practice due to shortness of time and resources; tendency of colleagues from other disciplines to disregard setting features related to time and space (inadequate rooms, e.g. too busy or noisy); limited time for face-to-face discussion of cases or problems; conflicts with patients/relatives/colleagues, and fear of reciprocal manipulation.
Discussion Moving on the interface between psychiatry and the somatic disciplines, CL specialists need to develop special skills, not only those strictly technical, but also those "soft skills" including relational abilities and flexibility. Understanding the systemic aspects of referrals in the relationship between physician, staff and patients is usually essential in the process of consultation.
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W15

Psychotherapeutic interventions in consultation-liaison psychiatry implications for psychiatric trainees

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In clinical reality, psychiatric trainees working in consultation and liaison psychiatry (CLP) face a lot of obstacles to gain satisfactory results from their work on somatic wards. Specifically, the deliverance of psychotherapeutic interventions in every-day CLP is a topic of discussion. The talk will present a case of a young anorectic patient that will exemplify the difficulties in delivering psychotherapeutic treatment in every-day clinical work and will outline common difficulties, specifically in relation to interactions with staff of somatic units. The presentation will be wrapped-up by suggestions on how to deal with the most common problems.
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W16

Psychopharmacological treatments strategies in consultation-liaison psychiatry: Clinical vignette and pros and cons

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Introduction Multimorbidity and polipharmacotherapy are crucial features influencing the psychiatrist's prescription in the consultation-liaison psychiatry (CLP) setting.
Aims to provide an example of computer-assisted decision-making in psychotropic prescriptions and to provide hints for developing pharmacological treatment strategies in the CLP setting.
Methods Case report. A clinical vignette is presented, followed by a review of available online computer-assisted prescription software.
Results A woman in her seventies was repeatedly referred for psychiatric consultation. Eleven different medications were administered daily, because of multimorbidity. A diagnosis of distymia was established, with comorbid mixed pain (partly fulfilling the criteria of somatic symptom disorder) and substance use disorder (opioids). After the first assessment, six follow-up visits were needed during hospitalization. Mirtazapine and benzodiazepines were introduced. Beside the pharmacological intervention, conflict mediation was performed in the relationship with the patient, her relatives, the ward personnel and the GP, to develop a long-term rehabilitation project. Pros and cons of online computer-assisted prescription software were discussed together with the ward personnel, as well.
Conclusions Computer-assisted decision-making in psychotropic prescription is becoming more common and feasible. The use of available software may contribute to safety, effectiveness and cost-effectiveness of clinical decision-making. Risks are also possible: depending for example from regional differences in prescription indications, different guidelines, pharmacogenomics, frequency with which databases are updated, sponsorships, possible conflicts of interest, and real clinical significance of highlighted interactions – all issues the clinician willing to benefit from this modern tools should pay attention to.
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W17

Drugs pharmacokinetics interactions with cardiac and renal disease patients in consultation-liaison psychiatry

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The prevalence of psychiatric disturbances in patients with cardiovascular disease is elevated. For example the prevalence of major depression can reach 15–20% and of anxiety disturbances 5–20%.
When we treat psychiatric symptoms in cardiovascular disease we must have in mind four particular effects of psychiatric drugs: (1) disturbances of atrial-ventricular conduction; (2) QTc interval prolongation that can lead *to torsade de pointes* and ventricular fibrillation; (3) hypertension; (4) changes in platelet aggregation.
On the other hand, there is a great prevalence of psychiatric disease in patients with renal disease. For example, about 5–25% of the patients with advanced renal disease have major depression.
Renal disease patients can evidence changes in several pharmacokinetic parameters such as: (1) biodisponibility; (2) distribution; (3) metabolism; (4) excretion. Therefore, when we treat these patients we have to keep in mind the effect of psychiatric drugs over the renal functioning, but also the effect of the deficient renal function in the pharmacokinetics of the drugs.
I this presentation we intend to reveal what are the main concerns when we prescribe psychiatric drugs in patients with cardiovascular and renal disease.
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How should psychopharmacotherapy be learned by residents in psychiatry – proposals of psychopharmacology curricula

W18

The present situation of psychopharmacology teaching suggests the need for a European curriculum

