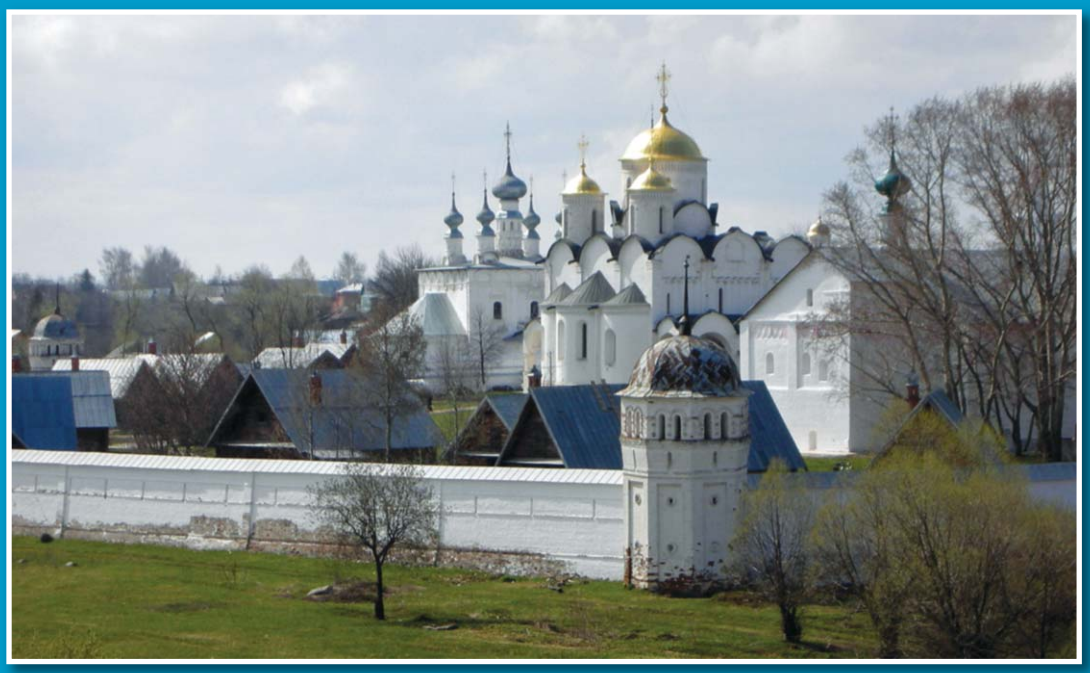

ECNP Seminar

in Neuropsychopharmacology

16–18 April 2013, Suzdal, Russia

ECNP

Introduction

The European College of Neuropsychopharmacology (ECNP) was established in 1987 on the initiative of scientists and clinicians working in Europe in the convergent disciplines in neuropsychopharmacology and related neurosciences.

ECNP aims to widen knowledge in regard to central nervous system disorders, and to increase awareness, recognition and improvement of the treatment of these disorders. To fulfil this aim ECNP organises, amongst others, yearly the ECNP Congress that comprises at least 3 plenary lectures, 28 symposia and 6 educational update sessions. The latter sessions target issues such as updates on evidence-based treatment and new developments in the preclinical area that influence the clinical field. The annual meeting attracts more than 7,000 participants and is considered to be the largest event in neuropsychopharmacology in Europe.

ECNP also supports on an annual basis participation of 100 young psychiatrists and researchers in an intensive three-day Workshop in Nice. Other activities of ECNP include the journal European Neuropsychopharmacology that promotes scientific knowledge along with publishing consensus statements. These consensus statements are products of an annual meeting with delegates from the scientific community in neuropsychopharmacology (scientists and clinicians), European regulators and industry in which discussion about issues such as use of placebo, guidelines for long-term maintenance are discussed. In addition, since 2009 ECNP organises a summer school of neuropsychopharmacology in Oxford, since 2012 a school of child and adolescent neuropsychopharmacology in Venice and since 2013 a school of old age neuropsychopharmacology in Venice.

Finally, ECNP organises seminars, as the one you have been invited to participate, in areas where there are less opportunities for psychiatrists to participate in international meetings. So far, ECNP has organised this meeting in Poland, Estonia, Turkey, Bulgaria, Slovak Republic, Hungary, Czech Republic, Moldova, Romania and Greece. Interaction is the keyword at these meetings and they have proved very successful both for the participants and for the faculty.

Please see the ECNP website (**www.ecnp.eu**) where you can find information about the above initiatives and additional information.

I look forward to a fruitful and inspiring meeting in Russia!

Celso Arango, MD
Chair ECNP Educational Committee

Provisional programme
ECNP Seminar in Neuropsychopharmacology 16-18 April 2013, Suzdal, Russia

TUESDAY 16 APRIL 2013

Arrival of participants and experts	
19.00	Welcome and dinner

WEDNESDAY 17 APRIL 2013

09.00 – 09.15	Introductions to the programme, Celso Arango, Spain
09.15 – 10.00	Updates in the treatment of acute psychoses, Celso Arango, Spain
10.00 – 10.45	Choosing the adequate antidepressant treatment, Alessandro Serretti, Italy
10.45 – 11.30	Coffee break
11.30 – 12.15	Update on Alzheimer's disease treatment, Michael Davidson, Israel
12.15 – 12.30	How to give a talk, Celso Arango, Spain
12.30 – 13.30	Lunch
Presentations participants in 3 groups in 3 parallel workshops	
Round 1	
13.30 – 15.00	Celso Arango and Sergey Mosolov
Group 1	Alessandro Serretti and Margarita Morozova
Group 2	Michael Davidson and Elena Kostioukova
Group 3	
15.00 – 15.15	Break
15.15 – 15.45	How to prepare a scientific paper. Celso Arango, Spain
16:00 – 21.00	Cultural event and dinner

THURSDAY 18 APRIL 2013

Presentations participants in 3 groups in 3 parallel workshops	
Round 2	
08.30 – 10.00	Celso Arango and Sergey Mosolov
Group 2	Alessandro Serretti and Margarita Morozova
Group 3	Michael Davidson and Elena Kostioukova
Group 1	
10.00 – 10.30	Coffee break
Round 3	
10.30 – 12.00	Celso Arango and Sergey Mosolov
Group 3	Alessandro Serretti and Margarita Morozova
Group 1	Michael Davidson and Elena Kostioukova
Group 2	
12.00 – 14.00	Lunch and preparation for plenary session
Plenary 14.00 – 15.00	
14.00 – 14.20	
Group 1	Presentation
14.20 – 14.40	
Group 2	Presentation
14.40 – 15.00	
Group 3	Presentation
15.00 – 15.15	Preparation of awards ceremony
15.15 – 15.30	Short break
15.30 – 15.45	Awards ceremony
15.45 – 16.00	Concluding remark and thanks, Celso Arango, Spain

CURRICULUM VITAE
Celso Arango

Celso Arango, MD, PhD is a psychiatrist and Associate Professor of Psychiatry at the University of Maryland in Baltimore and Full Professor of Psychiatry at the Universidad Complutense in Madrid. He is also Head of the Child and Adolescent Department of Psychiatry at Hospital General Universitario Gregorio Marañón. Dr. Arango is the Scientific Director of the Spanish Psychiatric Research Network with 25 centers and more than 400 researchers. He is also Coordinator of the Child and Adolescent First-Episode Psychosis Study (CAFEPS) funded by the Spanish Ministry of Health (with eight centers in Spain) and the Child and Adolescent Neuropsychiatry Network funded by the European

College of Neuropsychopharmacology (ECNP). He has written more than 240 peerreviewed articles, 6 books, and more than 35 book chapters. Many of his articles and book chapters have focused on the neurobiology of early-onset and first-episode psychoses as well as the safety of psychiatric medications in pediatric patients. In addition, his group has shown how patients with a first psychotic episode experience greater losses of gray matter than expected and a correlation of gray matter loss with antioxidant status. Dr. Arango has participated in more than 62 competitively funded research projects, as Principal Investigator in 46 of them, including projects with international funding (Stanley Foundation, NARSAD, European Commission, etc.) and several clinical drug trials. He is also coordinator of several multicenter projects that assess multiple prognostic factors and treatment in early-onset psychosis, and is currently participating in five EU projects funded by the VII Framework.

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How to prepare a scientific presentation

Celso Arango

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Before you start

- What does the audience already know about your topic?
- What are their interests?
- Why are you giving presentation?

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Before you start

- What is your desired outcome?
- How much time do you have?
- What are key points?

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Common Causes of Ineffective Presentations

- Failure to prepare the talk
- Confusing structure/not giving take home messages
- Gaps in logic
- Poorly designed slides
- Poor delivery

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Organizing a Presentation

i. Outline
ii. Problem and background
iii. Design and methods
iv. Major findings
v. Conclusion and recommendations

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Making slides

- Main points only
- One idea per slide
- Short words, few words (5 per line)
- Strong statements: active voice

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The start

- Let audience know what they are going to hear
- Let them know how the presentation will be organized

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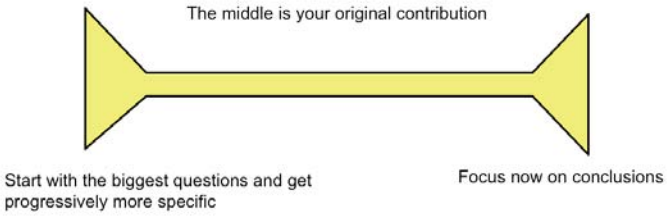
Start broad, get specific, and end broad



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Introduction

- Context
- Study question
- Relevant knowledge on issue

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Major findings

- Text and or table/graph
- One slide for each
- Message should be unambiguous

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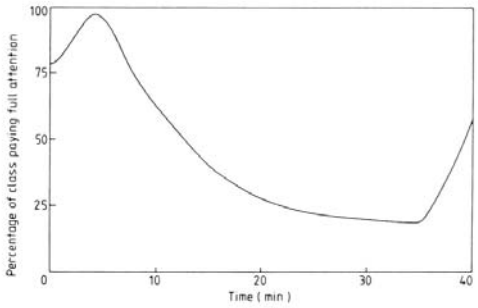
Audience attention curve



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Conclusion and Recommendations

- Key points
- Implications
- One slide for each message

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Formal aspects

•AVOID USING ALL CAPITAL LETTERS BECAUSE IT'S REALLY HARD TO READ!

•Dark letters against a light background (or the opposite) work

•Avoid some colour combinations (red-green)

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Formal aspects

•Choose style that supports the tone

•Apply the same style to each slide

•**Don't Say It, Show It**

Be consistent!

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Formal aspects

•Every slide should have a heading.

•Lists should contain no more than 3-4 items

•Limit text blocks to no more than two lines each.

•Be careful with the pointer!

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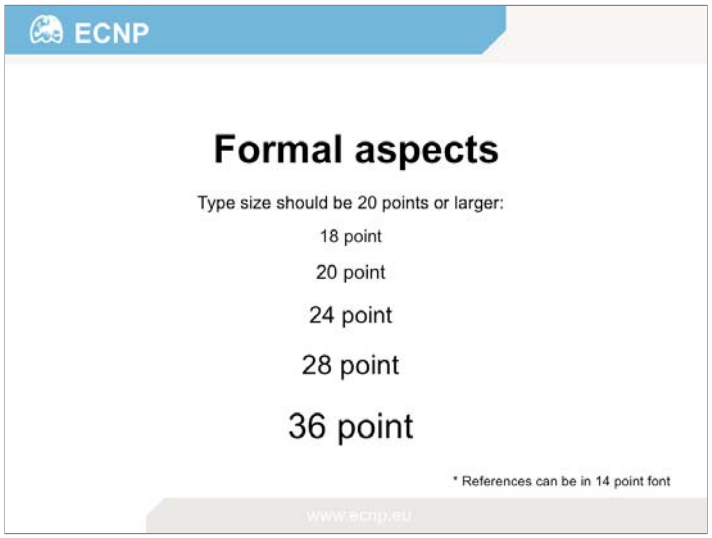
ECNP
Formal aspects
Type size should be 20 points or larger:
18 point
20 point
24 point
28 point
36 point
* References can be in 14 point font
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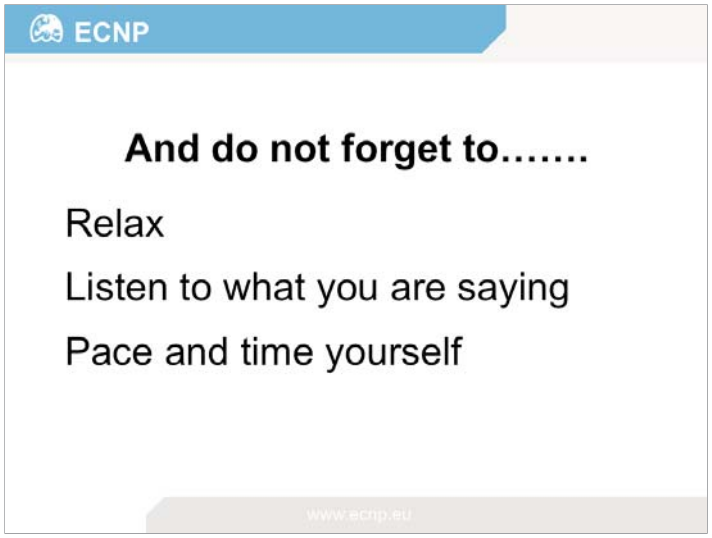
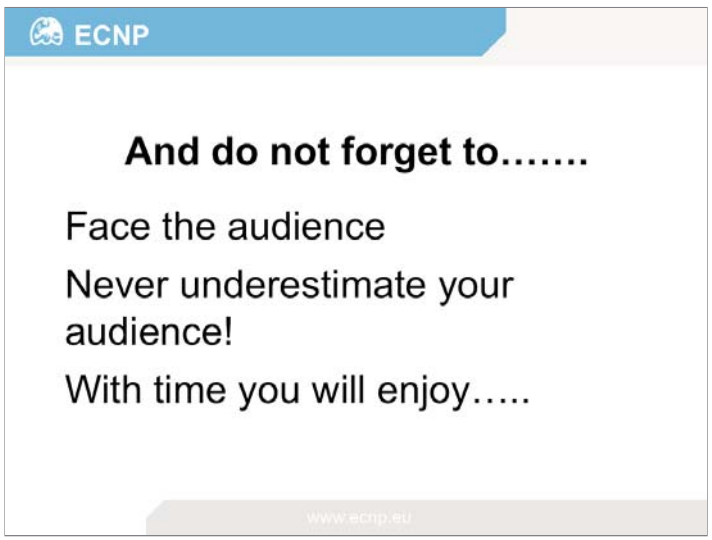

ECNP
And do not forget to…….
Relax
Listen to what you are saying
Pace and time yourself
www.ecnp.eu


ECNP
And do not forget to…….
Face the audience
Never underestimate your audience!
With time you will enjoy…..
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How to prepare a scientific presentation

"Tell me and I will forget, show me and I will remember, involve and I will understand"

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How to prepare a manuscript

Celso Arango

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Categories

- Original research (focus of this talk)
- Reviews (invited vs. not invited)
- Case reports/series
- Letter to the editor

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The Journal

- Does the article fit the aims and scope of the Journal?
  - Choose before writing
  - General vs. subespecialty journal
- Read the table of contents of potential journals
- Examine several articles in potential journals
- Which journals will you cite in your article?

