patients were initiated on 25mg of RLAI. At 12-months 63% of patients were still on RLAI. The reasons for discontinuation were lack of response (14%); loss-to-follow-up (10.5%); other (7.5%); patient or family choice (6%); adverse events (6%); tolerability (2%); and adherence (1.5%). Young age at schizophrenia onset and suicidal behavior at baseline were significant risk factors for time to discontinuation ($p < 0.04$). **CONCLUSIONS:** The treatment continuation rate with RLAI at 12-months is consistent with the results of Fleischhacker et al (2003), but superior to oral typical and atypical agents (Lieberman et al, 2005). Fleischhacker et al (2003); J Clin Psychiatry 64(10):1250–1257. Lieberman et al (2005); NEJM 353:1209–23.

PMH4

META-ANALYSIS OF SNRIS, SSRIS, AND TCAS IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER USING REMISSION AS THE CLINICAL OUTCOME

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OBJECTIVE: To summarize rates of clinical remission and dropouts/withdrawal due to adverse drug reactions (ADRs) or lack of efficacy/effectiveness (LoE) of serotonin-norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs). **METHODS:** We searched Medline, Embase, International Pharmaceutical Abstracts, and The Cochrane International Library from 1980 to 2005 for clinical trials using MeSH terms "serotonin norepinephrine reuptake inhibitors", "selective serotonin reuptake inhibitors", "tricyclic antidepressants", "major depression", and "clinical remission". Accepted languages were English, French, German, Portuguese, and Spanish. A meta-analytic approach was used to synthesize outcome rates from published head-to-head clinical trials comparing two or more drugs (in therapeutic doses) from SNRIs, and/or SSRIs, and/or TCAs from 6 to 12 weeks of treatment. Remission was defined as a final score = <7 on the Hamilton Depression Rating Scale or = <12 in the Montgomery-Asberg Depression Rating Scale. Data were combined across arms of individual studies using a random effects model, producing point estimates with 95% confidence intervals. **RESULTS:** Data were gathered from 30 arms of 15 head-to-head trials of 2524 patients. TCAs had the highest overall remission rate (45.7%), followed by SNRIs (45.0%), and SSRIs (38.8%) ($p > 0.05$ for TCAs versus SNRIs; $p < 0.001$ for TCAs versus SSRIs; and $p < 0.001$ for SNRIs versus SSRIs). When patients were categorized as inpatients (n = 582) and outpatients (n = 1613), SNRIs had the highest remission rate (52.0% for 144 inpatients and 49.3% for 559 outpatients). SNRIs had the lowest overall discontinuation rates (24.3%), followed by SSRIs (27.1%), and TCAs (34.9%). Rates of discontinuation due to ADRs and LoE were 9.8% and 5.2% for SNRIs, 7.3% and 7.0% for SSRIs, and 18.9% and 9.1% for TCAs, respectively. **CONCLUSIONS:** SNRIs have the highest efficacy/effectiveness remission rates (statistically significant for inpatients and outpatients), and the lowest overall dropout/withdrawal rates suggesting clinical superiority for this class in treating major depressive disorders.

PMH5

INCIDENT DIABETES ASSOCIATED WITH USE OF SECOND-GENERATION ANTIPSYCHOTIC (SGA) THERAPY: AN EVALUATION OF THE IMPACT OF DOSE AND TREATMENT INDICATION

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OBJECTIVE: While SGA therapy has been associated with new-onset diabetes, the relative risk of the agents and the impact of possible confounding variables have been questioned. This study evaluated the impact of dose and treatment indication on the relative risk of new-onset diabetes associated with SGA therapy while controlling for demographic, clinical and medication variables. **METHODS:** A retrospective database analysis capturing electronic medical records for adult Texas Medicaid enrollees taking antipsychotic monotherapy from January 1997 to December 2001, with a maximum follow-up of 12 months was used. Patients were stratified according to treatment dose (low, medium, high) and a hierarchy of mutually exclusive diagnostic categories: schizophrenia, bipolar disorder, dementia, psychotic disorder, non-psychotic disorder and no mental health indication. The incidence of diabetes was examined using multivariate logistic regression analysis. **RESULTS:** Data were available for 13,731 patients. At treatment-onset, the prevalence of diabetes was 16.9%. The mean (SD) dose by indication for the most prevalent conditions (schizophrenia, bipolar disorder and dementia, respectively) were as follows: olanzapine (12.04mg (6.73); 8.91mg (5.78); 4.87mg (3.00)); quetiapine (273.16mg (203.86); 146.33mg (142.29); 79.59 (82.57)); and risperidone (3.55mg (2.37); 2.05 (1.76); 1.12 (0.85)). The overall incidence of diabetes was 2.6%. Multivariate logistic regression analysis showed no difference in the incidence of diabetes according to the agent used ($p = 0.281$). Compared to risperidone, the odds of new-onset diabetes were 0.879 (95% CI: 0.653 to 1.184) and 0.683 (95% CI: 0.414 to 1.126) for olanzapine and quetiapine, respectively. Neither treatment indication ($p = 0.876$) nor antipsychotic dose ($p = 0.274$) were associated with the development of diabetes. **CONCLUSIONS:** Results indicate that the risk of new-onset diabetes does not differ among SGA agents (i.e., olanzapine, quetiapine and risperidone). While the dose of antipsychotic prescribed varied significantly according to treatment indication and patient age, neither dose nor indication were associated with the development of diabetes.

PMH6

NEW-ONSET DIABETES MELLITUS ASSOCIATED WITH USE OF ATYPICAL ANTIPSYCHOTICS AMONG SCHIZOPHRENIC PATIENTS IN TAIWAN

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OBJECTIVES: Atypical antipsychotic-induced diabetes has raised concerns recently, while the extent of atypical antipsychotic-induced diabetes mellitus among Asians with schizophrenia is not well known. This study aims to compare the association of atypical antipsychotic treatments and diabetes mellitus with that of haloperidol treatment and diabetes mellitus among schizophrenic patients in Taiwan. **METHODS:** Data used in this study came from Taiwan's National Health Insurance claims database for the period 2000–2004. This study identified antipsychotic treatment episodes of clozapine, olanzapine, risperidone, quetiapine, amisulpride, ziprasidone, and haloperi-