458msecs.In 18 patients (34%) the ECG analysis was determined by the analyser to be difficult to analyse due to significant baseline patient movement.

Conclusion: Significant BP and ECG abnormalities are common and require evaluation for treatment. QTc abnormalities are detected significantly less often than other important abnormalities. Using the most conservative definition of hypertension 53% of this cohort would be defined as needing antihypertensive treatments and lifestyle interventions in 64%.

P022

Categorical prevalence of hyperprolactinaemia in schizophrenia and bipolar outpatients in UK recieving antipsychotics

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Background: Increasing attention is paid to importance of hyperprolactinaemia. Sexual dysfunction and osteoporosis are reported in such patients. There is little naturalistic data showing prevalence and severity of hyperprolactinaemia in asymptomatic patients receiving antipsychotics.

Methods: All outpatients in a community mental health team in Halifax receiving antipsychotics with diagnosis of schizophrenia or bipolar disorder had prolactin measurements. Upper Limit of Normal (ULN) prolactin 500mIU/L (males) and 700mIU/L (females).

Results: Prolactin levels were obtained in 226 patients providing 253 incident cases as antipsychotic changes were made over 36-month period.

Abnormal values were found in 49% females and 29% males - 39% of the cohort. Levels >1000 mIU/L were seen in 23% (females 36%, males 10%). From the 61/125 females with abnormal levels, 74% of these had levels >1000 mIU/L and 16/125 (13%) >2000 mIU/L. Only 13/128 males had levels >1000 mIU/L. Prevalence of hyperprolactinaemia in those on antipsychotic monotherapy: olanzapine 7%, typicals 33%, amisulpride 92%, Clozapine 4%, risperidone oral 83%, and risperidone consta 65%. In Risperidone Consta patients, 15/23 (65%) had hyperprolactinaemia including 100% of females (10/10). Most females on oral risperidone (12/13) also had hyperprolactinaemia and had values >1000 mIU/L in11/12.

Conclusions: Routine prolactin screening showed abnormal values in 39% and significantly abnormal levels (>1000 mIU/L) that could lead to drug/dosage alterations in 23%. Exceptionally high levels >2000 mIU/L were found in 7%. Females on oral and consta risperidone may be particularly at risk of the effects of hyperprolactinaemia.

P023

Aripiprazole in schizophrenia: Dosing and switching in clinical practice

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This presentation will review the clinical evidence to date regarding the effective dose of oral aripiprazole and practical switching and administration regimens. Early and convenient dose optimization is a key determinant of treatment outcomes in patients with schizophrenia. Ease of dosing is essential to maintain compliance with antipsychotic agents, and rapid and sustained symptom relief will maximize treatment outcomes. Aripiprazole is the most recently available atypical antipsychotic, pharmacologically distinct from other antipsychotic agents. Clinical studies have demonstrated the rapid onset of symptom relief with a starting dose of aripiprazole 10 mg/day in patients with schizophrenia, and the effective dose range has been established with 10-30 mg/day. When switching to aripiprazole from another antipsychotic, this should be conducted according to good psychopharmacological principles. Clinical evidence with aripiprazole indicates that a favorable approach is to maintain the therapeutic dose of the previous antipsychotic in addition to aripiprazole 10 mg/day for at least two weeks. The previous antipsychotic can then be tapered off slowly. If necessary, benzodiazepines or antihistaminergic agents can be used with aripiprazole to treat potential sleep disturbances or to manage other transient emergent events that are most likely due to rebound effects and/or the differential pharmacological profiles of the previous antipsychotic versus aripiprazole. Concomitant anticholinergics can be used when switching from an antipsychotic with anticholinergic properties to smooth the transition between agents. Appropriate initiation and switching strategies should result in increased treatment successes with aripiprazole for short-term and long-term treatment goals.

P024

Analysis of the clinical profile of patients with schizophrenia and schizoaffective disorder at the acute care unit (profile 3 study)

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Background and aim: Characterizing the profile of schizophrenic patients with high hospitalization rates seems relevant. The aim of this study is to describe characteristics of patients with schizophrenia hospitalized at Acute Care Units, and identify clinical profiles associated to relapse.

Methodology: Observational retrospective study (case-control). Hospitalized patients diagnosed for schizophrenia or schizoaffective disorder for more than 2 years. Data related to the previous 3 years and current hospitalization were recorded: sociodemographics, diagnosis, CGI, reason for current/previous hospitalizations, life events, drug abuse, therapy prior and during hospitalization and compliance.

Results: Preliminary results from 1607 patients are presented: cases are patients with no hospitalization (No-HOSP) in the previous 3 years (N=508); controls are those who had some hospitalization (HOSP) during that period (N=1099). HOSP patients were significantly younger than No-HOSP ($p<0.0001$). 41% of HOSP and 28.4% of No-HOSP patients showed No-Low family support ($p<0.0001$). 55.9% of HOSP and 50.2% of No-HOSP patients showed some drug abuse close to current hospitalization ($p<0.05$). The most frequent factor for current hospitalization was relapse due to non-compliance in both HOSP (66.2%) and No-HOSP (59.4%; $p=0.0092$). Through artificial intelligence methods, fourteen variables are identified as related to relapse (Number of previous antipsychotics, Time of evolution, CGI, Age, Gender, Educational Level, Family support, Compliance, Heroine, Cocaine or Cannabis abuse, Stressing events, Diagnosis, Number of previous hospitalizations), which have permitted to develop a predictive model for relapse (PRECOG Project).

Conclusion: The main factor for hospitalization was non-compliance. Age, family support, drug abuse seem to be also related to hospitalization.

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