CALL FOR PAPERS

*CNS Spectrums* is accepting submissions of *case reports, review articles, and original research* on a variety of neuroscientific and clinical neuropsychiatric topics.

**Examples of topics include:**

- **Clinical interface of psychiatry and neurology**
- **Neurology and neuropsychiatry in a clinical setting addressing spectrum disorders**
- **Applications of psychopharmacology and pharmacokinetics across the neuropsychiatric spectrum**

Especially encouraged are papers covering comorbidities in neurologic disorders (e.g., epilepsy with schizophrenia). Other crossover manuscripts geared to deepening the clinician’s understanding of neuropsychiatric disorders and treatments will be given highest priority. (Please see the Author Guidelines at [www.cnsspectrums.com/aspx/authorguidelines.aspx](http://www.cnsspectrums.com/aspx/authorguidelines.aspx)).

MBL Communications, Inc., is proud to announce the 2005 ISI Journal Citation Reports’ impact factor for *CNS Spectrums*. The current impact factor of 2.037 for *CNS Spectrums* and is based on a total of 580 citations. *CNS Spectrums'* impact factor is ranked 58 out of 148 journals in the ISI Journal Citation Report's Clinical Neurology category and 48 out of 94 journals in the Psychiatry category—the top half of the psychiatry journals worldwide.

*CNS Spectrums* has the largest circulation among *Index Medicus*-approved publications with a monthly readership of 50,000 neurologists and psychiatrists worldwide.

Submissions should be sent to Eric Hollander, MD, Editor (In Europe, to Joseph Zohar, MD, International Editor), c/o Virginia Jackson, Acquisitions Editor, *CNS Spectrums*, c/o MBL Communications, 333 Hudson Street, 7th Floor, New York, NY 10013, E-mail: vj@mblcommunications.com.
the first injection and 12.8 msec following the second injection. The mean increase in QTc from baseline for haloperidol was 6.0 msec. As with other antipsychotic drugs and placebo, sudden unexplained deaths have been reported in patients taking GEODON at doses up to and including the recommended dose of 40 mg bid. Although these deaths were unexplained, it is not possible to rule out the possibility that they were due to drug-induced QTc prolongation. 

Mortality in Elderly Patients with Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs for any indication other than a behavioral or psychiatric symptom are at risk for death compared to placebo-treated patients. In one of the placebo-controlled trials, the risk of death in patients treated with ziprasidone was over 2.5 times that in patients treated with placebo. In another, the risk of death was close to 2.4 times in patients treated with ziprasidone compared to placebo. In the pooled analysis, the risk of death in patients treated with ziprasidone was close to 2.3 times that in patients treated with placebo. These differences were consistent across subgroups of patients (e.g., age, sex, dementia severity).

In patients with Alzheimer's dementia, haloperidol 6 mg/day given for 4 years was associated with a 3 times higher mortality rate than placebo. Over a 1.3 year follow-up period, haloperidol was associated with a 3.4 times higher mortality rate than placebo in patients with Alzheimer's dementia treated with oral antipsychotics. Although atypical antipsychotics (risperidone, olanzapine, quetiapine, and ziprasidone) appear to carry a lower risk than typical antipsychotics, the risk remains significant (about 2 times placebo) for all atypical antipsychotics. In addition, the risk of death in patients treated with placebo was significantly higher than in patients treated with placebo in the majority of studies. The risk of death in elderly patients treated with atypical antipsychotics is unknown. It is unknown whether the risk of death in patients treated with atypical antipsychotics is due to a specific treatment effect of the drug or reflects the underlying disease process.

In a 14-week, double-blind, placebo-controlled study of patients with dementia-related psychosis treated with ziprasidone, the incidence of sudden death was 0.2% (1 out of 492 patients) with ziprasidone and 0.1% (1 out of 483 patients) with placebo. In a 36-week, placebo-controlled study of patients treated with haloperidol, the incidence of sudden death was 0.4% (1 out of 205 patients) with haloperidol and 0.1% (1 out of 203 patients) with placebo. The risk of sudden death in patients treated with atypical antipsychotics is unknown. It is unknown whether the risk of sudden death in patients treated with atypical antipsychotics is due to a specific treatment effect of the drug or reflects the underlying disease process.

The effects of atypical antipsychotics on QTc have been evaluated in short-term, placebo-controlled trials and in long-term, open-label studies. In short-term, placebo-controlled trials, the effects of GEODON on QTc have been evaluated in patients with schizophrenia or schizoaffective disorder. In these studies, GEODON was not associated with an increase in QTc from baseline. The mean increase in QTc from baseline for GEODON was 6.0 msec. In long-term, open-label studies, the effects of GEODON on QTc have been evaluated in patients with schizophrenia or schizoaffective disorder. In these studies, GEODON was not associated with an increase in QTc from baseline. The mean increase in QTc from baseline for GEODON was 6.0 msec. As with other antipsychotic drugs and placebo, sudden unexplained deaths have been reported in patients taking GEODON at doses up to and including the recommended dose of 40 mg bid. Although these deaths were unexplained, it is not possible to rule out the possibility that they were due to drug-induced QTc prolongation. 

WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. In clinical trials, elderly patients with dementia-related psychosis treated with ziprasidone had a mortality rate close to 2.5 times that of placebo-treated patients. In another, the risk of death was close to 2.4 times in patients treated with ziprasidone compared to placebo. In the pooled analysis, the risk of death in patients treated with ziprasidone was close to 2.3 times that in patients treated with placebo. These differences were consistent across subgroups of patients (e.g., age, sex, dementia severity).

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Control acute agitation with

GEODON®
for Injection (ziprasidone mesylate)

In schizophrenia...

Rapid improvement with low EPS\(^1,2\)

- Significant control achieved between 15 and 30 minutes* after injection\(^1,3\)
- Proven advantages over haloperidol IM
  - twice the improvement as measured on the BPRS\(^4,^\dagger\)
  - significantly lower incidence of movement disorders\(^2,^\ddagger\)
- Smooth transition, with continued improvement, from IM to oral therapy\(^2,^4\)
- May be used concomitantly with benzodiazepines

\(^*\) In 2 pivotal studies vs control, significance was achieved at 15 minutes (with 10 mg dose) and 30 minutes (with 20 mg dose), respectively.
\(^1\) In a 7-day, open-label IM-to-oral transition study.
\(^2\) In a 6-week, open-label IM-to-oral transition study.

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. GEODON is not approved for the treatment of patients with dementia-related psychosis.

GEODON is contraindicated in patients with a known history of QT prolongation, recent acute myocardial infarction, or uncompensated heart failure, and should not be used with other QT-prolonging drugs. GEODON has a greater capacity to prolong the QTc interval than several antipsychotics. In some drugs, QT prolongation has been associated with torsade de pointes, a potentially fatal arrhythmia. In many cases this would lead to the conclusion that other drugs should be tried first.

In fixed-dose, pivotal studies, the most commonly observed adverse events associated with the use of GEODON for Injection (incidence \(\geq 5\%\)) and observed at a rate in the higher GEODON dose groups (10 mg, 20 mg) of at least twice that of the lowest GEODON dose group (2 mg control) were somnolence (20%), headache (13%), and nausea (12%).

Please see brief summary of prescribing information on adjacent page.