

and 1998 the time consulting requested were 100% respected. A few innovations have been introduced: morning meetings, mobile phones, list of the primary care physicians in our district and the data base. QM is related to need of producing documents for accreditation in accordance with Italian law. At the moment we are on the way to obtain certification according to ISO 9002 laws, by an improvement of documents for accreditation: Quality Assurance Plan, organisation chart, job description, responsibility matrix, product standard, consulting request procedure, guidelines (for attempted suicide, delirium, abortion), special services (diagnosis and therapy for psychiatric comorbidity, psychosomatic diagnosis for patients with cardiovascular diseases). This experience contributed in giving importance and recognition to the Service, both locally and nationwide (e.g. gave rise consulting requests by other Italian C-L Services).

S46.03

CONSULTATION-LIAISON PSYCHIATRY IN EUROPE: CURRENT ISSUES – THE IMPORTANCE OF COST-EFFECTIVENESS STUDIES

F. Creed. *School of Psychiatry & Behavioural Sciences, Rawnsley Building, Manchester Royal Infirmary, UK*

Background: Consultation-liaison psychiatry services are unlikely to be commissioned across Europe unless we can demonstrate their cost-effectiveness. We have previously demonstrated the effectiveness of psychological treatment for irritable bowel syndrome. The aim of the present study was to establish whether these treatments could be generalised and, if so, whether they were cost-effective.

Methods: Patients with moderate to severe irritable bowel syndrome were randomly allocated to either seven sessions of individual psychotherapy or 20 mgs of paroxetine daily for three months or routine care by gastroenterologist and general practitioner. Abdominal pain, bowel symptoms and health-related quality of life, healthcare and other costs were assessed after the three month treatment period and at follow-up one year later.

Results: 257 (81% of eligible subjects) from seven hospitals were recruited to the trial. 69% of psychotherapy and 50% of the antidepressant group completed the course of treatment. Abdominal pain and bowel symptoms improved slightly in all groups; there was no significant difference between the groups at 12 months follow up. Both psychotherapy and antidepressants were superior to treatment as usual in improving the SF-36 physical component score ($p < 0.0005$). The same pattern was recorded at 3 months for the mental component score ($p = 0.007$), but not at follow-up. Psychotherapy, but not antidepressant treatment, was associated with significant lower total costs during the follow-up compared to treatment as usual year [\$1,674 (sd = 1,798) v \$2,361 (sd = 3636)]. Psychotherapy also led to a significant reduction in the number of people on sickness benefit.

Conclusions: Patients with moderate to severe IBS, which has not responded to conventional therapy, attend all gastroenterology clinics. Their number is greatest in tertiary referral clinics. A significant improvement in health-related quality of life can be offered by psychological treatments but these do not improve bowel symptoms.

S46.04

CONSULTATION-LIAISON PSYCHIATRY AND PSYCHOSOMATICS: QUALITY MANAGEMENT AND GUIDELINE DEVELOPMENT – A EUROPEAN PERSPECTIVE

T. Herzog

No abstract was available at the time of printing.

S47. Neuropsychiatry of brain injury

Chair: S. Fleminger (UK)

S47.01

ABULIA FOLLOWING BRAIN INJURY

K. Barrett

No abstract was available at the time of printing.

S47.02

TREATMENT OF AFFECTIVE DISORDERS AFTER BRAIN INJURY

P. Eames. *Grafton Manor Brain Injury Rehabilitation Unit, Grafton Regis, Northamptonshire, UK*

Brain injury can disturb affect in a number of quite distinct ways; before rational treatment can be planned, it is essential that the particular individual's disorder be analysed carefully, so that appropriate steps can be taken. The least common disorders are those that closely resemble (and sometimes are) 'typical' depressive illness or hypomania: these require traditional treatments, though there are some necessary caveats related to potential adverse effects that are particularly likely in the already injured brain. Probably the most common disorder is depression of mood reactive to the person's changed circumstances as a result of the injury, though most often this can be dealt with simply by giving adequate support and information to both the person and his or her family. The most important disorders to learn to recognise, because they are not widely enough known and need very specific treatment, are the quite common episodic mood disorders. The characteristics of the various forms of affective disorders will be presented and details of treatment regimes will be discussed.

S47.03

PHARMACOTHERAPY OF NEUROPSYCHIATRIC DISORDERS FOLLOWING BRAIN INJURY

U. Müller. *Department of Psychiatry, University of Leipzig, 22 Liebigstr., 04103 Leipzig, Germany*

Background: Neuropsychiatric disorders like depression, apathy, anxiety and post-traumatic stress disorder, sleep disturbances, aggression and agitation are common findings after traumatic brain injury (TBI). The correct diagnosis and optimal treatment of psychiatric complications has a strong impact on the outcome of patients with both mild and severe forms of TBI. Cognitive deficits like aphasia, amnesia, working memory and attentional deficits have recently become a new focus of pharmacotherapy after TBI.

Methods: A literature search in MEDLINE and PsychINFO databases was performed, specialized journals and textbooks were screened to retrieve relevant publications. Proposals for pharmacological treatment are also based on the author's own clinical experiences.

Results: There is only a limited number of randomized controlled trials, most publications are open studies, case series or single case reports. Some evidence-based recommendations can only be given for the treatment of depression and agitation after TBI.

Conclusions: (1) The first principle in pharmacotherapy of neuropsychiatric disorders following TBI is to avoid neurotoxic medications. Cognitive, epileptogenic, and neuroplasticity-decreasing