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Sequence

- The syndrome of the blank screen
- Figures, tracings, tables
- Methods and Results
- Discussion and Introduction
- Abstract and Title

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Tables and Figures

- Do before writing
- Exceed 1 sheet: redraw
- If small: move data to text
- Should be able to stand alone

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Methods

- Draft can be made while doing the study
- Enough information for an experienced investigator to repeat your work
- Avoid tiresome detail
- Tables preferred to long list of numbers or statistics

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Methods

- Refer to data (Fig. X, Table Y)
- Do not repeat numbers in Tables
- Include ethics information (with Ethics Committee approval and i.c.)
- Include complete statistics section

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Discussion

- First paragraph
  - State major findings
- Last paragraph
  - "In summary…" (2-3 sentences)
  - "In conclusion…" (biggest mensage, return to Intro, avoid speculation, avoid "need more work"

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Discussion

- Middle paragraphs
  - Base each on a major result
- Always focus on your results
- Explain what is new without exaggerating
- Never discuss prior work without reference to your work (but do not forget appropriate identification of prior research)

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Discussion

- Refer Tables and Figures
- Do not repeat results
- Include limitations section

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Introduction

- Keep it short. In most cases 3 graphs make it.
  - 1. Why the study is interesting (broad)
  - 2. Why did we do it? (specific)
  - 3. Hypothesis

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Abstract

- Is your visiting card
- In most cases make the editor to send the ms to reviewers or reject it.
- Some numbers, but not in excess
- Determines if paper will be read
- Is distributed freely in databases
- Avoid acronyms

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Title

- Max information in least words
- The title is an invitation to read the paper
- Use catchy titles
- State results

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Keywords

- Make them easy for indexing and searching! (if you want to be cited)

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References

- Cite the Journal you are submitting the paper to
- Reviewers may be selected from your references
- Use editing programs
- Relevant and recent

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The context

- Need stretch of several hours
- Avoid distractions: phone, e-mail
- Ideas come while writing

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First draft

- Write as quickly as possible
- As if thinking out loud
- Get everything down
- Ignore spelling, grammar, style
- Correct and rewrite only when the whole text is on paper
- Do not split the manuscript among the co-authors

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Introduction

- Context
- Study question
- Relevant knowledge on issue

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Major findings

- Text and or table/graph
- One slide for each
- Message should be unambiguous

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Formal aspects

- Avoid ambiguity
- Concise: Least words, short words, one word vs many
- Strengthen transition between sentences

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Formal aspects

- Check narrative flow: tell a story that the reader wants to read from start to end
- Smooth transitions
- Writing improves in proportion to deletion of unnecessary words
- Keep senteces short

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Formal aspects

- After the second draft send ms to your coauthors
- After the suggestions have been incorporated leave it for some time a re-read

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Formal aspects

- **If you do not have time to check the spelling you may have not had time to check the quality of your experiments.....**

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Formal aspects

- Prepare article, figures and table according to the journal's 'Guide for Authors'
- Adherence to the style of the journal is crucial
- Check references
- Check and double check your work

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Authorship

- Decided as early as possible
- The journal has instructions on who should/should not be an author
- Basically all authors should have done a major contribution to the study

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Authorship

- Approval of final version must be obtained from all coauthors before submission
- The first author is primarily responsible for collecting and analyzing data, and writing

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Authorship

- The manuscript is not under consideration elsewhere and will not be submitted elsewhere until a final decision has been made by the journal
- All funding sources must be acknowledged
- All conflicts of interest should be reported

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Peer Review

- Authors write
- Reviewers comment
- Editors decide
- Readers read (only what they like)

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Peer Review

- Peer review helps to determine the significance, contribution to what is already known and originality of research
- Most journals reject some paper prior to peer review (on basis of Editor's own evaluation)
- Usually 2-3 reviews sought (per manuscript)

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Possible Decisions

- Reject (up to 90-95% in good journals, do not give up!)
- Major revisions required (it will be reviewed again, may be rejected)
- Minor revisions needed (usually accepted)
- Accepted (congratulations! Enjoy and celebrate!)

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Response to the editor

- Reviewer´s are (almost) always right. Editor is always right.
- Response to all the comments in a nice and polite way
- Thank the reviewers for their contribution

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When the study is negative

- If your result is not as expected, you should understand the reason. It may be something really new. (Must find out why it did "not work" in the expected way!)

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"Scientists are rated by what they finish, not by what they attempt"

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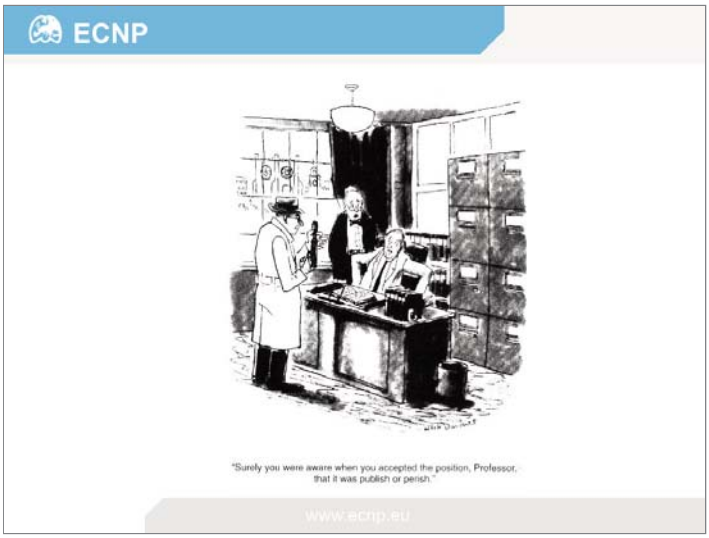
ECNP
"Surely you were aware when you accepted the position, Professor, that it was publish or perish."
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Abstracts

Celso Arango
Hospital General Universitario Gregorio Marañón, CIBERSAM,
School of Medicine, Universidad Complutense, Madrid, Spain.

The first episode of psychosis is a critical period in the course of each patient's illness and perhaps the most important opportunity for therapeutic intervention. The first experience of the patients with the psychiatric system should be less traumatic as possible. The treatment provided in the emergency setting should not jeopardize long-term objectives. This also includes that whenever is possible the patients is given the option to choose among different recommended treatments. Randomized controlled trials show no difference between different antipsychotics in terms of efficacy for the short-term acute treatment of psychosis. Main differences between antipsychotics are more markedly in side effects. This is even more important for pediatric patients that seem more vulnerable to some of these side effects. In the acute setting benzodiazepines are sometimes of great help. For the treatment of mania many different therapeutic options have shown to be effective. Second generation antipsychotics are used more frequently nowadays to treat acute mania. Patients usually need lower doses than used with more chronic patients. Recovery is a multidensional process, improving psychotic symptoms is not the most difficult task for the clinician. Engaging the patient with a good therapeutic alliance, reducing the risk of lack of adherence and provide the proper psychoeducation are more difficult tasks that influence the long-term prognosis.

Treatment of Acute Psychoses

Celso Arango
Hospital General Universitario Gregorio Marañón,
Madrid, Spain
carango@hggm.es
Russia, April 2013

Index

- Review of first episode studies
- Treatment in the acute setting
- Treatment of acute mania
- Special Population: children and adolescents
- Discussion

The first episode of psychosis is a critical period in the course of each patient's illness and perhaps the most important opportunity for therapeutic intervention

Placebo-Controlled First-Episode Maintenance Trials

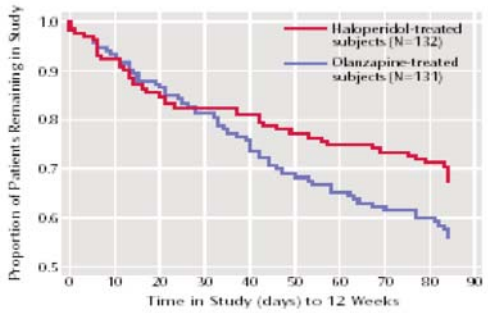
	Relapse Rate (%) Placebo	Relapse Rate (%) Antipsychotic	*P*-value
Kane et al, 1982	41 (7/17)	0 (0/11)	<0.01
Crow et al, 1986	62 (41/66)	46 (25/54)	0.002*
McCreadie, et al (Scottish Schizophrenia Research Group), 1989	57 (4/7)	0 (0/8)	NS
Hogarty and Ulrich, 1998	64	43	N/A

*When period between onset of index episode and hospital admission is taken into account

Kane JM et al. *Arch Gen Psychiatry.* 1982;39:70; Crow TJ et al. *Br J Psychiatry.* 1986;148:120; McCreadie RG et al. *Acta Psychiatr Scand.* 1989;80:597; Hogarty GE, Ulrich RF. *J Psychiatr Res.* 1998;32:243

Olanzapine vs haloperidol

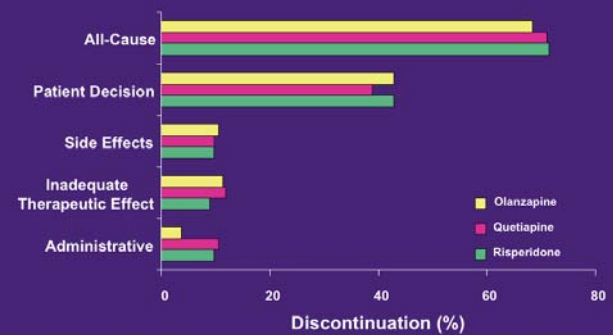
FIGURE 1. Time to Study Discontinuation for Any Reason of Subjects With First-Episode Psychosis in the 12-Week Acute Treatment Phase of a Long-Term Comparison of Olanzapine and Haloperidol[a]



[a] No significant difference between treatment groups in time to discontinuation (p=0.06, log rank test).

Lieberman et al, Am J Psychiatry 2003;160(8):1396-404

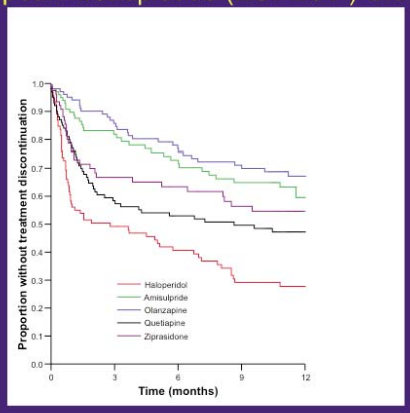
Primary Outcome: All-Cause Treatment Discontinuation



For each category above, the comparison of quetiapine vs olanzapine and quetiapine vs risperidone met the *a priori* test of noninferiority (20%) at *P*<0.05

McEvoy et al 2007

European first episode (EUFEST) Study



Time to treatment discontinuation for any cause

First-Episode Patients: Lower Medication Doses Than Multi-Episode Patients

Study	Mean Modal Daily Dose (mg)
Lieberman et al 2005	Haloperidol: 4.4 Olanzapine: 9.1
Schooler et al 2005	Haloperidol: 2.9 Risperidone: 3.3
Robinson et al 2006	Olanzapine: 11.8 Risperidone: 3.9
McEvoy et al 2007, Am J Psychiatry. In press	Olanzapine: 11.7 Quetiapine: 506 Risperidone: 2.4

Lieberman J et al. *Eur Neuropsychopharmacol*. 2005;15(suppl 3):S526; Schooler N et al. *Am J Psychiatry*. 2005;162:947; Robinson DG et al. *Am J Psychiatry*. 2006;163:2096; McEvoy JP et al. 2007. *Am J Psychiatry*. 2007

Treatment goals in the emergency setting

- Reducing acute symptoms
- Minimising risk of harm
- Calming agitation
- Improving role functioning

Achieving these goals must not be at the expense of long-term treatment objectives

Arango & Bobes 2004

Patient requirements and preferences in the acute setting

- Receive a rapid and accurate diagnosis
- Be offered a choice of treatment
- Benefit from a good therapeutic alliance
- Receive verbal rather than physical interventions
- Receive oral medication

Allen et al 2003; Arango & Bobes 2004; Allen et al 2005

Recovery is a multidimensional process

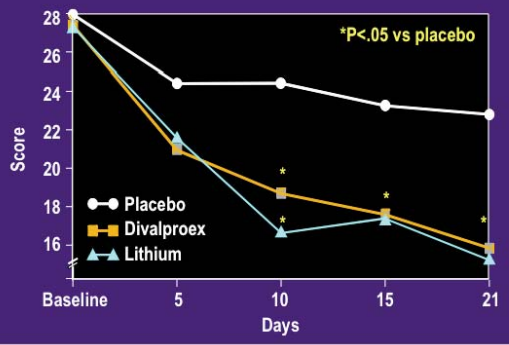
- Quality of life
- Control of symptoms
- Social and family interactions
- Relapse prevention
- Daily functioning
- Improved cognition
- Return to work
- Overcoming stigma

Fenton et al 1997; Lacro et al 2002

Treatment Options for Acute Mania

- Classical antipsychotics
- Atypical antipsychotics
- Lithium
- Valproate
- Carbamazepine
- Combinations
- Benzodiazepines
- ECT

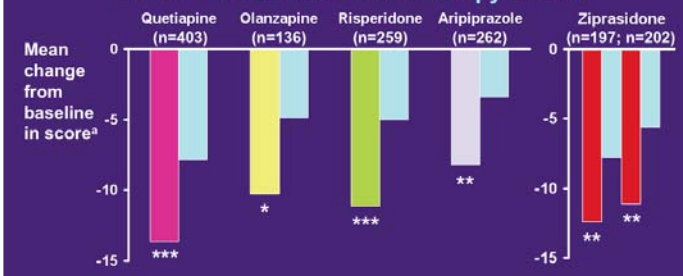
Divalproex vs Lithium vs Placebo



Bowden CL, et al. *JAMA*. 1994;271(12):918-924.

Efficacy of atypical antipsychotics: improvement in manic symptoms

Data from 6 selected monotherapy studies

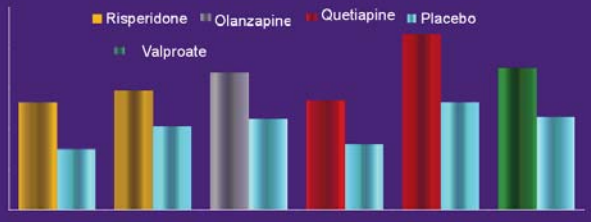


[a]Ziprasidone: SADS-C MRS; others: YMRS; columns are active drug vs placebo
*p<0.05; **p≤0.01; ***p<0.001 vs placebo

Vieta et al, 2005; Tohen et al 1999; Hirschfeld et al 2002; Keck et al 2003; Keck et al 2003; Segal et al 2003

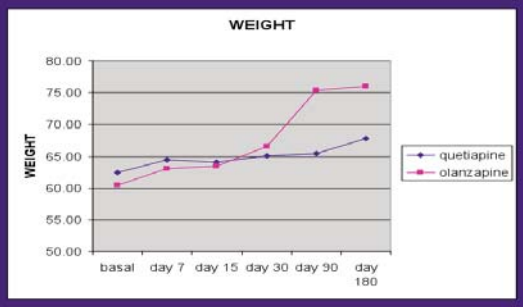
Atypical Antipsychotics As Adjunct to Mood Stabilizers Vs. Mood Stabilizer Monotherapy

Response Rate (≥50% Reduction YMRS)



Sachs et al. 2002 (3 wks, n=156, YMRS=28), Yatham et al. 2003 (3 wks, n=151, YMRS=29), Tohen et al. 2002 (6 wks, n=344, YMRS=22), Sachs et al. 2002 (3 wks, n=190), Delbello et al. 2002 (6 wks, n=30, YMRS=33).