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Introduction In most European countries postgraduate training for specialization in psychiatry and psychotherapy is acquired over the course of 4–6-year programs. In the European Union, qualification in one country is recognized within other countries of the Union.
Objectives and aims To analyze the present situation of psychopharmacology-pharmacopsychiatry postgraduate teaching in Europe and to present the needs and preliminary instruments for improving the situation by harmonization of the programs.
Methods Analysis of the data available from national psychiatric societies and from the literature; development of a consensus among experts in this field.
Results Despite efforts to standardize post-graduate training, the curricula in different European countries vary greatly. This variability limits comparability between countries and international exchange while carrying consequences in the breadth and quality of education that trainees receive. Literature and curricula mainly published in USA as well as a recently published curriculum and learning catalogue in Germany [1] offer useful tools for the development of a curriculum at a European level.
Conclusions There is clearly a need for standardization of psychopharmacology-pharmacopsychiatry teaching at the European level. This can be achieved by the introduction of a curriculum and learning catalogue developed by European experts and based on tools already available.
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Reference
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W19

Proposal for a model psychopharmacology curriculum for psychiatric residents in Germany

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All German societies of medicine have been ordered by the Federal Association of Physicians (Bundesärztekammer) to propose new revised regulations for the education of residents. The German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN) is offering a broad extension of education in psychotherapy while education in pharmacotherapy is still rather small and limited. The working group Biological Psychiatry of the German Association of Psychiatric Hospitals (Bundesdirektorenkonferenz, BDK) suggests a detailed proposal of a psychopharmacology curriculum based on a Delphi method consent of medical directors involved in the education of the majority of German psychiatric residents. Issues include general pharmacology, neurobiological principles, clinical pharmacology of different classes of psychotropics (antidepressants, antipsychotics, mood stabilizers, anxiolytics, hypnotics, stimulants etc.), special aspects (e.g. pregnancy, geriatric patients) as well as ethical, legal and economic aspects. About 160 hours of theoretical education are proposed, clinical teaching should be interactive, with vignettes and supervision covering about 300 hours.
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W20

Psychopharmacology during residents' training: The role of scientific societies

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In France, psychopharmacology is supposed to be one of the bases of the training during the first year of residency. But there is no standardization in the content of the psychopharmacology courses for residents from one region to another. There is also a debate around the way psychopharmacology has to be learned by young professionals, with the development a narrative approach that seems to have a pedagogic relevance, opposed to a more academic approach. In this context, the French Society for Biological Psychiatry and neuropsychopharmacology developed a program of specific psychopharmacology workshops for residents. These workshops combine a fundamental pharmacologic approach, with a more clinical evidence-based one, trying to take into account the discrepancy that residents may experienced between knowledge and every day practice, around specific topics (e.g. polypharmacotherapy). This program highlights different issues in the domain of the psychopharmacology courses for residents around the format (e.g. on-line courses versus face-to-face courses), the topics and the content of the courses (e.g. categorical approach of prescription versus dimensional approach). It underlines the need for a clear definition of what has to be known by residents in this field but also how this initiative can be implemented for a large number of residents using numeric tools and what is the role of scientific societies and their interactions with academic teaching. The funding of such programs has also to be defined and clarified.
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W21

The new neuroscience based nomenclature of neuropsychotropic drugs: A chance for a better understanding and teaching of clinical psychopharmacology

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Traditional psychopharmacological terminology is based on historical grounds and under different aspects not systematic and rational. It even tends to confuse patients by prescribing a drug that does not reflect their identified diagnosis, prescribing "antipsychotics" to depression. Four major colleges of neuropsychopharmacology (ECNP, ACNP, Asian CNP, an CINP) proposed a new multi-axial pharmacologically-driven nomenclature. The template has five axes: 1- class (primary pharmacological target and relevant mechanism); 2- family (reflecting the relevant neurotransmitter and mechanism); 3- neurobiological activities; 4- efficacy and major side effects; and 5- approved indications. The results of the surveys suggest that the clinicians found the available indication-based nomenclature system dissatisfactory, non-intuitive, confusing, and doubt-inducing for them and the patients. The proposed five-axis template seeks to upend current usage bay placing pharmacology rather than indication as the primary axes. With the proposed nomenclature relating primarily to Axis 1 – the class, and usage of the other axes would largely depend the extent to which the clinician seeks to deepen the scientific and clinical base of his involvement.