S42. WHO ICD-10: Evaluation and evolution

Chairmen: JE Cooper, D Goldberg

THE REVISED ICD10-PHC CLASSIFICATION

David Goldberg. *Institute of Psychiatry, London SE5 8AF, UK*

The ICD10-PHC is simple, user-friendly and orientated towards management. It has been subjected to field trials in a number of countries and revised with feedback from GPs themselves. The Classification will be described with examples, and some results given from the British field trial. Two studies designed to evaluate the new system will be described.

The need is for training materials to assist GPs in familiarising themselves with the cards. These need to be prepared in local languages, taking into account the typical conditions of primary care in a particular country.

ICD-10 MULTIAXIAL PRESENTATION

A. Janca, M. Kastrup, H. Katschnig, J.J. Lopez-Ibor Jr, J.E. Mezzich, N. Sartorius. *Division of Mental Health & Prevention of Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland*

The multiaxial presentation of ICD-10 for use in adult psychiatry uses the following three axes: Axis I Clinical diagnosis of both mental and physical disorders; Axis II-Disabilities; and Axis III-Contextual factors. The ICD-10 multiaxial presentation is intended for use in clinical, educational and research activities and aims to ensure that disabilities and factors relevant to the management of the patients clinical condition are systematically recorded.

The ICD-10 multiaxial system was tested in two international field trials involving 21 countries, 63 centres and 274 clinicians. About 90% of participants found the ICD-10 multiaxial systems easy to use and useful in routine clinical work, in the training of mental health professionals and in research on mental disorders. The ICD-10 multiaxial system has now been released for general use. WHO plans to collect reports on experience with the proposed ICD-10 multiaxial system and will take them into account in producing its next edition.

ICD-10 CASEBOOK AND LEXICA

C.B. Pull. *Service de Psychiatrie, Centre Hospitalier de Luxembourg, 4 rue Barblé, L-1210 Luxembourg*

The ICD-10 Classification of Mental and Behavioural Disorders represents a major step towards the attainment of a common language among mental health professionals worldwide. The Classification is published in different versions for different users and is accompanied by a series of publications developed from Chapter V (F) of ICD-10.

The ICD-10 Casebook contains a collection of cases provided by clinicians from different backgrounds and cultures. For each case, the Casebook presents a description of the patient's problem and history, and the clinician's findings, followed by a comprehensive discussion concerning the diagnosis and differential diagnosis according to ICD-10 diagnostic guidelines and/or diagnostic criteria for research.

The second edition of the Lexicon of Psychiatric and Mental Health Terms contains some 700 terms that appear in the text of the ICD-10 and that, in the judgment of experts, require definitions.

The Lexicon of Alcohol and Drug Terms provides a set of definitions of terms concerning alcohol, tobacco and other drugs, which will be useful to clinicians, administrators, researchers and others interested in this field.

The ICD-10 Casebook and Lexica will be presented, using examples taken from the texts, and their aims in clinical practice and research will be discussed.

WHO ICD-10 EVALUATION AND EVOLUTION: ICD-10 TRAINING COURSES

J.J. van Drimmelen-Krabbe. *Division of Mental Health and Prevention of Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland*

The appearance of the ICD-10 Classification of Mental and Behavioural Disorders in its various versions and many languages has been an event of great importance for psychiatry. The new classification is an essential part to the effort to develop a language which will allow national and international communication in the field of mental health and facilitate joint work across cultures and countries. The next challenge is to familiarize psychiatrists and other mental health workers — as well as others involved in mental health and general health care — with the principles on which the ICD classification of mental disorders is based and to help them to use it well.

Since the publication of the ICD-Classification of Mental and Behavioural Disorders, lectures and training seminars have been organised all over the world, through ICD-10 Reference and Training Centres for Assessment and Classification and directly through WHO, for instance in most of the new countries in Eastern Europe. To date Chapter V of ICD-10 has already been translated in more than 30 languages.

To further stimulate training in the use of this classification WHO and the World Psychiatric Association have jointly undertaken the production of an educational programme for the familiarization with ICD-10, Ch. V and its related assessment instruments. The package includes guidelines for training seminars of different lengths, a great number of transparencies and written case summaries for case exercises.

The key to effective treatment of patients with a mental disorder is recognition of the disorder. Education and training is an important tool in improving the fate of mentally ill.

S43. Obsessive action

Chairmen: S Montgomery, L Ravizza

BEHAVIOURAL TREATMENTS IN OBSESSIVE COMPULSIVE DISORDER

L.M. Drummond. *Department of General Psychiatry, St. George's Hospital Medical School, Cranmer Terrace, Tooting, London SW17 0RE*

The behavioural treatment of exposure and self imposed response prevention has been used since the 1970s for patients with obsessive compulsive disorder. Success rates are high with over 70% of patients responding to this therapy. This paper partially examines those who fail treatment.

The study is a naturalistic study examining 49 patients with obsessive compulsive disorder who were treated in a specialist in-patient setting. Treatment consisted of exposure which was combined with other treatments if necessary. Overall, 63% of these severely disabled

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patients improved by an average 40% reduction in rituals after an average of 10.5 weeks in hospital. These gains were maintained at an average 19 month follow-up. Predictors of outcome were looked for but only female success and checking rituals were found to effect outcome.

This study will be discussed in light of more recent work advocating the use of cognitive therapy in obsessive compulsive disorder.