Change in weight over time by treatment group olanzapine/quetiapine



Arango et al, 2009

Metabolic side effects in young people treated with second-generation antipsychotics

At risk for adverse health outcome
- BMI≥95 or
- BMI>85 +
  - •hypertension >90th or
  - •fasting cholesterol≥ 200mg/dl or
  - •LDL cholesterol > 130 or
  - •HDL cholesterol <40 or
  - •TGC≥150 or
  - •Hyperglycaemia ≥110 mg/dl)

At risk adverse	Baseline	6 month
RIS	22.7%	36.4%
OLZ	15.0%	60.0%*
QTP	12.5%	20.8%

* p<0.05

Significant weight gain
Defined as > 0.5 increase in body mass index (BMI) z-score (adjusted for age and gender) at 6 months
RIS: 50%
OLZ: 75%*
QTP: 29%
*p<0.01

- **Total cholesterol** increased in patients receiving olanzapine (p=0.047) and quetiapine (p=0.016).
- •Treatment with quetiapine was associated with a decrease in **free thyroxin** (p=0.011).

Fraguas et al, J Clin Psychiatry 2008

SATIETY study design

Treatment with all antipsychotics was associated with changes in metabolic parameters at 12 weeks

All values refer to mean change from baseline (p value)

	Aripiprazole (n=41)	Olanzapine (n=45)	Quetiapine (n=36)	Risperidone (n=135)	Untreated (n=15)
Weight (kg)	4.44 <0.001	8.54 <0.001	6.06 <0.001	5.34 <0.001	0.19 0.77
Fat mass (kg)	2.43 <0.001	4.12 <0.001	2.82 <0.001	2.45 <0.001	0.35 0.39
Waist (cm)	5.40 0.001	8.55 <0.001	5.27 <0.001	5.10 <0.001	0.70 0.40
Glucose (mg/dl)	0.54 0.76	3.14 0.02	2.64 0.12	1.14 0.26	0.69 0.81

Correll CU, *et al. JAMA* 2009:302;1765–1773.

Treating first-episode patients

The most difficult task is not getting them to respond to treatment, but getting them to *continue* to take medication

The course of an acute episode of psychoses can be directed towards successful treatment outcomes by…

- Prompt intervention with agents that are well tolerated
- Initiating a programme of long-term therapy (including social services, psychoeducation, accessibility to health facilities and intervention with family is possible) to maintain and build upon the initial success of treatment
- Consider polypharmacy in the acute treatment of bipolar disorders
- Ensuring a positive experience in the acute setting and establishing an interactive therapeutic alliance

Alessandro Serretti

Choosing the adequate antidepressant treatment

Alessandro Serretti
Institute of Psychiatry, University of Bologna, Italy.

Selective Serotonin Reuptake Inhibitors (SSRI) are the first line treatment for depressive disorder according to all Guidelines. Tricyclic Antidepressants (TCA) present some advantages in the most severe forms of depression but with a heavy tolerability toll. The choice of the best drug for each patient is a formidable challenge for the clinician, in the future we will rely on pharmacogenetic indications, but as for now we must use evidence coming from clinical studies.

Regarding SSRIs, tolerability, though good, is not perfect. In fact weight gain and sexual dysfunctions are frequently observed. Antidepressants' effect on weight varies depending on specific drug administered and also on specific class (SSRIs, TCAs, etc.). At present, there are no formal indications out than clinical experience about the choice of the drug antidepressant considering weight gain. We conducted a meta-analysis for each antidepressant drug. Both TCA and SSRIs greatly differed in this effect. Amitriptyline, mirtazapine and paroxetine had the highest impact on weight while bupropion the lowest.

Regarding sexual dysfunction, another meta-analysis of ours revealed significantly higher rates of total treatment emergent sexual dysfunctions compared to placebo for the following drugs: sertraline (absolute percentage value (APV)=80.5%, OR versus placebo=32.71), citalopram (APV =78%, OR=27.72), paroxetine (APV=72%, OR=19.9), fluoxetine (APV=70%, OR=19.4), escitalopram (APV=37%, OR=3.53) and fluvoxamine (APV=30%, OR=3.73).

In conclusion SSRIs are valuable in a wide range of conditions, their tolerability is high but some adverse events occur, in the present overview we give indications of specific efficacy and tolerability profile for each compound in order to allow the clinician to better choose the best individualized treatment.

Choosing the adequate antidepressant treatment

Prof. Alessandro Serretti, MD, PhD
Institute of Psychiatry
University of Bologna, Italy

Disclosure: Dr. Serretti is or has been consultant/speaker for: Abbott, Astra Zeneca, Clinical Data, Boheringer, Bristol Myers Squibb, Eli Lilly, GlaxoSmithKline, Janssen, Lundbeck, Pfizer, Sanofi, Servier.

Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis

Andrea Cipriani, Toshiaki A Furukawa, Georgia Salanti, John R Geddes, Julian P T Higgins, Rachel Churchill, Norio Watanabe, Atsuo Nakagawa, Ichiro M Omori, Hugh McGuire, Michele Tansella, Corrado Barbui

Lancet 2009; 373: 746–58
Published Online January 29, 2009
DOI:10.1016/S0140-6736(09)60046-5
See Comment page 700

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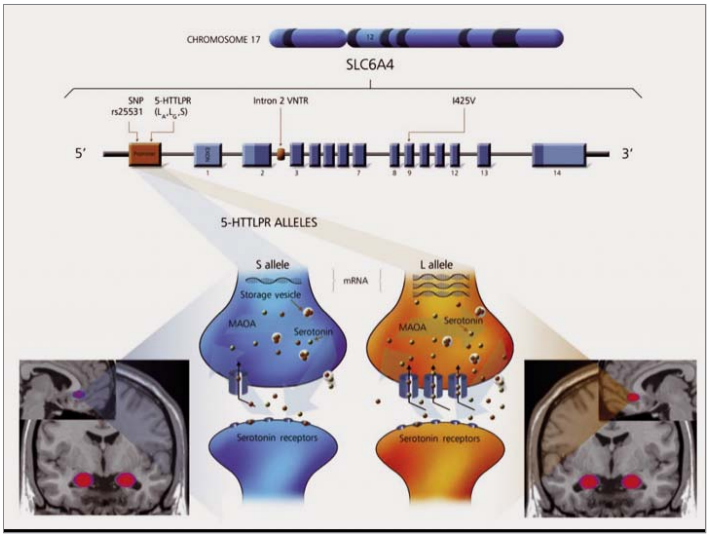
Summary

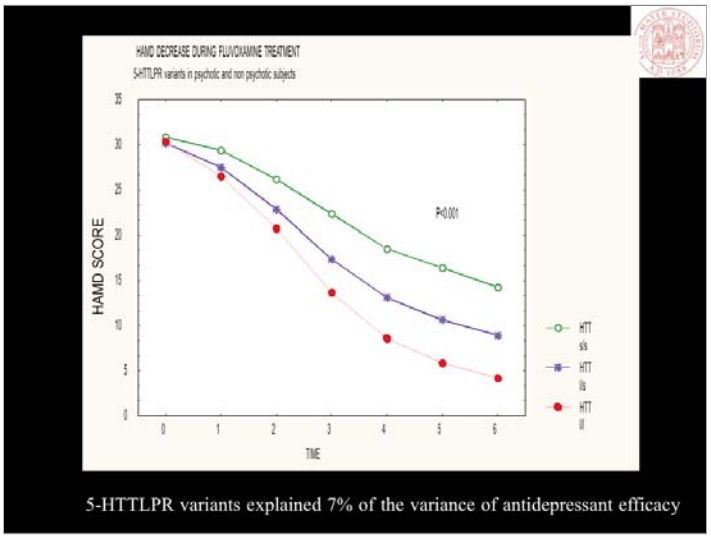
Background Conventional meta-analyses have shown inconsistent results for efficacy of second-generation antidepressants. We therefore did a multiple-treatments meta-analysis, which accounts for both direct and indirect comparisons, to assess the effects of 12 new-generation antidepressants on major depression.

Methods We systematically reviewed 117 randomised controlled trials (25 928 participants) from 1991 up to Nov 30, 2007, which compared any of the following antidepressants at therapeutic dose range for the acute treatment of unipolar major depression in adults: bupropion, citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, milnacipran, mirtazapine, paroxetine, reboxetine, sertraline, and venlafaxine. The main outcomes were the proportion of patients who responded to or dropped out of the allocated treatment. Analysis was done on an intention-to-treat basis.

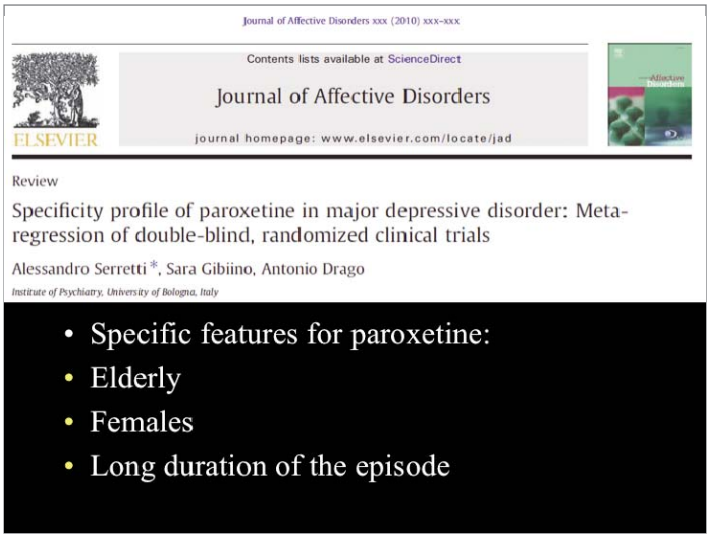
Findings Mirtazapine, escitalopram, venlafaxine, and sertraline were significantly more efficacious than duloxetine (odds ratios [OR] 1·39, 1·33, 1·30 and 1·27, respectively), fluoxetine (1·37, 1·32, 1·28, and 1·25, respectively), fluvoxamine (1·41, 1·35, 1·30, and 1·27, respectively), paroxetine (1·35, 1·30, 1·27, and 1·22, respectively), and reboxetine (2·03, 1·95, 1·89, and 1·85, respectively). Reboxetine was significantly less efficacious than all the other antidepressants tested. Escitalopram and sertraline showed the best profile of acceptability, leading to significantly fewer discontinuations than did duloxetine, fluvoxamine, paroxetine, reboxetine, and venlafaxine.

Interpretation Clinically important differences exist between commonly prescribed antidepressants for both efficacy and acceptability in favour of escitalopram and sertraline. Sertraline might be the best choice when starting treatment for moderate to severe major depression in adults because it has the most favourable balance between benefits, acceptability, and acquisition cost.

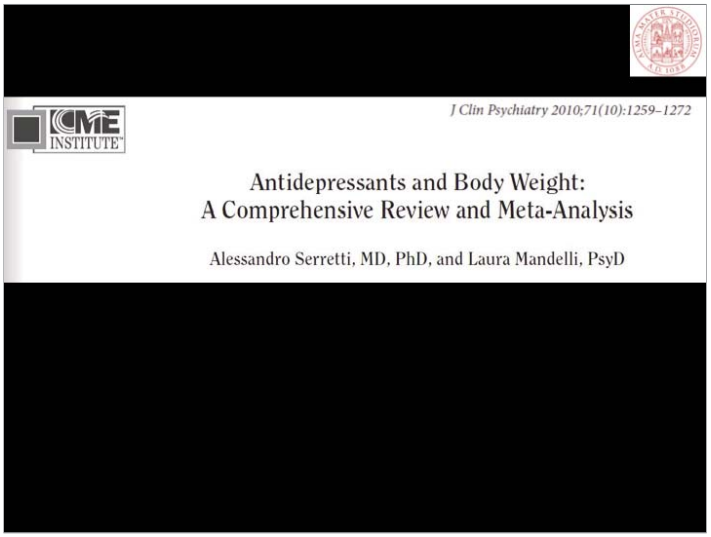




5-HTTLPR variants explained 7% of the variance of antidepressant efficacy



- Specific features for paroxetine:
- Elderly
- Females
- Long duration of the episode



Difference among SSRIs: HYPOTHESES

Block of pre-synaptic α-2 adrenoceptors

Effects on 5-HT2 and 5-HT3

\+

α

APPETITE

\+

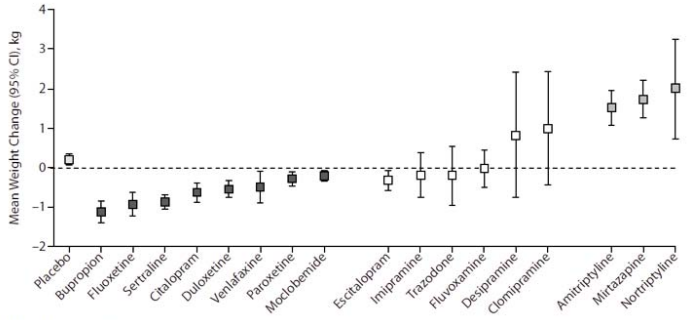
\+ +

Little affinity for D1 and D2 receptors

affinity for muscarinic and H1 receptors

SHORT TERM

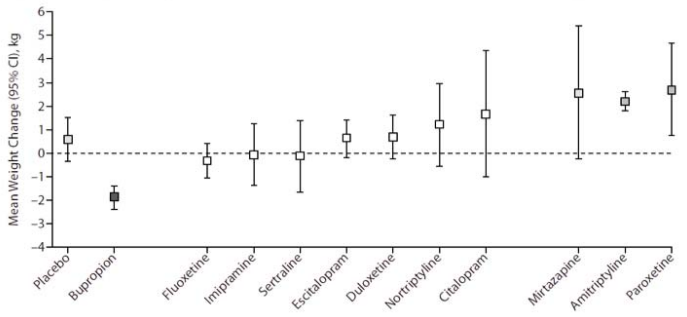
Figure 2. Weight Change During Acute Treatment With Different Antidepressants[a]



[a]Filled squares indicate a significant effect.

