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## Antidepressant package inserts criticised

**Tony James**

Mandatory information for patients inserted into packets of antidepressants vary widely in their content, quality and usefulness and need to be improved, a **study** of British products has concluded.

The report quoted earlier Australian research indicating that patients required information to dispel commonly-held erroneous beliefs, for example that it is only necessary to take medication on those days when you feel depressed.

The patient information leaflets presented information

about side effects – a major concern for many patients – in a “strikingly heterogeneous” way. In some products they were listed by severity, and in others by frequency, body system, or randomly. The lack of standardisation made it difficult to compare the side effect profiles of different treatment options.

Half the leaflets gave no information about how the medications were thought to work. More than 90% said it would take two to four weeks of treatment before there was any benefit, even though earlier improvements in mood were



**Almost half did not mention use of St John's Wort**

known to be quite common. None warned about

discontinuation syndromes. Most stated simply, but unhelpfully, that concurrent alcohol use was prohibited. Almost half made no mention of using St John's wort during treatment, even though this was common and there was a potential for adverse interactions.

Further work was needed to ensure that patient information was standardised and contained more information that was wanted by, and useful to, patients, the study concluded.

*Journal of Affective Disorders 2010; published online.*

**What do you think?**

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## HAMD cut-off score for remission in MDD too high

**Laura Macfarlane**

The threshold for remission in major depressive disorder needs to be lowered, a **study** concludes, because under the current threshold, patients in remission may not be functioning normally.

Since 1991, remission has been defined as a Hamilton Rating Scale for Depression (HAM-D<sub>17</sub>) score of  $\leq 7$  but several studies have concluded that this may be too high to consider that a patient “is truly in remission,” because functionality is not taken into account, the study authors wrote in *Psychiatry Research*.

In the present study the Spanish researchers performed a



**HAMD and SOFAS were inversely correlated at baseline**

post-hoc analysis on almost 300 patients (half were unemployed

and 77% were female) with MDD (in partial or complete remission) in order to find an optimal cut-off in the HAM-D<sub>17</sub> scale.

To assess HAMD scoring efficacy subjects' normal levels of functionality were evaluated using the Social and Occupational Functioning Assessment Scale (SOFAS).

The results showed a HAMD score of  $\leq 5$  maximized both sensitivity and specificity for identifying normal levels of functionality with respect to the other scores.

HAM-D<sub>17</sub> score and SOFAS were significantly inversely correlated at baseline ( $P < 0.0001$ ), at three months ( $P < 0.0001$ ), and at six months ( $P < 0.0001$ ).

Symptoms measured by the Hamilton explained approximately 38% of the variation in functioning, the authors noted.

“Having a HAMD score of  $\leq 7$  does not necessarily imply normal levels of functionality...when tracking the outcomes of depression an assessment of a person's functional status in addition to an evaluation of symptoms, would be desirable,” they concluded.

*Psychiatry Research 2010 published online ahead of print*

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from 1st April 2010



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<sup>†</sup>Now PBS listed for maintenance treatment of bipolar I disorder in combination with lithium or sodium valproate. Now PBS listed for monotherapy, for up to six months, of an episode of acute mania associated with bipolar I disorder. Reference:

1. Seroquel XR Approved Product Information, March 2010. AstraZeneca Pty Ltd (ABN 54 009 682 311) Alma Rd, North Ryde, NSW 2113, Australia. HAZ0256/PU/B 03/10.

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# High depression during internships mediated by genetics

Michael Slezak

The rate of depression among medical students jumps sixfold when they begin their internships, with nearly half of all interns meeting the criteria for major depression at some time during the internship, according to the largest prospective study of depression during medical internships.

The study of more than 650 medical interns at 13 US hospitals found that medical specialty and age were not associated with the development of depression, work hours, female sex and genetic factors were.

The participants completed a baseline survey at 1 to 2-months prior to commencing internship and were assessed at months 3, 6, 9 and 12 of their internship year.

"The proportion of participants who met PHQ-9 criteria for depression increased from 3.9% prior to internship to a mean of 25.7% during interhsip ( $p < 0.001$ )," the researchers wrote in *Archives of General Psychiatry*.

"We found that 41.8% of



Female sex was associated with development of depression

subjects met criteria for major depression at one or more quarterly assessments."

The researchers found a marked difference in the risk of depression among European American interns who had 1 low-functioning 5-HTTLPR allele and those with 2 high-functioning 5-HTTLPR alleles.

Among the former, the number of students who met the criteria for depression rose from 2.4% before the internship to 42.5% during the internship.

However, among the lat-

ter, the figure only rose from 5.1% to 36.2%.

Baseline factors that predicted depression included female sex ( $r = 0.147$ ), personal history of depression ( $r = 0.206$ ) and US medical education ( $r = 0.115$ ).

Within the internship, the number of hours worked and reported medical errors were associated with depressive symptoms.

*Archives of General Psychiatry* 2010; 67(6):557-65.

**What do you think?**

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## Music and beta brain-wave activity in psychosis

Laura Macfarlane

Australian research has shown that listening to music decreases delta, alpha and beta waves on EEG in subjects experiencing an acute psychotic episode.

Few studies have explored music's effects in schizophrenia despite its use as a therapeutic modality, however one such study, using electronically generated keyboard music, found no marked changes on EEG activity between resting and music conditions, the study authors wrote in, *Psychiatry Research*.