REFINING THE PHARMACOLOGICAL TREATMENT FOR OBSESSIVE COMPULSIVE DISORDER

N.A. Fineberg, A. Roberts, S.A. Montgomery. *Academic Department of Psychiatry, St Mary's Hospital, Praed Street, London W2, UK*

Obsessive Compulsive Disorder (OCD) is unusual because it responds selectively to drugs with potent serotonin -reuptake inhibitors (SRI) properties. Clomipramine and the selective serotonin reuptake inhibitors (SSRIs) fluvoxamine, fluoxetine, sertraline and paroxetine, have all been demonstrated to be effective following extensive placebo-controlled investigation. The antiobsessional effects of these compounds emerge slowly and incrementally, and do not depend upon the coexistence of depression. A growing number of fixed-dose treatment studies support the traditional view that higher doses may be more effective for some patients. Long-term treatment studies suggest that the antiobsessional effect of treatment is sustained in the longer-term, but clinical benefits are usually lost once treatment is discontinued. Patients are therefore encouraged to continue with their drug treatment for many years.

There is insufficient study data addressing the comparative efficacy of individual SRIs in OCD. Placebo response rates have risen from < 5% in the early studies to exceed 20% in recent studies, while treatment response rates have fallen, indicating changes in the OCD study population over the course of time. Meta analyses, reviewing large quantities of data pooled from existing studies, are disadvantaged by their inability to control for such changes. For this reason, head-to-head comparator studies are to be preferred, but extremely large numbers are needed in order to avoid missing clinically relevant differences. A preliminary report from the recent, large comparator study demonstrated superior efficacy for sertraline compared with clomipramine, on the intent-to-treat analysis [1].

Given that OCD patients worry a great deal about side effects, and in the absence of convincing comparative data, it would seem sensible to favour the treatments with the better side effect profiles. SSRIs, even at the higher dose levels, appear better tolerated and safer than clomipramine and ought to be considered as first line treatments in OCD.

[1] Bisserbe J.C (1995) Refining treatment approaches in obsessive compulsive disorder abstracts, 1st International Congress on Education and Progress in OCD. Barcelona, Spain 22–25 June. p10.

SLEEP PATTERNS IN OCD

A. Okasha, T. Asaad. *Ain Shams University, 3 Shawarby Street, Kasr El Nil, Cairo, Egypt*

There is a paucity in research on polysomnography of OCD patients as a biological marker. The present study was designed to evaluate the sleep profile in patients with OCD, with and without sleep complaints. 19 patients fulfilling ICD-10 criteria of OCD in addition to 10 controls matched for age, sex and the patient group have been studied with standardized sleep questionnaired and all-night polysomnography. An attempt was made to identify a possible correlation between the severity of OCD (assessed by means of the YBOCS) and the sleep profile of patients. The results showed a significantly decreased REM latency and increased arousal in the patient group. The difference in other sleep measures was not significant. The finding of decreased REM latency in the abscence of depression may question the diagnostic specificity of REM latency in depression and the possible biological overlap between OCD and major depression.

BODY DYSMORPHIC DISORDER AND THE RELATIONSHIP TO OCD

D. Veale. *Grovelands Priory Hospital, The Bourne, Southgate; University Department of Psychiatry, Royal Free Hospital*

Body Dysmorphic Disorder (BDD) is hypothesised as being closely related to OCD. Evidence is based upon a range of different factors including similarity of symptoms; the overlap with the need for symmetry and order; frequent comorbidity; temporal transition from one syndrome to another; specific responses to treatment; sex ratio; and age of onset. We assessed 50 patients with a structured diagnostic interview who satisfied DSMIV criteria for BDD as their primary disorder. We excluded patients who were psychotic and those who were preoccupied by their weight and shape. The average age of onset was 18 years and average duration of symptoms 14 years. The most common additional axis I diagnoses in our study were either a mood disorder (26%), social phobia (16%) or obsessive compulsive disorder (6%). 24% had made a suicide attempt in the past. 72% of patients had one or more personality disorders diagnosed. The most common personality disorders were avoidant (38%), paranoid (38%) and obsessive compulsive (28%). There was extensive checking and avoidance behaviour that was focused on the perceived defect. 19 of the patients were treated in a pilot randomised controlled trial of cognitive behavioural therapy against a waiting list. There was a mean reduction of 50% of symptoms in those who received cognitive behavioural therapy and a slight increase in those who were on the waiting list. We conclude that BDD patients have some similarities to OCD in so far as the nature of their symptoms, the age of onset and duration before presentation. The sex ratio was different in our study even when we excluded patients who were preoccupied with their weight and shape. There was no control group of OCD patients but there appears to be a higher proportion of comorbidity in both axis I diagnoses of a mood disorder or social phobia than in OCD. Patients appeared to respond well to cognitive behaviour therapy but this cannot be regarded as a specific response.

TREATMENT OF RESISTANT OCD

J. Zohar, Y. Sasson, I. Iancu.

Despite the significant progress that has been achieved in the past decade in the treatment of obsessive compulsive disorder (OCD), 20 to 30 percent of OCD patients are still resistant to treatment. OCD patients tend to require higher doses and longer periods of treatment. Therefore, before assuming resistance, a duration of ten weeks of treatment with the highest recommended dose of the relevant medication is in order. While there is no controlled data regarding the beneficial effect of switching from one anti-obsessive medication to another, this is a common practise. During this process it may be especially useful to attempt a high dose (250 mg per day) of clomipramine. To date there is only one subtype of OCD patients who have shown beneficial effects from augmenting strategy. Patients with a combination of OCD and tic-disorder get additional benefit when a small dose of neuroleptics is added to their anti-obsessive treatment. Other augmenting agents that have been attempted with differing degrees of success are: fenfluramine, lithium, trazodone, tryptophan, buspirone and pindolol. The role of monoamine oxidase inhibitors (MAOIs) in treatment-resistant OCD is not yet quite clear. However, in resistant cases, a trial of non-reversible MAOIs may

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