The relationship between cholesterol and self-harm behaviour can be, in our opinion, considered the epiphenomenon of a complex and still uncleared biological modification that occurs somehow in impulsive and suicidal patients.

Tues-P11

SUCCESSFUL PHARMACOTHERAPY OF COTARD SYNDROME WITH REDUCTION OF D_2 RECEPTORS IN BASAL GANGLIA

S. De Risio*, M. Sarchiapone, G. Camardese, F. Calvosa, A. Buonanno, E. Barbarino. *Institute of Psychiatry, Catholic University of Sacred Heart, Rome, Italy*

A case of "delire de negation", a rare condition described first by Cotard in 1880, is presented here. The syndrome appeared suddenly in a male of 43 years as an acute manifestation of a major depressive disorder. The central symptom was an intense nihilistic delusion with denial of the organs of his body, of his own existence and of all his internal and external world. The regional cerebral blood flow measured by 99mTc-HMPAO-SPECT was normal but the study of the D_2 receptors by 123I-IBZM-SPECT showed a reduction of the striatum uptake of the D_2 receptor ligand bilaterally. The syndrome was successfully treated by a combined therapy with clozapine, fluvoxamine and imipramine. Neurobiological hypothesis explaining the pathogenesis of the disease will be proposed.

Tues-P12

PREDICTIVE POWER OF BECK'S DEPRESSION INVENTORY IN THE GENERAL POPULATION

L. Lasa[1], J.L. Ayuso-Mateos[1]*, J.L. Vázquez-Barquero[1]. [1]*Clinical and Social Psychiatry Research Unit; "Marqués de Valdecilla" University Hospital, University of Cantabria, Santander, Spain*

The aim of the present paper is to study the predictive power of Beck's Depression Inventory (BDI) for depressive disorders in general population sample.

Methods: 1.250 subjects, from 18 to 64 years old, were randomly selected from the Santander (Spain) municipal census. A two-stage method has been used: in the first stage, all individuals selected completed the BDI; in the second, "probable cases" (BDI cut-off $\geq$ 13) and a random 5% sample of all respondents were interviewed by psychiatrists using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), which generates diagnoses of depressive disorders.

Results: We can confirm the predictive power of the selected cut-off point (12/13): 100% sensitivity; 98% specificity; 0.73 positive predictive power (PPP); 1 negative predictive power (NPP) and 98% overall diagnostic power. The area under ROC (AUC) was found to be 0.99 $\pm$ 0.0001. There were no statistic differences in terms of sex or age.

Conclusions: The BDI is a good instrument for detecting depressive disorders in the general population.

Tues-P13

HEALTH ECONOMICS OF ANTIDEPRESSANTS: A METHODOLOGICAL REVIEW

T.R. Hylan*, D.P. Buesching, G.D. Tollefson. *Lilly Research Laboratories, Eli Lilly and Company, Indianapolis, IN 46285, USA*

In an era of constrained health care financing, clinicians are increasingly faced with considering the economic consequences in addition to the clinical outcomes associated with initiating a patient on antidepressant therapy. This has increased the demand for health economic studies comparing antidepressant use and associated health care expenditures in clinical practice.

In this study, we review the published health economic literature as it pertains to antidepressants. Our study reveals at least five types of study methods that have been used to conduct health economic evaluations of antidepressant pharmacotherapy: randomized controlled clinical trials, meta-analyses of clinical trials, decision-analytic models, retrospective database studies, and prospective naturalistic economic clinical trials. Each method has certain advantages and disadvantages. Conclusions which are drawn from results consistent across a variety of methods are less subject to criticisms of any one method.

Broadly considered, health economic studies of antidepressants have consistently found differences in clinical practice between the tricyclic antidepressants (TCAs) and the selective serotonin reuptake inhibitors (SSRIs) as well as among the SSRIs. These differences relate to the pattern and duration of antidepressant use as well as total direct health care expenditures. Future health economic research studies in clinical practice should focus on the economic consequences of long-term antidepressant use as well as the impact of antidepressant use on indirect costs such as productivity and absenteeism.

