minimal adverse events in addition to functional improvement in acute manic patients. This result suggests that quetiapine may be preferred as one of the first-line agents in the treatment of acute manic patients.

References

[1] Vieta E, Mullen J, Brecher M, Paulsson B, Jones M, 2005, Quetiapine monotherapy for mania associated with bipolar disorder: combined analysis of two international, double-blind, randomised, placebo-controlled studies, Curr Med Res Opin, 21, 923–934.

P.2.e.016 Antipsychotic treatments during acute mania with prominent aggressive behaviour

A. González-Pinto[1]*, J.A. Micó[2], F. Mosquera[1], C. González[1], A. Aldama[1], S. Barbeito[1], P. Vega[1], C. Matute[3], E. Vieta[4]. *[1]Santiago Apostol Hospital, Psychiatry, Vitoria, Spain; [2]University of Cádiz, Neurosciences, Cádiz, Spain; [3]University of the Basque Country. UPV-EHU, Neurosciences, Leioa (Bizkaia), Spain; [4]University Hospital Clinic of Barcelona, IDIBAPS, Neurosciences, Barcelona, Spain*

Introduction: Bipolar patients experiencing an acute descompensation often present in an agitated/hostile state which requires rapid assessment and effective psychopharmacological treatment to shorten the time to recovery, as hostility represents a handicap to therapy creating a disruptive enviroment between the patient and the psychiatrist (Baker et al., 2003). Antipsychotics are widely used as adjunct treatments to mood stabilisers in bipolar disorder, especially when psychotic, anxiety or aggressive symptoms are prominent during acute episodes. Up to date, antipsychotics and benzodiazepines are considered as adjunct treatment in mania with psychotic symptoms or hostility (Thomas et al., 2004). Despite new generation antipsychotics are the first election as adjunctive medication, there is a tendency to use conventional antipsychotics (typical antipsychotics) for the treatment of aggressive manic patients in clinical practice (Amann et al., 2005). Objective: The aim of this study is to compare the antipsychotic treatment during acute mania between patients with and without prominent aggressive behaviour.

Method: A cross-sectional study was carried out with 173 manic inpatients consecutively admitted to the only psychiatric ward in an area of 350.000 inhabitants from February 1997 to January 2000. The DSM-IV axis I diagnosis for bipolar I disorder (manic or mixed) was made by using the Structured Clinical Interview SCID-I. Subjects with schizoaffective disorder, organic brain disorders or mental retardation were excluded. No patient was rated in more than one episode. Subjects were included after informed consent to participate was obtained Clinical and sociodemographical data collection was performed on the week following admission. The severity of mania was evaluated by the Young Mania Rating Scale (YMRS) and the severity of depressive symptomatology was assessed by the 21 item version of the Hamilton Depression Rating Scale (HDRS-21). Aggressiveness was defined based on scores $\geqslant$4 in item 9 ("aggressive behaviour") of the Young Mania Rating Scale. We employed multivariate logistic regression modeling to test the independence and significance of associations of psychopharmacological treatment variables with aggressive behaviour.

Results: The mean age of the patients was 35.1 ($\pm$12.4). Gender distribution was almost identical in the total sample: 49.7% of women/50.3% of males. Medium score in YMRS was 32.6 ($\pm$8.0) and in HDRS-21 was 14.8 ($\pm$6.4). 40% (69) of the patients presented aggressiveness. Logistic regression showed that compared with the non-violent subgroup, aggressive manic patients were 2 times more likely to be treated with typical antipsychotics [p = 0.04; OR = 2.017 (1.010–4.029)].

Conclusions: Despite atypical antipsychotic treatment have demonstrated their efficiency for the treatment of violent behaviour during acute manic episodes (Baker et al., 2003), typical antipshichotics seem to be widely used in clinical practice. There are necessary more experimental studies that support empirical evidence about the effectiveness of atypical and typical antipsychotics in the management of violent behaviour during mania.

References

[1] Amann B., Sterr A., Mergl R., Dittmann S., Seemuller F., Dobmeier M., Orth M., Schaefer M., Grunze H., 2005, Zotepine loading in acute and severely manic patients: a pilot study, Bipolar Disorders, 7(5), 471–6.
[2] Baker R.W., Kinon B.J., Maguirre G.A., Liu H., Hill A.L., 2003, Effectiveness of rapid initial dose escalation of up to forty milligrams per day of oral olanzapine in acute agitation, Journal of Clinical Psychopharmacology, 23, 342–8.
[3] Thomas P., 2004, Adjunct treatments in acute mania: Encephale, 30(1), 80–9.

P.2.e.017 Safety, tolerability and efficacy of rapidly-initiated quetiapine in acutely ill patients with bipolar I disorder

I. Cobo[1], J. Hernandez[2], F. Vazquez-Gutierrez[3], J.L. Galan[4], M. Tafalla[4]*. *[1]Hospital Marítimo, Department of Psychiatry, Malaga, Spain; [2]Hospital Universitario Virgen de la Arrixaca, Department of Psychiatry, Murcia, Spain; [3]Hospital de Poniente, Department of Psychiatry, Almería, Spain; [4]AstraZeneca Farmaceútica, Medical Department, Madrid, Spain; The quetiapine rapid initiation study group, Spain*

Objective: To explore the safety, tolerability and efficacy of rapid versus standard initiation of quetiapine in patients with bipolar I disorder experiencing a manic episode.

Methods: A 21-day, multicentre, randomised, parallel-group, open study of acutely ill inpatients with bipolar I disorder experiencing a manic episode. Patients were randomised to one of two quetiapine dose initiation schedules: rapid (200, 400, 600, 800 mg/day on Days 1–4) or standard (100, 200, 300, 400 mg/day on Days 1–4). Both groups received flexible dosing (400–800 mg/day) thereafter. The primary outcome was the number of withdrawals attributed to an adverse event (AE) at Day 7 of treatment. Secondary safety measures included ECG at baseline and last visit, spontaneous AE reporting throughout the study and the proportion of patients experiencing a significant change in vital signs. Efficacy was assessed using the Young Mania Rating Scale (YMRS), the Positive and Negative Syndrome Rating Scale and the Clinical Global Impression (CGI) scales.

Results: Forty-nine patients (mean age, 41 years; 41% male) were included in the study, 25 in the rapid and 24 in the standard initiation group. Mean YMRS and CGI-Severity of Illness scores at baseline were 33.1 and 5.2, respectively. There was only one withdrawal due to an AE in the first 7 days: one patient from the standard initiation group suffering from severe mania. A total of 17 patients in the rapid initiation group completed the study, versus 18 patients in the standard initiation group. Mean doses in the rapid versus standard initiation group, respectively, were 809 versus 557 mg/day at Day 7, and 800 versus 690 mg/day at Day 21. Vital signs (blood pressure, pulse rate, and ECG) remained stable after rapid or standard quetiapine administration,