S53-2
SHORT AND LONG TERM TREATMENT OF OCD

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The data froam the studies of the pharmacotherapy of OCD provide striking evidence of the important role of serotonin in the disorder. OCD only responds to those treatments with potent reuptake of serotonin such as the SSRIs fluoxetine, fluvoxamine, paroxetine, and sertraline or the non-selective SRI clomipramine. Six studies have now compared SSRIs with clomipramine in head to head double blind randomised comparisons and found no advantage for clomipramine in efficacy but a significant disadvantage in terms of side effects, which indicates that the activity of clomipramine in inhibiting noradrenaline reuptake has no extra therapeutic advantage in OCD and some disadvantages. This conclusion is supported by the consistent finding that SSRIs are significantly more effective than noradrenaline reuptake inhibitors and that antidepressants without potent SRI properties are ineffective.

OCD is largely a chronic disorder with a lifetime prevalence close to the six month prevalence. It is no surprise that OCD requires long term treatment. Randomised relapse prevention studies of both behaviour therapy and SSRIs show high and predictable relapse rates when treatment is discontinued. This finding, particularly in the more severe populations included in studies contradicts the widespread assumption, based on optimistic open studies, that response once achieved with behavioural treatment will be self perpetuating. All the controlled efficacy data support the need for maintenance treatment in OCD and clinicians would do well to be aware of the chronicity and high chances of relapse of this disabling disorder when treatment is discontinued. Treatment in the severe populations studied is like to be indefinite.

S53-3
CO-MORBIDITY OF OCD, PANIC DISORDER AND DEPRESSION — A DIAGNOSTIC DILEMMA AND CLINICAL CHALLENGE

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The co-morbidity of Obsessive-Compulsive Disorder (OCD) with Major Depression (MD) is about 80%[1]. However, in the clinical practice has been observed more frequently the co-occurrence of obsessive-compulsive and depressive symptoms and/or MD and some obsessive-compulsive symptoms, rather than a (pure) co-morbidity between the two categorical disorders.

Literature data concerning the frequency of co-morbidity of Panic Disorder (PD) and OCD seem to indicate that it ranges from 5 to 27% [2,3]. Moreover, patients suffering from PD associated (or not) to other Anxiety Disorders, including OCD, seem to be more vulnerable for developing secondary depressive symptoms.

Finally, it seems to be a direct correlation between the severity of agoraphobic symptoms and the percentage of patients suffering from the association of PD and OCD[4].

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S53-4
BIOLOGICAL MARKERS IN OCD AND PREDICTORS OF RESPONSE

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Neurobiological studies continue to generate new clues to the pathophysiology of obsessive-compulsive disorder (OCD). Currently, the weight of evidence implicates serotonin (5-HT) receptor dysfunctions, but there is also evidence for abnormalities in other neurotransmitters, such as dopamine and noradrenaline, in neuropeptides, and for infective and immunological mechanisms.

Our studies in OCD patients confirm the role of the 5-HT system and of immune abnormalities. In addition, the serotonergic dysfunction seems to be linked to the pharmacological response. Latest findings from our research group indicated the possible involvement of 5-HT receptors of type 2C, on the basis of the observation of increased mRNA expression in lymphocytes of patients, as compared with controls, and of protein kinase of type C.

S53-5
OCD SPECTRUM DISORDERS — FROM IMPULSIVITY TO COMPULSIVITY

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Obsessive-compulsive spectrum disorders are manifested by repetitive behaviors or obsessional concerns, and they have diagnostic and treatment implications for up to 10% of the U.S. population. This presentation provides an overview of the obsessive-compulsive spectrum and examines the diagnostic issues, dimensional issues, and biological mechanisms that may underlie obsessive-compulsive behaviors, as well as treatment successes with selective serotonin reuptake inhibitors (SSRIs) and the behavioral therapies.

In addition, examples of body dysmorphic disorder (BDD), pathological gambling, and sexual compulsions are discussed in detail. These examples include information about diagnostic controversies, comorbidity, family history, serotonergic function and recent imaging findings, and current treatment findings with SSRIs.

S54. Brain electric field studies in schizophrenia

Chairs: D Lehmann (CH), W Strik (D)

S54-1
EEG REACTIVITY MAPPING IN FIRST EPISODE, NEUROLEPTIC-NAIVE SCHIZOPHRENICS AND RELATIONS TO PSYCHOPATHOLOGY

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From nine first episode, neuroleptic-naive schizophrenics and 18 matched controls, 19-channel EEG was collected during initial

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