negative life events(P=.033);more maternal interfere and protection(P=.024).

Conclusions: Our retrospective findings indicate that a history of automutilation behavior and suicidal ideation is associated with a more negative life events and more negative parental rearing style. Greater attention to realizing those at high risks for self-injury behavior and suicidal thinking could have an impact on bipolar disorder among adolescents.

P139

Maniacal type of bipolar affective disorder and sexual dysfunction

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Bipolar affective disorder (BAD) in 50% cases, begins after 40 years, when the sexual dysfunction number rises. In hypomaniacal condition patients don't apply to sexologists, as they percieve sexual sphere changes as positive. But psychotropic therapy influences on intimate patient's life, causing genital reactions weakness, libido decrease and orgasm disappearence. Psychotropic therapy effect on the sexual function depends on sensity of a patient. We've described a patient P, 49 years old, with BAD. His complains went into clinical picture of sexual failure expectation syndrom, that have appeared after erectil dysfunction episode in time of psychotropic therapy (risperidone 0.012 per day, contemnol 0.6 per day). Patient interrupted this therapy independently and in order to prevent erectil dysfunction, began to intake the next mixture before intimacy: methyltestosterone 0.005 per intake, impaza 1 tab, johimbine 2 tab. Today, taking this therapy in combination with clopixol-depot 0.2 per month, contemnol 0.3 per day, cyclodol 0.002 per day, patient evaluates his erections as sufficient. But existing anxiety was the reason to visit sexologist. At reception he appeared hypomaniacal features with safety on the sufficient level libido. So, the psychotropic therapy, have been prescribed without taking into account it's sexual function influence, leads patient independently change basic therapy. This causes unobservance therapy regime and it's low effect on the main psychiatry disorder, delaying remission appearance. This has to be remembered by the doctor, prescribing psychotropic therapy, especially upporting one, in patients, suffering from BAD.

P140

Oxcarbazepine as a mood stabiliser.

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Carbamazepine as a mood stabiliser: A well-known mood stabiliser. Oxcarbazepine is a metabolite of carbamazepine and works as an anti-epileptic, but it has a more favourable pharmacological profile. Researchers have been studying its mood stabilising effect in bipolar disorders for decades. We have carried out a retrospective study of 7 patient charts.

Results: 7 women; average age: 44 years old; onset of bipolar disorder at the age of 32.

Continous use of oxcarbazepine: 26.1 months and continuous use of the previous mood stabiliser: 20.6 months. The percentage of time spent in euthymia improved from an average of 48% with the previous mood stabiliser to 62% with oxcarbazepine. The percentage of time spent ill both of (hypo)mania and of depression decreased respectively from 24% to 18% and from 25% to 19% with the use of oxcarbazepine. Improvement occurred with 4 of the 7 patients.

Conclusion: These results are in accordance with the literature. Oxcarbazepine has the advantage of fewer (drug-to drug) interactions than carbamazepine.

P141

Augmenting antidepressant psychopharmacological approach with cognitive-behavioural therapy in bipolar depression

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Background: Cognitive- behavioural therapy (CBT) is an augmentation strategy used in bipolar depression because it improves compliance to treatment, patient's insight into specific areas of daily behavior, allows patient to recognize early signs of disease and to cope with stressfull events.

Objective: To analyse the efficacy and action onset of augmentation cognitive- behavioural specific techniques in patients diagnosed with bipolar depression that receive an antidepressant and anticonvulsant combination therapy.

Methods: A group of 18 patients, 6 male and 12 female, mean age 32.9, admitted in our clinic with bipolar disorder type I, major depressive episode (DSM-IV-TR) were distributed in two equally groups, one of them received only antidepressant drug plus anticonvulsant, the other combined psychopharmacological treatment with CBT. All patients received carbamazepine (flexible dose 400-600 mg/day) and selective serotonin reuptake inhibitor (SSRI): 7 patients fluoxetine 20-40 mg/day, 6 patients paroxetine 20-40 mg/day and 5 sertraline 150-200 mg/day. Inclusion criteria: Hamilton Depression Rating Scale 17 items (HAMD-17) over 17, Young Mania Rating Scale (YMRS) under 10. Exclusion criteria: axis I or II comorbidity. We used weekly for 4 weeks and monthly for 5 months HAMD, YMRS, Global Assessment of Functioning (GAF) and Clinical Global Impression (CGI).

Results: There was a significant better improvement in patients receiving CBT treatment (-12%HAMD, -14%GAF, -16%CGI). YMRS was stable in both groups. The onset of antidepressant action was observed earlier in CBT group (10.5 days compared to 17.5).

Conclusions: CBT stands as an efficacious augmentation strategy for patients who are treated with antidepressant and anticonvulsant therapy.

P142

Double-blind comparison of addition of acanthopanax senticosus versus fluoxetine to lithium for treatment of adolescent patients with bipolar depression

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Bachground: Adolescents with bipolar disorder are much more than people once thought. Although there have been multiple reports published regarding the treatment of manic symptoms in children and adolescents, albeit mostly open studies, the efficacy of agents to treat bipolar depression in this population has not been adequately studied. Treating with antidepressants such as tricyclic antidepressants and SSRI(selective serotonin reuptake inhibitors) should face the risk of mood switching and suicide. Acanthopanax senticosus has shown some antidepressant effect since the ancient china, and preliminary

https://doi.org/10.1016/j.eurpsy.2007.01.879 Published online by Cambridge University Press

studies also indicated it may be helpful to depression. Will it be helpful if treating the adolescent bipolar disorder?

Method: 76 patients were randomized into two groups, 37 treated with capsule Acanthopanax senticosus plus tablet lithium, 39 treated with capsule fluoxetine plus tablet lithium. Hamilton depression rating scale, 17 items (HAMD-17) was assessed during the trial.

