citalopram for a minimum of 1 month, without full therapeutic effect. Mean age was 47 years (range 21–82 years) and two thirds were female. Of all patients, 85 percent were judged as moderately or markedly ill on the Clinical Global Impression scale, and average MADRS (10 items) scores were 27.8 (range 13–42) at baseline. Average duration of current depressive episode was 515 days (range 42 days to 17 years), and the average period on SSRI treatment was 213 days (range 28 days to 27 months). At 4 weeks on augmentation treatment, 50 percent were much or very much improved on the Clinical Global Improvement scale, and the MADRS scores had decreased to 16.9 (range 0–39). Tolerance to treatment was good and there was no evidence of any serotonergic side effects or increasing frequency of other adverse events. The study will be unblinded in April 1996 when 120 patients have been included.

O-19-5 Pramipexole in Major Depression — An Open Clinical Trial

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Objectives: Pramipexole is a newly developed selective dopamine agonist preferentially interacting with D_2-like autoreceptors. Based on preclinical and clinical results, pramipexole may be of therapeutic value in depression with clinical features of psychomotor inhibition. In an open dose-finding study, we assessed the tolerability and safety of pramipexole at five escalating dose levels.

Methodology: At two centres, an open clinical trial was performed in depressed inpatients suffering from major depression (DSM-III-R) with predominant psychomotor inhibition and with a HAMD-17 score of ≥ 18 at baseline. Duration of treatment was 28 days with an initial wash-out period of up to 3 days. Doses were gradually escalated during the first 14 days to target doses of 1.75, 3.5, 4.875, 6.25 or 9.0 mg/day, respectively, which should be maintained for further 14 days. Subjects were rated by the HAMD-17, MADRS, BRMS, and CGI scale. Adverse events were registered by careful clinical interviews. Additionally, ECG, clinical laboratory tests and daily vital signs monitoring were performed. *Results:* A total of 26 patients were treated with pramipexole in this study. The mean HAMD-17 score was 24.3 (± 4.2 SD) points at baseline. Five patients prematurely dropped out, due to adverse effects (n = 4), and lack of efficacy (n = 1). The most frequent adverse events were nausea (n = 13), restlessness (n = 11), headache (n = 10), and insomnia (n = 9). Postural hypotension occurred in 1 patient. No changes of ECG or laboratory parameters were observed. Under the target dose of 9.0 mg/day (n = 1), this patient experienced visual hallucinations, restlessness, agitation, anxiety, insomnia and postural hypotension. Dose escalation within 14 days was tolerated up to target doses of 6.25 mg/day, with restlessness and insomnia occurring more often at higher dose levels. In 15 of 26 patients, depression tended to improve by 35% up to 73% HAMD-17 score reduction ($\geq$ 50% reduction; n = 7) within 4 weeks treatment. In 5 patients, pramipexole maintenance treatment was prolonged up to 1.5 years. *Conclusion:* This study supports the safety of pramipexole in major depression up to 6.25 mg/day. Further studies are needed for the evaluation of the efficacy of pramipexole in major depression.

O-19-6 A Six Month Sertraline Fluoxetine Comparative Study in Depressed Outpatients: Outcome and Costs

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SSRI's have demonstrated clinical efficacy comparable to tricyclics with better safety and treatment compliance. While sharing the same principal mechanism of action they present differences in pharmacological specificity, pharmacokinetic. Controlled comparative trials have not demonstrated superiority efficacy for any one of the SSRI. However the absence of predictive value of a previous response to an SSRI for the response to another SSRI suggest differences in clinical activity. Side effect profile might also differ among SSRI's. It is suspected that these differences might have impact on long term outcome of depressed patients. Two hundred and fourty four depressed outpatients fullfilling DSMIV criteria for major depressive episode (HAMD $\geq$ 20) were recruited by 57 GPs. Patients received in double-blind flexible dose of fluoxetine (20–60 mg, n = 120) or sertraline (50–150 mg, n = 122). Assessment including clinical evaluation (MADRS, CGI) quality of life measure (FSQ) were made at study entry and after 3 months and 6 months after inclusion. Use of medical service (consultation, hospitalisation, drugs, laboratory test, radiological precedure...) work and productivity losses were recorded for direct and indirect costs calculation. 236 patients (116 sertraline, 115 fluoxetine) were assessed up to the last visit; 23.5% in the sertraline group and 20.2% in the fluoxetine group had stopped the treatment before the 3 month visit. Significant clinical improvement over baseline was observed in both treatment group with no intergroup difference (ITT with LOCF). Significant quality of life improvement was observed in both treatment group. Consumption of medical resources was higher in fluoxetine treated patients with significantly more consultations to specialists (mostly psychiatrists). Patients in fluoxetine tended also to require more individual paramedic psychotherapies. Treatment groups did not differ for hospitalisation (number, duration) wether related or not to depression. There was no significant difference between groups for work or productivity losses. Cost comparison, favoured sertraline treated patients both in the society and payer point of view.

O-19-7 Comparison of Efficacy and Tolerability of Fluoxetine in Ambulatory and Hospitalized Patients with Major Depression

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The aim of our open study was to compare responses of 180 patients with DSMIII-R diagnosis of major depression divided in two groups: ambulatory and hospitalized. All patients received fixed dose of fluoxetine (20 mg) during 6 weeks. Hamilton Depression Rating Scale (21 items) and CGI were used to assess drug efficacy. Item 4 of CGI, incidence and severity of side effects and number of drop-outs were used to assess tolerability. Response to treatment was defined as: 1) 50% or greater decrease in HDRS at baseline and 2) a score of "much improved" or "very much improved" on item 2 of CGI. Having in mind different conditions of daily activities and different surroundings, special attention was focused on the differencies in compliance between two experimental groups. Parameters such as: onset of action of fluoxetine and need for additional psychopharmacological treatment were also compared. The results obtained showed that fluoxetine is an effective and well tolerated antidepressant in both evaluated groups.

O-19-8 Comparison of Effects of Paroxetine and Amitriptyline on Driving and Psychomotor Performance in Depression

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The role of pharmacotherapy in the management of depression is usually assessed in terms of a reduction in depressive symptoms and the incidence of unwanted side effects. One of the key considerations in terms of patient safety and tolerability is behavioural toxicity, or the potential impairment caused by drug therapy on the patient's quality of life and daily functioning. Psychomotor performance, which examines the effects of drug therapy on mental alertness, co-ordination and the ability to perform essential daily tasks such as driving, is an important aspect of behavioural toxicity. This double blind, randomised study compared the effect of paroxetine and amitriptyline treatment on driving ability and psychomotor performance. Patients aged 18–65 years, diagnosed with depression consistent with DSM-IV criteria of mild to moderate severity (Montgomery Asberg Depression Rating Scale [MADRS] Score $\leq$ 20) and requiring treatment with antidepressant medication, were randomised to receive either paroxetine (20 mg) or amitriptyline (100 mg titrated from 75 mg). Medication was dispensed after all baseline assessments had been completed. Patients were considered to have completed the