P03.370
EFFECT OF AXIS I COMORBIDITY ON BIPOLAR II AGE AT ONSET

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Axis I comorbidity is common in mood disorders. Study aim was to find if axis I comorbidity was associated with lower age at onset in bipolar II. Different age at onset may be related to different genetics, and may support subtyping of mood disorders (McMahon et al 1994). Bipolar II is common in depressed outpatients (around 40%) (Benazzi, 1997, 1999).

Methods: The study was conducted by a senior psychiatrist in private practice, because private practice is more representative of mood disorder patients in Italy, where it is first or second (after family doctors) line of treatment of mood disorders, and where most severe patients are treated in national services or in university centers. Mood disorder patients from academic centers may not be representative of typical mood disorder patients (Goldberg and Kocsis, 1999). 218 bipolar II outpatients [age 40.4 y (SD = 13.8), females 69.4%], presenting for depression treatment, were included during the last 3 years. Substance and severe personality disorders were not included, because may be confused with bipolar II. Patients were interviewed by the author with DSM-IV Structured Clinical Interview. Family members or close friends supplemented clinical information. Means were compared with t test. Logistic regression was used to study associations (STATA 5). Two-tailed P < 0.05.

Results: Axis I comorbidity (not including substance disorders) was present in 62.8% (137/218) of patients. Mean (SD) age at onset (years) of first depression was significantly lower [23.9 (9.3) vs 28.7 (14.2), $t = 3.0$, $df = 216$, $p = 0.0029$] in bipolar II with axis I comorbidity ($n = 137$) than in bipolar II without ($n = 81$) axis I comorbidity. Axis I comorbidity was significantly negatively associated with age at onset (odds ratio = 0.9, $z = -2.8$, $p = 0.005$).

Discussion: Different age at onset supports subtyping of bipolar II based on presence of axis I comorbidity.

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PSYCHOTIC DEPRESSION: BIPOLAR II AND UNIPOLAR

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Background: To find if bipolar II psychotic depression (PD) was a severe variant of bipolar II depression, or a distinct disorder, by comparing bipolar II PD with bipolar II nonpsychotic depression (NPD), and with unipolar PD.

Methods: Two hundred and nineteen bipolar II, and two hundred and twenty nine unipolar, consecutive major depressive episode (MDE) outpatients, presenting for MDE treatment during the last three years, were studied in private practice. Private practice was chosen because it is more representative of mood disorder patients in Italy, where it is first or second (after family doctors) line of treatment of mood disorders, and where most severe patients are treated in national services or in university centers. Patients were interviewed by the author with the Structured Clinical Interview for DSM-IV. Family members or close friends supplementing clinical information. Outcome measures: Age, gender, age at first MDE onset, number of MDEs, chronicity (MDE/MDE without full interepisode recovery lasting more than 2 years), patients with atypical features, psychotic features, and axis I comorbid disorders, and MDE severity (assessed by Montgomery Asberg Depression Rating Scale, Global Assessment of Functioning Scale). Means compared with t test, and proportions with two-sample test of proportion (STATA 5). Two-tailed P values, $P < 0.05$.

Results: Bipolar II PD (n 20) vs NPD (n 199) had significantly more females, higher severity, and fewer patients with atypical features. Bipolar II (n 20) vs unipolar (n 21) PD had significantly more females, lower age at onset, and more axis I comorbid disorders.

Conclusions: As bipolar II PD was more severe than bipolar II NPD, and it had a lower age at onset than unipolar PD (different age at onset supports subtyping of mood disorders), results suggest that bipolar II PD is a severe variant of bipolar II depression, distinct from unipolar PD.

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FROM AMISULPRIDE TO REHABILITATION

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Major part of patients in psychiatric hospitals are the ones with chronic schizophrenia. Presence of prominent negative symptoms creates big problem for their resocialization. Hence, the question of management of deficiency states still remains open for researchers and clinicians. Present paper reflects the experience of new drug-amisulpride (Solian) administration together with psychosocial rehabilitation. 17 patients with diagnosis of paranoid schizophrenia (according to ICD-10 criteria) with the stabile defect in the phase of reconvalescence after the treatment with conventional neuroleptics were included in the stude on the basis of informed agreement. All of them were not able to discharge from the hospital because of persisting prominent negative symptoms and consequent difficulties in social adaptation. For 4 weeks patients participated in rehabilitation trainings program and simultaneously received 100 mg of amisulpride per day. Evaluation was done with PANSS in the beginning, on the 2d week and in the end of treatment course. As result, we achieved improvement in most of patients (67%) – that was evidenced by changes in PANSS negative cluster-and to diminish the term of stay in the hospital. During all the period of treatment no changes in biochemical parameters were revealed. Therefore, we could say that amisulpride in relatively low doses is able to influence the negative symptoms of schizophrenia, and in combination with appropriate rehabilitative measures benefit in restoring of social functioning of patients with chronic schizophrenia.

P03.373
EXPERIENCE OF STABLON (TIANEPTINE) ADMINISTRATION IN NEUROTIC STATES WITH ANXIETY

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Problem of neuroses became more actual in Ukraine today due to changes in economics and in social sphere with fall in well-being level. Conseqently, this leads to growth in number of neurotic patients. We observed 19 patients with neurotic states, who recieved treatment with new antidepressant - Stablon (tianeptine). All patients showed high anxiety level on the background of slight depression. Beside that, in 6 of them obsessive disorders were present. All patients previously recieved treatment with tranquillizers, but without significant improvement. As it is known, tianeptine is 5-HT reuptake enhancer and exhibits a mechanism of action, totally opposite to 5-HT reuptake blockers, providing antidepressive and anxiolytic effect. Group consisted of outpatients, who started treatment with 2 tablets/day (25 mg) with following increase to 1

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