S22.4

The immune pathophysiology of fibromyalgia and somatoform disorders

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Major depression is accompanied by an activation of the inflammatory response system (IRS), with an increased production of pro-inflammatory cytokines, such as interleukin-1 (IL-1), IL-6 and interferon-α (IFNα). Administration of the latter to animals and humans may induce depression/sickness behavior (psychomotor retardation, anorexia, weight loss, sleep disorders and anhedonia), anxiety and psychosomatic symptoms. Although depression may be causally related to IRS activation, a possible link between IRS activation and somatoform disorders has remained elusive. We found that somatizing disorder is accompanied by significantly lower serum IL-6 values than in normal controls, whereas serum IL-1 receptor antagonist (Il-1RA) concentrations are significantly higher in somatization. Fibromyalgia is characterized by lowered serum IL-6 concentrations and increased serum gp130 (the IL-6 signal transducing molecule). These findings suggest that both fibromyalgia and somatization are not accompanied by activation of the IRS.

On the contrary, both conditions show some signs of immunosuppression. It is concluded that while pro-inflammatory cytokines can play a role in the pathophysiology and etiology of depression, they are probably not involved in the pathophysiology of somatoform disorders.

S22.5

Hypochondria and cognitive therapy

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Hypochondria is an annoying disorder, which can be primary, secondary or comorbid. The prevalence of primary hypochondria in population studies is around 1%, the prevalence in medical outpatient clinics is 3–4,5% and in psychiatric outpatient clinics 1%. Several controlled, clinical studies have found positive effect of cognitive-behavioural therapy. If the excessive health anxiety is secondary, it disappears when the primary disorder is treated. Serotonin reuptake inhibitors are found to be effective in primary hypochondria, but randomised, controlled clinical trials of medication is lacking. Traditionally hypochondria was considered a difficult diagnosis to present to the patient and hard to treat. Research has increased our knowledge and understanding of the disease, and structured treatment protocols have led to a well-founded optimism concerning prognosis. In the lecture cognitive-behavioural therapy is explained and exemplified. Central themes in the consultations are the question of life and death, interpretation of subjective somatic symptoms and the ability to make decisions when still in doubt.

S22.6

Epidemiology and primary-care oriented interventions for somatoform disorders

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"Unexplained" physical symptoms are a frequent phenomenon. We present data of an epidemiological survey in Germany including more than 2000 representative individuals who have been selected following a random-route procedure, and asking for unexplained physical symptoms during the last 2 years. Six symptoms have frequencies in the general population of above 10%, with pain symptoms being the most frequent (back pain: 30%). The high frequency of symptoms makes it necessary to develop intervention programmes which are feasible in Primary Care. We present first data of 2 primary care studies, one evaluating the effect of a 1-session (3–4 hour) intervention, the other evaluating the effects of a GPs training package (1 day of training course). The studies included data of 100 (intervention) resp. 200 (GP training) patients with somatoform symptoms. General satisfaction scores of >90% revealed that both appoaches were highly accepted from the patients resp. physicians, and are associated with a reduction of insecurity and unnecessary treatment attempts. Further aspects of the interventions will be outlined in the presentation.

S23. Longitudinal studies on psychiatric epidemiology into old age

Chairs: I. Skoog (S), J. Copeland (GB)

S23.1

The Lundby Study – fifty years of psychiatry

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Objective: In 1997 Per Nettelbladt and collaborators launched a new re-examination of the Lundby population, previously examined in 1947, 1957 and 1972. This investigation focused on the 1799 probands, aged 40+, still alive on the cut-off date July 1, 1997, and on the 1028 probands who had died since the 1972 field study.

Method: In June 2001 the field work was finished. At present (October 2001) the interviews are being completed with information from other sources (relatives, other key informants, hospital and autopsy records and other official registers) in order to enable us to make the final evaluation according to the DSM-IV, ICD-10 and the Lundby classification system.

Results: As we are now very close to publishing our final data, we refrain from presenting preliminary data at this stage.

Conclusion: The past and present history of the Lundby Study, the methods and the principal fields of investigation will be presented.

S23.2

Longitudinal study on depression in the elderly

A. Beekman*. *The Netherlands*

No abstract was available at the time of printing.

S23.3

Depression from middle age to old age. A 32-year follow-up of women

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Objectives: We aimed to assess the prevalence of depression in elderly women followed for 32 years.

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Methods: The study is part of the Women's Health Study, a prospective population survey of women in Gothenburg, which started in 1968. The participants were re-examined in 1974, 1981, 1992–93 and 2000–2001. Mental disorders were diagnosed according to the DSM-III and DSM-III-R.

