CLINICAL AND PERSONALITY CHARACTERISTICS OF SEASONAL AFFECTIVE DISORDER

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Clinical and personality characteristics of patients with seasonal (SD) and nonseasonal (NSD) depression were compared. Seasonal Pattern Assessment Questionnaire and Structured Interview for the Hamilton Depression Rating Scale (SIGH-SAD) were used. Personality was assessed clinically and psychometrically.

In a sample of 150 depressive patients, 27 cases (18%) met DSM-IV criteria for Seasonal Affective Disorder (SAD) and other 35 cases (23%) reported lifetime seasonal variation, but hadn't recurrences of clinical depression in two consecutive years (P-SAD). The following seasonal patterns were found in the SAD group: winter depression (N = 20), summer depression (N = 5), spring depression (N = 2).

The SD and NSD groups didn't differ on socio-demographic variables, depression history and severity of the index episode. Bipolar forms and normal personality were more frequent in the SD group. The scores on the SIGH-SAD items evaluating atypical symptoms -hypersomnia, overappetite, hyperphagia, carbohydrate craving, weight gain, fatigue and social isolation- were higher in the SD group in comparison to the NSD one, the difference being statistically significant. Full remissions or a change from depression to mania/hypomania occurred more frequently in the SD group compared to the NSD group.

A relationship between seasonal depression and atypical symptom profile, favourable course and normal personality was found.

THE MAIN TENDENCIES OF COURS OF ENDOGENOUS AFFECTIVE PSYCHOSES MANIFESTATED IN CHILDHOOD

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The issue of cours of affective psychoses in children is not enough developed and needs refinement, though this problem mainly defines the preventive and correctional-educational tactics. The research was aimed at the determination of main tendencies of cours of cyclothymia and circular schizophrenia if they manifestate before the age of 12. *Methods:* prospective and clinical-statistical.

The investigation was based on 237 patients ill with cyclothimia and schizophrenia who was observed dynamically for a long time (over 10 years). The general feature of yearly started affective disorders was the tendency towards prolonged monopolar course — depressive (with reiteration of depressive phases only) or hypomaniac (with the chronicity of hypomaniac mood). In prevailing majority of cases occurred the change from monopolar cours to bipolar one near the age of 10 when the depressive phases was joined up with maniac ones or when the first depressive states arose on the background of chronic hypomania. The second peculiarity was the existence of a distinct long-standing period of active manifestations of the disease, on the conclusion of which we marked a gradual reduction of productive symptoms with the formation of long-term, sometimes probably life-long remission.

The statistical processing of catamnestic material showed the distinct dependence of the age in the moment of the end of active illness period on the age of debute manifestation. By the debute of affective psychosis before the age of 10 come the end of active illness period in adolescence, and by debut in preadolescence — in juvenile age.

COMPARISON OF THE THERAPEUTIC EFFICACY OF ELECTROCONVULSIVE THERAPY IN MEDICATION RESISTANT MAJOR DEPRESSIVE DISORDERS AND SCHIZOAFFECTIVE DISORDERS-DEPRESSIVE TYPE

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Although it is still used a relatively wide spectrum of disorders, medication-resistant major depression is currently the primary clinical indication for electroconvulsive therapy (ECT). Its antidepressant efficacy has been conclusively demonstrated in a series of double-blind studies, rigorously controlled by the use of simulated treatments. The aim of the study was to investigate and compare therapeutic efficacy of ECT in medication-resistant major depressive disorders and schizoaffective disorders-depressive type, according to DSM-IV criteria. 21 patients with major depressive disorders included in study (I group), 13 females and 8 males, age range 31–68 (mean = 48), duration of illness was from 2–30 years (mean = 12.6); and 10 patients with schizoaffective disorders-depressive type (II group), 6 males and 4 females, age range 31–61 (mean = 47.69), duration of illness 3–30 years (mean = 7.9). All patients were resistant on previous antidepressive therapy (I group) and classical neuroleptic therapy (II group). The resistance was defined as lack of satisfactory clinical improvement despite the use of at least two potent antidepressants (I group) and two classical neuroleptics (II group administrated during 3–6 months of acute phase-relapse. The number of applied ECT was 3–12 (mean = 7.6). The therapeutic efficacy of ECT was assessed by using Hamilton Rating Scale for Depression (HRSD), Beck Depression Inventory (BDI), Brief Psychiatric Rating Scale (BPRS) and Clinical Global Impressions Scale (CGI) before and after the ECT treatment. The results showed significantly improvement according to mean change from baseline in score on HRDS, BDI and BPRS after application ECT in both groups. There were no significant differences between therapeutic efficacy of ECT in therapy resistant major depressive disorders and schizoaffective disorders.