The present study led by researchers from the University of Queensland, recruited 15 subjects (mean age of 36 years) from an acute psychiatric inpatients unit with schizophrenia, schizoaffective disorder or bipolar (manic phase).

Subjects, who were currently experiencing an acute psychotic episode, underwent a quantified



Subjects chose their own music to listen to

electroencephalogram (qEEG) with eyes closed resting and then with eyes closed as they listened to music of their own choosing. Six subjects chose pop/rock, four chose classical and the remaining four chose easy listening.

The results showed a significant decrease in delta, alpha and beta

waves when listening to music compared to the resting condition.

"It was hypothesised that exposure to music would increase beta wave activity in patients with acute psychosis... the decrease in beta activity was an unexpected result in this reserach," the authors noted.

They suggested that individualised music may have had meaning and relevance to the subjects. "However, a more detailed examination of sub-band activity and topography along with an increased number of subjects would help resolve the functional implications of this reduction in beta activity," they wrote.

Overall they concluded that the study results should encourage further research of music's effect in psychosis.

*Psychiatry Research* 2010 published online before print

**What do you think?**

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### In brief

#### Mental health investments welcome, but where is the plan?



The Royal Australian and New Zealand College of Psychiatrists welcomes the Labor government's announcement of a \$277 million investment in suicide prevention but says more comprehensive mental health reforms are needed.

According to a new blueprint for a comprehensive mental health system Mental Health Deserves a Better Deal released by The Royal Australian and New Zealand College of Psychiatrists this week, people experiencing mental illness do not get a fair deal.

In a media statement the RANZCP outlined the main needs for addressing the mental health of all people in Australia as, increased funding, improved treatment and care for people with mental disorders throughout their lives, and extension of resources and support for mental health centres and staff.

If the government is re-elected \$113.9 million will go to frontline mental health services, including \$22 million for specialist psychiatry – and \$74.3 million for direct suicide prevention and crisis intervention services.

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**Stable<sup>†</sup>**

**Mania**

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<sup>†</sup>Now PBS listed for maintenance treatment of bipolar I disorder in combination with lithium or sodium valproate. Now PBS listed for monotherapy, for up to six months, of an episode of acute mania associated with bipolar I disorder.

Please review full Product Information before prescribing SEROQUEL XR<sup>®</sup> (quetiapine fumarate). Product Information is available from AstraZeneca on 1800 805 342.

Streamlined authority numbers: 1589 (treatment of schizophrenia), 3151 (maintenance treatment of bipolar I disorder in combination with lithium or sodium valproate), 2765 (monotherapy, for up to 6 months, of an episode of acute mania associated with bipolar I disorder). **Indications:** *Bipolar disorder:* Maintenance treatment of bipolar I disorder, as monotherapy or in combination with lithium or sodium valproate, for the prevention of relapse/recurrence of manic, depressive or mixed episodes • Treatment of depressive episodes associated with bipolar disorder • Treatment of acute mania associated with bipolar I disorder as monotherapy or in combination with lithium or sodium valproate. *Schizophrenia:* Treatment of schizophrenia, prevention of relapse and maintenance of clinical improvement during continuation therapy. \*Major depressive disorder (MDD): Treatment of recurrent major depressive disorder in patients who are intolerant of, or who have an inadequate response to alternative therapies. \*Generalised anxiety disorder (GAD): Treatment of generalised anxiety disorder. **Dosage:** Once daily, without food. Tablets should be swallowed whole and not split, chewed or crushed. *Maintenance treatment of bipolar I disorder:* SEROQUEL XR responders for acute treatment should continue therapy at the same dose. Usual effective dose 300 to 800 mg/day. *Bipolar depression:* Treatment should be initiated either by psychiatrist or by general practitioner after consulting the psychiatrist. 50 mg (Day 1), 100 mg (Day 2), 200 mg (Day 3), and 300 mg (Day 4). May be titrated to 400 mg (Day 5) and up to 600 mg (Day 8). *Acute mania:* 300 mg (Day 1), 600 mg (Day 2), up to 800 mg after Day 2, alone or in combination with a mood stabiliser. Usual effective dose 400-800 mg/day. *Schizophrenia:* 300 mg (Day 1), 600 mg (Day 2), up to 800 mg after Day 2. Usual effective dose 400-800 mg/day. *Switching from SEROQUEL immediate release:* Divided doses of SEROQUEL immediate release may be switched to SEROQUEL XR at equivalent total daily dose taken once daily. (Day 1 & 2), 150 mg (Day 3 & 4), adjusted within 50-150 mg/day. *Switching from SEROQUEL immediate release:* Divided doses of SEROQUEL immediate release may be switched to SEROQUEL XR at equivalent total daily dose taken once daily.

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\*Please note changes in Product Information.

**PBS Information:** Authority required (STREAMLINED). Maintenance treatment of bipolar I disorder in combination with lithium or sodium valproate. Monotherapy, for up to 6 months, of an episode of acute mania associated with bipolar I disorder. Treatment of schizophrenia. This product is not listed on the PBS for bipolar depression, major depressive disorder or generalised anxiety disorder. Seroquel XR 150 mg tablet is not listed on the PBS.