Results: In 1992–93 (age 70/74) the prevalence of depression was 11.6 %, including 8.4% with major depression (MDD) and 2.8 % with dysthymia. Eight years later (age 78/82) the prevalence was 10.4 %, including 4.6 % (MDD) and 5.6 % with dysthymia. Among those who were currently mentally healthy in 1992–93, 43.0 % had a history of previous depression in 1992–93. Thus the lifetime prevalence was 43.3 % in 1992–93. Women clinically depressed in 1969 had an increased risk of being depressed again in 1992/93 (OR = 5.94 (2.28–14.73)). Those with MDD in 1992/93 continued to show increased risk of depression eight years later (OR = 11.6(3.9–32)).

Conclusions: The prevalence of depression continues to be high in elderly women despite new treatment options.

S23.4

A 15-year follow-up on psychotic symptoms in the non-demented elderly

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Background: Psychotic symptoms in non-demented elderly are reportedly rare and little is known about the incidence of these symptoms.

Method: A representative sample of non-demented 70-year-olds (N=382) from Gothenburg, Sweden were examined in 1971. One-hundred of these individuals were examined both at ages 70 and 85 (response rate among survivors 64%) and are included in this report. Hallucinations and delusions according to the DSM-IV were assessed by a psychiatrist during a semi-structured psychiatric examination at ages 70, 75, 79, 81, 83 and 85. Information was also extracted from key informant interviews and reviews of medical records. Psychotic symptoms which appeared after onset of dementia were not included.

Results: One of the non-demented individuals had psychotic symptoms at age 70. During the 15 year follow-up, another 17 (17%) developed psychotic symptoms. Among these, five were diagnosed from the psychiatric examination and 12 from information from key informants or medical records.

Conclusion: We found a higher incidence of psychotic symptoms after age 70 than previously believed. It is necessary to have several sources of information to elucidate psychotic symptoms in the elderly.

S23.5

A 40-year follow-up of patients with obsessive compulsive disorder

I. Skoog, G. Skoog. *Institute of Clinical Neurosciences, Sahlgrenska Academy, Göteborg, Sweden*

Patients admitted to a university hospital for obsessive–compulsive disorder (OCD) in 1947–53 were examined by a psychiatrist in 1954–56 and 1989–1993 (n=144). OCD was diagnosed according to Schneider's criteria, and comorbid psychiatric conditions according to DSM-IV. The mean length of follow-up from onset was 47 years.

At the end of follow-up, 48% had recovered from OCD, but 25% of those were diagnosed with another mental disorder. All OCD patients had some form of comorbid psychiatric condition during their life-time: depressive disorder in 85% (major depressive syndrome in 44%), panic anxiety disorder in 48%, social phobia in 48%, generalized anxiety disorder (GAD) in 72%, specific phobia in 65%, psychotic disorder in 15%, alcohol abuse in 13% (39% in men) and drug abuse in 17%. Onset of comorbid psychiatric conditions occurred most often after the onset of OCD. Life-time history of GAD, psychotic disorder and drug abuse were related to a worse prognosis of OCD.

Comorbid psychiatric conditions are common in patients with OCD, and includes a wide spectrum of disorders. The onset of these conditions occurs throughout the course of OCD.

S23.6

Longitudinal study on neurotic disorders in the elderly

J. Copeland*. *Department of Psychiatry, University of Liverpool, UK*

A random community sample of 1070 subjects aged 65 years and over was interviewed at home using the GMS AGECAT package and followed up 3 years later. Neurotic symptoms were common, but symptoms sufficient to reach "case" level were much less frequent. The overall prevalence of neurotic cases was 2.4% in year 0 and 1.4% in year three. The incidence was estimated as a minimum of 4.4 per thousand per year over age 65. Women were more likely to be cases than men but not sub cases, and there was a general decline in prevalence with increasing age, particularly for sub cases. Anxiety was the commonest neurotic subtype. After three years, cases were shown not to persist, but this did not reflect wellness.

S24. Drug safety – important side effects scarcely noticed in the past

Chairs: J. Gerlach (DK), M. Hummer (A)

S24.1

Osteoporosis in young patients with schizophrenia

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A major risk factor for the development of osteoporosis is the decrease in levels of gonadal hormones. Schizophrenia and antipsychotics are associated with significant neuroendocrine changes. Therefore, it is suggested that psychiatric patients might have decreased bone mineral density, and an increased risk for fractures. In a cross sectional study, we investigated the bone mineral density of 75 patients (76 % male, 24 % female) suffering from schizophrenia. The mean age was 34.7 years (range 22–49 years). The duration of antipsychotic treatment was at least one year. We measured bone density (bidual-photon absorptiometry) and several neuroendocrine parameters, and found the following

Results: 45.6% of male patients showed osteopenia in the lumbal region, 10.5% suffered from osteoporosis, while 33.3 % of female patients showed osteopenia in the lumbal region, but none had osteoporosis. There was no correlation between the duration of

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