## P-10-22

Neurocognitive differences between female and male with major depression

G. Faludi, A. Sarosi, G. Balogh. *Semmelweis University Dept. of Psychiatry, Budapest, Hungary*

Epidemiologic data indicate that MD is approximately twice as common in women as in men. The biological hypotheses have been proposed to explain the predominance of MD in women attributes the sex difference in brain structure and function between men and women. Little is known about the effects of gender differences on cognition in depression. The objective of the study was to compare cognitive function between female and male patients suffering from DSM IV. major depressive episode. We hypothesized that both patient groups will show some gender-specific neurocognitive functioning. The neuropsychological battery included tests that assessed attention, verbal memory, non verbal memory, working memory, executive function. Results showed that females had better recalling memory as compared to men. There was a significant difference, males attained lower verbal memory scores as compared to females. While reproducing from memory the performance of both females and males was worse in comparison to normative data. When compared the colour identification period in patient group with the normative data obtained from generally accepted studies, it was observed that depressed group took a significantly longer period to identify colours. For measures visual scanning ability and speed attention there were significant differences between the patient group and standard subjects, women performed somewhat faster than men. The findings of this study suggest that although global cognitive impairment is absent in major depressive episode, deficit in most of the specific domains are present. Most individual test score differences were found within the memory and executive functioning domains, where depressed males typically were most impaired.

## P-10-23

Mood disorders and their treatment in patients with epilepsy

C. Prueter, C. Norra. *Hospital Maria Hilf Psychiatry and Neurology, Gangelt, Germany*

**Objective:** Mood disorders in patients with epilepsy are frequently not diagnosed and not treated. Because of the high prevalence of depression and the resulting high suicide rate, precise diagnosis and effective therapy are very important.

**Methods:** A review of the literature is given

**Results:** Frequently, the clinical pictures of depressive syndromes in epileptics do not correspond with those described in operationalized classification systems such as ICD-10. or DSM IV. The incidence of depressive disorders in epileptics is estimated in the literature to be 30-70%. Multifactorial pathogenetic models include the type of seizures, the location of the epileptic focus, and neurotransmitter dysfunctions, as well as hereditary and psychosocial influences, and negative psychotropic effects of antiepileptic drugs (AEDs).

**Conclusion:** Despite an insufficient number of available controlled studies, based on the current data, treatment with the newer serotonergic antidepressants can be recommended for patients with epilepsy.Recommendations for therapy are given.

## P-10-24

Comparison among measures of depression: Reliability, validity, relationship to anxiety and personality and the role of age and life events

K. N. Fountoulakis, P. Panagiotidis, S. Kaltartzis, M. Siamouli, A. Papadopoulou, M. Papadopoulou, S. G. Kaprinis, A. Iacovides. *3rd Dept. of Psychiatry Aristotle Univ Thessaloniki, Aretsou, Greece*

**Objective:** During the last decades, several scales assessing depressive symptoms emerged, however there are only a few studies comparing them in terms of reliability and validity.

**Methods:** The study sample included 40 depressed patients 29.65 ± 9.38 years old, and 120 normal comparison subjects 27.23 ± 10.62 years old. Clinical Diagnosis was reached by consensus of two examiners with the use of the SCAN v.2.0. The depressive scales applied and standardized were the CES-D, ZDRS, BDI-I, and the KSQ. Also, the STAI, the Life Events scale (Holms and Rahe), and the EPQ were administered. The analysis included the comparison of psychometric properties and the use of Pearson correlation coefficient and factor analysis.

**Results:** The results suggest that all scales correlated with anxiety measurements, sociodemographic variables, personality dimensions and non-significant indices to a similar extend. However, the MDI performed somewhat better, while the ZDRS had a very low internal consistency.

**Conclusion:** The comparison of several depressive scales provided no impressive results on the superiority or inferiority of a specific scale on the others.

## P-10-25

Clinical, neurobiological and psychometric differences between early and late onset depressive illness

K.N. Fountoulakis. *Aretsou, Greece*

**Tuesday, April 5, 2005**

# P-12. Poster session: Affective disorders II

*Chairperson(s):* Jules Angst (Zürich, Switzerland), Eduard Vieta (Barcelona, Spain)
11.15 - 12.15, Gasteig - Foyers

## P-12-01

Olanzapine/fluoxetine and olanzapine treatment for bipolar depression: Open-label continuation in rapid cycling patients

S. Corya, P. Keck Jr., E. Vieta, J. Niswander, W. Xu, M. Tohen. *Eli Lilly and Company Lilly Research Laboratories, Indianapolis, USA*

**Objective:** Olanzapine/fluoxetine combination (OFC) has demonstrated efficacy in treatment of bipolar depression. This secondary analysis of patients with a history of rapid cycling (RC) examines the efficacy of OFC and olanzapine (OLZ) during a 6-month open-label (O-L) extension.

**Methods:** 833 subjects with an index depressive episode enrolled in an 8-week, double-blind, randomized trial with 315 RC patients receiving OFC (n=37), OLZ (n=140), or placebo (n=138). Patients achieving remission (MADRS≤8; YMRS≤12) entered O-

L treatment receiving OLZ initially and switching to OFC any time after one week as needed.

**Results:** Compared to placebo and OLZ, mean change in total MADRS score revealed that OFC-treated RC patients improved significantly; 34.3% (12 of 35) achieved remission. During the O-L phase, 64.7% of RC (22 of 34) patients remained free from relapse (vs. 61.9% for non-RC patients). Mean time to relapse (MADRS≥16; YMRS≥15) into any mood episode was 141 days for rapid cyclers and 177 days for non-rapid cyclers. Mania relapse occurred in 12% of RC patients.

