FC09

Delays to diagnosis and treatment in patients presenting to mental health services with bipolar disorder

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Introduction There are often substantial delays before diagnosis and initiation of treatment in people bipolar disorder. Increased delays are a source of considerable morbidity among affected individuals.
Aims To investigate the factors associated with delays to diagnosis and treatment in people with bipolar disorder.
Methods Retrospective cohort study using electronic health record data from the South London and Maudsley NHS Foundation Trust (SLaM) from 1364 adults diagnosed with bipolar disorder. The following predictor variables were analysed in a multivariable Cox regression analysis on diagnostic delay and treatment delay from first presentation to SLaM: age, gender, ethnicity, compulsory admission to hospital under the UK Mental Health Act, marital status and other diagnoses prior to bipolar disorder.
Results The median diagnostic delay was 62 days (interquartile range: 17–243) and median treatment delay was 31 days (4–122). Compulsory hospital admission was associated with a significant reduction in both diagnostic delay (hazard ratio 2.58, 95% CI 2.18–3.06) and treatment delay (4.40, 3.63–5.62). Prior diagnoses of other psychiatric disorders were associated with increased diagnostic delay, particularly alcohol (0.48, 0.33–0.41) and substance misuse disorders (0.44, 0.31–0.61). Prior diagnosis of schizophrenia and psychotic depression were associated with reduced treatment delay.
Conclusions Some individuals experience a significant delay in diagnosis and treatment of bipolar disorder, particularly those with alcohol/substance misuse disorders. These findings highlight a need to better identify the symptoms of bipolar disorder and offer appropriate treatment sooner in order to facilitate improved clinical outcomes. This may include the development of specialist early intervention services.
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FC10

Trends of hospitalization for major bipolar II in USA: A Nationwide analysis

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Objectives Bipolar II (B-II) is an important cause of morbidity and mortality in hospitalized patients. While B-II has been extensively studied in the past, the contemporary data for impact of B-II on cost of hospitalization are largely lacking.
Methods We queried the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (HCUP-NIS) dataset between 1998–2011 using the ICD-9 codes. Severity of comorbid conditions was defined by Deyo modification of Charlson comorbidity index. Primary outcome was in-hospital mortality and secondary outcome was total charges for hospitalization. Using SAS 9.2, Chi^2 test, *t*-test and Cochran-Armitage test were used to test significance.
Results A total of 107,152 patients were analyzed; 62.61% were female and 31.39% were male ($P<0.0001$); 78.19% were white, 11.44% black and 10.37% of other race ($P<0.0001$). Rate of hospitalization increased from 866.87/million to 8156.03/million from 1998–2011. Overall mortality was 0.32% and mean cost of hospitalization was 19,447.89$. The in-hospital mortality increased from 0.00% to 0.07% ($P<0.0001$) and mean cost of hospitalization increased from 7565.20$ to 26,511.95$. Total yearly spending on B-II related admissions have increased from $52.24 million/year to $1.6 billion/year.
Conclusions While mortality has slightly increased from 1998 to 2011, the cost has significantly increased from $52.24 million/year to $1.6 billion/year, which leads to an estimated $1.55 billion/year additional burden to US health care system. In the era of cost conscious care, preventing B-II related hospitalization could save billions of dollars every year. Focused efforts are needed to establish preventive measures for B-II related hospitalization.
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FC11

Analysis of genetic polymorphisms, adverse drug reactions and targeted treatment

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Introduction Bipolar disorders (BD) are chronic and recurrent psychopathological conditions characterized by therapeutic failures (TFs), regardless of the initial choice of psychiatric medication with a high prevalence of adverse drug reactions (ADRs). Cytochrome P450(CYP)2D6 genetics has been recently suggested to have a role in the response to treatment and extra-pyramidal symptoms (EPS) across several psychiatric conditions.
Objectives To evaluate interindividual differences in CYP2D6 enzyme activities, TFs and ADRs rates in BDs patients.
Aims To tailor psychiatric medication choice and dose based on pharmacogenetic test.
Methods We analyzed 16 clinical relevant polymorphisms CYP2D6 genotype in Psychiatric Unit of Foggia using the InfinitiTM Analyzer; the Simpson Angus Scale (SAS) was used to measure drug-induced EPS and Brief Psychiatric Rating Scale-24 (BPRS-24) response to treatment.
Results Ten drug-resistant patients were consecutively enrolled, and six of these experience major ADR during therapy with worsening of symptoms before screening for CYP polymorphism: BM (*2A/*5 genotype, BPRS-24 T_0: 63, T_{14}: 51), SR (*2A/*4, BPRS-24 T_0: 66, T_{14}: 59), LT (*4/*17 BPRS-24 T_0: 72, T_{14}: 64), DC (*2A/*4A BPRS-24 T_0: 69, T_{14}: 54), AL (*2A/*2A, BPRS-24 T_0: 72, T_{14}: 64), PA (*2A/*2A BPRS-24 T_0: 52, T_{14}: 46).
Conclusions According to the specific CYP2D6 polymorphism, we personalized patients' treatment considering that poor and extensive metabolizers have different rates of ADR and responses to treatment. CYP2D6 genotype's knowledge is useful for the reduction of therapeutic attempt during patient clinical history, thus

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reducing admission time and costs, and to guide clinicians toward a better patient management.