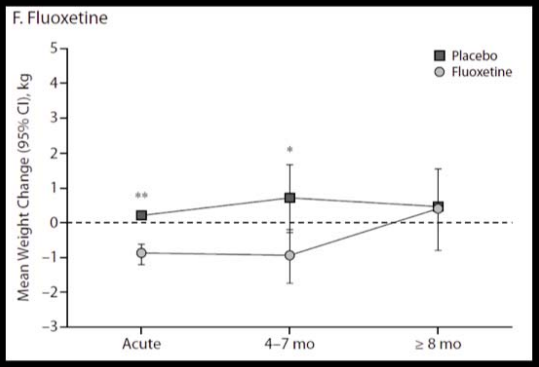
LONG TERM

Figure 3. Weight Change During Mai¬tenance Treatment With Different Antidepressants[a]



[a]Filled squares indicate a significant effect.

fluoxetine



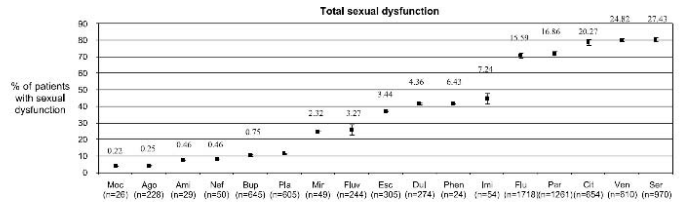
REVIEW ARTICLE (*J Clin Psychopharmacol* 2009;29: 00–00)

Treatment-Emergent Sexual Dysfunction Related to Antidepressants

A Meta-Analysis

Alessandro Serretti, MD, PhD and Alberto Chiesa, MD

Antidepressants and Sexual dysfunction



Other Criteria for choosing?

- Sedation/Insomnia
- Gastrointestinal
- QTc
- Apathy inducing
- Anamnestic and family positive response
- Symptomatology profile
- Psychiatric comorbidities
- Residual symptoms
- Cost
- Interactions/medical comorb.

Michael Davidson, MD

Professor **Michael Davidson**, MD
Sheba Medical Centre
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Tel Hashomer, 52621, Israel
E-mail: mdavidson6@gmail.com

Michael Davidson, MD is psychiatrist, Professor of Psychiatry at the Sackler School of Medicine. Dr Davidson started his psychiatrist career at the Mount Sinai Medical School in New York where he stayed for about 15 years, the last 5 years as Professor of Psychiatry. His research career has begun studying dopamine activity in schizophrenic patients, which was cutting edge research in 1980 and his paper was published in Science. He has written more than 250 peer-reviewed articles. Many of his articles have focused on neurobiology of schizophrenia, risk factors of schizophrenia, bipolar disorder, Alzheimer‘s disease. In addition, his group is producing interesting results upon premorbid markers in schizophrenia. Dr. Davidson has awarded more than 50 research grants, including projects with international funding (Stanley Foundation, NIMH, European Commission, etc.). During the late eighties dr Davidson has initiated the set-up of the Schizophrenia Brain Bank at the Mount Sinai Medical School in New York. Dr Davidson initiated and conducted more than 40 clinical drug trials. He is presently Principal Investigator in a multicenter project that studies the link between diabetes and Alzheimer‘s Disease, and is currently participating in OPTiMiSE EU project funded by the VII Framework. Dr Davidson has been awarded with ECNP-Psychopharmacology Award 2004, CINP Neuroscience Award 2006 and he is was a ACNP Fellow. Dr. Davidson is Chief Editor for European Neuropsychopharmacology, he is reviewer or board member to the Archives of General Psychiatry; American Journal of Psychiatry; Biological Psychiatry; Schizophrenia Bulletin; Schizophrenia Research; Psychiatry, Dialogues in Neurosciences, Alzheimer's disease and Related Disorders Journal .

Dementia.
Abstract

Dementia is a clinical diagnosis based on progressive cognitive decline of such severity that it affects daily functioning. DSM-V has made minor changes in that it established “Neurocognitive Disorders” instead of the DSM-IV terminology of “Delirium, Dementia, and Amnestic and Other Cognitive Disorders”. “Neurocognitive Disorders” has been subclassified into two categories based on severity of functional and/or neurocognitive impairment: a) Minor Neurocognitive Disorder (often called Mild Cognitive Impairment or MCI), with the necessary neurocognitive impairment in only one domain, and b) Major Neurocognitive Disorder or Dementia, which would typically involve at least two domains. However, memory impairment would not be necessary for diagnosing either of these conditions. Both Minor and Major Neurocognitive Disorders may be further sub-classified according to etiology – e.g., Alzheimer disease, vascular neurocognitive disorder, Fronto-temporal degeneration, Lewy Body disease, Mixed dementia. However, it appears that the ethologic sub-classification is far from absolute or even informative since most dementias are mixed dementias. Furthermore, the ability to image amyloid has indicated that the amyloid plaques deposit, which are the hallmark of Alzheimer’s disease, is often present in normal individuals, absent in individuals with dementia and, does not progress as dementia progresses. Pharmacological interventions which reduce amyloid deposits, have not reduced the severity of dementia. A possible explanation to it suggests that the amyloid deposit is an end stage epiphenomena hence, not relevant or too late to make a difference. Preventive trials in non-demented elderly are currently in prog.ress. In additional to pharmacological trials to reduce amyloid other trials are aimed at protecting brain tissue and reducing risk factors contributing to dementia.

UPDATE ON ALZHEIMER'S DISEASE TREATMENT

A PESSIMIST IS AN OPTIMIST WITH ACCESS TO DATA

Michael Davidson MD

Why is it important to find a treatment for AD?

- Exceed 1% of global GDP at $604 billion
- If dementia were a country, it would be the world's 18th largest economy
- If it were a company, it would be the largest annual revenue, exceeding Wal-Mart and Exxon
- If no new drugs are found to delay AD than the number of AD patients in 2050 will be 110 M millions and the cost of carrying for them XXX trillions
- ***So what? If it was less expensive would it be less important to find a treatment?***

AD is a disease of the 78-82 years old Only 1% of all AD cases arises during middle age and are associated with inherited mutations in one of the genes: APP, PSEN1, PSEN2.

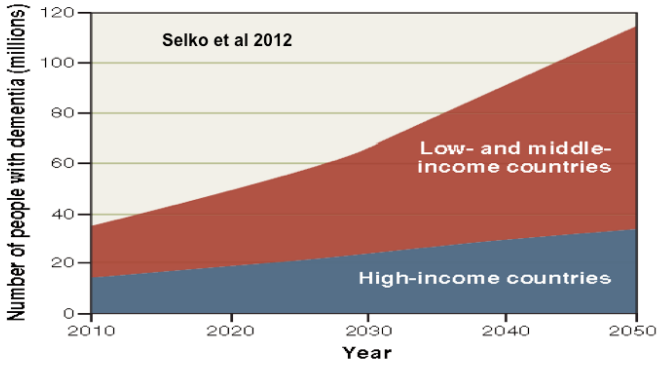

Fig. 1. Projected increases in the numbers of people with dementia in high-income countries and in low- and middle-income countries. [Figure reproduced, with permission, from (2)]

Questions on the currently approved drugs for AD

Choline-esterase-inhibitors and memantine

- What is their mechanism of action?
- Are these drugs effective or is it Is it placebo for families?
- What kind of effect?
- Are these less effective than
  - Cholesterol lowering drugs?
  - Antihypertensive drugs?
- The difference between treating and preventing
- The role of measuring in medicine

Phase II and IIT treatment failures in AD

- **Anti-inflammatory:** flurbiprofen
- **Vascular:** statins, anti-diabetics
- **Hormone: oestrogen**, testosterone, DHA, GH
- **Antioxidant:** Omega3, fish oil**, E/C/ALA** combo
- **Neurotransmitter:** atomoxetine, nicotinic agonist
- **Neuroprotective:** tramiprosate, Cognishunt
- **Mitochondrial function:** dimebon
- **Amyloid:** bapineuzimab (Phase II), **semagacestat**, PF-04494700 (Rage inhibitor)

Source: multiple references

Assuming that we understand the pathophysiology

- **Prevent build up of plaque (anti-amyloid)**
  - slow or prevent amyloid production by inhibiting clipping enzymes or by vaccine therapyand
  - slow aggregation into plaques
  - dissolve plaques
  - increase clearance
- **Prevent build up of paired helical filaments (tau focused)**
  - slow or prevent tau aggregation and dysfunction
  - dissolve paired helical filaments
- **Prevent brain cell dysfunction and death**
  - slow or prevent oxidative stress, inflammation, reduced blood flow
  - increase levels of protective molecules in brain
  - maintain viable connections between cells

Potential Targets

- Cholinergic loss
- Trophic factors loss
- Aluminum toxicity
- Calcium excitotoxicity
- Oxidative stress
- Glutamate toxicity
- Protein misfolding
- Inflammatory processes
- Tau hyperphosphorylation
- Amyloid toxicity
- Mitochondria and oxidative stress
- Amyloid synthesis and removal
- Tau hyperphosphorylation
- Ubiquitination and protein misfolding
- Block cell-to-cell transmission
- Calcium, iron and other metals homeostasis
- Apolipoprotein E
- Inflammation
- Cardiovascular co-morbidity

Immunization

- Active
  - A phase II active immunization AN1792 failed because of meningitis
- Two phase III failed because
  - lack of efficacy (Pfizer)
  - lack of efficacy on the main a-priori outcome (Lilly) solanezumab
- Passive
  - Phase II mildly positive with IVIg – Intravenous Immunoglobulin (Gammagard)
  - NIA/Baxter funeded phase III ongoing.

Why do we fail ?

We are looking for one magic bullet for a complex problem. However, complex problems have many simple solutions, unfortunately all of which are wrong.

Why do we fail ?

- Good reasons
  - Clinical and pathological diagnostic inaccuracy
  - Ante-mortem and post-mortem biological markers are not on the pathophysiological path but innocent bystanders
  - AD is a heterogeneous disease and we are looking for a single magic cure
  - Treatment starts too late
  - Inevitable decay of the brain
- Real reason
  - We don't know!

Limits of pathology

- **Pathologists cannot diagnose dementia**
- **Plaques and tangles can occur in non-demented elderly**
- **Plaque load does not correlate with severity of dementia**
- **Pathologists cannot establish time of onset of the cognitive decline or of brain damage**
- **Pathologists probably miss evidence of vascular damage**
- **Changes of vessels are not explored systematically**

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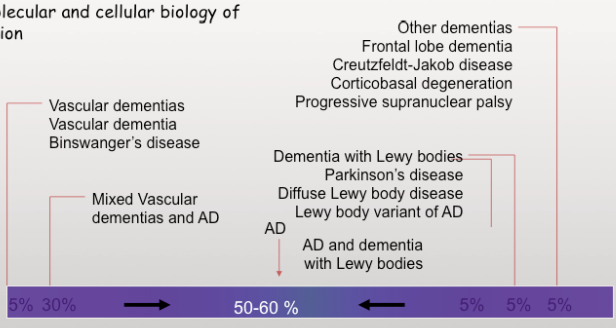
Is there a correlation between phenomenology and neuropathology ?

12

- Phenomenology and course
- Histology
- Anatomical distribution of lesion
- Combination of lesion
- Molecular and cellular biology of
- lesion



Which one is responsible (or the main responsible) for the cognitive decline?

- Amyloid plaques
- Neurofibrillary tangles
- Synaptic loss
- Cholinergic depletion
- Hippocampal degeneration
- Vascular pathology
- Others
- All of the above

Why the amyloid hypothesis could be misleading

- Association is not causation
- Amyloid can be deposited after ischemia, trauma and in epilepsy
- Plaques occur in elderly without dementia and there is no quantitative relationship with cognition
- Enhanced Aβ synthesis would not be consistent with reduced CSF Aβ concentrations
- PIB studies demonstrate that progression of dementia is not associated with additional deposits of amyloid

Just get rid of amyloid and everything will be OK

Just get rid of the cemeteries and we will live eternally

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Are all dementias mixed dementias?

Vascular risk factors for senile dementia

- Hypertension
- Atherosclerosis
- Coronary artery disease
- Smoking
- Hyperhomocysteinemia
- Diabetes mellitus
- High dietary saturated fat and cholesterol
- Serum cholesterol
- Physical inactivity

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The long march from Gens-Wide Association Studies to Rx

associations between single-nucleotide polymorphisms (SNPs) and diseases. Examples APOE, inflammatory genes, lipid transporting genes

- Association is not causation
- Statically models of associations are non-transparent and can be misleading
- Once the association is found the functional meaning is not clear
  - What protein if any
  - Interactions with other gens and respective SNPs
  - Interactions with other genetic and epigenetic factors
- SNPs do not cover the whole genome

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Alternative Strategies Towards Disease Modification

- Both chronic inflammation and oxidative stress are likely to contribute to the degenerative process (Akiyama *et al.* 2000).
- However, to date, treatments targeting these processes (e.g, NSAIDs, Vitamin E, B vitamins, DHA) have not shown efficacy in human trials.

Neuroprotective/Restorative Strategies: Neurotrophins

- Nerve Growth Factor (NGF): Hypotheses - NGF will protect cholinergic neurons in the pathogenic environment of the AD brain, targeting of the cholinergic system will be sufficient to meaningfully benefit quality of life in patients.
  Tuszynski, *ADAD*, 21, 2007

- NIA Funded Gene Therapy Trial – AAV-NGF:
  - Phase II NGF placebo controlled trial to restore function to degenerating cholinergic neurons; effect on cognition, brain metabolism, safety/tolerability in AD

Take home messages

- **Pure Alzheimer's disease is very rare**
- **Senile dementia is multifactorial**
- **The distinction between AD and VaD is impossible and unproductive, since these two entities share risk factors, phenomenology, evolution and therapy**
- **Downstream changes are false targets for treatment**
- **Curative therapy is unlikely**
- **Preventative therapy should start early**
- **Therapy should be directed at many targets simultaneously**

Sergey N. Mosolov

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Fax: +7 (495) 9631002
E-mail: profmosolov@mtu-net.ru
Date of Birth: 11 Sept 1955
Place of Birth: Moscow, USSR

Education at University/Medical School level:				
3-d Moscow Medical Institute	1972	1978	(Moscow)	MD
Thesis	1983		(Moscow)	Cand.Med. Sci.
Stages in CHS (residence)	1989		(Rouffach,France)	
Thesis	1992		(St. Petersburg)	Dr.Med.Sci.
	1994		(Moscow)	Professor in psychiatry

Post Graduate Positions:		
Resident in Psychiatry	Moscow Research Institute of Psychiatry, Moscow	1978-1980
Junior researcher	Dept. Therapy of Mental Disorders, Moscow Research Institute of Psychiatry, Moscow	1980-1985
Senior researcher	Ibid.	1985-1993
Chief, Department	Ibid.	1993-present
Professor	Chair of Psychiatry and Clinical Psychopharmacology, 3rd Moscow Medical Institute, Moscow	1993-2000
Director	Federal Scientific Center for Therapy of Mental Disorders, Ministry of Public Health of Russian Federation, Moscow	1994-present
Consultant	Clinical Hospital №85	2007-present

Current position:
Department for Therapy and Rehabilitation of Mental Disorders, Moscow Research Institute of Psychiatry, Chief
Federal Scientific Center for Therapy of Mental Disorders, Ministry of Public Health of Russian Federation, Head, Moscow
Journal “Current Therapy of mental disorders”, Editor in chief, Moscow

Membership in professional organizations:
Moscow Society of Psychiatrists and Addictologists, President.
Russian Society of Biological Psychiatry, President
Russian Society of Psychiatrists, member, Presidium member.
National Ethic Committee, member,
Commission on Psychotropic Drugs of the National Pharmacological Committee, member
Moscow Government Commission on Licensing in Psychiatry, Psychotherapy and Medical Psychology
Association of European Psychiatrists, member.
European College of Neuropsychopharmacology, member.
World Federation of Biological Psychiatry, member, International and Ethical Committees,
World Psychiatric Association, section for Methodology of clinical drug trials, member,
World Journal of Biological Psychiatry, Editorial Board member

Publications:
More than 600 publications (mostly in Russian), 18 monographies and 12 patents.