PAROXETINE LONG-TERM SAFETY AND EFFICACY IN PANIC DISORDER AND PREVENTION OF RELAPSE: A DOUBLE-BLIND STUDY

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This is the only published study to assess the role of a selective serotonin reuptake inhibitor (SSRI) in relapse prevention in a double-blind fashion. One hundred and thirty-eight responders from a 10-week, double-blind, placebo-controlled study in patients with DSM-III-R panic disorder [1] were entered into a 6-month extension study to evaluate the long-term efficacy and safety of paroxetine in panic disorder. This study comprised two phases. In the maintenance phase (MP), patients continued on current medication for 3 months, while in the randomisation phase (RP), responders were re-randomised, in a double-blind fashion, to either their current treatment or to placebo for a further 3 months. Of the 138 responders who entered MP (30 placebo, 34 paroxetine 10 mg, 34 paroxetine 20 mg, 40 paroxetine 40 mg), 76% (105 patients) continued to RP (62 placebo, 43 paroxetine combined). During MP, the efficacy of paroxetine (mean frequency of full panic attacks; mean CGI Severity of Illness; % with no full panic attacks or > 50% decrease in attack frequency) remained unchanged relative to the end of the 10-week study. Thirty per cent (11/37) of patients crossing over

from paroxetine to placebo relapsed during RP, while only 5% (2/43) of patients continuing on paroxetine treatment relapsed ($p = 0.002$; Chi-square test). The median time to relapse after crossing over from paroxetine to placebo was 14 days and for the two patients in the paroxetine group was 14 and 28 days. Paroxetine treatment for up to 6 months demonstrated continuing therapeutic efficacy, and during MP was associated with a generally lower incidence of adverse events compared with the initial 10-week study. During RP the incidence of most common adverse events was not appreciably different between the placebo and combined paroxetine groups. In conclusion, therapeutic efficacy was maintained during long term paroxetine treatment for up to 6 months and importantly, paroxetine was effective in the prevention of relapse. Furthermore, good tolerability for paroxetine was evident with a lower incidence of adverse events compared with the short-term study.

[1] Dunbar G, et al. Eur Neuropsychopharmacol 1995; 5: 361.

ELECTROCONVULSIVE THERAPY AND DO NOT RESUSCITATE — A PARADOX

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Electroconvulsive therapy (ECT) is an effective treatment for affective and schizoaffective disorders. Legislated pre-ECT requirements include: indications consultation, explanation of procedures/alternatives/benefits/risks, minimum 24 hr delayed signed consent, and competency consultation. When does it become unethical to pursue ECT even though a consent has been obtained?

This 84yowmf presented with recurrent psychotic depression. The indications consultation concluded that ECT was merited in light of historical response but that the patient had clearly verbalized her desire to refuse such treatment. The competency consultant found the patient competent to refuse. When marked deterioration occurred within one week, this same consultant found the patient to be incompetent to consent or refuse. The court concurred and empowered the family to consent.