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FC12

Trends of hospitalization for major bipolar unspecified in USA: A nationwide analysis

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Objectives Bipolar unspecified (BP-U) is an important cause of morbidity and mortality in hospitalized patients. While BP-U has been extensively studied in the past, the contemporary data for impact of BP-U on cost of hospitalization are largely lacking.

Methods We queried the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (HCUP-NIS) dataset between 1998–2011 using the ICD-9 codes. Severity of comorbid conditions was defined by Deyo modification of Charlson comorbidity index. Primary outcome was in-hospital mortality and secondary outcome was total charges for hospitalization. Using SAS 9.2, Chi^2 test, *t*-test and Cochran-Armitage test were used to test significance.

Results A total of 711,147 patients were analyzed; 61.33% were female and 38.67% were male ($P<0.0001$); 77.63% were white, 13.17% black and 9.2% of other race ($P<0.0001$). Rate of hospitalization increased from 2,310.28/million to 74,908.88/million from 1998–2011. Overall mortality was 0.81% and mean cost of hospitalization was $25,152.02. The in-hospital mortality reduced from 1.24% to 0.97% ($P<0.0001$) and mean cost of hospitalization increased from 11,308.05$ to 32,211.67$. Total yearly spending on BP-U related admissions have increased from $207 million/year to $19.15 billion/year.

Conclusions While mortality has slightly decreased from 1998 to 2011, the cost has significantly increased from $0.21 billion/year $19.15 billion/year, which leads to an estimated $18.94 billion/year additional burden to US health care system. In the era of cost conscious care, preventing BP-U related hospitalization could save billions of dollars every year. Focused efforts are needed to establish preventive measures for BP-U related hospitalization.

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FC13

Trends of hospitalization for major bipolar I (most recent episode-manic) in USA: A nationwide analysis

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Objectives Bipolar I most recent episode-manic (BP-I-M) is an important cause of morbidity and mortality in hospitalized patients. While BP-I-M has been extensively studied in the past, the contemporary data for impact of BP-I-M on cost of hospitalization are largely lacking.

Methods We queried the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (HCUP-NIS) dataset between 1998–2011 using the ICD-9 codes. Severity of comorbid conditions was defined by Deyo modification of Charlson comorbidity index. Primary outcome was in-hospital mortality and secondary outcome was total charges for hospitalization. Using SAS 9.2, Chi^2 test, *t*-test and Cochran-Armitage test were used to test significance.

Results A total of 10,875 patients were analyzed; 57.13% were female and 42.87% were male ($P<0.0001$); 74.78% were white, 14.51% black and 10.71% of other race ($P<0.0001$). Rate of hospitalization increased from 528.71/million to 588.76/million from 1998–2011. Overall mortality was 0.42% and mean cost of hospitalization was 22,215.77$. The in-hospital mortality increased from 0.37% to 0.82% ($P<0.0001$) and mean cost of hospitalization increased from 10,580.54$ to 40,737.65$. Total spending on BP-I-M related admissions have increased from $44.24 million/year to $187.00 million/year.

Conclusions While mortality has slightly decreased from 1998 to 2011, the cost has significantly increased from $44.24 million/year to $187.00 million/year, which leads to an estimated $ 142.76 million/year additional burden to US health care system from. In the era of cost conscious care, preventing BP-I-M related hospitalization could save billions of dollars every year. Focused efforts are needed to establish preventive measures for BP-I-M related hospitalization.

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Child and adolescent psychiatry

FC14

Separating efficacy and sedative effects of guanfacine extended release in children and adolescents with ADHD from four randomized, controlled, phase 3 clinical trials

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Introduction Guanfacine extended release (GXR) is a non-stimulant treatment for attention-deficit/hyperactivity disorder (ADHD).

Objective To separate efficacy and sedative treatment-emergent adverse events (TEAEs) associated with GXR in four randomized, controlled trials in children (6–12 years) and adolescents (13–17 years) with ADHD.

Methods SPD503-301 ($n=345$) and SPD503-304 ($n=324$) were 8 and 9 week studies of fixed-dose GXR (≤ 4 mg/day). SPD503-312