Tues-P14

DOES ST. JOHN'S WORT HAVE AN EFFECT ON AUTONOMIC RESPONSES OF CUTANEOUS CIRCULATION?

M. Mück-Weymann[1]*, T. Mösler[2], R. Buche[2], T. Rechlin[2]. [1]*Dept. of Psychosomatic Medicine, Dresden University of Technology;* [2]*Dept. of Psychosomatic Medicine, University of Erlangen, Germany*

Intro: High dosages of *St. John's wort* show a strong impact on patients with mild and moderate depressions as well as on patients with somatoform disorders. By measuring skin blood flow one can observe the influence of autonomic functions on cutaneous vessels. A deep inspiration into the chest causes vasoconstriction followed by dilation. Emphasizing the functional side of this autonomic response, we propose to call it *"voluntary inspiratory constrictor episode" (VICE).* The constrictive phase of such VICEs is mediated via efferent sympathetic nerve fibres, the mechanism of the redilation is suggested to be due to central blocking of sympathetic outflow. The aim of this preliminary study was to evaluate the impact of a treatment with St. John's wort on VICEs.

Methods and Results: We investigated 25 healthy untreated control subjects and 12 subjects with mild depressions and/or somatoform disorders treated with 900 mg/day of hypericum extract LI 160 (*Jarsin 300,* Lichtwer Pharma, Berlin, Germany) using the PhotoPlethysmoGraphic-technique. VICE-measurements were evaluated off-line by calculating the half time period $\Delta t_{50\%up}$. We found that $\Delta t_{50\%up}$ of the St. John's wort treated group did differ from those of the control group (mean: **3.2 s** versus **4.3 s;** SD: 1.2 s/1.9 s).

Conclusion: The finding, that the standardized application of St. John's wort did lead to shorter redilation phases of VICEs (under tricyclic antidepressants this period is considerably prolonged), suggests that this drug does not increase central sympathetic activation. The tendency of lower mean values for the redilation

period may imply a more rapid blockage of central sympathetic outflow, possibly an anti-noradrenergic effect of St. John's wort.

(1) Mück-Weymann M, Rechlin T (1996b). Reflexes of the cutaneous microcirculation in amitriptyline and in fluoxetine treated patients. *Psychopharmacology,* **124,** 241–244.

Tues-P15

PHARMACOTHERAPY OF DEPRESSION AND CHRONIC PAIN

M. Munjiza*, S. Popović-Deušić, M. Nikolić, N. Ljubomirović, N. Veličković. *Institute for Mental Health, Palmotićeva 37, 11000 Belgrade, Yugoslavia*

Depression and chronic pain syndrome often go together. This is confirmed by numerous clinical experiences; their mechanism of onset is often similar and the analysis of biological markers also shows that pain and depression are interrelated. Clinical similarity if often very marked, especially in the case of masked depression and various forms of chronic pain (idiopathic pain, chronic abdominal pain, tension headaches, some forms of migrainous syndrome, etc.). Prevalence of chronic pain syndrome is about 10% of general population. In this study, the sample consisted of 60 patients aged 20–74 years ($x = 43.2$, SD $\pm$ 12.4) of both sexes. The sample is divided into two subgroups with 30 patients in each. These subgroups are homogenous in relation to clinical and sociodemographic characteristics. Among diagnostic instruments, structured interviews according to DSM-IV and ICD-10 criteria were used. If the pain lasted more than six months it was defined as "chronic". HAMD-11 was used for evaluation of results of depressive syndrome treatment, and WHO criteria for pain syndrome. The first group was treated with combination of antidepressants from SSRI's group (fluoxamin) 50–100 mgr/day and the newest generation of antiepileptics (gabapeptin) 600 mgr/day in the period of six weeks. The second group was treated with classic antidepressants (maprotiline) in the doses of 250125 mgr/day with usual doses of nonsteroid analgesics in the same period of 6 weeks. The evaluation was done at the beginning of the treatment, and at intervals of seven days. The final evaluation showed that the effectiveness of applied therapy in the first group (fluoxamin + gabapeptin) is 65% better than in the control group (maprotiline + NAIS analgesics), $p = 0.001$. The improvement in the first group was observed already after two weeks of treatment, it was 41%, while the improvement in the second group was 19.2% ($p = 0.05$). Possible explanation of the difference is in the fact that both syndromes are conditioned by similar neurochemical changes primarily by the change in serotonergic neurotransmitter system and partially in the gabaergic system.

