remained postictally significant for 6 minutes and in the diastolic RR for 4 minute.

As there are no differences in the therapeutic efficacy, propofol is preferable due to the only minor postictal increase in blood pressure. Instead of the seizure duration, the postictal suppression index should be used as a parameter of efficacy of the treatment.

HOSPITALISATION OF DEPRESSED PATIENTS AND ANTIDEPRESSANTS SYNERGY IN CARE

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ERASMA is an extensive survey which was conducted on more than 1800 depressed patients, who underwent hospital treatment between January and June 1993. It was a naturalistic survey which aimed to explore real performances of antidepressants prescribed within the context of everyday hospital use.

Design Protocol — Inclusion criteria:

* man or woman > 18 years old
* major depressive episode according to DSM-III-R
* MADRS: Score $\geq$ 25, major depression, of moderate to severe intensity
* patient whose condition requires hospitalisation for at least 12 days and oral antidepressant treatment
* antidepressant prescription details and any concomitant treatments are left to the discretion of the practitioner

Evaluation criteria from Day 0 to Day 60:

MADRS scale/COVI scale/CGI scale

Overall improvement/Clinical index of assessment/Adverse events

Patient self-assessment visual scale

Results: MADRS scale: percentage of patients with a 50% improvement in score: it can be seen that nearly half of them achieved this level on D12, 80% on D30 and 88% on D60. At the end point, 74% of patients had improved by 50%, which is consistent with the efficacy rates usually observed with antidepressants.

Apart from providing a substantial amount of information concerning current practice in the treatment of depression in hospitals, the survey supports many others so far carried out which have not demonstrate any differences in the time to onset of therapeutic effects, just at global efficacy level, between the various therapeutic classes of antidepressants currently on the market. However, a very clear synergy appears between drug treatment and hospital care, which is crucial for the depressed patient, since any delay in the provision of effective care can lead to an exacerbation or chronicity of the symptomatology, or even to suicide.

Conclusion: For any furture survey of this type, it would be a good idea to attempts to make a better assessment of the importance of these non-pharmacological factors which most definitely lie in the relational dimension of care. It should therefore be possible to take into account, at least in part, the importance of relational and psychological factors, which are often, if not always, not taken into account in conventional therapeutic studies.

MANIA IN EUROPEAN MIGRANTS

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The relationship between migration and mental illness has been recognized for many years although most interest has focused on the association of migration with schizophrenia especially in Afro-Caribbean patients. Little has been written about the link between migration and mania.

We present details of four individuals who migrated within Europe and were admitted to the acute psychiatric unit of our hospital with a manic episode. These cases represent one fifth of all patients admitted with a manic episode during a six month period. Of these four cases, two were born in mainland Europe and two in the United Kingdom. All were living in a non-native European country prior to presentation and two had returned to their native country immediately prior to admission. These cases presented communication problems because of difficulties with the English language and linking up with professionals abroad. The obtaining of a collateral history was also problematic. In all four cases there were difficulties with follow up after discharge with one individual returning abroad directly from the ward. These four cases presenting over a relatively short period of time suggest that mania in European migrants may be a common problem. Whether mania is precipitated by the stress of travel or whether migration is a manifestation of manic illness is unclear.

Individuals who develop a manic illness following emigration from their native country face additional problems. These include language difficulties, diagnostic difficulties across cultures and difficulties adjusting to admission and ward routine away from their native culture. Rehabilitation may be delayed by the absence of family and friends to plan aftercare and facilitate leave. Aftercare may be difficult to establish and maintain in this group who are less likely to remain resident in one place.

Movement within one continent may be just as stressful as intercontinental travel. Mania in European migrants may be an increasing problem in the future with the expansion of the European Union, loss of border controls and travel between all European countries becoming easier. Under such circumstances the care of these patients should not stop at the national boundary.

PATIENTS ACCESS TO THEIR OWN RECORDS: A COMPARISON OF PATIENTS WITH SOMATISATION DISORDER (SD) AND GENERAL PSYCHIATRIC OUTPATIENTS

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Introduction: Patients have had the right of access to their medical records since 1991. Some authors have shown beneficial effects of encouraging patients to read their records, but it is not known whether this applies to different groups of psychiatric patients. The aim of this study was to evaluate the effects of patients with SD reading their clinical summary.

Method: Patients meeting diagnostic criteria for SD were recruited from a psychiatric-medical liaison clinic with a specialist interest in SD. The comparison group were consecutive attenders at a general adult psychiatric outpatient clinic. All patients were sent a copy of their main clinical summary with a questionnaire designed to report: the reaction to reading the summary, if there had been any change in symptoms, change in their desire for further medical investigations and any greater concern over undiagnosed illness.

Results: Of 30 patients recruited to each group, 80% of each group gave favourable ratings for 8 of the 11 questionnaire items. Comparing the groups, significantly more of the SD patients rated the written summary unfavourably in respect of its emphasis (Odds Ratio [OR] 4.6; 95% CI 1.3 to 17.4) and their being more worried about an undiagnosed physical illness (OR 3.6; 95% CI 1.1 to 12.4). On the other hand, 26 (87%) of the 30 SD patients thought that the summary provided helpful information, the same number was reassured by seeing it and in the opinion of 28 (93%) it was a good idea to have read the summary. Logistic regression showed that age, sex and social class had no significant effect.

Conclusion: Giving this group of patients the main written summary about themselves is appreciated by them and can be used as part of their overall management.

