their families bear the costs of the mental disorder and those of the concomitant physical illnesses, which can exacerbate psychopathological manifestations and impair the subjects' ability to adhere to treatment. Access to physical health care of the same quality as that available to the rest of the population should be considered a basic right of people with schizophrenia and a crucial dimension on which their quality of life has to be evaluated.

Satellite Symposium: Realizing the potential of new antipsychotics: Practical advice for optimizing schizophrenia care. Sponsored by Bristol Myers Squibb

SS01.01

The art and science of switching in patients with schizophrenia: Strategies for achieving a smooth transition

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Many patients with schizophrenia experience persistent symptoms or side effects on their current antipsychotic regimen. Such patients, particularly those treated with conventional antipsychotic agents may benefit from switching to atypical agents, which offer broader efficacy and improved tolerability compared with earlier counterparts. In addition, patients already receiving treatment with an atypical agent may benefit from switching to an alternative atypical, given that there is great variation in (1) individuals' response to different atypical antipsychotics, and (2) the side-effect profile of the atypicals. With switching from one antipsychotic to another becoming increasingly common, there is an urgent need to define optimal switching strategies. The main goal when switching antipsychotics is to improve or (in stable patients) maintain the symptomatic and functional level, while improving (or not worsening) tolerability. It is important to identify patients who would be likely to benefit from switching and to discuss with them and their carers the advantages and potential problems of the switching process. To date, four strategies have been effective in controlled studies of switching to atypical antipsychotics: therapeutic dose initiation of the new antipsychotic and abrupt discontinuation of the first ('abrupt switch'); gradual dose escalation of the new antipsychotic and abrupt discontinuation of the first ('ascending switch'); therapeutic dose initiation of the new antipsychotic and gradual discontinuation of the first ('descending switch'), and; gradual dose escalation of the new antipsychotic and gradual discontinuation of the first ('cross-titration'). An individualized approach is key to the success of switching, as are patient cooperation and carer support.

SS01.02

Shifting schizophrenia treatment paradigms: The scope for adjunctive therapies

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Combination therapy is well established in bipolar disorder; however, the evidence for this approach in schizophrenia is less robust. Despite the absence of clear guidance, antipsychotic combinations are commonly used in real-life practice, with estimates suggesting that 20–60% of patients receive multiple antipsychotics concurrently. Such polypharmacy may be clinically useful, combining diverse pharmacological actions. However, a clear pharmacological rationale for specific antipsychotic combinations has not yet been elucidated. In this presentation, we consider the varying pharmacological profiles of agents currently used for schizophrenia and explore how best this pharmacology may be exploited to maximize the newer atypicals in clinical practice. For decades schizophrenia has been treated with some success using typical antipsychotics, which are antagonists at dopamine D2 receptors. Atypical antipsychotics were then developed, having D2 antagonism with additional affinity for other receptors, such as serotonin 5-HT2A and 5-HT1A receptors. Most recently, partial D2 agonists have been developed with efficacy to treat schizophrenia and bipolar disorder. These agents have lower intrinsic activity than full agonists, so can act either as functional agonists or antagonists. Additionally, actions to increase noradrenergic function in the prefrontal cortex may be implicated in the efficacy of some antipsychotics. Given the rich pharmacology of antipsychotics, can the combined use of agents with synergistic mechanisms of action provide a true clinical advance in schizophrenia treatment? Polypharmacy is a complex challenge that requires further study in well-designed, randomized, controlled studies. We will review the pharmacological rational for antipsychotic combination therapy and recent clinical evidence for their benefits.

SS01.03

Meeting the need for efficacy without over-sedation in patients with schizophrenia

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Although the induction of sleep was originally considered to be a desirable therapeutic endpoint for the rapid control of agitation, it is

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increasingly recognised that sedation is not a prerequisite for acute symptom control. Moreover, excessive sedation or 'over-sedation' can interfere with the physician's ability to evaluate the patient and establish an effective therapeutic alliance with them, thus potentially influencing future compliance and treatment outcomes. Over-sedation is also strongly disliked by patients. Thus, achieving control of agitation via rapid calming rather than sedation is becoming an important therapeutic goal. Sedative agents, such as lorazepam, have traditionally been used for the management of acute agitation. However, problems with over-sedation have led to the increased use of intramuscular (IM) antipsychotics – which are easy to administer and provide rapid symptom relief of acute agitation – as a first-line approach in the acute setting. The recent availability of atypical antipsychotics as IM formulations represents a significant step towards meeting the goal of efficacy without over-sedation. Aripiprazole, olanzapine and ziprasidone have demonstrated efficacy in the management of acutely agitated patients with schizophrenia. Indeed, IM aripiprazole has been shown to be equally effective as IM haloperidol with a lower risk of extrapyramidal symptoms. Importantly, calming of acutely agitated patients without excessive sedation is emerging as a significant clinical advantage of IM atypicals over older treatments such as typical antipsychotics or benzodiazepines. Thus, physicians should consider the specific, sedation-independent calming effects of atypicals.