Result: After 6 weeks treatment, There was a main effect for duration of treatment for Hamilton depression scale scores ($F=183.06$, $P<0.01$), but there was no group main effect($F=0.99$, $P=0.323$) or group-by-duration of treatment interaction($F=0.779$, $P=0.437$). The response rate and remission rate between the two group were similar. 3 patients suffered mood switching in fluoxetine treated group while no patients in Acanthopanax senticosus treated group.

Conclusion: This preliminary study suggested that lithium adding Acanthopanax senticosus was as effective as lithium adding fluoxetine for treating adolescent bipolar depression, and Acanthopanax senticosus may be more safer and less risk to mood switching.

P143

Response- and remission rates as efficacymarker of monotherapy with atypical neuroleptics in the treatment of acute mania

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Introduction: Numerous studies on the treatment of acute mania in bipolar patients have demonstrated the efficacy of atypical neuroleptics versus placebo or active comparator. However, there is a lack of direct comparative studies between atypicals. We present an overview on the efficacy (response and remission rates) of atypicals.

Methods: Using MEDLINE-analysis, all prospective double-blind studies of atypical neuroleptics in acute mania published until November 2006 were identified. Response was defined as 50% improvement and remission as an endpoint ? 12 in YMRS. The following parameters were calculated: response rates, remission rates, odds ratios, adjusted odds ratios.

Results and Discussion: Response rates in placebo controlled studies (duration 3-4 weeks) ranged from 18.9% to 42.9% (placebo) and from 39.8% (aripiprazol) to 72.9% (risperidone) for comparators. The adjusted odds ratios ranged from 1.946 (ziprasidone) to 2.727 (risperidone), all differences versus placebo were statistically significant in favor of the atypical. Remission rates ranged between 22.1% and 35.7% (placebo) and for comparators between 27.7% (quetiapine) and 61.1% (olanzapine). In comparator controlled studies (duration 3-12 weeks) response rates ranged between 42.3% and 74.2%. With odds ratios between 0.580 and 1.629, differences versus comparator were not statistically significant. Remission rates in these studies varied from 27,7% (quetiapine) to 49% (lithium). The observed trends for treatment effect differences between the atypicals are confounded by different study designs and patient characteristics. Thus, direct comparative studies between atypicals in acute mania are required to detect potential treatment effect differences, e.g. in special patient subgroups.

P144

Preventing bipolar relapse: Which factors are associated with different mood stabilizer therapy?

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Background: As bipolar disorder drastically afflicts the patient's family, social, and occupational life alongside with a high suicide rate, early initiation and maintenance of pharmacotherapy is crucial. However, bipolar relapse prevention including modern atypical antipsychotics still deserves research.

Methods: Targeting relapse prevention in a natural setting, this ongoing 18-months, prospective, multicenter, non-interventional study compares mood-stabilizing therapies in German outpatients with bipolar disorder.

Results: The present analysis of baseline-data reveals that of 761 adults included, 26.1% are receiving olanzapine monotherapy (OM), 21.2% lithium monotherapy (LM), 30.1% anticonvulsant monotherapy (AM), 6.4% olanzapine/lithium combination therapy (OLC), 9.5% olanzapine/anticonvulsant combination therapy (OAC), 6.7% other combinations of mood stabilizers (OC) and 5.8% no mood stabilizers (NO). A higher rate of females receive AM (32.5%, males 22.9%) while males are rather treated with OM (26.6%, females 23.0%). At baseline, 36.4% of the patients had been hospitalized within the last 12 months due to psychiatric disorder, 26.8% had a history of suicide attempts, 10.7% were considered rapid cyclers.

Within the last 12 months 66.5% of the patients experienced manic episodes, 88.6% depressive episodes and 43.1% mixed episodes. The highest rates of prevalent diabetes mellitus (12.6%) and lipid disorders (17.5%) and second highest of cardiovascular disease (20.4%) was found in Patients receiving LM. Employment rate at baseline was highest in the AM-group (39.6%) and lowest with OC (29.2%).

Conclusion: The present data show that these patients in whom maintenance therapy was initiated, form an exceedingly heterogeneous population, suggesting a strong demand for individually customized therapies.

P145

Preventing bipolar relapse: In which way do patients with mixed episodes differ?

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Introduction: Treating bipolar disorder, patients with mixed episodes are considered the most problematic subgroup as they do not respond easily, which makes the choice and dosage of the respective pharmacotherapy difficult. One objective of this ongoing 18-months, prospective multicenter, non-interventional study on mood-stabilizing therapies is to find out what specific patient features are associated with mixed episodes.

Methods: Observational data from 761 outpatients are collected by 150 office or hospital based psychiatrists throughout Germany in the course of standard treatment for bipolar disorder. A baseline analysis was run and patients without mixed episodes (0-MX) were compared to those with one (1-MX) and more (>1-MX) mixed episodes.

Results: 30.9% patients experienced mixed episodes within the last 12 months, with a hospitalization rate of 33.2% for the 0-MX, 36.5% for the 1-MX and 43.4% for the >1-MX group. The 0-MX group had 5.6% rapid cyclers, while it was 11.0% for the 1-MX and 32.8% for the >1-MX group. Regarding treatment, 0-MX mostly receive anticonvulsive monotherapy (31.1%), 1-MX olanzapine monotherapy (31.8%) and >1-MX anticonvulsive monotherapy (35.3%). A higher psycho-education rate appeared with the 1-MX (19.0%) and >1-MX (28.8%) than with the 0-MX group (14.8%).

https://doi.org/10.1016/j.eurpsy.2007.01.879 Published online by Cambridge University Press