

## Mental health research challenges in Africa

An increasing number of epidemiological mental health studies have been carried out in sub-Saharan Africa in the last decade. However, in developing short-, medium- and long-term strategies, it is clear that further research will have to be carried out in order to provide the evidence necessary to strengthen the mental health care systems of sub-Saharan Africa, say Florence K Baingana, World Bank senior health specialist, Atalay Alem, psychiatrist at Amanuel Psychiatric Hospital, Addis Ababa University, Ethiopia, and Rachel Jenkins, director of the WHO UK Collaborating Centre, Institute of Psychiatry, Kings College London, writing in the new World Bank publication *Disease and Mortality in Sub-Saharan Africa*.

Some of the recommended research areas that could be pursued are:

- Cross-sectional and longitudinal studies of mental disorders, including validation of the standardised testing instruments, to establish the epidemiology and causative and risk factors, as well as links to sexual abuse, violence against women, HIV/AIDS and conflicts.
- Multisite studies on the mental well-being of children to establish the incidence and prevalence of mental disorders and links to abuse, malnutrition, conflicts, poverty and vulnerability.
- Stigma and other cultural beliefs.
- Cost-effectiveness, cost-minimisation, and cost-benefit analyses should be undertaken to provide government officials and funding agencies the necessary economic perspective.
- Family, twin, and adoption studies in Western countries have provided evidence of the genetic contribution to the aetiology of depressive disorders, as well as the role of the non-shared environment in the causation of depression. Thus, examination of gene-environment interactions is essential.
- Defective neurotransmission and neuroendocrine receptor responses are associated with depression. It is still unclear whether associations with neurological function represent cause or effect in the pathogenesis of depression and whether neurological function is the major risk factor for depression in sub-Saharan Africa.
- Cost-effectiveness of cognitive behavioural therapy in primary health care settings.

## Providing quality of life to those caught in the grip of neuropsychological illness



**Wellbutrin SR**  
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Positively treating depression.

**Aropax CR**  
paroxetine 12.5/25 mg  
Superior efficacy starts with improved tolerability.

**Lamictin**  
lamotrigine 2, 5, 25, 50, 100 and 200 mg

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For full prescribing information, refer to the package insert. **AROPAX CR 12.5**. Reg. No. A381/2/0612. Each controlled release tablet contains paroxetine hydrochloride equivalent to 12.5 mg paroxetine free base. **AROPAX CR 25**. Reg. No. A381/2/0613. Each controlled release tablet contains paroxetine hydrochloride equivalent to 25 mg paroxetine free base. **PHARMACOLOGICAL CLASSIFICATION**: A 1.2 Psycho-analgetics (Antidepressants). **INDICATIONS**: Major depressive disorder, Panic disorder with or without agoraphobia, Social Phobia. **REQUIP 0.25, 0.5, 1.0, 2.0, 5.0 Tablets**. Reg. No's. 31/5.4.1/0301 – 0305 respectively. Each tablet contains 0.25 mg, 0.5 mg, 1.0 mg, 2.0 mg, and 5.0 mg ropinirole as the hydrochloride respectively. **PHARMACOLOGICAL CLASSIFICATION**: A 5.4.1. Anti-Parkinsonism preparations. **INDICATIONS**: Treatment of Parkinson's Disease as early therapy in patients requiring dopaminergic therapy and as adjunctive treatment to L-dopa. **LAMICTIN 25, 50, 100 and 200 Tablets**. Each tablet contains 25 mg, 50 mg, 100 mg and 200 mg lamotrigine respectively. Reg. No's. 32/2.5/280 – 282, 29/2.5/0472 respectively. **LAMICTIN P2, P5, P25, P50, P100 and P200 Dispersible Tablets**. Each tablet contains 2mg, 5 mg, 25 mg, 50 mg, 100 mg and 200 mg lamotrigine respectively. Reg. No's. 36/2.5/0407, 29/2.5/0303 – 304, 32/2.5/0459, 29/2.5/0305, 32/2.5/0460 respectively. **PHARMACOLOGICAL CLASSIFICATION**: A 2.5 Antiepileptics. **INDICATIONS**: For the prevention of mood episodes in patients (over 18 years of age) with bipolar disorder, predominantly by preventing depressive episodes. **Adults and children over 12 years**: as monotherapy or add-on treatment of partial epilepsy with or without secondary generalised tonic-clonic seizures and in primary generalised tonic-clonic seizures. **Children 2 to 12 years**: as add-on treatment of partial epilepsy with or without secondary generalised tonic-clonic seizures not satisfactorily controlled with other antiepileptic medicines. Monotherapy in children under 12 years of age is not recommended. **Lennox-Gastaut syndrome**: as add-on treatment for seizures associated with Lennox-Gastaut syndrome. **PAXIL 20 (tablet)**. Reg. No. A391/2/0078. Each tablet contains paroxetine hydrochloride equivalent to paroxetine 20 mg free base. **PHARMACOLOGICAL CLASSIFICATION**: A 1.2 Psycho-analgetics (Antidepressants). **INDICATIONS**: Depression, Panic Disorder with & without agoraphobia, Obsessive Compulsive Disorder, Social Phobia, Generalised Anxiety Disorder. **WELLBUTRIN SR Tablets**. Reg. No. 34/1.2/0266. Each tablet contains 150 mg of bupropion hydrochloride. **PHARMACOLOGICAL CLASSIFICATION**: A 1.2 Psycho-analgetics (antidepressants). **INDICATIONS**: For the treatment of depression as defined by DSMIV Criteria. Following a satisfactory response, continuation with therapy is effective in preventing relapse and preventing recurrence of further depressive episodes. **NAME AND BUSINESS ADDRESS OF THE APPLICANT**: GlaxoSmithKline South Africa (Pty) Ltd., (Co. reg. no. 1948/030135/07), 57 Sloane Street, Bryanston, 2021.