**Conclusion:** As management of depression is the primary unmet need in RC patients, OFC may represent an efficacious treatment for bipolar depression in patients with a history of rapid cycling.

## P-12-02

A 24-week open-label extension study of olanzapine-fluoxetine combination and olanzapine monotherapy in the treatment of bipolar depression

S. Corya, D. Williamson, M. Case, D. Lin, M. Tohen. *Eli Lilly and Company Lilly Research Laboratories, Indianapolis, USA*

**Objective:** Olanzapine-fluoxetine combination (OFC) has shown efficacy in the acute treatment of depressive episodes in patients with bipolar I disorder. The present analyses examined the efficacy and safety of longer-term treatment with OFC or olanzapine monotherapy in a 6 month open-label extension study.

**Methods:** 376 patients with bipolar depression who completed an acute trial entered the open-label study and received 1 week of olanzapine monotherapy (5-20 mg/day). At all subsequent visits, patients could stay with olanzapine monotherapy (OLZ), or change to OFC (6/25, 12/25, or 12/50 mg/day). Three treatment groups were defined retrospectively according to the medication course taken from week 1: OLZ, OFC, or Switched. The efficacy measures were the MADRS, CGI, and YMRS.

**Results:** Among patients who started in remission, MADRS total scores did not change significantly from baseline to endpoint in the OFC (-0.7) or OLZ (1.4) groups, but increased slightly in the Switched (3.3, p=.02) group. For patients who started in non-remission, MADRS total scores decreased significantly in all groups (OFC -6.2, p<.001; OLZ –6.5, p=.003; Switched –4.4, p=.016). The majority of patients who entered the study in non-remission achieved remission (MADRS total score ≤12) during the trial (OFC: 66.7%, OLZ: 64.7%, Switched: 62.5%). The overall rate of depressive relapse was 27.4% and the overall incidence of mania emergence was 5.9%.

**Conclusion:** The present findings suggest that long-term treatment with olanzapine-fluoxetine combination is efficacious in the management of depressive symptoms and carries a low risk of mania emergence.

## P-12-03

Safety and tolerability of quetiapine in bipolar mania

C. Adler, S. M. Strakowski, D. Fleck, M. Brecher. *Un. Cincinnati College of Med Department of Psychiatry, Cincinnati, Ohio, USA*

**Objective:** To review safety/tolerability in four placebo-controlled studies of quetiapine in bipolar mania.

**Methods:** Laboratory evaluations, adverse events, and Simpson Angus Scale (SAS) and Barnes Akathisia Rating Scale (BARS) scores were monitored in patients with bipolar I mania (DSM-IV) randomized to double-blind, placebo-controlled treatment with quetiapine (up to 800 mg/day) monotherapy (2 studies; 12 weeks) or in combination with lithium (0.7-1.0 mEq/L) or divalproex (50-100 mcg/mL) (2 studies; 3 or 6 weeks). The effect of quetiapine monotherapy on serum prolactin was also assessed.

**Results:** There were no clinically significant changes in laboratory tests, vital signs, weight, or ECG. Most adverse events were mild to moderate. Common adverse events (³10% and at least twice the placebo rate) with quetiapine monotherapy and combination therapy were somnolence and dry mouth. Treatment-related discontinuations due to adverse events were no different between quetiapine and placebo, nor was the incidence of extrapyramidal symptoms (including akathisia) (quetiapine monotherapy 12.9% vs placebo 13.1%; combination therapy 21.4% vs 19.2%). Mean change from baseline to treatment end in SAS and BARS scores was not significantly different between groups. Mean weight change (last observation carried forward) at treatment end was moderate: quetiapine monotherapy versus placebo +1.8 vs -0.15 kg; combination therapy +1.97 vs +0.27 kg. No patients withdrew due to weight gain. The effect of quetiapine monotherapy on serum prolactin levels was no different from placebo.

**Conclusion:** Quetiapine monotherapy and combination therapy are well tolerated in the treatment of bipolar mania. Supported by a grant from AstraZeneca.

## P-12-04

Double-blind comparison of divalproex versus quetiapine monotherapy for adolescent patients with mania

C. Adler, M. DelBello, R. Kowatch, K. E. Stanford, J. Welge, D. Barzman, S. Strakowski. *Un. Cincinnati College of Med Department of Psychiatry, Cincinnati, Ohio, USA*

**Objective:** Determine whether quetiapine monotherapy is at least as effective (defined as at least 80% as effective) as divalproex for the treatment of adolescent mania.

**Methods:** Fifty adolescents (aged 12-18 years) with bipolar I disorder, manic or mixed episode, were randomized to quetiapine monotherapy or divalproex for 28 days.

**Results:** Twenty-five subjects were randomized to each treatment group. The mean (SD) decrease from baseline to endpoint in Young Mania Rating Scale (YMRS) score was 19.5 (2.4) in the divalproex group and 22.8 (2.4) in the quetiapine group. Based on the change in YMRS score in the divalproex group, we determined that the response in the quetiapine group needed to be within 4 points. The mean (SD) group difference in YMRS change from baseline to endpoint was 3.3 (3.4) (95% CI, -3.5, 10.1). Response rate for improvement in mania (Clinical Global Impression score </=2) was significantly greater in the quetiapine group than in the divalproex group (84% vs. 56%, p=0.03). There were no statistically significant group differences in rates of adverse events. The most common adverse event in both groups was sedation: quetiapine n=15 (60%) vs divalproex n=9 (36%, p=0.1).

**Conclusion:** Quetiapine is at least as efficacious as divalproex, and may be more efficacious than divalproex, in the treatment of adolescent patients with mania. Therefore, quetiapine may be used as monotherapy for the treatment of adolescent patients with mania. This research was supported by AstraZeneca.