

that psychostimulant use can be understood as the representation of and identification with the cultural messages and models (e.g. quality of life, consumption patterns, etc.) on microcultural and individual level.

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LACK OF EFFECT OF VITAMIN B₆ ON PSYCHOTIC SYMPTOMS IN CHRONIC SCHIZOPHRENIC AND SCHIZOAFFECTIVE PATIENTS: A DOUBLE-BLIND PLACEBO-CONTROLLED STUDY

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Deficiency of certain vitamins, and especially from the 'B' complex, can produce symptoms of psychiatric disorder. Vitamin B₆, or pyridoxine plays an intrinsic role in the synthesis of certain neurotransmitters which take part in development of psychotic states. There are a number reports that vitamin B₆ may be a factor in a number of psychiatric disorders, such as autism, Alzheimer's disease, hyperactivity, learning disability, anxiety disorder and depression. Moreover, there are anecdotal reports of a reduction in psychotic symptoms after vitamin B₆ supplementation of psychopharmacologic treatment of patients suffering from schizophrenia or organic mental disorder. The aim of this study was to systematically examine whether vitamin B₆ therapy influences psychotic symptoms in patients suffering from schizophrenia and schizoaffective disorder. The effect of the supplementation of vitamin B₆ to antipsychotic treatment on the positive and negative symptoms in 15 schizophrenic and schizoaffective patients were examined in a double-blind, placebo controlled, crossover study spanning 9 weeks. All patients had stable psychopathology for at least a month before entry into the study and were maintained on their pre-study psychoactive and antiparkinsonian medications throughout the study. All patients were assessed by Positive and Negative Syndrome Scale for Schizophrenia (PANSS) on weekly base. The patients randomly received increasing doses of vitamin B₆ or placebo at 100 mg/day for the first week, 200 mg/day for the second week, 300 mg/day for the third week and 400 mg/day for the fourth week. PANSS scores revealed no differences between vitamin B₆ and placebo-treated patients in amelioration of their mental state.

P01.59

IS PRESCRIPTION OF CYAMEMAZINE USEFUL TO FAVOR WITHDRAWAL OF BENZODIAZEPINES AFTER LONG TERM TREATMENT?

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Long term prescription of anxiolytic benzodiazepines (BZD) is frequently associated with dependence. The objective of our study was to evaluate the efficacy and tolerance of an anxiolytic neuroleptic: cyamemazine used at low doses to avoid anxiety rebound, withdrawal signs, reintroduction of BZD when a long term anxiolytic benzodiazepines prescription had to be stopped.

Method: A multicentric, double blind, randomised study was conducted in 168 patients taking BZD (5 to 20 mg equivalent diazepam) for anxiety since more than 3 months. The study compared two groups of treatment, one with a substitution from BZD initial to bromazepam during 14 days then prescription of half the dose of bromazepam during 14 days then prescription of placebo for 14 days, and the other group with a substitution from

BZD initial to cyamemazine during 14 days then half the dose of cyamemazine during 14 days then placebo for 14 days. The doses of cyamemazine used were 12.5 mg to 50 mg and for bromazepam 1.5 mg to 6 mg. Six month-follow-up was carried out to collect data after a withdrawal period of 6 weeks.

Results: There was no significant difference between the two groups neither on maximal amplitude of anxiety rebound on HARS between DO and D42 (main criteria), nor on percentage of anxiety rebound on HARS or Zung anxiety scale, nor on number of new or worsened symptoms on Rickels withdrawal scale. After 6 months, the physician estimated that the rate of success was better in the cyamemazine group than in the bromazepam group ($p = 0.03$). Cyamemazine was well tolerated without extrapyramidal symptoms. Cyamemazine could be useful to favor long term maintenance of BZD withdrawal among patients supposed to be subject to relapse and reintroduce BZD.

P01.60

WHAT'S BENEATH THE SKIN?

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The relationship between the skin and the psychic system has been well-known for a long time.

The skin is a surface for the projection of physical processes and changes-the explanation of the psychosomatic dermatological symptoms are based on the dysfunction of the emotional and autonomic nervous system. Behind the non-improving, itching and scratched ekzema we sometimes find either Ekbohm-syndrome/ often diagnosed AS gerontological delusions of parasitosis,/ or therapy-resistant allergy/which conceals depression.

The authors present condensed case-stories about delusions of parasitosis and allergic syndromes-proving the excellent results achieved using risperidone-therapy and citalopram.

P01.61

STUDY OF CONVERSION FACTOR BETWEEN ZUCLOPENTHIXOL (ZCP) ACETATE AND ZCP DECANOATE IN PATIENTS RECEIVING HIGH DOSES OF ZCP ACETATE

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More and more consideration has been given to the high doses often used in the treatment of the schizophrenic patients presenting acute psychotic symptomatology. Zuclopenthixol has been found to be efficacious in the treatment of schizophrenia either with its depot (decanoate:AP) an semi prolonged (acetate:ASP) formulations. Recommendations for the transfer from ASP to AP treatment are used on the estimated daily dose of ASP. The objective of this multicentric study is to determine a conversion factor (CF) between ASP an AP in psychotic patients receiving high doses of ASP (mean dose ≥ 150 mg/day). The CF is bound to establish the minimal antipsychotic efficacy dose of AP. The determination of CF is based on both clinical (CGI, item 2) and pharmacokinetic (serum dosage of zuclopenthixol) assessment, the AP dosage used is then linked to the ASP posology. 48 patients were included in this open-label pilot study that comprises. 2 periods: I (acute treatment): ASP treatment until stabilisation/improvement assessed on the CGI item 2; II (maintenance treatment): switch to AP/14 days. Duration of period I must not be less than 4 days and total duration of period II is 80 days. Blood samples will be taken 7 days after each AP injection. The first AP/14 days dose was 3 fold the mean value of the last two ASP injections (dose A). The next AP doses (dose A \times 2 or 3 or 4) were decided upon the results of the clinical response