P11.24

Olanzapine-fluoxetine combination for treatment of psychotic depression

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Objective: Two parallel, 8-week double-blind trials, with an optional 48-week open-label extension, compared olanzapine-fluoxetine combination (OFC) to olanzapine (OLZ) or placebo (PLA) in psychotic depression (PD).

Method: 249 PD patients were randomized to OFC, OLZ or PLA treatment groups, and efficacy evaluated with the HAMD-24.

Results: Pooled data showed a significantly greater total score decrease with OFC than with OLZ or PLA (-18.3, -14.4, -11.4). OFC endpoint response (&61619;50% total score decrease) was significantly greater than OLZ or PLA (56%, 36%, 30%). 71% of acute OFC responders maintained response in the open-label phase. More OFC partial responders (&61619;25% total score decrease at 2 weeks) achieved full endpoint response compared with OLZ or PLA (64%, 35%, 32%). OFC median time to response was similar to OLZ, but faster than PLA (12, 12, 20 days). OFC remission rate and median time to remission was better (20%, 20 days) than OLZ (13%, 56 days) and PLA (11%, 24 days). OFC's safety profile was similar to OLZ.

Conclusion: OFC demonstrated greater acute improvement in depressive symptoms than OLZ or PLA, and 71% of acute OFC responders maintained response during the 48-week extension

P11.25

HPA axis activation in patients with few versus multiple episodes of depression

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Background: Activation of the hypothalamic–pituitary–adrenal (HPA) hormonal axis is commonly seen in affective disorders, but little is known about the outcome when correlated to illness course over a lifetime.

Methods: We evaluated the HPA axis in patients with treatment–refractory affective disorder by measuring adrenocorticotropin hormone (ACTH) and cortisol responses following administration of corticotropin-releasing-hormone (CRH) in 37 patients with treatment–refractory affective disorder and in 27 healthy volunteers. In retrospective life charts were recorded every previous illness episode for each patient.

Results: Seven of the patients had had one or two illness episodes ('pauciepisodic') and 30 had had three or more episodes ('multiepisodic'). The pauciepisodic patients had significantly larger peak and total ACTH responses to CRH compared to the multiepisodic patients as well as to the control group. Multiepisodic patients showed no difference compared to controls in ACTH secretion pre- and post-CRH. Cortisol secretion was the same in all three groups.

Conclusions: The pituary adrenocortical responses in pauciepisodic patients were higher than in multiepisodic patients and in volunteers. This suggests that the HPA axis in refractory multiepisodic affective disorders might change its original activity as illness proceeds.

P12. Dementia – Alzheimer type

P12.01

Dementia: neuroradiological imaging and neuropsychological testing are useful and necessitive extensions of clinical diagnostics

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Objective: The significance of extended diagnostics in dementia has been controversary discussed under the view of cost-effectiveness. The contribution of neuromaging and neuropsychological testing to diagnosis of dementia is evaluated.

Methods: Of 127 patients of a memory clinic the first clinical diagnosis, the diagnosis of neuroimaging and of neuropsychology are registered under equal criterias and compared with the final clinical diagnosis. The MRI-examination consists of standard-, FLAIR-, and special Hippocampus-oriented sequences. Power- and Speed-Tests are used by neuropsychology. Differentiation between demented vs. non-demented and vasculary vs. neuro-degenerative dementia (e.g. Alzheimer's disease) is made.

Results: Only 50,5% are demented patients. At 26% the results of extended clinical diagnostic are leading to changes of the final clinical diagnosis, compared with the first clinical examination. Statistical coherences can be found:

	ND/VD/XD		
	First clin. Exam.	Neuroradiol.	Psychology
Sensitivity	0.66/0.70/0.80	0.93/0.90/0.55	0.83/0.60/0.98
Specificity	0.90/0.83/0.90	0.89/0.79/0.96	0.88/0.94/0.98
PPV [%]	74/50/89	78/51/93	75/71/98

Contribution is given by neuropsychology to dementia-diagnosis (XD = non-demented) and by neuroimaging for the differentiation of vaskulary (VD) vs. neuro-degenerative (ND) dementia.

Conclusion: The extended diagnostics contribute to the diagnostic correctness, the contribution is complementary. Even with regard to cost-effectiveness, early secondary prevention, and therapy of the dementias neuroimaging and neuropsychological testing are essential.

P12.02

Alzheimer's disease diagnostics and the treatment at the psychiatric out-patients department

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Alzheimer's disease (AD) is a primary degenerative disease with multi-factorial etiology and with specific neuropathological and neurobiochemical changes.

AD is the most common form of dementia, 65% of all dementia of the population over 65 years of age have AD. Alzheimer's disease has an insidious star followed by a steady and quick progression of cognitive impairment, aphasia, agnosia, apraxis, are very quick.

Since we have no satisfactory biological marker for making the diagnosis of AD, clinical diagnosis is based on symptomatolgy, neuropsychological tests and computer tomography or magnetic nuclear imaging or PET, SPECT.

In our practice we used clinical criteria for Alzheimer' disease described in the International Classification of Diseases, 10th

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