Most important books:
• Interactions of psychotropic drugs, Moscow (1991)
• Psychopathology and therapy of continuous forms of psychoses with phase-like course, Moscow, (1992), 647 p.
• Use of anticonvulsants in psychiatric and neurological practice. (eds. A.M. Vein, S.N. Mosolov) St.Petersburg, (1994), 228 p.
• Clinical use of contemporary antidepressants, St.Petersburg, (1995), 565 p.
• Fundamentals of psychopharmacotherapy", Moscow, (1996), 263 p.
• Clinical pharmacology", (ed. V.G. Kukes), chapter 18 "Psychotropic drugs, Moscow, (1999), 425-480 p. "Federal formular for the drugs use in medical practice" (ed. A.I. Vjalkov), chapter 4.1. "Psychotropic drugs", Moscow (2000), 680 p.
• Psychometric rating scales of schizophrenia symptomatology and positive-negative concept", Moscow (2001), 238 p.
• Emergency states and medical care" (ed. E.I. Chazov), selective chapters on psychiatric emergencies, Moscow (2002), 702 p.
• Concise handbook of psychotropic and antiepileptic drugs, permitted for use in Russia", Moscow (2002), 176 p.
• "New achievements in the treatment of mental disorders", Moscow (2002), 622 p.
• Pharmacotherapy of mental disorders. Moscow, 2004, 415 p.
• Psychopharmacological and antiepileptical drugs, permitted for use in Russia (2nd edition), Moscow, 2004, 302 p.
▪ Obsessive-compulsive disorder. Moscow, 2005, 64p.
▪ Biological methods of treatment. Chapter 8. In: Concise handbook of Psychiatry. Moscow, 2006, p.337- 448
• Treatment guidelines of schizophrenia, Moscow, 2007, 246p.
• Emergency psychiatry. In: Rational pharmacotherapy of emergent states. Moscow, 2007, p.422-469
• Anxiety and depression: comorbidity and therapy, Moscow, 2007, 64p.
• Dopaminergic hypothesis of schizophrenia, Moscow, 2007, 167p.
▪ Bipolar affective disorder. Diagnosis and treatment. Moscow, 2008, 390p.
• Biological methods for treatment of mental disorders: evidence based medicine to clinical practice. Moscow, 2012, 1128p.

Experience in GCP drug clinical trials:
Chief investigator in 54 multicenter clinical trials (phases 1b-IV)
Certificate in GCP (Wien School of Clinical Studies)
15 publications on methodology of clinical trials

Other information:
Special interest in clinical psychopharmacology, methodological and ethical problems of clinical drug trials, affective disorders and schizophrenia, chronobiology and sleep research.

Margarita A. Morozova

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FAX Number (Country Code, Area Code, Number): + 7 495 225 95 67

Education and Training (List all Colleges, Universities and Medical Schools attended, postdoctoral/fellowship training, board certification/medical license)

Name and Location of Institution (City, State or Province and Country)	Degree and Year Awarded	Area of Study
1st Moscow Medical Institution named after I.M. Setchenov, Moscow, USSR	MD, 1982 Diploma G-1 453284	General medicine
Institute of Psychiatry AMS USSR, Moscow, USSR	Psychiatrist, 1983 Diploma # 55	Psychiatry
National Centre of Mental Health, Moscow, Russia	1992, PhD Diploma MD No. 033938	Psychiatry
National Centre of Mental Health, Moscow, Russia	2004, Doctor of Medical Sciences Diploma N 1d/20	Psychiatry
National Centre of Mental Health, Moscow, Russia	1999, Psychiatrist Diploma N 114	Psychiatry

Professional Experience		
Position/Title	**Name and Location of Institution (City, State or Province and Country)**	**Dates (Start/Stop Dates as applicable)**
Current Leading research worker Chief of the laboratory psychopharmacology	Institution of Russian Academy of Medical Sciences "Research Centre for Mental Health of RAMS", Moscow, Russia	1995 – at present
Previous		
Senior research worker	Research Centre for Mental Health, Moscow, Russia	1990-1995
Research worker	Research Centre for Mental Health, Moscow, Russia	1988 – 1990
Junior research worker	Research Centre for Mental Health, Moscow, Russia	1984 – 1988

Previous participation in clinical trials			
Indication of Trial	**Clinical Phase of Trial (I-IV)**	**Role in Trial (e.g. Investigator, Sub-Investigator)**	**Year in which trial was conducted**
Schizophrenia	IV	Principal Investigator	1997
Schizophrenia	III	Principal Investigator	1998-1999
Major Depression	IV	Principal Investigator	2000-2001
Dementia	III	Principal Investigator	2000
Schizophrenia	III	Principal Investigator	2001-2002
Schizophrenia	III	Principal Investigator	2001-2002
Bipolar Disorders	III	Principal Investigator	2001-2002
Bipolar Disorders	II	Principal Investigator	2002-2003
Major Depression	IV	Principal Investigator	2001
Major Depression	III	Principal Investigator	2001
Major Depression	III	Principal Investigator	2003
Schizophrenia	III	Principal Investigator	2003
Schizophrenia	II	Principal Investigator	2003-2004
Schizophrenia	II	Principal Investigator	2003
Major Depression	II	Principal Investigator	2004-2005
Schizophrenia	II	Principal Investigator	2004-2005
Schizophrenia	III	Principal Investigator	2004-2005
Schizophrenia	III	Principal Investigator	2004-2005
Schizophrenia	III	Principal Investigator	2004-2005
Schizophrenia	III	Principal Investigator	2004
Schizophrenia	III	Principal Investigator	2004-2005
Schizophrenia	II	Principal Investigator	2006
Schizophrenia	II	Principal Investigator	2005-2006
Schizophrenia	III	Principal Investigator	2005-2006
Bipolar Disorders	III	Principal Investigator	2005-2006
Bipolar Disorders	III	Principal Investigator	2005-2006
Bipolar Disorders	III	Principal Investigator	2005-2006
Bipolar Disorders	III	Principal Investigator	2006
Schizophrenia	III	Principal Investigator	2007 ongoing
Major Depression	III	Principal Investigator	2007 ongoing
GAD	III	Principal Investigator	2006-2007
GAD	III	Principal Investigator	2007 ongoing
Schizophrenia	II	Principal Investigator	2008 ongoing
Schizophrenia	II	Principal Investigator	2008 ongoing
Schizophrenia	II	Principal Investigator	2009 ongoing
Schizophrenia	II	Principal Investigator	2009 ongoing
Schizophrenia	II	Principal Investigator	2010 ongoing
Schizophrenia	II	Principal Investigator	2010 ongoing
Schizophrenia	II	Principal Investigator	2010 ongoing
2010, GCP training provided by Pfizer			

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DOUBLE-BLIND PLACEBO-CONTROLLED RANDOMIZED EFFICACY AND SAFETY TRIAL OF ADD-ON TREATMENT OF DIMEBON PLUS RISPERIDONE IN SCHIZOPHRENIC PATIENTS DURING TRANSITION FROM ACUTE PSYCHOTIC EPISODE TO REMISSION Psychiatria Danubina, 2012; Vol. 24, No. 2, pp 730-999

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Medicine (post-graduate education)	1983	1985	(Moscow)	Psychiatrist
Medicine (post-graduate education)	1986	1989	(Moscow)	Cand.Med.Sci.
GCP	1998		(Smolensk)	sertificate

Details of Medical License, Certification, etc:		
MD	1983	Diploma No ИВ 487192
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Certificate (Psychiatry)	1998	Diploma No 199

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Psychopathology, personality traits, and cognitive functioning in patients with acromegaly.

Maria Alexandrova

My current research is a prospective study of 140 patients with pituitary adenomas. The aim is to assess the influence of pituitary adenomas and hormones on emotional and other disorders, psychopathology, personality traits, and cognitive function and to discover why acromegaly remains under-recognized and under-diagnosed. We compare patients before and after treatment, and with somatotroph adenomas and others. Study is close to conclusion but not finished yet.

Abstract

Pavel Alfimov

Currently I am working on my PhD research (head-to-head randomized placebo-controlled comparison of two methods of clozapine augmentation in treatment-resistant schizophrenia). Primary objective of the study is the direct comparison of efficacy and safety of clozapine monotherapy and two clozapine augmentation strategies (clozapine with amisulpride and clozapine with mirtazapine). Secondary objectives include dynamic evaluation of social and personal functioning as well as cognitive impairment in three treatment arms. Target study population consists of inpatient individuals with ICD-10 treatment-resistant paranoid schizophrenia (according to IPAP criteria of treatment-resistance in schizophrenia, 2003). After verifying the inclusion criteria and signing the informed consent form patients will be treated with clozapine (300-700 mg daily, dose will be defined with consideration of individual tolerability) for 6 weeks (Phase I). Primary outcome measure in Phase I is the reduction of overall PANSS score. Secondary outcome measures include reduction of PSP, UKU and CGI-S scores. If overall PANSS score reduction exceeds 20% patient will be excluded from the study. If overall PANSS score reduction is less or equal to 20% patients are to be randomized in one of three treatment arms of Phase II for 6 weeks. Patients in arm 1 will be treated with clozapine and placebo, patients in arm 2 — with clozapine and amisulpride (400 mg daily), patients in arm 3 — with clozapine and mirtazapine (30 mg daily). Previous doses of clozapine will be used during Phase II. Primary outcome measure in Phase II is also the overall PANSS score reduction. Secondary outcome measures include change in PSP, UKU, CGI-S and CGI-I scores. CGI rating will be provided by an independent researcher to maximize objectivity of results. Additionally, BACS rating will be performed during weeks 6 and 12. Monitoring of low neutrophil count and agranulocytosis will be provided (blood tests on weeks 1, 4, 8 and 12). Augmentation strategies and doses were selected with consideration of latest systematic reviews and meta-analyses (e.g. Porcelli S., et al., 2011; Taylor M.D., et al., 2011). Limited group of patients will be treated and monitored for additional 4 weeks of follow-up. Serum levels of 5-HIAA, HA, and NA as well as 5-HIAA/HA ratio are to be defined in a limited sample during week 1 (these are presumable biological predictors of response to clozapine). It is planned to include at least 35 patients in each treatment arm in Phase II. Validated Russian versions of psychometric scales will be used.

Acronyms
PANSS = Positive and Negative Symptoms Scale, Kay S., Opler L., Fiszbein A., 1987
PSP = Personal and Social Performance, Morosini P., Magliano L., et al., 2000
UKU = Udvald for Kliniske Undersogelser Scale, Lingjaerde O., Ahlfors U.G., Bech P., 1987
BACS = Brief Assessment of Cognition in Schizophrenia, Keefe R.S., et al., 2008
CGI-S = Clinical Global Impression Severity Scale, Guy W., 1976
5-HIAA = 5-Hydroxyindoleacetic acid
NA = Noradrenaline
HA = Homovanillic acid

Clinical Case Description

Nadezda Bobrova

A 30 year-old woman came to theresidential psychiatric facility named after S.S. Korsakov in March of 2011 with complaints about depressed mood, oppression, decreased libido and persistent constipation.

The patient was married, had a 5 year-old son. None of her relatives had ever been treated by a psychiatrist. From the history of life we knew, that she'dsuffered from mood swings from childhood. In the periods of depressed mood it was hard to attend school, she quarreled with her parents and much later with her husband. And on the contrary, increased activity, sociability and reduction in hours of sleep accompanied the periods of mood elevation.

The first picturesque episode of depression was observed 3 years before the described hospitalization. The patient complained about depressed mood, oppression, lack of initiative, sleep disorder, delusions and probably suicidal thoughts (she suffered from fear, that her body would 'jump out of the window'). The symptoms disappeared with time without any special treatment. Several subsequent catadromes also terminated spontaneously.

In December of 2010 the patient was hospitalized with another catadrome and got Paxil therapy, on the therapy the phase change was observed (mood elevation with hyperactivity).

The latest catadrome occurred in Junuary of 2011, when the list of complaints replenished with libido decrease, genital anesthesia and vital anguish.

On the 14th of March 2011 the patient was hospitaliszed to the residential psychiatric facility named after S.S. Korsakov. The diagnosis was Bipolar disorder with hypochondriac syndrome.She was prescribed Venlafaxine 75 mg 2 times a day, Finlepsin 200 mg 2 times a day and Trifluoperazine 5 mg before bed.Significant improvement was observed during the treatment.

SOMATOFORM DISORDERS: PERSONALITY, CLINICAL FEATURES AND COGNITIVE DISTURBANCES

Maria Bobrova

Objectives: Somatoform disorders (SFD) represent variable and poorly diagnostically delineated group of psychopathological syndromes. The aim of the study was to analyze the relationship among personality types, clinical manifestations, and cognitive disturbances that occur in SFD patients. **Material and Methods:** 77 patients with different SFD were studied with the help of clinical and psychological tests. **Results:** Five types of SFD patients were reveal. **Conclusion:** SFD have complex and various psychopathological structure, which includes not only quantity of somatic complaints, intensity of hypochondriac concerns, evidence of anxiety and depressive symptoms.

A comparative study of risperidone (speridan) in general psychiatric hospital

Pavel Bomov

The new generation of antipsychotics has demonstrated its advantage over classical antipsychotics in treatment schizophrenia, as determined by fundamental differences in the mechanisms of action of drugs. To get your own results on the efficacy and tolerability risperidone (speridan) in patients with schizophrenia, a comparative study speridan and haloperidol, which is called the "gold standard" in the treatment of schizophrenia.

The main group received speridan (13 patients), the control - haloperidol (15 patients). In all patients, according to the ICD 10 was diagnosed with schizophrenia, with prevalence in the clinical picture of hallucinatory-delusional (11 patients), catatonic-paranoid (2 patients), affective-delusional (8 patients) and psychopathic symptoms (7 patients). Age ranged from 42 to 61 years, with disease duration from 1 year to 22 years. We used the CGI, adverse events SAS, PANSS. Duration of the study was 8 weeks, the dose of speridan increased during the first 4-6 days from 2 to 8 mg per day. By the end of the study reported on a scale of CGI "much improved" in 39% of the control - improving performance on a scale of only a "modest improvement". Reducing the total score on a scale RANSS in the study group 42% in the control group - 31%, indicating that the overall reduction psychopathic and negative disorders. Tremor, bradykinesia, akathisia in the treatment of speridan, in comparison with similar manifestations of haloperidol expressed slightly, are dose-dependent and self-leveled character that quickly allows you to achieve compliance. Apparent high efficiency of speridan in relieving acute and balanced effect on the positive and negative symptoms in schizophrenic patients. These significant subjective side effects like weight gain, allergic reactions, galactorrhea during our study were not observed.