Core Symposium: Combined psychopharmacotherapy and psychotherapy

CS02.01

Combination of antidepressants and cognitive behaviour therapy

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The investigation of the comparative efficacy of the combination of pharmacotherapy and psychotherapy versus either modality alone has to consider several methodological issues. Neglect of these methodological aspects can lead to severe pitfalls. Also, the interpretation of the results of such studies should be performed very carefully, considering several aspects. Among others, the following questions have to be addressed:

- Was the study performed in a more psychopharmacology-oriented or more psychotherapeutically-oriented institution?
- Were the patients acutely or chronically ill?
- Were the patients already refractory to pharmacotherapy or psychotherapy prior to inclusion in the study?
- Was the pharmacotherapy performed according to the state of the art?
- Was the psychotherapy performed according to the state of the art?
- Was the pharmacotherapy administered under double-blind conditions, using a placebo control or another kind of control?
- Was the psychotherapy administered in the context of a pseudo placebo control group?
- Was the sample size adequate for a confirmative trial?

Generally it has to be taken into consideration that it is much more difficult to prove efficacy of a combination therapy versus an active mono-therapy then to prove efficacy of a mono-therapy or combination therapy versus placebo. Overall, there seems to be evidence for superior efficacy of the combination of antidepressants with cognitive behaviour therapy, especially in certain subgroups of patients.

CS02.02

Psychological treatments combined with drug therapy in bipolar disorder

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There is now a large body of controlled trial research into the efficacy of psychological treatments in unipolar affective disorder, indicating their place in acute treatment and in prevention of relapse and recurrence. In bipolar disorder the evidence is still less strong, but studies are rapidly accumulating. Psychological treatments have been almost always combined with medication. The psychological approaches have included psychoeducation, cognitive therapy (CBT), interpersonal and social rhythm therapy (IPSRT), family therapy. Some approaches have used mixtures of elements, particularly psychoeducation with family or cognitive therapy. Benefits found have included symptom improvement, improvement in social function, relapse prevention and improved adherence to drug regimes. However findings have not been entirely consistent, so that definitive recommendations are still premature. Effects may be weaker than in unipolar disorder. In contrast to unipolar disorder, where the strongest body of empirical evidence favours cognitive therapy for symptom remission and relapse prevention, in bipolar disorder psychoeducationally-based approaches may emerge to be of greater benefit.

CS02.03

The relevance of psychoeducation in the treatment of schizophrenia

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Background and Aims: Due to the multifactorial origin of Schizophrenia, a multidimensional therapeutic approach has become state of the art in our days (APA 2004; DGPPN 2006). Whereas the efficacy of pharmacotherapy has been proven in a great number of studies (Möller 2005), data concerning the efficacy of psychotherapeutic and psychosocial measures are mixed up to now.

Methods: There are many studies about psychoeducation, cognitive behavioural therapy, cognitive remediation, social skills training and other psychotherapeutic interventions, but we don't know exactly if these measures are successful on their own or only in combination with other therapeutic measures. The newest findings in the literature will be screened concerning their efficacy.

Results: Significant results have meanwhile been found concerning the rehospitalisation-rate during the first and the second year after discharge (Pekkala 2004; Pitschel-Walz et al 2006). For the time frame of 5-8 years after discharge in a pooled data analysis, a rehospitalisation rate of 54% among the intervention group and 80% among the controll group ($p < .05$) could be found in the tree long term follow-up studies of Tarrier et al (1994), Hornung et al (1999) and Bäuml et al (2007).

Conclusions: Psychoeducation has proven as most effective, if relatives were included into the intervention (Pitschel-Walz, Bäuml et al 2001). The newest data concerning psychosocial interventions in general and concerning psychoeducation in particular will be

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