THE FIRST BAIL HOSTEL IN THE UK SPECIFICALLY FOR MENTALLY DISORDERED OFFENDERS. AN ANALYSIS OF THE FIRST 100 RESIDENTS

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Background: In the UK there is a policy to divert those with a mental disorder away from custodial remand facilities to facilities where their mental health needs can be assessed and treatment provided. Elliott House is the first bail hostel in the UK specifically for mentally abnormal offenders. This paper describes how the facility is run and provides information regarding those who were resident there from October 1993 to November 1994.

Method: This paper presents information collected retrospectively on the first 100 residents. Sufficient information for study was available from 92 of the residents because others remained in the hostel for too brief a period to allow an assessment to be made.

Results: The study provides information on demographic features, past and present psychiatric care, index and previous offences, current psychiatric diagnosis, perceived needs and outcome. Analysis of the index offences shows that a significant proportion of the residents were currently charged with serious offences. 53% of the residents were receiving psychiatric care at the time of the offence, and a greater percentage have received psychiatric care in the past. 25% had a primary diagnosis of schizophrenia. Only 16% had a primary diagnoses of personality disorder. The range of primary diagnosis is wide. 14% were found to have no mental abnormality. The commonest perceived need was liaison with other agencies: 54% required medication, 49% needed accommodation and 16% required a court report. Difficulties posed by the residents are presented and discussed. 50% of the residents breached the conditions of bail. The other reasons for leaving the hostel are presented and discussed, including the judicial outcome of those who returned to the court in the normal way from the bail hostel.

DIMETHYLSULFOXID APPLICATION FOR OVERCOMING OF THERAPY RESISTANCE IN PATIENTS WITH LINGERING DEPRESSIONS

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Understanding the universal and multifactoral effectiveness of dimethylsulfoxid (DMSO) we used it in complex with antidepressants to break therapy resistance in patients with lingering depressions. We had 17 patients (aged 28–55 years) with 5 to 20 years history of definite disease & 8 months to 2 years anamnesis of depression by the experiment's beginning. They were prescribed DMSO 50% solution, 1 ML 3 times a day for 3–5 weeks, with 70 ML of water (to prevent GIT side effects). We also continued basic antidepressive therapy (amythriptilin, pirasidol, anafranil) which had had been insufficient recently. We succeeded in 14 patients (82.3%) with 1 to 4 years katamnesis. Control group included 20 patients with primary episodes of depression: 10 on amythriptilin and 10 on amythriptilin with DMSO. The treatment was successful in both subgroups, but in the 1-st one it had taken 83 days; in the second one — only 52 days. So DMSO can be used in complex with basic antidepressants for overcoming therapy resistance in patients with lingering depressions, and as a sours of reducing the treatment duration. Such a complex does not increase the side effects of antidepressants.

CENT CAS DE SUICIDES DANS LES HÔPITAUX DU GRAND MONTRÉAL (1986–1991)

F. Grunberg.

Objectifs: Évaluer les caractéristiques cliniques et démographiques, la prévisibilité et les mesures de prévention dans des suicides de personnes hospitalisées.

Méthodologie: Tous les suicides de personnes hospitalisées qui se sont suicidées dans les hôpitaux du Montréal Métropolitain (du 1er avril 1986 au 31 mars 1992) ont été identifiées en utilisant les dossiers des coroners et les dossiers médicaux de ces personnes.

Résultats: On a pu dénombrer 3,079 suicides au cours de cette période (taux annuel 16,4 pour 100.000) dont 104 ont pris place chez des personnes au cours d'hospitalisation (3.38%). Quatre cas ont été exclus de l'étude dû à des dossiers médicaux insuffisants. Les 100 cas restants ont été divisés en trois groupes: 22 (22%) étaient hospitalisés dans des hôpitaux psychiatriques, 48 (48%) avaient été hospitalisés dans le service de psychiatrie d'un hôpital général et 30 (30%) avaient été hospitalisés dans une unité de soins médico-chirurgicale d'un hôpital général ou d'un hôpital pour patients chroniques.

A peu près la moitié des personnes qui se sont suicidées en cours d'hospitalisation (48%) ont posé leur acte en dehors des murs de l'hôpital pendant des absences autorisées ou en évasion. Les suicides étaient beaucoup plus prévisibles dans les hôpitaux psychiatriques que dans les autres établissements. Cependant, les mesures de prévention de suicide ne différaient pas d'un établissement à l'autre.

Conclusion: Le suicide à l'hôpital demeure un phénomène rare. Si quelques suicides nous sont apparus rétrospectivement plus prévisibles que d'autres, nos constatations ne semblent pas justifier un resserrement des mesures préventives dans les hôpitaux étudiés.

Il faut signaler qu'à Montréal au cours des vingt dernières années, aucune poursuite intentée contre les hôpitaux ou des psychiatres pour cause de suicide n'a aboutie.

NOCTURNAL ENURESIS: IMIPRAMINE TREATMENT AND PLASMA LEVELS

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Objectives: To value antienuretic response to imipramine in relation to clinical and pharmakinetic variables.

Material and method: We studied 85 patients with primary daily nocturnal enuresis treated in outpatients consultancies with a mean doses of imipramine of about 1.5 mg/kg/day and we determined, by means of cromatographic gases, the plasma levels. Mean age was 8.5529 ± 2.5889 years (mean ± SD). 75% of the sample (60 patients) were younger than 10.

Results: 75% of the patients obtained a good or very good response and the mean concentration of the overall sample was 73.38 ± 59.25 ng/mL.

98.8% (83 children) did not have family history of urologic disease; 52.4% (44 children) had family background of psychiatric disease and 53.57% (45 children) had family background of enuresis.

Conclusions: Imipramine is a useful treatment for enuresis and its side-effects are minimal and without complications. Although the plasma levels of the patients sample with a good response was 78.28 ± 58.05 ng/mL we did not find a significant correlation between the plasma levels and the enuretic response.