Abstract

Yulia Bubnova

The topic of my scientific work is role of hormonal status in pathogenesis of depression in patients with schizophrenia. For my study to be a reliable I have to investigate 100 patients. They are examined at the admission to our hospital and after 6 weeks of specific treatment. I use several scales to assess depressive and schizophrenic symptoms: PANSS, CDRS, UKU, MADRS, BAS. Furthermore, I am using laboratory diagnostics, to determine the level of hormones. The aim of my study is development of approaches to the combination therapy of patients with schizophrenia.

Anxious depressions and personality disorders

Victoria Chitlova

Objectives: It was hypothesised that typological heterogeneity of anxious depressions is based on constitutional predisposition.

Aims: Development of the systematic of anxious depressions.

Results: There were defined 2 types of anxious depressions. Cyclothymic anxious depression is characterized by cothymia – the double affect with coexisting vital melancholy and generalized/floating anxiety; psychomotor and conative (motivational/cognitive) dysfunction with domination of depressive/anxious ruminations. Anxious depression of self-torture type has congealing ("frosting") affect without vital signs accompanied with ideas of inadequacy to high intrapersonal standards; ruminative thinking dominates along with cognitive-negative catathymic (Beck A., 1962) substantial complex of symptoms.

Conclusions: It was defined that anxious depressions were related to premorbid personality features attributable to claster C personality disorders (DSM-IV). First type depressions corresponds to psychasthenia P. Janet (1903) or anxious-sensitive type of personality (Sukhanov S., 1905); second type of depressions corresponds to anancastic features/statothymia (Shimoda M., 1960) in premorbid.

Social and negative consequences of phobias

Dmitry Chugunov

We examined 210 patients with phobic disorders, neurotic and schizophrenic spectra, whose pathological fear has held a leading position in the clinical picture. All respondents - residents of Moscow at the age of 18 to 60 years who were hospitalized in the psychiatric hospitals of the city. We used clinical and psychopathological, clinical and prospective follow-up, statistical methods and a modified questionnaire for the assessment of social functioning and quality of life of patients.

We found that many patients with phobias have led to significant and often to a profound decrease in social functioning of patients with complete or almost complete avoidance of frightening situations. In 26% of surveyed a 2 or 3 of disability. Almost the same proportion of patients was actually unable to work, being dependent on relatives. These patients have a negative attitude to the design of disability in relation to a possible defamation, or for similar reasons. Phobic disorders maladjusted, creating numerous, intractable problems of marital, sexual, career, personal and of a different order. Especially significant social cost of transport phobias, tanatofobii, dispsihofobii, homicide - and suicidefobii, hypochondria phobias (infarct-, cardio-,-stroke, AIDS, sifilofobiyah) and several others was found. It phobic neurosis with great firmness and severity of fears led to hospitalization in hospital for psychotic patients, and in some cases - of involuntary hospitalization. The greatest social harm had panagorafobiya. As a result, there were persistent and intense fear with complete or almost complete rejection of out of home.

Phobias took first place among neurotic disorders for a variety of disorders of social functioning of patients.

Characteristics of alcohol dependence in Russia and in Germany

Maria Denisenko

The aim of this study was to examine alcohol-dependent patients. 75 patient from Department of addictive behaviour (Germany) and 100 patient from State Clinic of addictive behaviour (Russia), were interviewed using CIWA and EuropASI. Results: Groups did not differ in respect of age, gender and educational level. There were no significant differences in the age of first drink, years of consumption. Amount of alcohol consumed per day were higher among Russian patients. No significant difference was found in psychiatric complications. Russian patients had significantly more diagnosed somatic complications. Treatment strategies were very different.

Cliniconeurovisualizational criteria of the vascular dementia and Alzheimer's disease differentiated diagnosis

Svetlana Duduk

Key words: vascular dementia, Alzheimer's disease, magnetic resonance imaging, psychopathology, neuropsychological characteristics.

Aim of study: to create and introduce the differentiated diagnostic algorithm in vascular dementia and Alzheimer's disease.

Methods of investigation: epidemiological, clinicopsychopathological, psychometric, neuropsychological, MRI of the brain, somatoneurological examination, statistical technology.

Obtained results and their novelty: For the first time the assessment of the later life dementias prevalence, dynamics of main epidemiological indices (disease incidence, morbidity, disability) over the period from 2002 to 2010 in Grodno region subjected to the sex, age, living place, profession was performed; separately the structure of the primarily disability severity connected with VD and AD was studied.

The proposed methodology of the brain MR-images assessment in normal involutional changes and the way of the hyppocampus atrophy diagnosis in Alzheimer's disease with a glance to the diagnostic relevance of its lesion are highly informative in diagnostic and differentiated diagnostic of the late age dementias.

The introduced in the practical health care service algorithm of the clinical dementias diagnosis enables state fact about the cognitive, emotional and behavioral disorders; to assess the intensity degree of dementia syndrome and character of the disease course impartially; to perform the differentiated diagnosis while psychiatric help administration during the outpatient and in-hospital treatment.

Range of application: psychiatry, gerontology, neurology, radiodiagnostics.

The clinic-pathogenic study of computer addiction

Anton Dyachenko

Motivation: To date, there is no clinical-dynamic description of computer addiction (CA) in the literature, which allows to allocate the clear-cut differential-diagnostic criteria for this disorder. No effective therapeutic methods are offered.

Objective: To study clinic-pathogenic features of CA, to develop the diagnostic and therapeutic recommendations.

Methods: The clinical-phenomenological, psychological, neuroimaging, electrophysiological, biochemical, mathematical.

Expected results: the creation of clinic-pathogenic model of CA, the establishment of differential diagnostic criteria, to highlight the structural and functional brain changes in patients, the creation of disease progression assessment method, the development of pathogenetically oriented treatment method.

Cognitive-behavioral psychotherapy for patients, suffering from paranoid treatment-resistant schizophrenia

Alexander Erichev

In this article the authors' experience in the field of implementation of cognitive-behavioral psychotherapy (CBT) for patients suffering from paranoid treatment-resistant schizophrenia is given. Two phases of this implementation are mentioned: evaluative phase and delusional beliefs modification phase. Special features of CBT implementation in individual and group forms of work are recounted. It is also stated that inclusion of CBT into the complex of medicinal-restorative measures contributed to decrease of anxiety and depression level with the patients suffering from paranoid disorders, which in its turn led to a more qualitative, stable and durable forming remission.

Psychopathology of Self-Destruction in Dermatology

Veronica Frolova

The clinical and follow-up observation of 45 patients with monosymptomatic delusional parasitosis (DP) and 17 patients with so-called circumscripta hypochondria (CH). Monosymptomatic DP is characterized by autochthonous onset (idea of being contaminated) with elementary sensopathies. Secondly, highly systematized delusion is accompanied by tactile hallucinations. Delusional behavior is bizarre with a frank autodestructive behavior. First stage of CH is characterized by local idiopathic algias. In the second stage affective charged sensations dominate in perception. The last stage is characterized by autoaggressive behaviour with striving for repeated operations to eliminate «foreign» part of skin. DP and CH are psychopathological disorders requiring psychopharmacological treatment.

Psychopathological aspects of alimentary obesity

Natalia Gueguel

Alimentary obesity is often accompanied by mental disoders. However the structure of mental disoders concomitant to obesity has not been sufficiently studied. The aim of the work is to give a description of mental disorders in case of alimentary obesity.

Source material: 62 alimentary obesity patients, consulted endocrinologist (45 women, 17 men) aged 35 ± 12 who suffered the disease for 16 ±9,2 years. The average value of body mass index is (BMI) 39,8 ± 6,1.

Methods of research: clinical psychopathological research.

Clinical psychopathological research showed that all 62 patients suffered mental disorders. 13 people (21,0%) were given a diagnosis of generalized anxiety disorder, 6 (9,7%) - social phobia, 8 (12,9%) – specific phobia, 2 (3,2.%) – panic disorder, 6 (9,7.%) –depressive episode,11(17,7%)– adjustment disorder,10 (16,1%) – dysthymic disorder, 3 (4,8%) – bipolar disorder, 5 (8,1%)–somatoform disorder, 4 (6,5%) – hypomania, 6 (9,7%) – cyclothymia, 6 (9,7 %)– organic mental disorder. Besides, 17 patients have been diagnosed as comorbide mental disorders.

23 people had personality disorder or accentuation by emotionally unstable type.

11 patients have been diagnosed as personality disorder or accentuation by anancastic, 5 - accentuation by dependant , 8 - accentuation by anxiety, 3 - accentuation by schizoid , 6 - accentuation by hystrionic. There was accentuation of hypertemic in 6 cases.

At the same time, psychopathological assessment eating disorders has been studied. 9 patients revealed eating excesses, 14 patients patients revealed a tendency to, so called, night eating, 4 to stable (uncontrolled) eating, 6 had carbohydrate addiction, and 4 – to stress eating. 11 patients have been diagnosed as atypical nervous bulimia.

So alimentary obesity define by multiform psychopathological symptomatology mainly of border-line disorders.

New strategies in the work of psychiatrist in general hospital

Andrey Genno

In modern mental health care in Russia there is a gap between science dealing with co-morbidity of mental and physical disorders and practical needs that arise because of the increasing psychiatric symptoms in physically ill people. In particular, using of psychiatric ICD-10 codes in general hospital is quite difficult and classification for mental disorders with management guidelines for use in primary care (ICD-10 PHC) is unknown in Russia. A lot of people with comorbid illnesses do not receive adequate care in general medical settings. On the other hand, general practitioners tend to attract psychiatrists for solving non-psychiatric issues when Law "On psychiatric care" is often violated. In addition to this, it is still remain unclear what sort of people with comorbid disorders are more likely to be treated in general hospital and those ones are supposed to be transferred into the mental health institutions. Two other challenges that psychiatrists routinely deal with involve refusal of a somatically ill patient from the emergency surgery and need to commit people with urgent somatic illnesses in intensive psychiatric care. These chief issues will be discussed in this presentation as well as the interventions that could be resolved them and therefore diminish some misunderstandings between psychiatrists and internists.

Clinical and dynamic characteristics of organic personality disorder

Olga Izmailova

Objective: to determine the clinical and prognostic characteristics of the dynamics in patients with organic personality disorder. Material and methods. The study involved 85 patients aged over 18 years with organic personality disorder (F07.0 in ICD-10), hospitalized in a psychiatric hospital of Samara. At this stage of the study the clinical characteristics of psychiatric disorders and dynamics are assessed; there were defined four main clinical groups which differ in degree of emotional and volitional, cognitive and behavioral disorders, as well as the quality of social adaptation. The data obtained allow to implement a predictive assessment of the different variants of the organic personality disorder, according to which it is necessary to use a differentiated approach to pharmacotherapy and psychotherapy of these patients.

PSYCHIATRIC CO-MORBIDITY IN TYPE 1 AND TYPE 2 DIABETES MELLITUS

Olga Karpenko

Introduction. Treatment regimen adherence is crucial for patients with diabetes, and it could be improved by treatment of comorbid psychopathology. **Objective.** To assess the prevalence and identify difference of psychiatric pathology among in-patients with type 1 (DM1) and type 2 diabetes (DM2). **Methods.** Ninety nine diabetic in-patients (DM1, 47; DM2, 52) were assessed clinically by a psychiatrist according to ICD-10 criteria. **Results.** Several most prevalent groups of disorders were identified: anxiety (43,4%), depressive (23%), stress-related (23%), somatoform (12% DM2 only), eating disorders (30,3%), personality (13,1%) and organic disorders (20,2%). In DM2, total prevalence of anxiety disorders was significantly higher (67%) than in DM1 (17%, $p<0,001$, $\chi 2$). Prevalence of depressive, stress-related and organic disorders was about 30% each in DM2, with significant difference compared to DM1 (13%, 13%, and 9%, respectively, $p<0,05$, $\chi 2$, Fisher'exact test). Though DM1 population seemed much «healthier» than DM2, with comorbid mental disorders being absent in 49% patients vs. 19% in DM2 ($p<0,001$), but higher proportion of DM1 patients had personality disorders (predominantly, emotionally unstable personality disorder - 12,7% patients). **Conclusions.** Mental comorbidity in DM1 and DM2 shows significant differences which could be attributed to age-related, metabolic, hereditary, and psychological factors. These differences should be taken into account because of their substantial impact on the approaches to therapy and psychosocial rehabilitation of the patients with DM.

USING INTERNET IN PSYCHOTHERAPY PRACTICE

Kseniya Kiyan

In our study, we use online counseling, online therapy, online support. The purpose of this study is to define the contingent, advantages and disadvantages of this method. The material for this study is a forum and email of Institute of Psychiatry and patients that have internet psychotherapy as addition to full-time work. There are 3 groups: 1.Patients who have only online psychotherapy; 2.Patients who have mixed psychotherapy (online and full-time psychotherapy); 3. Patients who have only full-time psychotherapy (control group). From February 2010 to November 2011 we got 191 letter on e-mail. (67% female, 33 % male) from 17-53 years old. About 1 % of this patients wanted only online psychotherapy. In the 2 group we have 14 patients (78% female, 21 % male), from 20-53 years old. In the 3 group we have 30 patients (64% female, 36 % male), from 17-60 years old. In our study we use specially designed questionnaire, content-analysis, MMPI, pf16. In general online counseling is pervasive among women, men, and in the different age. This method saves time, improves compliance, and ensures the continuity of the therapeutic process.

Improving Compliance in outpatients with schizophrenia in the application of prolonged forms of antipsychotics(Rispolept – Consta).

Denis Kuchmenko

In doctors clinical practice anti-psychotics are the most effective “tools” in treatment of schizophrenia. Their use allows us to reduce psychosomatic symptoms during periods of exacerbations and prevent recurrence of the application of these drugs for maintenance treatment.

In the treatment of patients with schizophrenia (at any stage of the disease) outpatient, physician faces a number of difficulties due to bad compliance. Among the main causes of the drugs can be distinguished: the severity and duration of disease, low level of illness understanding, the need for multiple drug intake, the need to visit health facilities for the regular performance of intramuscular injections, side effects of drugs.

Prolonged forms of neuroleptics better tolerated than their oral equivalents. Side effects are typical of many drugs for the treatment of mental illness are found in the application of risperidone consta. Among them: weight gain (up to 3 kg per year), depression, irritability, sleep disturbances, headache, dizziness, insomnia, constipation, nausea, blurred vision, and rarely seizures, allergic reactions at the injection site.

However, the majority of cases with risperidone Consta treatment of any adverse events did not occur, and patients have the opportunity for a long time to receive treatment with this drug, without resorting to psychiatric hospitals and changing lifestyles.

