Aim: of the study was the observation of the efficacy and tolerability of escitalopram in patients with recurrent unipolar major depression (MD-RUP) over a 6-month period.

Method: 23 patients with MD-RUP in acute phase, diagnosed according to DSM-IV-R (DIGS-interview) were followed-up for 6 month from the beginning of the treatment with escitalopram (10mg-20mg/day). Five measurements were undertaken: on the first treatment day, after two weeks, one month, two months and six months of continuous treatment. Measurements included the modified Hamilton Rating Scale (25 items) (HAMD-25) (Miller et al, Psychiatry Research, 1984) for depressive and anxious symptoms and the CGI-S (Clinical Global Impression–Severity).

Results: There were 3 drop-outs because of the drug side effects during the first treatment week. In the remaining 20 patients worsening of insomnia, anxiety, and concentration was noticed during the first two treatment weeks. In 20% (4/20) of the cases the reduced sleep accentuated the depression and generated pessimistic ideation during the first two weaks. The first significant improvement of the depressed mood, lack of energy, insomnia and concentration appeared after one month ($p=0.05$) in patients with reduced anxiety and after two months in patients with high anxiety. The remission remained stable in 80% (16/20) of the cases over 6 months.

Limitation: The study investigated a small sample and had no placebo control group.

Conclusion: Escitalopram may worsen some symptoms like insomnia and anxiety in the clinical picture of major depression during the first two weeks of treatment.

P035

Are depressive and seasonal symptoms associated?

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Background and aims: Previous studies identified seasonal symptoms in mood disorders (recurrent depression, and bipolar disorder I and II). In this study we tested the dual vulnerability hypothesis, assessed the seasonal changes and the presence of depressive symptoms.

Method: 8028 subjects aged 30 to 99, 55% women and 45% men were interviewed and invited to the health examination. The process was: a) interview at home, b) health examination at the local health centre, c) telephone interview and/or a mail questionnaire, d) Registration of information for baseline and follow-up purposes. The questionnaires analyzed for this study were Beck Depression Inventory (BDI) and Seasonal Pattern Assessment Questionnaire (SPAQ). Surveys were applied by 5 field teams in 80 Finnish regions.

Results: The prevalence of seasonal symptoms together with depression was 9%. Individuals with a high BDI score and a low SPAQ comprised 19% against those 11% having low BDI and a high SPAQ, which makes 30%. Sum scores correlated ($r=.31$, $p<001$) corrected for gender and age. In logistic regression models, higher scores on the SPAQ were associated with depression (OR=2.76, 95% CI of 2.41- 3.18) and higher scores on the BDI with the seasonal pattern (OR=2.76, 95% CI of 2.40-3.18).

Conclusions: Our results now extend the findings of [1] that 10% of all mood disorders followed a seasonal pattern. Therefore, a seasonal pattern can be detected not just in clinical, but in general populations, too.

References

[1] Faedda. Arch Gen Psychiatry 1993;50:17–23.

P036

Depression on late life: Epidemiologycal data, risk factors and therapeutic approach

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The possibilities of suffering from a depression increase as we get older. The medical profile of a depression is very varied on elderly patients and the fact that the cognitive deterioration may organize a pathoplasty is also to be taken into account so we must be very precise when making the differential diagnosis as the possibility of an organic pathology is higher.

It is highly more likely for women than for men to suffer this pathology, but the possibilities tend to equalize as people get older.

Depression affects between 5 and 15% of people older than 65 who live in our community (NIH, 1992) (3 - 5% Major Depressive Disorder; Disthymia 10 – 12%); the 15%-50% of elderly persons who live in an old people's home suffer from a certain depressive disorder, and 10% - 20%of hospitalized are depressed. Aethiologycal factors are multifactoral and can be classified in genetic, biological or psychosocial groups.

Regarding the treatment it is very important to make a global valuation as well as assuring the compatibilities and interactions of all the medicines to be taken, we must be careful at the beginning of the treatment and give the patient a progressive dosification of the medicines.

This report describes the main characteristics of depression on old people that may be useful to distinguish it from the affective pathology that affects another group of age, but it also deals with the therapeutic-non medical approaches that the family or others may use to help the patient.

P037

Update on the treatment for refractary depression

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Background: Mayor Depression affects 340 millions of people in the world 16.2% of risk of life prevalence, 2/3 are women. A refractary depression is the one that does not respond to a well found treatment in a period of time (usually around 8 weeks). It is associated to a higher rate of suicide, 15% higher rate of suicidal thoughts and actions, 33%, which means a worse prognosis. Higher costs; they visit the doctor three times as much as people who are not depressed.

Methods: we have analysed the main therapeutic reports on refractary depression.

Results: ECT, may be effective if it is administrated acutely, but results tend to be poor if it is used for a long period of time. The STAR D report (Rush, 2006) showed that 25% of the patients improved as they were given a different antidepressant

The potentation of citalopram with bupropion or buspirone may also be useful (Madhulkar, 2006); combinations of antidepressants with some atypical antipsychotics have given good results (Nemeroff, 2004).

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