drug doses above concentrations corresponding to this occupancy, have limited beneficial effects. Finally, the occupancy found in the animal models correlates with those published for humans in a PET study of citalopram and paroxetine using the SERT ligand DASB[2],indicating that the doses used in our animal studies are clinically relevant.

References

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P.1.171 Impairment in major depressive disorder

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Objectives: 1) Evaluation of impairment in occupational, social and family functioning in primary care patients with a diagnosis of Major Depressive Disorder (MDD) by DSM-IV criteria and by PHQ; 2) Investigating whether impairment increases in a (dis)continuous way with increasing number of positive DSM items (or increasing number of positive PHQ items) for MDD.

Methods: Patients with clinical diagnosis of major depression were included in the study. After inclusion PCPs completed a list with DSM-IV criteria for MDD and patients completed the different modules of the PHQ, a self-report version of PRIME-MD (1). In addition the Sheehan Disability Scales and the SCL90 were completed.

Results: Among a total of 1072 patients who were considered as evaluable for baseline-analysis, 969 (90%) were diagnosed with MDD by the physician. On basis of the patient' s self-diagnosis (PHQ) only 668 (68%) had MDD. Results on Sheehan Scales showed that impairment scores were always (for subsequent groups with 5, 6, 7, 8 or 9 positive DSM items) higher for social functioning and family functioning than for occupational functioning. A statistically significant gender effect (p=0.006) was observed, women having higher scores on the Sheehan item 'impairment in family functioning' (even when correcting for professional activity) but lower scores on the Sheehan item 'impairment in occupational functioning' . In this large group of patients with MDD, impairment decreased with age (p<0.0001) and patients living alone had higher Sheehan scores for impairment in social functioning (p=0.002). Associated complaints on PHQ: Comorbidity of somatoform disorder, panic disorder and alcohol abuse was found in respectively 42%, 29% and 16% of the patients. Women had a higher risk (p=0.005) on somatoform disorder than men (OR=1.5) and the impairment in family functioning was higher when a somatoform disorder or alcohol abuse was diagnosed. After analysing the relation between impairment and number of positive DSM items we found a linear increase in impairment with increasing number of positive DSM items for the three impairment items (occupational, social, and family functioning), suggesting that the discrimination between minor and major depression is artificial.

Conclusions: Impairment in this group of patients with MDD was moderate to severe (most scores between 5 and 8 on the Sheehan Disability Scale). The impairment was higher for social and family functioning than for occupational functioning. Moreover, impairment in family functioning (but not occupational or social functioning) was higher when there was somatoform disorder or alcohol abuse comorbidity. The linear relation between impairment and number of positive DSM items add to the evidence found in the literature that the distinction between minor and major depression is rather artificial.

References

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P.1.172 Bright light therapy in seasonal affective disorder – does it suffice?

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Objectives: Seasonal affective disorder (SAD) is defined as a form of recurrent depressive or bipolar affective disorder characterized by recurrent affective episodes that occur annually at the same time of the year (Kasper et al., 1988). Guidelines for SAD have proposed bright light therapy (BLT) as the treatment of choice (Terman et al., 1989). However conventional antidepressant treatment has also been found to be effective in this condition (Kasper et al., 2001). The aim of this investigation was to assess the importance of drug treatment in a clinical sample of SAD patients.

Methods: We examined the psychopharmacologic treatment of 578 outpatients (446 females, 132 males) suffering from SAD (unipolar depression: 77.9%, bipolar-II disorder: 19.6%, bipolar-I disorder: 2.2%) that had been treated with BLT at the Department of General Psychiatry (University of Vienna).

Results: 47.9% of all patients received psychopharmacologic treatment in addition to BLT. 34.6% were treated with antidepressants (24.9% SSRI [selective serotonin reuptake inhibitors], 6.6% NaSSA [noradrenergic and specific serotonergic antidepressants], 5.2% tricyclic antidepressants, 3.3% tetracyclic antidepressants, 1.4% SNRI [serotonin and noradrenalin reuptake inhibitors], 1.2% RIMA [reversible inhibitors of monoaminoxydase A], 0.2% NARI [noradrenalin reuptake inhibitors]), 5.2% received phase prophylaxis with lithium or antiepileptics, 9.0% were treated with anxiolytic substances (mostly benzodiazepines), 7.6% with phytopharmaceutical medication (7.4% hypericum extract, 0.5% valerian extract), 3.3% with typical neuroleptics, 1.0% with atypical neuroleptics, 3.3% with other medication. No significant differences in medication were observed in regard to gender, age, duration of hospitalization or number of affective episodes. Patients suffering from bipolar disorder received phase prophylactic medication more frequently (bipolar-I: 38.5%, bipolar-II: 8.0%) than patients with unipolar depression (3.6%; Likelihood ratio ÷2=17.591, df=3, p=0.0005).

Conclusions: A substantial part (about one third) of our patients was treated with antidepressant medication concomitant to BLT. Obviously BLT does not suffice as only antidepressant regimen for all SAD patients. Opposed to the guidelines for the treatment of depression patients with several depressive episodes did not receive antidepressant long-term medication or phase prophylaxis more often than patients with only a few episodes. Our results also show, that the majority of patients with bipolar disorder still does not receive any phase prophylactic medication, which could indicate the need for further treatment.