Comparing risperidone Consta with other classical neuroleptics, the majority of patients with schizophrenia indicate that the drug improves their condition, and at the same time, much less depressing motor activity. Risperidone Consta injected only once every two weeks, allowing sick people to avoid hospital admission during exacerbations, gets rid of regular visits to health facilities, and allows treatment at home.

Therefore, in order to improve compliance and dosing regimen for patients with schizophrenia is the best use of prolonged forms neuroleptics, in particular, rispolept Consta (25 mg, 37.5 mg, 50 mg). The use of risperidone Consta provides stabilization of the drug in the serum and the belief that the patient received the drug at the desired dosage. Compliance with the doctor and patient transfer to the depot medication is usually better, because it allows the patient to achieve greater autonomy. Finally, the metabolism of parenteral drug eliminates the problems associated with the absorption of drugs in the gastrointestinal tract and its transformation in the liver.

The clinic-pathogenic study of computer addiction

Dkhaval Chandrakant Mavani

Motivation: To date, there is no clinical-dynamic description of computer addiction (CA) in the literature, which allows to allocate the clear-cut differential-diagnostic criteria for this disorder. No effective therapeutic methods are offered.

Objective: To study clinic-pathogenic features of CA, to develop the diagnostic and therapeutic recommendations.

Methods: The clinical-phenomenological, psychological, neuroimaging, electrophysiological, biochemical, mathematical.

Expected results: the creation of clinic-pathogenic model of CA, the establishment of differential diagnostic criteria, to highlight the structural and functional brain changes in patients, the creation of disease progression assessment method, the development of pathogenetically oriented treatment method.

COGNITIVE IMPAIRMENT BEFORE AND AFTER CAROTID ENDARTERECTOMY

Polina Maksimova

Held the structurally-dynamic analysis cognitive disorders at 103 patients with an atherosclerotic stenosis of carotids before and after carotid endarterectomy, including the nearest catamnesis observation (six months). Separation cognitive disorders on «easy» and «mild». Dynamics revealing cognitive disorders after carotid endarterectomy.

Before carotid endarterectomy cognitive disorders (including in a combination with disturbing and depressive) have been taped at 95 patients (92,2 %). Patients have made of them 1/3 with «easy» cognitive disorders, and 2/3 – with «mild» cognitive disorders. Patients with «mild» cognitive disorders have appeared the least subject to positive dynamics.

After carotid endarterectomy discovered positive dynamics cognitive disorders.

Depressive symptoms in women with epilepsy

Igor Medvedev

Aim: Learning development, clinical performance and treatment features of depressive disorders in women with epilepsy.

Material and Methods: Patient's status was assessed using clinical and psychometric rates: Hospital Anxiety and Depression Scale, Beck Depression Inventory, Zung Anxiety Rating Scale, Simptom check list.

Conclusion: Strong correlation was shown between psychopathologic indications of depression and basic features of epilepsy. Depression development depends on different factors such as duration of epilepsy and its localization, type and frequency of seizures, presence of antiepileptic therapy (barbiturates doses). Antidepressants without potential ability to decrease seizure threshold, such as selective serotonin reuptake inhibitor – paroxetine, fluvoxamine, must be given to suppress depression sings.

An Effect of Personality Disorders on Cardiovascular Diseases' Courses

Vladimir Medvedev

We investigated an effect of personality disorders dynamics on manifestation and clinical presentation of cardiovascular diseases (CVD).

Two groups of patients were defined. In the first group clinical course of CVD is subjected to the dynamics of personality disorder. Synergistic type of clinical course of CVD is characterized by reactive somatopsychic lability, CVD manifestation at the time of stressful situation, CVD symptoms redoubling carried out by somatoform disorders. In the second group clinical course of CVD doesn't correlate with dynamics of personality disorder. Alternating type of clinical course of CVD is characterized by hereditary and somatogenic factors.

Abstract

Alexandr Merkin

Confusional states (or delirium) are common in geriatric inpatients in general hospital. However, diagnosis of this syndrome in the elderly is especially difficult due to imprecision of the clinical criteria. Diagnosis of confusional state presents a serious challenge both to non psychiatrist specialists and even to psychiatrists. We evaluated the percent of missing and misdiagnosis of delirium in the 65 and older inpatients by psychiatrists, physicians and nurses in Russia. In the studied population, rate of delirium was found to be 28%. The rate of delirium misdiagnosis in the traumatology unit in Russia was 28,6%, comparable to rates published from research elsewhere. In contrast, the rate of missed diagnoses in the psychogeriatric population studied was 8,7% and of overdiagnosis 22,2%. The authors evaluated the features associated with delirium misdiagnoses, discuss the reasons and ways to improve the relevant psychiatric diagnoses and care.

Abstract

Ekaterina Misevich

The aim of the research is to prove the effectiveness of the adoption of psychosocial rehabilitation programmes for the in-patient hospital departments.

Scientific novelty: There is plenty of research about rehabilitation assistance of patients, treated in mild conditions of "the Cabinets of the first episode of schizophrenia" and branches of day stay.

There is no or very few research analysing specifics of implementation of programmes about the psychosocial rehabilitation of patients in in-patient mental diseases hospital department of mixed type (joint stay of patients with psychoses, chronic mental illness and compulsory medical treatment's patients) in Russia.

In this research, we are planning to analyse the statistical data for 2 years of existing of psychosocial rehabilitation units. The author has organised the psychosocial rehabilitation units and is making research in parallel with working as a psychiatrist, psychotherapeutist, and was lately promoted to the chef of rehabilitation team.

THE INFLUENCE OF THE TELEVISION ON THE MENTAL CONDITION OF THE CHILDREN AND THE TEENAGERS

Irina Morozova

The studying of the influence of the television on a mental condition of children and teenagers was an aim of this research.

35 children and teenagers at the age of from seven to seventeen years (23 boys and 12 girls) have taken part in the research, which was made on the base of the Samara children's city clinical hospital № 1. The technique of the screening-diagnostics of mental pressure and neurotic tendencies of the children and teenagers (by Nosachev G. N, Hajretdinov O. Z, Pechkurov D.V., Uvarovsky Island Ю, 2004) was used in the research. The technique has been modified by the researcher and the authors for children and teenagers because primary it was a questionnaire for parents. The technique is directed on revealing of symptoms of mental pressure and neurotic tendencies of children and teenagers which are classified in 9 scales. These scales reflect the degree of expressiveness of vegetative infringements, astenization, frustration of a dream, infringements of appetite, the sympthoms of the depressive spectrum, the increased uneasiness, phobias, pathological habitual actions, extrapunitive aggressions.

The research has revealed the specific negative influence on a mental condition of children and teenagers. The received results can be used in working out of the psychopreventive and rehabilitation programs of the complex treatment of children and teenagers with the somatic pathology.

NOSOGENIC REACTIONS IN CANCER PATIENTS WITH SCHIZOPHRENIA AND SCHIZOPHRENIA SPECTRUM DISORDERS

Liubov Myasnikova

The clinical typology of nozogenic reactions in 43 cancer patients with schizophrenia and schizophrenic spectrum disorders (SSD) has been developed including 6 types of nosogenias: 1) hysteric-hyperestetic («normal grief»); 2) aberrant hypochondriasis (absence of emotional reaction); 3) endoform depression (with negative affectivity); 4) dissociative; 5) manic paranoia (with self-treatment); 6) nosogenic exacerbation of slowly progressing schizophrenia. These nosogenic reactions can be presented in a continuum of consecutive changes in registers of psychopathology and levels of contribution of endogenous and constitutional factors to the clinical features of nosogenias.

Alcohol abuse and hospitalizations in schizotypal patients

Maria Orlova

Introduction. Comorbidity of schizophrenia and substance use continues to be a major problem in this population. The presented study is a part of comprehensive research, devoted to schizophrenia spectrum disorders, comorbided with alcoholism.

Objective. To analyze and compare the reasons of hospitalizations in schizotypal patients with alcohol abuse or dependence.

Methods. A total of forty-one consecutive inpatients with schizotypal personality disorder (STPD) and alcohol abuse/dependence were interviewed by psychiatrist. Clinical data and treatment characteristics were collected. All previous hospitalizations were included into analysis. Patients were followed-up during two years.

Results. Patients reported consuming alcohol before hospitalization in more than 90% of admissions. In 55,4% (n=113) the reason for admission to hospital was acute psychotic state. In 44,6% (n=91) hospitalization was due to alcohol withdrawal or disturbed behavior during alcohol withdrawal/intoxication. The leading behavioral pattern was aggression towards family members and self-injury. Acute psychotic states during withdrawal were abrupt and symptoms improved during standard detoxification treatment. 87,2% (n=34) patients met criteria for alcohol dependence and 12,2% (n=7) – for alcohol abuse, according to DSM-IV. During all studied disease course patients were hospitalized 204 times, it is equal to 4,97 hospitalisations per one patient. Comparing rate of hospitalizations between alcohol dependent and alcohol abusing individuals, it was found that alcohol abusing STPD patients are three times more likely to be admitted to hospital then alcohol dependent STPD patients.

Conclusion. Obtained data suggests that severity of alcohol misuse in STPD patients was not proportional to frequency of hospitalizations. Data also may suggests that alcohol abusing STPD patients have more behavioral disturbances and severe course STPD of in comparison to alcohol dependent ones. It is important to consider these differences in management of alcohol misusing STPD patients.

Abstract

Aleksey Pavlichenko

An objective of the study was to evaluate cognitive functioning in the long-term outcomes of bipolar disorder in absence of mood symptoms. The study included 42 bipolar inpatients in remissions in 10 years and more after index hospitalization. In our study we used «The MATRICS Consensus Cognitive Battery». The average age of the inpatient sample was 48.9 years. Most people have not worked over the year (85.7%) and were alone (64.3%). The long-term outcomes of bipolar disorder (inpatient sample) were characterized by significant impairment in social functioning and general cognitive deficits that were more expressed in such domains as speed of processing and attention.

To the problem of minor psychiatric illness of climacterium: Involutional Hysteria

Tatiana Polyakovskaya (Yanshina)

Our sample includes 85 women (average age - 49,1 ± 5.22 years). Typology developed in our study is based on clinical variety of psychosomatic disorders, named Involutional Hysteria (IH). Two variants of IH are identified. I type (55 cases) – Somatized Hysteria - is characterized by prevalence of conversions, organo-neurotical and hypochondrical symptoms in clinical sign. Basic tendency of dinamics – persistency in the form of hystero-hypochondriac development. II type (30 cases) - Hysteroid Disphoria – is characterized by hysterical depression in the form with dissociative symptoms and disphoric outbursts. Phenomena of «la belle indifference» contrast to hypochondria in clinical sigh of Somatized Hysteria. Dinamics is characterized by gradual reduction of symptoms.

Complex therapy of neurocognitive deficits in schizophrenia patients: pharmacological treatment and rehabilitation aspects

Savelyev AP, Spikina AA

Neurocognitive deficits in schizophrenia patients is a major health and social problem of modern psychiatry nowadays. Many patients with schizophrenia are of working age and there is a high enough percentage of their disability. That is why this problem is of very high social and medical importance.

Objective: to study the influence of neurocognitive training on higher cortical functions in schizophrenia patients and to evaluate their effectiveness in the treatment of schizophrenia.

Material and Methods: we formed groups of patients diagnosed with paranoid schizophrenia undergoing treatment in the departments of rehabilitation and day hospital. All patients received adequate pharmacotherapy with atypical neuroleptics. Patients of the main group (102 patients) additionally participated in the training of cognitive deficits. Patients included in the comparison group (48 patients) received only pharmacotherapy.

Methods: Clinical (advanced clinical psychopathological interview), paraclinical (psychological study of neurocognitive deficits in a battery of standard tests, the study of social functioning of patients - the scale of PSP).

STUDY DESIGN: Initial evaluation of patients was carried out at the first call, prior to the neurocognitive training. Follow-up study was conducted one month after completion of training programs and the final examination, after a year. In the comparison group surveys were conducted with the similar frequency.

Structure of trainings: Intensive training is conducted during the stay of patients in the department of rehabilitation at a frequency of at least two times a week. The duration of each session not exceeding 60 minutes. The total number of classes at the stage of intensive training is 10-12. Trainings are held two times a week. Supporting phase is aimed at maintaining and strengthening depleted during an intense phase of cognitive skills, as well as strengthening of the studied material, with following inclusion of patients in social programs. Trainings performed with a frequency of 1 every 2 weeks for six months. The duration of each session is 60 minutes. On stage, supporting the group can include more people from different groups (10-14), past the stage of intensive training.

Results: After training the cognitive processes in schizophrenia patients were obtained by increasing the tempo of the performance, improving concentration, improving the adequacy of long-term thinking and memory have been identified trend towards an increase in operational short-term memory. According to the survey indicated an increase in all indicators (the difference with the control group ranged from 3% to 26%), the maximum improvement falls on visual memory, and minimal attention to the function.

Conclusion: The neurocognitive training showed itself as an effective method of correcting neurocognitive deficits. Inclusion of these trainings in the rehabilitation program helps to reduce the term of the patients stay in hospital and rapid integration into society.

ASSESSING THE IMPACT OF PLACEBO EFFECT ON THE SCORES ON A SCALE OF PANSS (DEVELOPMENT OF A CORRECTIONAL SCALE)

Rinat Shamenov

Over the past 10 years the frequency of response to placebo in placebo-controlled clinical trials of neuroleptics has considerably increased. It has become a serious problem for developers of new drugs. The main tool for assessing the effectiveness of antipsychotics in clinical trials is the scale of PANSS.The items of the scale of PANSS are the space where the placebo effects are apparent. We plan to create a questionnaire that will assess the impact of the placebo effect on the dynamics of points on a scale PANSS. The questionnaire will include the following categories: trust to the doctor and the drug, faith healing, doubts about the drug, the expectations coming from the doctor. We suggest a questionnaire to be used as a correction scale of scores of PANSS, depending on the degree of placebo effect.

Mental illness effect on parenting

Olga Shishkina

Purpose: Investigation of the most common expertise situations in civil suits under the order of parenting when the folks are mentally ill.

Sample (Materials & Methods): 18 mentally sick parents were exposed to the complex forensic psychological-psychiatric expertise (2011).

Results In most cases the participants had:

1. delusional disorders effecting negatively on their parenting;
2. emotional-volitional disorders leading to the child neglect;
3. some peculiarities contributing to adverse impact on the psychic development of their kids;
4. no ability to take care of the child suffering from a severe somatic disease due to their psychic condition.

Resting-state networks in temporal lobe epilepsy patients with comorbid affective symptoms

Liubov Shmeleva

The main interest of research is focused on psychopathological features in temporal lobe epileptic (TLE) patients and their neurophysiological and neurofunctional basis.

Most of TLE patients have comorbid affective depressive and anxiety symptoms.

Aim: To characterize regional brain activation in resting-state networks(RSN) in TLE patients with current affective depressive and anxiety symptoms

Subjects and methods: TLE patients with and without current anxiety-depressive symptoms and healthy control group. All patients underwent psychiatric assessment and neurovisualisation procedures (routine MRI, VBM and resting-state fMRI) Independent component analysis was used to isolate RSN.