Tues-P16

EFFICACY AND TOLERANCE OF VENLAFAXINE IN HOSPITALIZED AND AMBULATORY PATIENTS

K. Kontis[1], N.P. Zissis*, E. Bouka, A. Vidalis, E. Pappas, L. Polyzoidis, A. Kalogeropoulos. [1]*Psychiatric Hospital; Athens, Greece*

Venlafaxine is a newly introduced noradrenaline/serotonin reuptake inhibitor (SNRI) antidepressant. Its efficacy and safety has been studied in various subsets of patients. This open, prospective study attempted to further investigate the safety and efficacy of venlafaxine in a large cohort of patients. One hundred and twenty six patients [30 males/96 females, mean age 49 years, hospitalised ($n = 26$), ambulatory ($n = 100$), newly diagnosed ($n = 83$), refractory to previous antidepressants ($n = 43$)], with mild to moderate (MADRS score 20–25) or severe (MADRS score > 25) major depression (DSM-IV), were enrolled in six psychiatric centers. The initial mean MADRS and 21-item HAM-D scores were 30.6 and 29.9 respectively. Repeated episodes were diagnosed in 30.6% of the patients and 91.6% had melancholic features. Patients were evaluated before and at 1, 2, 4 and 6 weeks. The initial venlafaxine dose was either 75 mg/d (mild/moderate disease) or 150 mg/d (severe) and was further titrated according to the response up to 375 mg/d.

Full response (MADRS and HAM-D scores reduced by at least 50% and CGI rating 1 or 2) was achieved by 102 (81%) patients. Seventy of them (55.6%) achieved full response by week 4. Improvement in all rating scales was statistically significant ($p < 0.001$). The CGI rating at last visit was very much better in 68.1% and much better. Six patients (4.7%) discontinued therapy due to nausea (3), vomiting, sweating or vertigo in 28.3% of the patients.

The present study reconfirms the high efficacy and safety of venlafaxine in major depression.

Tues-P17

PRIDICTORS OF RESPONSE TO ANTIDEPRESSANT DRUG THERAPY AND THEIR SIGNIFICANCE FOR THE DURATION OF TREATMENT

Gregor Laakmann*, Cornelius Schüle, Thomas Baghai, Jürgen Kraus. *Department of Psychiatriy, University of Munich, Nussbaumstr. 7, D-80336 Munich, Germany*

In this retrospective investigation on 659 depressive outpatients and 157 depressive inpatients, treated with antidepressants (amitriptyline, fluoxetine), benzodiazepines (alprazolam, lorazepam, or diazepam) or placebo, predictors of antidepressant drug response were evaluated. A therapeutic response was defined as a reduction of at least 50% in the Hamilton Psychiatric Rating Scale for Depression (HAM-D) at the end of the study. Neither demographic variables nor duration of the current episode, severity of depressive symptoms or baseline scores of psychiatric rating scales showed any clinically relevant relation to therapeutic outcome. It was shown that the clinical improvement according to HAM-D scale within the first two weeks of treatment was of high predictive value with respect to the final therapeutic outcome. In all, 76% of patients without a significant reduction (less than 20%) of the score in the Hamilton Psychiatric Rating Scale for Depression after 2 weeks of treatment did not fullfill response criteria after 6 weeks. The predictive value of the improvement criterion after two weeks did not depend on the treatment procedure (antidepressants, benzodiazepines, placebo). For clinical practice these results imply the necessity of reviewing the applied drug regimen early, i.e. about 2 weeks after beginning, to check for compliance with treatment or an individual problem of resorption or metabolism in order to amend the regimen by increasing dosage and/or adding sleep deprivation, lithium, thyroxine or psychotherapy. After 4 weeks of treatment without any recognizable success the therapeutic procedure should be changed and the usage of an antidepressant with different biochemical properties should be taken into account.