SAJP GOES OPEN ACCESS

The *South African Journal of Psychiatry* is moving to 'open access' through the open access online biomedical research publisher BioMed Central.

From the *SAJP's* perspective its publishing policy will remain essentially unchanged, with peer review continuing as before. There will also be citation tracking, with the addition of on-line tracking options (Scopus and Google Scholar), which will enable authors to monitor their own citation statistics directly. Copyright for articles is retained by authors, licensed under the Creative Commons Attribution License, which allows articles to be freely downloaded from the BioMed Central website and re-used and re-distributed without restriction, as long as the original work is correctly cited.

Open access will significantly broaden the reach of the *SAJP*, effectively making it global, and ensuring that the contents get the widest distribution.

Source: www.biomedcentral.com

NEUROLOGICAL DISORDERS AND THE PUBLIC HEALTH CHALLENGES

Neurological disorders, including dementia, epilepsy, headache disorders, multiple sclerosis, neuroinfections, neurological disorders associated with malnutrition, pain associated with neurological disorders, Parkinson's disease, stroke and traumatic brain injuries, affect up to one billion people worldwide, according to a new survey by the World Health Organization (WHO).

Of these, some 50 million people suffer from epilepsy and 24 million from Alzheimer's or other dementias, and together these disorders, along with Parkinson's disease, are estimated to have accounted for 1.3% of total global DALYs in 2005. This number is expected to rise to 1.5% in 2015 and more than 1.8% by 2030 – an increase brought about by a demographical transition from predominantly youthful populations to older and ageing ones as a result of increased life expectancy and reduced fertility.

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 Tablets. Reg. No's. Z/2.5/280 – 282, 29/2.5/0472 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 2mg, 5 mg, 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 acutely 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 thrombocytopaenia. 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, phenobarbitone 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, parasthesia. 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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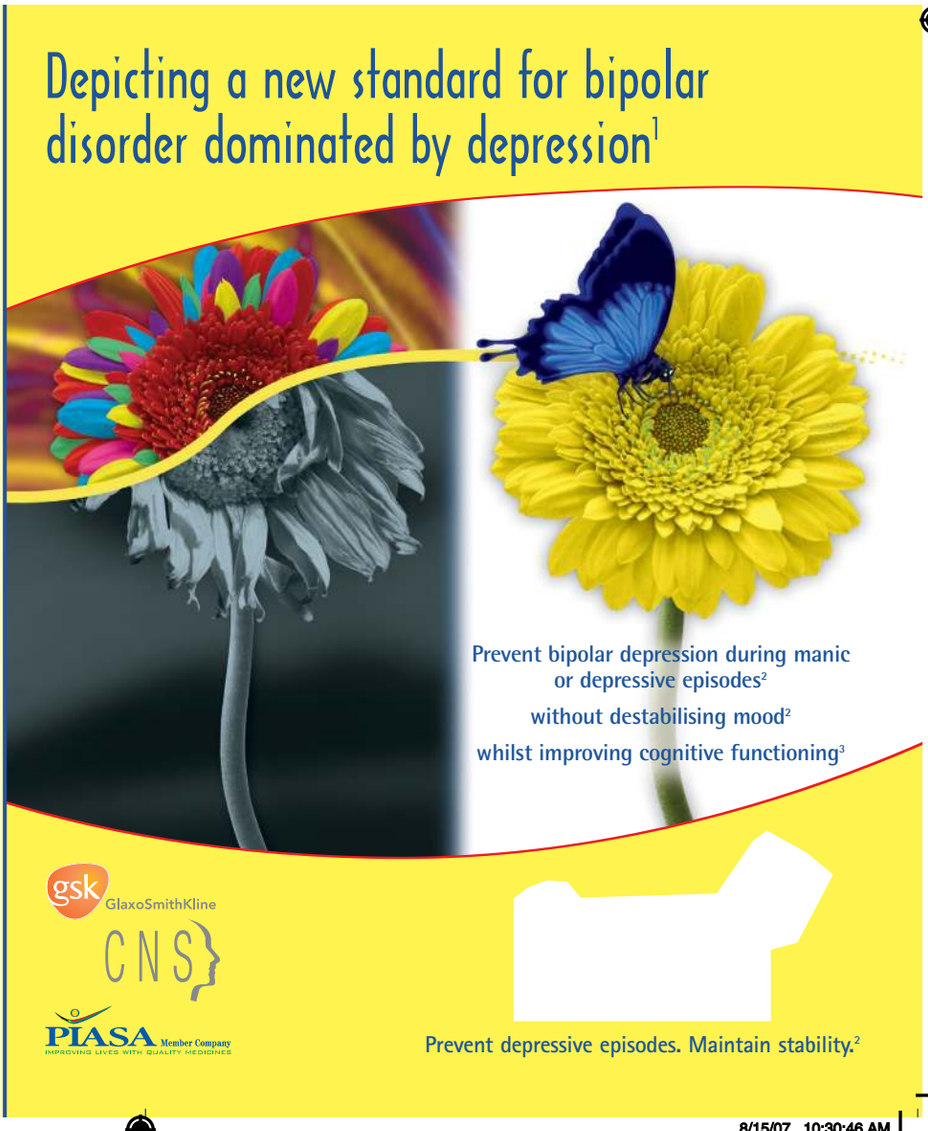

These disorders are found among all age groups and in all geographical regions.

Despite the fact that effective, low-cost treatments are available, large numbers of people go untreated for reasons including inadequate health delivery systems, lack of trained personnel, the absence of essential drugs and the prevalence of traditional beliefs and practices.

The report says that a clear message emerges: unless immediate action is taken globally, the neurological burden is expected to become an even more serious and unmanageable threat to public health. Accordingly it recommends a series of 'simple but effective' actions, including greater commitment from decision makers, increased social and professional awareness, strategies that address stigma and discrimination, national capacity building and international collaboration. The research agenda for developing countries, including operational research, also needs to be developed to gain better understanding of the problem so that appropriate responses can be developed and evaluated.

Most importantly, neurological care may be integrated into primary health care. In these settings, doctors can use low-technology interventions, and community-based rehabilitation is also an option.

Source: www.who.int

GlaxoSmithKline launches HIV/AIDS and Mental Health Newsletter

Neuropsychiatric disorders comprise the second largest component of HIV/AIDS, our national burden of disease.

The National Research Foundation has provided funding for a cross-university brain-behaviour initiative (CUBBI), a research initiative focused on the psychobiology of vulnerability and resilience after psychological trauma.

GSK initiated this newsletter, in association with the CUBBI, as a service to the medical community The newsletter will provide practitioners with a series of updates on HIV/AIDS and mental health, written by respected professionals in their individual fields of expertise. It also aims to raise awareness and highlight the role and gravity of mental health in HIV/AIDS patients.

Professor Dan Stein, Professor and Chair of the Department of Psychiatry, University of Cape Town and Director, MRC Unit on Anxiety and Stress Disorders, University of Stellenbosch, has been appointed as editor. The first issue appeared at the end of June 2007.

Parties interested in receiving or contributing to future issues of the newsletter are welcome to contact Madelein Steyl, CNS Brand Manager, GSK South Africa, tel (011) 745-6046 or e-mail: madelein.m.steyl@gsk.com.
Reference available on request.

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