P34.03

Acute effect of deep brain stimulation on psychopathology in OCD

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Objective: Evaluation of changes in appearance, attitude, speech, affect and overall psychopathology prompted by Deep Brain Stimulation (DBS) in 3 OCD patients.

Method:: Reviewers analyzed video-recordings of a standardized semi-structured interview obtained during consecutive randomized one-hour sessions: 2 in stimulation-on (DBSON) and 2 in stimulation-off (DBSOFF). Changes in eye contact, facial expression, cooperation, assertiveness, spontaneity, speech (voice-intonation and speed), attention/concentration, motor-activity level, tension, anxiety and discomfort were evaluated using Likert-type interval scores and reviewers rated whether DBS was on or off. The interviewer completed the Brief Psychiatric Rating Scale (BPRS) after each interview.

Results:: Mental status aspect scores evolved toward normalization in all 3 patients in DBSON. Significant changes ($p<0.05$) were found for spontaneity in 3/3 patients, for facial expression, assertiveness, voice-intonation and discomfort in 2/3 and for eye contact, speed of speech, attention/concentration and tension in 1/3. 93% of the sessions were rated correctly as being on/off. Total BPRS scores decreased respectively by 35%, 50% and 75% in DBSON

Conclusion:: DBS elicits immediate, prominent and beneficial changes in several mental status aspects and overall psychopathology in treatment-refractory OCD patients.

P34.04

Attention/executive control systems hyperactivity in OCD

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Previous studies reported that fronto-striato-thalamic pathways are involved in the pathogenesis of obsessive–compulsive disorder (OCD).

In the present study, the hypothesis that a hyperactive executive control is involved in the pathogenesis of OCD was explored by means of neuropsychological and electrophysiological measures.

Quantitative EEG (qEEG) characteristics were investigated in 32 patients with DSM-IV OCD and 31 healthy controls, comparable with patients for age, sex, education and handedness; all subjects were administered tests exploring executive functions, attention, short term memory and the ability to learn supraspan recurring sequences.

A decrease of the slow alpha band power was observed; a significant negative correlation between this neurophysiological abnormality and time to complete neuropsychological tests exploring executive functions was found.

Findings are discussed in relationship with the presence of a hyperactivity of attention/executive control mechanisms in obsessive subjects.

P35. Panic disorders

P35.01

Factors influencing treatment choice in panic disorder with agoraphobia

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Objective: To determine patient characteristics that influence treatment choice in successfully treated patients with panic disorder with agoraphobia (PDA).

Methods: 24 PDA patients were treated with cognitive-behaviour therapy alone (CBT), 47 with CBT and a high-potency benzodiazepine (HPB), and 31 with CBT, HPB and fluoxetine (FLX). Assessment instruments included SCL-90 and a clinician-rated Panic and Agoraphobia Scale (PAS). Two stepwise logistic regressions were performed to identify predictors of decisions: 1) to add a HPB to CBT; 2) to add FLX to CBT and a HPB.

Results: Clinicians were more likely to add a HPB to CBT in patients with higher scores on the SCL-90 somatization scale and panic attacks subscale of PAS, and more likely to add FLX in patients with higher scores on the SCL-90 depression scale and disability subscale of PAS.

Conclusions: In PDA patients with more severe and frequent panic attacks and more severe somatic symptoms, a HPB may be useful to add to CBT, while patients who are more depressed and impaired may benefit from additional antidepressant.

P35.02

Combination of benzodiazepines and SSRI in treatment of panic disorder

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Objective: To evaluate the efficacy of combining a high-potency benzodiazepine and SSRI – fluoxetin in treatment of panic disorder with agoraphobia (PDA).

Methods: 37 outpatients with the DSM-IV diagnosis of PDA with severe symptoms were treated with combination of a high-potency benzodiazepine (either alprazolam or clonazepam) and fluoxetine. The treatment efficacy variables were scores on: Panic and Agoraphobia Scale (PAS) and CGI severity and improvement scales. The patients were compared in terms of their PAS and CGI scores at the beginning and at the end of the treatment.

Results: At the beginning of treatment patients had more sever symptoms (PAS mean score: 35.46 (SD=8.09); CGI severity scale mean score: 5.76 (SD=0.80)) than after the treatment (PAS mean score: 11.84 (SD=7.96); CGI improved scale: 1.95 (SD=0.74)). The differences between means at the beginning and at the end of treatment were statistically significant (2-tailed parried samples t-test – PAS: p=0.000; CGI: p=0.000).

Conclusions: Use of SSRI – fluoxetin together with a high-potency benzodiazepine is associated with great treatment gains for patients with sever panic and agoraphobic symptoms.

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