two patients, zuclopenthixol in combination with chlorprothixene in one, haloperidol alone in one and chlorprothixene and clozapine in one patient) severe dystonic reactions appeared in all patients with lateralization in four of them. The observed dystonic reactions lasted up to 30 days and did not improve with anticholinergics. One of the patients died suddenly three days after the appearance of the dystonic reaction and the post mortem did not reveal an obvious cause for this fatal outcome. The reported cases underline the high risk of the occurrence of manic symptoms shortly after lithium withdrawal. Moreover, they are an indication of a heightened risk for severe side effects of neuroleptic treatment in patients after abrupt lithium withdrawal.

THE PATIENT UNDER NEUROLEPTIC TREATMENT

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The patient under neuroleptic treatment.

This study treats:

- Neuroleptic prescription practice in the field of psychiatry in the French public health services.
- according to a naturalistic method which respects the usual modes of prescription
- in the context of the organisation of psychiatry in the French public health service in sectors which allow a coherent network of the different investigators involved.

The results presented concern more than 4,000 files of patients gathered by a network of 85 public health service psychiatrists from all over France and working under the same conditions. These patients' files which follow up hospitalisation and consultation have been collected over a nine-month period at three intervals (M0, M4 and M9).

This at the same deadline and under the same conditions of place for each of the investigators.

All analysed files are exhaustively documented on clinical particularities as well as on the drug and non-drug treatments.

This approach is a research method on prescription modes but also an excellent method of training since the different investigators receive, in return, their personal data accompanied by global results to which they can compare. They also receive the main elements which are the consensus in this field.

SEVERE DEPRESSION: RECOGNITION AND TREATMENT

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There is no single definition of severe depression, however, all the following variables should be considered in patient assessment: intensity of specific symptoms; diagnostic subgroups (eg, bipolar depression); stage of evolution (chronic or recurrent); comorbidity; and resistance to treatment. Elderly patients are more likely to have severe depression because of the high incidence of chronicity, recurrence and comorbidity in these patients. Severe depression is mainly treated with tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs). Comparative studies have shown that TCAs and SSRIs are effective in patients with a baseline HAM-D score > 25 and/or melancholia; a meta-analysis in 244 patients with melancholia showed that paroxetine was significantly more effective than placebo. As maintenance therapy may be necessary for many years, the tolerability of agents is of major importance. SSRIs appear to be better tolerated than TCAs, with fewer patients stopping treatment because of adverse events; pooled comparative data of paroxetine, placebo and active comparators (mainly TCAs) in almost 5000 patients showed a lower incidence of anticholinergic, neurological and cardiovascular effects with paroxetine. However, SSRIs are associated with a higher incidence of nausea although few patients discontinue treatment. Numerous long-term studies also demonstrate the efficacy of TCAs and SSRIs in prevention of relapse and recurrence and the superior tolerability of SSRIs compared with TCAs.

COMPULSIVE BUYING IN DEPRESSED PATIENTS

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Compulsive buying is defined by the presence of repetitive impulsive and excessive buying leading to personal and familial distress. Patient presenting this disorder also suffer from mood disorder in 50 to 100% of the cases and antidepressants help to decrease the frequency and the severity of uncontrolled buying. In order to precise the correlation between compulsive buying and depression, we assessed this behavior among 119 inpatients answering to DSM-III-R criteria of major depressive episode. We also evaluated the comorbidity in the patients suffering from compulsive buying (CB+) and in those who were free from this disorder (CB−). In addition, impulsivity and sensation seeking were compared in the two groups.

Diagnosis of compulsive buying was made using standardized criteria and a specific rating scale. Diagnosis of depression and assessment of comorbidity was investigated using the Mini International Neuropsychiatric interview. The prevalence of the disorder was 31.9%, 38 of the 119 depressives being diagnosed as compulsive buyers. Patients from the CB+ group were younger, more often women and unmarried. They had experienced irresistible urges, uncontrollable needs, or mounting tension that could be relieved only by buying. For all patients, compulsive buying had tangible negative consequences. Postpurchase guilt was present in 21 (55%) patients. 24 (63%) of compulsive buyers described attempts to resist urges to buy.

Patients with compulsive buying presented more often than others recurrent depression (relative risk = 1.4), impulse control disorders as kleptomania (RR = 8.5) or bulimia (RR = 2.8), benzodiazepine abuse or dependence disorder (RR = 4.68), associations of dependences (RR = 1.99). Compulsive buying was thus frequent among depressives and associated with other impulse control disorders or dependence disorders.

ROUTINE ASSESSMENT OF PATIENT HEALTH: A WORST CASE SITUATION WITH REGARDS TO INTER-RATER RELIABILITY

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Global Assessment of Functioning (GAF) has been selected as the variable for routine assessment of patient health in the Norwegian national Minimal Basis Data Set for Psychiatry. The objective is to obtain reliable data on patient status at the beginning and the end of every treatment episode for all psychiatric patients. High quality routine data provide a new and fascinating possibility: To be able to perform retrospective longitudinal studies, and thus avoid the major problems associated with such prospective studies. However, this can only be achieved if good reliability of the data is ensured.

In order to test the reliability of GAF-scores in routine settings, we let more than one hundred persons rate the same clinical case-vignettes. Reliability is generally better with case-vignettes than with patients, due to a restricted variance of information. But this only means that any shortcomings demonstrated in this "in vitro" situation represents understatements of actual problems in clinical settings.