Old age depression: Do we need a special approach

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Clinical pharmacological management of polypharmacy in old age depression

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Polypharmacy is the rule in psychogeriatric patients, as they present frequently comorbidities such as depression, dementia [often including Behavioral and Psychological Symptoms of Dementia (BPSD)] and somatic diseases. Recommended treatments for geriatric depression are antidepressant medications, psychotherapy and psychosocial interventions [1]. Besides antidepressants, other psychotropic drugs are often co-prescribed, but somatic drugs are also needed for the treatment of other concomitant diseases. This situation increases the risk for adverse effects due to pharmacokinetic and pharmacodynamic interactions, especially since the organism of elderly patients displays a lowered homeostatic reserve and a decrease of functions, which allows resisting to xenobiotic influences.
On the other hand, there are also studies which suggest that in hospitalized psychogeriatric patients, the incidence of severe adverse reactions is lower in patients > 60 y than in those < 60 y [2]. This is one of the results of the AMSP-study group, which in German speaking countries has developed a pharmacovigilance program in psychiatric hospitals.
Disclosure of interest The authors have not supplied their declaration of competing interest.
References
[1] Dines P, Hu W, Sajatovic M. Depression in later-life: an overview of assessment and management. Psychiatr Danub 2014;26(Suppl. 1):78–84.
[2] Greil W, Haberle A, Schuhmann T, Grohmann R, Baumann P. Age and adverse drug reactions from psychopharmacological treatment: data from the AMSP drug surveillance programme in Switzerland. Swiss Med Wkly 2013;143:w13772.

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Physical comorbidity and consequences for mortality and treatment

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Introduction Ageing is related to an increase rate of physical comorbidity. However, the interaction between physical comorbidity and the development of depression in the elderly is not yet clear. Depression may be the cause or consequence of physical morbidity. Both may increase mortality.
Methods A total of 9604 patients with depression and a control sample of 96040 patients who attended a general hospital were followed-up for up to 12 years. Physical comorbidity and mortality was assessed.
Results Twenty-nine physical disorders were more prevalent in subjects with depression, but the effect of individual disorders on mortality did not differ significantly in the depressed and control sample.
Conclusions Patients with depression suffer more physical health problems than control patients that lead to death. The implications for early treatment will be discussed, a preventative approach may be most relevant.
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Distinction of dementia and depression in various stages of the disease processes

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Old age depression is often difficult to discriminate from dementia (particularly of Alzheimer type) – particularly cross-sectionally. Incident dementia is frequently associated with depressed mood and agitation; depression in the elderly goes together with executive and memory dysfunctions; associated psychotic symptoms and activity-of-daily-life dysfunctions are shared by both conditions as well as major risk factors as vascular and metabolic factors. Frequently both syndromes are "masking" each other; depression may furthermore present as the first clinical sign of Alzheimers disease. Yet, both clinical syndromes/disorders emerging from quite different are pathogenic neurobiological mechanisms with differentiating neuropsychological, – imaging and – chemical features. Clinical tools can be derived and enable accurate differential diagnosis. Thus, the distinction between both syndromes is a first instance for biomarker supported differential diagnoses in psychiatry.
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Overcoming the stigma of mental illness: Current proceedings and initiatives

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Seven years after ratification of the UNCRPD: Are there any advances for patients with mental health conditions?

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The Convention on the Rights of Persons with Disabilities (CRPD) is the first highest international legally-binding standard which aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, including those with mental health conditions, and to promote respect for their inherent dignity. The CRPD embodies a 'paradigm shift', from the charitable and the medical approaches to disability to one, which is firmly rooted in human rights. It provides a clear path towards non-discrimination, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity, equality of opportunity and accessibility just to name a few.
States which have signed the CRPD have an obligation to respect, protect and fulfil the internationally agreed upon set of standards