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**References:** 1. Judd LL, Akiskal HS, Schettler PJ, et al. The Long-term Natural History of the Weekly Symptomatic Status of Bipolar I Disorder. *Arch Gen Psychiatry* 2002; **59**: 530-537. 2. Goodwin GM, Bowden CL, Calabrese JR, et al. A pooled Analysis of 2 Placebo-Controlled 18-Month Trials of Lamotrigine and Lithium Maintenance in Bipolar I Disorder. *J Clin Psychiatry* 2004; **65**(3): 432-441. 3. Khan A, Ginsberg LD, Asnis GM, et al. Effect of Lamotrigine on Cognitive Complaints in Patients With Bipolar I Disorder. *J Clin Psychiatry* 2004; **65**(11): 1483-1490. **For full prescribing information, refer to package insert.**

**[S3] LAMICTIN®** 25, 50, 100 and 200 mg Tablets. Reg. No's: Z/2.5/280 – 282, Z/2.5/0472 respectively. Each tablet contains 25 mg, 50 mg, 100 mg and 200 mg lamotrigine respectively. **[S3] LAMICTIN®** P2, P5, P25, P50, P100 and P200 Dispersible Tablets. Reg. No's: 36/2.5/0407, 29/2.5/0303 – 304, 32/2.5/0459, 29/2.5/0305, 32/2.5/0460 respectively. Each tablet contains 25 mg, 50 mg, 100 mg and 200 mg lamotrigine respectively. **PHARMACOLOGICAL CLASSIFICATION:** A 2.5 Antiepileptics. **INDICATIONS:** For the prevention of mood episodes in patients (over 18 years of age) with bipolar disorder, predominantly by preventing depressive episodes. **CONTRA-INDICATIONS:** Known hypersensitivity to lamotrigine. **WARNINGS:** Severe convulsive seizures including status epilepticus may lead to rhabdomyolysis, multi-organ dysfunction and disseminated intravascular coagulation, usually with fatal outcome. Closely monitor patients (including hepatic, renal and clotting parameters) who develop any combination of unexplained rash, fever, flu-like symptoms, drowsiness or worsening of seizure control, especially within the first month of starting treatment with lamotrigine. Exceeding the recommended dose at the initiation of therapy may be associated with an increased incidence of rash requiring withdrawal of therapy. Abrupt withdrawal may provoke rebound seizures. Risk may be reduced by tapering off the withdrawal over a period of two weeks. **Skin Reactions:** Reports of adverse skin reactions, have generally occurred within the first 8 weeks after initiation of treatment. Majority of rashes are mild and self-limiting; however serious, potentially life-threatening skin rashes including Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported especially in patients who also used valproate. Although the majority recover on drug withdrawal, some patients experience irreversible scarring and there have been rare cases of associated death. **The initial presentation of a rash can be mistaken for an infection; physicians should consider the possibility of a drug reaction that develop symptoms of rash and fever during the first eight weeks of therapy. Additionally the overall risk of rash appears to be strongly associated with high initial doses and exceeding the recommended dose escalation, concomitant use of valproate, which increases the mean half-life of lamotrigine nearly two-fold. All patients who develop a rash should be promptly evaluated and LAMICTIN withdrawn immediately unless the rash is clearly not drug related. Rash has also been reported as part of a hypersensitivity syndrome associated with a variable pattern of systemic symptoms including fever, lymphadenopathy, pruritis, facial oedema, abnormalities of the blood and liver and thrombocytopenia. The syndrome shows a wide spectrum of clinical severity and may lead to disseminated intravascular coagulation and multi-organ failure. It is important to note that early manifestations of hypersensitivity (e.g. fever, lymphadenopathy) may be present even though rash is not evident. If such signs and symptoms are present, the patient should be evaluated immediately and LAMICTIN discontinued if an alternative aetiology cannot be immediately established. Caution advised when treating patients with renal failure. The possibility of a suicide attempt is inherent in bipolar disorder, and close supervision of high-risk patients should accompany drug therapy. **INTERACTIONS:** In patients taking oral contraceptives, any change in the menstrual bleeding pattern should be reported to the patient's physician. Antiepileptic agents (such as phenytoin, carbamazepine, phenobarbital and primidone) which induce hepatic drug-metabolising enzymes enhance the metabolism of lamotrigine, halving its elimination half-life. Sodium valproate, which inhibits hepatic drug-metabolising enzymes, reduces the metabolism of lamotrigine and increases the mean half-life of lamotrigine nearly two-fold. Reports of central nervous system events including dizziness, ataxia, diplopia, blurred vision and nausea in patients taking carbamazepine following the introduction of LAMICTIN, which resolve when dose of carbamazepine is reduced. **PREGNANCY AND LACTATION:** Safety not established. **DOSAGE AND DIRECTIONS FOR USE:** It is important to adhere to the recommended dosages especially in combination therapy with valproate where one-tenth to one-fifth of the normal dose is used. Do not exceed the maximum dosage. Because of the risk of rash the initial dose and subsequent dose escalation should not be exceeded. The transition regimen should be followed to prevent recurrence of depressive episodes. The transition regimen involves escalating the dose of to a maintenance stabilisation dose over six weeks after which other psychotropic and/or anti-epileptic drugs can be withdrawn, if clinically indicated. Refer to package insert for full dosage recommendations on the Transition Regimen; Maintenance stabilisation total daily dose following withdrawal of concomitant psychotropic or anti-epileptic drugs; Adjustment of lamotrigine daily dosing following addition of other medications. **Discontinuation:** Patients may terminate LAMICTIN without a step-wise reduction of dose. **Children (less than 18 years of age):** Not recommended. **Elderly (over 65 years of age):** No dose adjustment required. **Hepatic impairment:** Initial, escalating and maintenance doses should generally be reduced by 50 % in patients with moderate (Child-Pugh grade B) and 75 % in severe (Child-Pugh grade C) hepatic impairment. Escalation and maintenance doses should be adjusted according to clinical response. **Renal impairment:** Caution advised; reduced maintenance doses should be used for patients with significant functional impairment. **SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** Commonly reported: skin rash, irritability, drowsiness, insomnia, dizziness, tremor, vertigo, paraesthesia. Headache, dizziness, nystagmus, tremor, ataxia, drowsiness, insomnia, diplopia, blurred vision, nausea, gastrointestinal disturbance (including vomiting and diarrhoea), tiredness. Serious, potentially life-threatening skin rashes, including angioedema, Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported. In Bipolar Disorder trials, agitation, somnolence, arthralgia, pain, back pain, have also been reported. **MANAGEMENT OF OVERDOSAGE:** In the event of overdosage, the patient should be admitted to hospital and given appropriate supportive therapy. Gastric lavage should be performed if indicated. **APPLICANT:** GlaxoSmithKline South Africa (Pty) Ltd., (Co. reg. no. 1948/030135/07), 57 Sloane Street, Bryanston, 2021.**

