GBP. Symptoms severity was measured using the Clinical Global Impression Scale (CGI) and the Brief Psychiatric Rating Scale (BPRS), the prophylactic effect was classified into one of three categories: complete, partial or no response.

Results: 20 patients were displaying acute symptoms, 30 patients were in euthymic state and had to discontinuate the precedent treatment with lithium because of severe side effects. At the end of the study, 75% of the 43 patients treated with GBP for at least 24 weeks, had a positive response, as measured by changes in the CGI and BPRS scores. The prophylactic effect was complete for half of the euthymic patients. The average dose used was 900 mg. The only side effect observed was oversedation, decreasing with continuing treatment.

Conclusions: GBP was effective both in acute and maintenance phase treatment of patients with bipolar disorder. If confirmed in controlled studies, these findings suggest that GBP represents a well-tollerated, rapidly acting antimanic agent and mood stabilizer.

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Mon-P69

THE NIACIN SKIN PATCH TEST AS A DIAGNOSTIC AID IN PRIMARY CARE PSYCHIATRY

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The diagnosis of schizophrenia and manic depressive psychosis is at present made according to clinical criteria and by excluding organic brain disease. Oral nicotinic acid in doses of over 2 mg/kg produces in normal subjects marked skin flushing of the face and upper body, due to formation of prostaglandin D2 (PGD2) from arachidonic acid (AA) in dermal macrophages, but about one-third of all schizophrenic patients fail to flush one hour after 200 mg doses. For schizophrenic patients chosen for negative symptoms, absence of flushing rises to 50 per cent (Glen et al, 1996). Oral niacin can give rise to unpleasant skin flushing and recently Ward et al (1997) have described a skin patch technique which gives better separation between schizophrenia and other conditions. New data which we will present indicate separation between schizophrenia and bipolar manic depressive illness ($p < 0.01$ to $p < 0.001$, depending on time interval between application of patch and reading skin redness, and molar concentration of the test solution (methyl nicotinate)). Further work is in progress to evaluate the usefulness of the test as a diagnostic aid in primary care and in community mental health care.

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Mon-P70

CHRONOBIOLOGICAL MODEL OF MOOD STABILIZERS EFFECT

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Polysomnographic effects of acute and long-term use of different compounds with normothymic activity were analysed in 23 patients with rapid cycling bipolar disorder. 7 of them were treated with lithium carbonate (LC), 9 - with carbamazepine (CRB) and 5 - with sodium valproate (SV). Sleep registration was done before treatment (after 2 weeks wash-out period), in 3–5 days, in 2 weeks and after 3 months of treatment. LC from first days inhibited REM-sleep and later activated slow waves sleep (SWS), on the contrary anticonvulsants rapidly stimulated SWS and secondary inhibited REM-phase. After long-term use all drugs had resembled effects on sleep characteristics. They inhibited activity of REM-sleep including prolongation of REM-latency, restored SWS and normalised ultradian distribution of sleep cycles during the night. Chronobiological model of rapid cycling bipolar disorder and mood stabilisers action have been proposed to explain the results.

Mon-P71

CHARACTERISTICS OF MIXED AND PURE MANIA IN BIPOLAR DISORDER WITH PSYCHOTIC FEATURES

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We investigated whether mixed mania, also called dysphoric or depressive mania, was phenomenologically distinguishable from pure mania in a cohort of bipolar patients with psychotic features. The method of this study has been described in detail elsewhere[1]. Eighty-nine consecutively hospitalized patients with current mixed and manic bipolar psychotic symptoms were included in this study. Index episode psychotic diagnosis and psychiatric comorbidity were assessed using the Structured Clinical Interview for DSM-III-R (SCID-P). Psychopathology was assessed by the Brief Psychiatric Rating Scale (BPRS) and the Hopkins Symptoms Checklist (HSCL-90). Awareness of illness was assessed with the Scale to Assess Unawareness of Mental Disorders (SUMD). Of the 89 DSM-III-R bipolar I patients with psychotic features, 61 (75.2%) had a pure manic episode and 28 (24.8%) had a mixed manic episode at the time of the admission. Among sociodemographic characteristics, unemployment status was found to be significantly more frequent in mixed mania group than in pure mania group (82.1% vs 57.4%, $p < .05$). Age of onset of bipolar disorder was earlier in mixed mania group than in pure mania group (22.6 ± 5.6 years vs 25.0 ± 7.7), but this difference was not significant. Obsessive-compulsive disorder comorbidity was found to be significantly more associated with mixed mania than with pure mania (21.4% vs 6.6%, $p < .05$). At the BPRS, grandiosity (3.7 vs 2.3, $p < .01$), unusual thought content (4.9 vs 3.7, $p < .02$), excitement (4.1 vs 2.5, $p < .01$), conceptual disorganization (3.4 vs 2.7, $p < .01$) and activation (2.7 vs 2.1, $p < .01$) were more frequent in pure mania than mixed mania group; conversely, motor retardation (1.9 vs 1.3, $p < .02$) and factor 'anergia' (1.5 vs 1.8, $p < .03$) were significantly more frequent in mixed mania than in pure mania group. At the HSCL-90, only the factor 'psychoticism' was found to be more frequently associated with mixed mania than pure mania (1.1 vs 0.7, $p < .05$).

Conclusions: Patients with pure mania are likely to present more severe psychomotor symptoms and thought disorders, while those

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