

Poster Sessions

P-1 Affective Disorders and Antidepressants

P-1-1

Seizure duration and therapeutic efficacy of ECT in therapy refractory depression

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Key words: Electroconvulsive therapy; Efficacy; Seizure duration; Antidepressive resistant patients

Clinical studies examining the action of electroconvulsive therapy (ECT) have shown that the induced generalized seizure is necessary for therapeutic efficacy (Gregory et al., 1985). A certain minimum in the duration of seizures is also expected to play a substantial role (Maletzky, 1978), although there are no conclusive findings to support this assumption. In our ongoing study we treated 14 major depressed patients (four male, 10 female, mean age \pm SD 54 \pm 13 years) who were considered resistant to antidepressants according to standardized criteria. We administered 10 sessions of ECT (three sessions each week) and studied seizure duration which was measured after each ECT using the 'cuff technique' at forearm and lower leg. Furthermore, epileptic discharges were recorded in seven of 14 patients by means of an acoustic transducer. Responders to ECT were characterized by a decrease of 50% in the 21-item version of the Hamilton Depression Rating Scale.

We found (1) that there was no difference in tonic-clonic seizure duration between forearm and lower leg in all patients using the 'cuff technique', (2) that epileptic discharges (mean \pm SD: 284 \pm 95 s) compared to seizure duration (mean \pm SD: 228 \pm 69 s) took longer in all patients, (3) that seizure duration decreased in all patients from 31 \pm 22 to 21 \pm 9 s (mean \pm SD) comparing the first with the last ECT session, although the used energy increased from 284 \pm 41 to 454 \pm 81 mC, (4) that the switch from unilateral to bilateral ECT which was done in four patients increased seizure duration from 23 \pm 17 to 28 \pm 9 s (mean \pm SD), (5) that the nine responders had a shorter total seizure duration of all ECT sessions (mean \pm SD: 201 \pm 51 s) compared with the five nonresponders (mean \pm SD: 267 \pm 76 s) and that the mean seizure duration was lower in responders (mean \pm SD: 20 \pm 5 s) whereas it was higher in nonresponders (mean \pm SD: 27 \pm 8 s). Although our data are not conclusive yet due to the small number of patients, they do not support the assumption that seizure duration for at least 25–30 s should be achieved for a good clinical responsiveness for ECT.

References

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P-1-2

A double-blind comparison of paroxetine and fluvoxamine in major depression

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Key words: Depression; Paroxetine; Fluvoxamine

A double-blind multicentre study was undertaken to compare the efficacy and tolerability of paroxetine (20–30 mg daily),

and fluvoxamine (100–200 mg daily), in hospital in- and out-patients with major depression.

Patients presenting with major depression defined according to DSM-III-R criteria, who scored 18 points or more on the 21-item Hamilton Depression Rating Scale (HAM-D), were eligible for inclusion in the study. All patients gave informed consent to participate.

Those presenting with clinically significant co-existing diseases or a history of schizophrenia or psychosis were excluded, as were those with history of alcohol or drug abuse. Patients with epilepsy and women of child-bearing potential, not using adequate contraception, were similarly excluded. Recent treatment with monoamine oxidase inhibitors (MAOIs), neuroleptics or lithium and current treatment with oral anticoagulants and type 1c anti-arrhythmics were also reasons for patient exclusion.

After a 1-week placebo run-in period, patients were randomly allocated to receive paroxetine or fluvoxamine for a period of 6 weeks. Patients whose score had improved by 20% or more during placebo run-in were not randomised to active medication.

Patients allocated to paroxetine received 20 mg in the morning for the first 2 weeks, after which dose was either maintained or increased to 30 mg if clinically indicated.

Those allocated to fluvoxamine received 50 mg in the evening for the first week, after which the dose was increased to 100 mg in the evening for all patients. After the second week, dose was either maintained at 100 mg or increased to 200 mg (divided into a morning and evening dose), if required.

Patients were evaluated at baseline and at the end of weeks 1, 2, 4 and 6. Efficacy assessments comprised the HAM-D and HAM-A and the physician's Clinical Global Impression (CGI). A comprehensive safety evaluation included physical examination, vital signs, routine haematology and biochemistry, and evaluation of adverse experiences by a non-leading question.

One hundred and thirty-five patients entered the study, of whom 120 (56 paroxetine, 64 fluvoxamine) were evaluable on an intent to treat basis.

The two treatment groups were demographically well matched and showed similar improvements in mean total HAM-D during the study, with no significant differences between treatments at any visit. By week 6, the mean total HAM-D score had been reduced by 12.9 points in the paroxetine group and by 13.3 points in the fluvoxamine group.

There were more reports of emergent adverse events in the fluvoxamine group (64.1% vs. 51.8%) which also reported significantly more severe events (28.1% vs. 12.5%) ($P < 0.05$).

Adverse events led to the discontinuation of treatment in 11 (17.2%) fluvoxamine and three (5.4%) paroxetine treated patients.

The most frequently reported adverse events in both treatment groups were associated with the digestive system (paroxetine 18.6%, fluvoxamine 25%), with nausea being the most common.

In conclusion, the results from this study indicate comparable antidepressant efficacy for both agents with a significantly more favourable tolerability profile for paroxetine.

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Depression and associated anxiety in primary care: A double-blind comparison of paroxetine and amitriptyline

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Key words: Depression; Anxiety; Paroxetine; Amitriptyline

The joint occurrence of symptoms of depression and anxiety is commonplace in primary care. In 1988, Hamilton reported that 60–90% of depressed patients present with symptoms of anxiety.

Selective serotonin re-uptake inhibitors have been shown to be effective in the treatment of depression and evidence from the literature suggests that they may also be effective in the relief of anxiety symptoms (Sheehan et al., 1992).

A prospective double-blind multicentre study was undertaken to compare the efficacy and tolerability of paroxetine and amitriptyline in primary care patients presenting with symptoms of depression and associated anxiety.

Patients aged 18–65 years who scored at least 16 points on the Montgomery-Åsberg Depression Rating Scale (MADRS), and achieved a total score of 11 points or more on the Clinical Anxiety Scale (CAS), were eligible for inclusion. Patients were evaluated at baseline (week 0) and at the end of weeks 1, 3, 5 and 8. Assessments included the MADRS, CAS and the