A RANDOMISED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY OF DESVENLAFAXINE 10 AND 50 MG/D EFFICACY AND SAFETY IN DEPRESSED OUTPATIENTS

Michael Liebowitz[1], Karen A. Tourian[2], Eunhee Hwang[2], Linda Mele[2], Safir Riddington[3]
[1]*Columbia University, New York, New York, USA*
[2]*Pfizer Inc, Collegeville, Pennsylvania, USA*
[3]*Pfizer Australia and New Zealand Inc, Australia*

Background: Desvenlafaxine (administered as desvenlafaxine succinate) has demonstrated antidepressant efficacy at 50, 100, 200, and 400 mg/d.
Objective: To compare the antidepressant efficacy and safety of desvenlafaxine 10 and 50 mg/d doses with placebo.
Methods: Adult outpatients with MDD and a HAM D_{17} total score (TS) ≥20 at screening and baseline, were randomised to placebo or desvenlafaxine (10 or 50 mg/d) after a 6 to 14 d placebo lead-in period in an 8-week, phase three, fixed-dose trial. The primary efficacy endpoint was change from baseline in HAM D_{17} TS.
Findings: Change in adjusted HAM D_{17} TS for desvenlafaxine 10 mg/d (–9.28) and 50 mg/d (–8.92) failed to separate from placebo (–8.42) (ITT; n = 226, 224, 223). Treatment-emergent adverse events (AEs) occurred in 66% of placebo-treated patients, and 69% of patients treated with desvenlafaxine 10 or 50 mg/d. A total of 2/226 (0.9%) and 4/224 (1.8%) of patients discontinued desvenlafaxine 10 and 50 mg/d, respectively, due to AEs (placebo, 5/223 [2.2%]).
Conclusions: Although previous studies have confirmed the antidepressant efficacy of desvenlafaxine 50 mg/d, in this study the 50 mg/d dose failed to reach statistical significance. In addition, our finding that the 10 mg/d dose failed to separate from placebo is not surprising, given that doses <50 mg/d have not previously demonstrated efficacy.
Supported by funding from Pfizer Inc.

THE NIMH RESEARCH DOMAIN CRITERIA: BAD SCIENCE WILL BREED BAD PSYCHIATRY

N. McLaren
Northern Psychiatric Services, Darwin, NT, Australia

The National Institute of Mental Health has recently declared a new research program for psychiatry, the Research Domain Criteria (RDoC), as the successor of the long-standing diagnostic program. However, the new program is based on a series of assumptions which, on analysis, lack any formal scientific standing. Essentially, the RDoC program, as presently conceptualised, is no more than ideology masquerading as science, and cannot achieve its stated goals. It is argued that the program will lead psychiatry into intellectually sterile areas because it is in fact the wrong research program for this stage of our knowledge.

THE INABILITY OF DSM-5 TO DISTINGUISH BETWEEN TEMPER TANTRUMS AND MENTAL DISORDER: FAILURE IS INEVITABLE (BUT DON'T SHOOT THE MESSENGER)

N. McLaren
Northern Psychiatric Services, Darwin, NT, Australia

The diagnostic entity Intermittent Explosive Disorder will be examined from several points of view, including epidemiological and logical. The inevitable conclusion is that this is not a coherent entity in its own right but correctly belongs to the category of personality disorder. This raises the question of the nature of the process in modern psychiatry by which personality factors are reclassified as formal mental illnesses. It will be argued that this is because modern psychiatry lacks models of personality and thence of personality disorder, and has never articulated a model of mental disorder itself. The outcome is diagnostic anarchy, in which pressure groups trump science. This will inevitably lead to the failure of DSM-5, as has been widely predicted by eminent critics. This paper establishes epistemological reasons for those predictions, thereby immeasurably strengthening them.

EARLY USE OF CLOZAPINE MAXIMISES FUNCTIONAL RECOVERY IN SCHIZOPHRENIA

Dr Narinder Panesar[1], Dr Iveta Valachova[2]
[1]*Consultant Psychiatrist, MHRU Shellharbour Hospital*
[2]*Registrar, Braeside Hospital, SSWAHS*

Background: Psychiatric rehabilitation begins during the acute stage of a psychiatric disorder and continues throughout the person's life. Rehabilitation is not a specific technique but a strategy designed to contribute to recovery. The functional and symptomatic recovery from schizophrenia is the result of pharmacological and psychosocial interventions of which clozapine is the mainstay of treatment. Research has shown that early and effective pharmacological intervention of a person with a serious mental illness can prevent long-term disability. Among all antipsychotic medications clozapine is widely used in rehabilitation settings.
Objectives: The aim of this paper is to encourage clinicians to consider early use of clozapine in schizophrenia and related disorders as soon as treatment resistance is established.
Conclusion: Treatment with clozapine should not unnecessarily be delayed if a patient has not responded to adequate trials of other antipsychotic medication. We noted that a number of patients in rehabilitation units who had not achieved functional recovery had not received timely clozapine trials. We propose a model of early intervention with clozapine in rehabilitation psychiatry. One of the biggest problems in managing treatment-resistant schizophrenia is therapeutic nihilism, and this is likely to increase once a trial of clozapine has failed. Clozapine should not be viewed as the last therapeutic option; it is an opportunity to explore future treatments.

YOGA AND MENTAL HEALTH

Dr Narinder Panesar[1], Dr Iveta Valachova[2]
[1]*Consultant Psychiatrist, MHRU Shellharbour Hospital*
[2]*Advanced Trainee, Braeside Hospital, SSWAHS*

Background: The use of various evidence-based therapeutic interventions in psychiatry is a common practice. However yoga has hardly been considered as a part of treatment. It is not only an exercise for a healthy person but also an alternative therapy for an individual with a mental illness. Yoga is a scientific system of physical and mental practices