Results: Significantly increased functional connectivity in some brain regions were observed in affective group patients.

Conclusions: the results are in processing and need to be discussed.

THERAPY PROBLEMS OF PATIENTS WITH DEPRESSIVE DISORDERS IN PRIMARY CARE

Elena Shmunk

Depressive disorders (DD) are often underdiagnosed and undertreated. The objective of this study was to define methods of therapy in patients with DD before hospitalization to psychiatric unit. 102 patients with DD for the first time admitted to the psychiatric hospital were examined. The most part of patients (72,5%) took any medications in primary care. 38,2% of patients were prescribed tranquilizers and only 23,5% antidepressants, but 54,2% of them had suboptimal dosages. To summarize, in real clinical practice patients with DD still haven't enough opportunities for early diagnostics and appropriate treatment.

CLINICAL AND PSYCHOLINGUISTIC FEATURES OF MILD DEPRESSIVE STATE

Daria Smirnova

Mild depressive state is misdiagnosed in clinical practice. The precise study of speech in relationship with thinking is hypothesized to clarify the diagnosis and clinical perception of this mental state. 124 patients were studied. Speech was investigated using standard psycholinguistic procedures at superficial and deep levels. The deviations of speech indicators at superficial sublevels were observed in correlations with the mood state and clinical subtypes of depression. The most disrupted speech, mainly within deep structures, was revealed in melancholic subtype and connected with the most clinically pronounced disorders of thinking. Superficial level of speech was damaged mostly in asthenic-hypodynamic subtype. Speech was found similar to healthy controls, as well as higher cognitive adaptability, in anxious subtype.

The impact of personality traits on genesis, course and outcome of depression

Kseniya Smirnova

The objective of our study was to test the hypothesis that the Personality Disorders (PD) as a factor of constitutional predisposition, play a role not only in pathologic pathways of reactive depression, but also affect the prognosis of psychogeny and determine the subsequent development of the disease. Consequently two cohorts of patients were separated: those with depressive episodes of stereotypic psychogenic character and those with episodes progressing as endoreactive dysthymia. The distinction was based on whether the premorbid personality was within the affective spectrum PD or was of the histrionic PD.

COMORBIDITY OF PANIC DISORDER WITH AGORAPHOBIA AND ALCOHOL-RELATED DISORDERS

Dmitry Sobolev

Introduction Symptoms of Alcohol-Induced Disorders may resemble characteristic features of Panic Attacks. It is also known that individuals with fears occasionally use alcohol as an anti-anxious agent.

Objectives The objective of the study was to investigate the relationship between some common fears and Alcohol-Related Disorders. We have sorted out 61 inpatients with the diagnosis of "Panic Disorder (PD) with Agoraphobia" according to the DSM-IV criteria.

Results The rate of Alcohol Dependence among first-degree relatives of the patients was quite high (24, 6%). Approximately 10% had Alcohol Abuse within 5 years prior to PD onset.

Alcohol-Induced Panic Attacks (13,1%) were accompanied by predominance of somatic symptoms and fear of a life-threatening illness. Most individuals (95,1%) have completely abandoned any experience with alcohol in the first 3 months after manifestation of PD. Some months later, the repeated Panic Attacks could lead to avoidance of a variety of situations. About one-third occasionally used alcohol when they were travelling by public transport. Some patients (9,8%) took alcohol every time they intended being alone out of home which eventually led to Alcohol Dependence (6,5%).

When agoraphobia occurred soon after special treatment (so-called "coding from alcohol") just only the smell and view of alcohol beverages could provoke panic-like symptoms (8,2%).

Conclusion Both alcohol consumption and anti-alcohol treatment may immediately precede the onset of Panic Attacks. PD alone is associated with low risk of Alcohol Use Disorders. In contrast, agoraphobic symptoms are very likely to be accompanied with the frequent use of alcohol in fearful situations.

SOME ASPECTS OF THE COURSE OF ASPERGER SYNDROME

Veronica Somova

Introduction: Asperger syndrome (AS) is still misdiagnosed. It has also not many papers devoted to its course and outcomes.

Objective: To investigate the course of AS in different ages as well as identify the predictors of poor prognosis.

Methods We have sorted out 87 outpatients (78 males and 9 females) with the diagnosis of "Asperger syndrome" according to the DSM-IV. The research was naturalistic. We have also used the following rating scales: Asperger Syndrom Diagnostic Interview (ASDI), Autistic Spectrum Disorders in Adults Screening Questionnaire (ASDASQ), Adult ADHD Self- Report Scale (ASRS) Symptom Checklist.

The results: We have identified two groups of patients with AS. One group (55 persons) was characterized by predominance of different conduct disorders in their childhood. The symptoms of AS overlapped with ADHD signs. Most patients were treated then with psychotropic medicines as well as more than one third (35%) have been hospitalized. During adolescence a lot of symptoms were gradually decreasing except mild neurotic signs that did not lead to either inpatient or outpatient psychiatric service.

Another group (32 persons) was characterized in the childhood by only separate symptoms of attention deficit syndrome without taking any psychiatric drugs. However, in adolescence some affective and neurotic disorders have been exacerbated. Most individuals took psychotropic drugs (81%) and/or being hospitalized (38%). Symptoms of AS had declined that was accompanied with better prognosis.

Conclusion: Course of AS mainly depends on the age of individual and comorbid psychiatric disorders.

The role of fluvoxamine in treatment of neurocognitive disorders in schizophrenia patients

Anna Spikina, A.P. Savelyev

Currently, there is an intense accumulation of scientific evidence which consider schizophrenia as a neurodegenerative process. It was found with the help of modern neuroimaging that in most parts of the brain there is a significant reduction of gray matter volume, particularly in the parietal, occipital, frontal, temporal lobes. A significant decrease in brain volume was found by 3% in schizophrenia patients in comparison with the healthy population. About 85 per cent of schizophrenia patients have neurocognitive disorders which can be responsible for social maladjustment. There is a search for solutions for this problem nowadays. And one of these ways is pharmacological approach. The aim of our study was to investigate the possible influence of fluvoxamine on neurocognitive deficits in schizophrenia patients. To date, there are many data on the role of sigma receptors in the mechanisms of neuroprotection. Sigma-1 receptors play a specific role of a bridge in the CNS; they have a possible impact on neurotransmissive systems such as glutamatergic, noradrenergic, dopaminergic, serotonergic and cholinergic. It is assumed that dysfunction of glutamatergic neurotransmission through this type of receptors may underlie the pathophysiology of schizophrenia. Cognitive deficits can be reduced by the subsequent introduction of fluvoxamine and its effect, in turn, can be neutralized by the simultaneous administration of an antagonist of sigma-1 receptors, NE-100. In addition, a selective agonist of the sigma-1 receptor agonist SA4503 and endogenous digidroepiandrosterone sulfate may improve the cognitive deficits induced by phencyclidine. Agonistic activity of fluvoxamine at sigma-1 receptors may underlie the mechanism of its action. In addition, the agonistic activity of fluvoxamine at sigma-1 receptors may suggest its potential in the treatment of cognitive deficits in patients with depression and schizophrenia. As an adjuvant therapy in addition to antipsychotic medications may be used fluvoxamine for the correction of negative symptoms and cognitive deficits in schizophrenia. The study included patients suffering from paranoid schizophrenia at the age of 18 to 45 years. Patients were randomized into 2 groups: patients of the first group received fluvoxamine in the average daily dosage of 100 mg. As an antirecurrent antipsychotic zuclopentixole depot at a dose of 200 mg / m 1 every 3 weeks was used. Patients in comparison group received only monotherapy with zuclopentixole depot. The duration of the study was 1 year. Patients received the standard psychological examination before inclusion in the study, after 6 and 12 months after the study began. In accordance with the criteria for selection in the study included 100 patients with paranoid schizophrenia who were randomized into 2 groups of 50 people. The average duration of illness was 13 ± 1,3 years. The average patient age 33 ± 1,2 years. Average number of prior exacerbations - 1,7 ± 0,6. Average score on a scale of PANSS 60,1 +1,2. The clinical picture of neurocognitive deficits characterized by mild (67%) and moderate (33%)

Patients of the experimental group showed significant improvement in neurocognitive profile for the following: executive function, visual memory, working memory and selective attention. In comparison group patients were found, in general, a negative trend on the basic parameters of neurocognitive profile.

Conclusion: fluvoxamine may be recommended as a preparation for a possible correction of neurocognitive deficits in schizophrenia patients.

COGNITIVE DISTURBANCES IN THE PRIMARY HEALTH CARE PATIENTS SUFFERING WITH ORGANIC AND ANXIETY-DEPRESSIVE DISORDERS

Dmitry Tsarenko

A total of 60 patients (10 men, 50 female) aged from 18 to 75, that were on treatment in a district policlinic, were studied. Patients with mild organic mental disorders (MOMD) are characterized by disorders of verbal and visual image memory, decrease of internal determination of estimates, and narrowing of the range of the meaning articulation. The patients with anxiety-depressive spectrum disorders (ADSD) have no symptoms of the cognitive deficit changes, but they do have the cognitive style disturbances with some decrease of the working memory capacity, the trend to the decrease of the internal selection consistency and rather good ability to articulate the meanings. In the cases of patients with combination of these disorders ADSD+MOMD there is a combination of the above specified traits.

'Subjective psychology' of true hallucinations and pseudohallucinations

Natalia Voynova

True hallucinations and pseudohallucinations are well known as typical for some psychiatric disorders. Their correlation with normal psychical functions such as perception and conception has been discussed for a long time. Clue to this issue, particularly, could be found by careful examination of patient's subjective, self-reflexive psychic organization. In this way, the **aim** of present research was to investigate this possibility studying the patients' subjective psychic organization by taking their subjective interpretations of the "perception", "conception" and, after, their own correlation of their hallucinatory phenomenons with one of these terms.

The research was made on the base of Psychiatric Hospital №1 in Moscow. 25 patients having schizophrenia specrum disorders (F20, F23 in ICD-10) for 5 and more years (follow-up verified diagnoses) with hallucinations and/or pseudohallucinations in their structure were assessed (Group 1). Also two groups of comparison were combined: 4 patients with endogenous affective disorders without psychotic symptoms (F3 in ICD-10, Group 2) and 15 healthy people (Group 3). No special knowledges in psychiatry or psychology were allowed, what's gone as a main criterion of selection for all three groups. Research was made using clinical psychopathological **method** - a special questionnaire, with which patients (Group 1) were asked to correlate their "voices" (in- and/or external) with perceptions and conceptions, to explain why they preferred one or another variant then and, afterwards, to interpret both terms. Members of groups 2 and 3 had to do the third part, explaining the meaning of "perception" and "conception".

Results: patients from Group 1 had no difficulties with the task and mostly have brought their pseudohallucinations into correlation with perception. This result is contrary to our consideration at the start: more "complicated" psychopatological phenomenon (pseudohallucinations) was correlated with "simplier", less subjectively specified psychical function. This "paradoxality" was illustrated by patients: "I perceive from…", but not "… what". So, perception was reconsidered by patients as a forcible phenomenon, the display of influence extraneous for their psyche. Conception was interpreted by patients as a psychic process of their own. Characteristics of true hallucinations were less defined. Members of Group 3 hadn't the courage to give define terms without some minutes for reflection, but after thinking for a while, they gave definitions close to academic ones. Group 2 takes an intermediate position with their formulations in common similar to the Group 3. **Conclusions:** the results have shown the fundamental difference between perception as normal psychical function and perception as morbid, forcible experience. From this point of view, pseudohallucinations seem to be separate experiences of different structure, that are alien to normal psychic functions, and can not be considered as disorders of conceptions or perceptions. Thereby, patients with schizophrenia have their psychic organization to become more complicated in some ways. Results of this research open some perspectives for psychotherapeutic work with psychotic patients.

Psychosis in drug addict's adolescents

Yulia Yakovleva

Aim: To study the features of psychosis in drug addict's adolescents. **Material and Methods:** 56 fist time hospitalized adolescents from 13 to 18 years with psychotic disorders were examined by clinico-psychopatological methods. **Results:** Clinical features like apatho-abulitical syndrome was present in 29 (52%), depression in 48 (86%), anxiety in 34 (61%), hallucinations in 22 (39%), delusions in 6 (11%), derealization syndrome in 2 (4%) of patients. These states were long and resistance to treatment. All symptoms was reduced only in 5 (5%) of patients. **Conclusions:** Causes of psychosis resulting from the use of surfactants and their resistance to therapy must be study deeper.

Abstract

Aleksandra Yaltonskaya

Currently I work on a PhD project dedicated to the study of predictors of efficacy of group CBT in combined (pharmacological +CBT) treatment of inpatients with depressive disorders. This research project takes place in one of the psychiatry clinics of Moscow under the supervision of Department of Psychiatry, Addiction and Psychotherapy of Moscow State University of Medicine and Dentistry.The aims of my research are to establish the efficacy of group CBT combined with pharmacological treatment, as well as identify the factors associated with better outcomes in those patients who attend group CBT sessions. Two groups of patients are compared in this research: the main group receives standard psychopharmacological treatment and attend group CBT (10 sessions, 2, 5 hours long). The control group received only standard pharmacological treatment.

RISKS OF AMBULANCE WORKING AND ITS INFLUENCE ON THE WORKERS' MENTAL HEALTH

Konstantin Zalmunin

Professional activity of ambulance workers is associate with harmful interference of working environment. The goal of research is assessment of main harmful factors of ambulance workers environment and analysis of their influence on the workers mental health. While researching the working environment was analyzed and 43 workers of the Kazan Central Ambulance Station were examined. Materials and methods: hygienic assessment, monitoring of physiological and psychological condition of workers before and after duty. The "risk group" was discovered: the age of members was younger than 30 years and their work experience at the ambulance was between 5-9 years ($p < 0,05$).

Disturbances of one-carbon metabolism at patients with schizophrenia and depression

Tatiana Zhilyaeva

Research is devoted
- to studying of disturbances of an one-carbon metabolism at patients with endogenous mental disorders;
- to establishment of a role of folate deficiency, hyperhomocysteinemia and polymorphism of MTHFR677TT in an etiology and pathogenesis of schizophrenia and affective disorders;
- to development of algorithms of folate augmentation of psychopharmacotherapy of endogenous mental disorders;
- to assessment of efficiency of folate augmentation of psychopharmacotherapy of endogenous mental disorders;
- to development of algorithms of prevention of these diseases in population using folates.

MENTAL DISORDERS PROBLEMS IN CANCER PATIENTS AFTER PANGISTEREKTOMIA

Anastasia Zolotova

Mental disorders are common in women of childbearing age after panhysterectomya. 60 women examined using clinical method and Hospital Anxiety and Depression Scale (HADS) were used. The research of psychic sphere patients dentified mental disorders of different nosology with a predominance of anxiety and depressive symptoms in 75% of cases . The most frequently were: adjustment disorder: mixed anxiety and depressive reaction - 43,3%, organic asthenic disorder due to somatic disease -30%. Appropriate therapy of these disorders can improve the quality of life and social adaptation of such patients.