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## Depicting a new standard for bipolar disorder dominated by depression<sup>1</sup>



Prevent bipolar depression during manic or depressive episodes<sup>2</sup>  
without destabilising mood<sup>2</sup>  
whilst improving cognitive functioning<sup>3</sup>



Prevent depressive episodes. Maintain stability.<sup>2</sup>

- Evaluations of mental health services in sub-Saharan Africa.

Increasing the policy and service development and the clinical and research professional capacity in sub-Saharan African countries and stemming the flow of skilled health professionals to wealthy countries are key to developing sustainable, locally appropriate programmes.

Source: [www.worldbank.org](http://www.worldbank.org)

### International Conference on Philosophy, Psychiatry & Psychology

The 10th International Conference on Philosophy, Psychiatry & Psychology is to be held at Sun City from 26 to 30 August 2007, hosted by the International Network of Philosophy & Psychiatry (INPP) and the South African Society of Psychiatrists (SASOP). The conference is endorsed by the World Psychiatric Association (WPA), the African Association of Psychiatrists and Allied Professions (AAPAP), the Psychology Society of South Africa (PsySSA), and the Philosophical Society of Southern Africa (PSSA). The Annual General Meeting of SASOP will also take place at the conference.

The theme of the conference is 'Hypotheses, Neuroscience & Real Persons', and the following preliminary categories have been identified:

- conceptual advances and challenges in diagnosis and treatment
- theoretical advances and challenges in the neurosciences/psychopharmacology/psychophysiology
- diagnostic classification systems: the future
- scientific challenges at the edge in psychiatry/psychology
- ethics in mental health theory and practice
- relationships and interpersonal patterns – advances and challenges
- language and troubled minds and brains
- psychotherapy – conceptual issues of practical relevance
- cognitive neuroscience/cognitive psychology
- phenomenology of experiences in distress and difficulty
- analysis and interpretation in diagnosis/treatment
- computer modelling and Cyborg
- subjectivity in psychopathology: 'What is it like ...?'
- reality: world views and psychosis
- causation of mental disorder.

The deadline for abstracts is 31 March 2007 and further submissions are welcomed. For more information visit the website, or contact Sonja du Plessis at Londocor, [sonja@londocor.co.za](mailto:sonja@londocor.co.za)

Source: [www.ppp2007.co.za](http://www.ppp2007.co.za)