Medical decompensation required medical center transfer and the family/internist determined a Do Not Resuscitate (DNR) code status. Hospital policy necessitated complications that occur during surgery be resuscitated. The anaesthesiologist felt comfortable not resuscitating an ECT complication — the ECT treating physician did not. This impasse was reviewed with family members who desired both ECT and DNR. The paradox was cosmetically resolved by the family rescinding DNR status for the ECT procedure only. Ultimately after detailed discussions with family/internist/primary psychiatrist/anaesthesiologist, the ECT treating physician felt it unethical to proceed, especially since the patient's last competent desire was to refuse ECT.

LACK OF TYPICAL SSRI-RELATED ADVERSE EFFECTS AND SEXUAL DYSFUNCTION WITH MIRTAZAPINE IS RELATED TO SPECIFIC BLOCKADE OF 5-HT_2 AND 5-HT_3 RECEPTORS

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Mirtazapine, a noradrenergic and specific serotonergic antidepressant (NaSSA), potentiates noradrenergic neurotransmission directly via blockade of α_2-autoreceptors, and indirectly enhances 5-HT_1 -mediated serotonergic neurotransmission. Mirtazapine directly blocks the 5-HT_2 and 5-HT_3 receptors held responsible for development of typical SSRI-related side effects such as nausea, vomiting, diarrhea, insomnia, agitation and symptoms of sexual dysfunction. This novel pharmacological profile was expected to result in improved tolerability of the drug. We therefore analyzed the data of all patients (mirtazapine n = 359; placebo n = 328) who took at least one dose of study medication while participating in placebo-controlled studies of mirtazapine. Side effects where coded according to the WHO terminology. The data show that there are no statistically significant nor clinically relevant differences between mirtazapine and placebo regarding incidences of typical SSRI-related side effects. Only 2 symptoms typical of sexual dysfunction were registered during the use of mirtazapine: libido decreased (male), with incidence lower than in the placebo group (4% vs 7%), and libido decreased (female) with incidence equal to placebo group (4% vs 4%). Our analysis demonstrates that *in vitro* and *in vivo* data regarding mirtazapine's receptor binding profile can explain clinical data obtained during treatment of depressed patients. It may be concluded that the "designed" receptor binding profile of mirtazapine results in improved tolerability with respect to typical SSRI-related side effects.

CASE STUDY OF A PATIENT WITH DEPRESSIVE EPISODES WITHIN A COMPLEX BORDERLINE-, COMPULSORY- AND ANXIETY DISORDER. MEDICAL, PSYCHOTHERAPEUTIC AND REHABILITATION TREATMENT IN A COMMUNITY BASED PSYCHO-SOCIAL CENTRE

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The patient contacted the centre at the age of 23. Anxiety symptoms appeared when she was 8. At highschool loneliness, obsessive and compulsive disorders increased. A lack of sustaining power, the above mentioned problems and depressive episodes stopped her studies. She ceased all following jobs and the working time abridged from months to days. Diagnoses were based on phsychological testing and psychiatric interviews. The concept of therapy and care followed three main topics.

1.) Medical treatment: The maximum dosage she agreed to was 20 mg Fluoxetin per day. She complained of inner unrest several times. To prevent quitting all medication it was changed to Fluvoxamin 100 mg per day and after some months without side effects to 200 mg per day. This especially decreased the compulsory symptoms. The aggressive behavior relaxed and the anxiety descended a little, so that psychotherapy became possible. The patient tried to stop once, but the old symptoms appeared again, so she continued.

2.) Psychotherapeutic approach: Cognitive behavior therapeutic methods for anxiety and compulsary symptoms. Supporting her search for her place in a world which seems to be composed of extremities. Finding realistic goals by the patient and fixing small steps to reach them.

3.) Working rehabilitation: One attempt in a job finding course failed. Since August 1995 she has been working in a centre for work training up to this day.

Conclusion: For the treatment of complex disorders approaches from different sides are essential. The demanded flexibility is only possible in a multiprofessional team, which is very well embeded in and synergicing all possibilities attainable in the local area. Although only small improvements are reachable, they represent a big step in the quality of life to the patient.