changed the risk setting. The aim of this study was to estimate the cases of suicide of schizophrenics between 1990/2000 in the Psychiatric Service of Varese.

Method: a retrospective analysis about patients with schizophrenia spectrum disorders dead from suicide was carried out. Sociodemographic information (sex, age, school level, marital status, employment situation) and some aspects of illness (family history of affective disorders, illness duration, previous admissions and self-injuries, psychopathological condition) were evaluated.

Results: schizophrenic patients dead from suicide in contact with the service were 18 (M/F 12/6); that is approximately 2 suicides/year (1.7 events/100.000 inhabitants, 5.3 events/100 treated patients). Data confirm this high risk profile: young men, who commits suicide in the year after the last discharge and in any case in the first 10 years of illness, suffers from a paranoid form, has poor compliance, family history of psychiatric pathology, and previous suicide attempts.

Conclusions: findings emphasise the importance of monitoring trends in schizophrenic mortality from suicide for corrective strategies. Several prevention measures must be make to improve compliance and prevent loss of contact.

P18.05

12-month prevalence of panic disorder in the Swedish general population

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Objective: The present study examined the prevalence of panic disorder with or without agoraphobia according to DSM-IV criteria in the Swedish general population.

Method: Data were obtained by means of a postal survey administrated to 1000 randomly selected adults. The panic disorder module of the World Health Organization's Composite International Diagnostic Interview (CIDI) was included in the survey.

Results: 12-month prevalence was estimated at 2.2% (CI 95% 1.02–3.38%). There was a significant sex difference, with a greater prevalence for women (5.6%) compared to men (1.0%).

Conclusion: The Swedish panic disorder prevalence is relatively consistent with findings in most other parts of the western world.

P18.06

Suicide risk in relation to socioecomonic, demographic, psychiatric and familial factors

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Objective: To address suicide risk in relation to the joint impact of factors regarding family structure, socioeconomics, demographics, mental illness and family history as well as gender differences in risk factors.

Method: Data was based on 4 Danish longitudinal registers. Subjects were all 21,169 suicides in 1981–1997 and 423,128 controls matched for age, gender and calendar time using a nested case-control design. The effect of risk factors was estimated through conditional logistic regression, gender interaction was examined using the likelihood ratio test, the population attributable risk was calculated.

Results: A previous psychiatric disorder leading to hospitalisation was the most important risk factor and associated with the highest attributable risk for suicide. Cohabitation, being single, unemployment, low income, retirement, disability, sickness absence from job and a family history of suicide and/or psychiatric disorders were also significant risk factors for suicide. Moreover, significant gender differences were found in risk factors for suicide. A psychiatric disorder increased suicide risk more while having a young child reduced suicide risk more in females than in males. Unemployment and low income had stronger impacts on the risk of suicide for males. Suicide risk was increased for females but reduced for males living in urban areas. A family history of suicide increased suicide risk more in females than in males.

Conclusions: Suicide risk is strongly associated with mental illness, unemployment, low income, marital status, and family history of suicide. The effect of most risk factors on suicide differs between the two genders.

P18.07

Psychiatric epidemiology and genetics

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Epidemiology studies prevalence and incidence of mental disorder and tries to connect mental illness to age, sex and social conditions. Modern epidemiology has gone from a descriptive to an analytical phase. A worrisome observation is that disorders such as alcohol and substance abuse, common depression and suicide, antisocial behaviour and bulimia have increased during the last decades, particularly in the young age group. These epidemiological changes cannot be ascribed to heredity since the gene pool does not change in such a short time span.

Genetic research, family studies, twin and adoption studies have established that Alzheimer's disease, manic depressive disorder and schizophrenia have a major genetic component. However, obviously genes also play a role in anxiety states, common depression and even posttraumatic stress disorder. Molecular biological research has shown that schizophrenia is linked to chromosome 6 and other chromosomes. Genes linked to these chromosomes provide an increased risk of schizophrenia, but cannot in themselves create illness. To complicate the matter, in several studies one has reported that schizophrenia and manic depressive illness are linked to the same chromosome.

During the last thirty years psychiatric epidemiology and genetics have prospered. In order to advance psychiatric theory we need, however, to combine the empirical facts from modern epidemiology and genetics.

P18.08

Occupational and industrial differences in anxiety and depression

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Objectives: Study the relationship between level of anxiety and depression, measured by HADS (Hospital Anxiety and Depression scale), and occupation and industry (recorded according to Standard Classification of Occupations and Standard Industrial Classification). Various demographic and job characteristics will be adjusted for. Possible explanations to the findings will be discussed.

Method: The sample consists of the 17.384 participants of The Hordaland Health Study 1997–99 (HUSK) born 1953–57 and 1950–51 who had valid HADS scores on both anxiety and depression, and had given information on industry, occupation or both. Occupation and industry was registered and classified manually. Self-administered questionnaires includes information on level of anxiety and depression measured by HADS, demographic characteristics and various job characteristics.

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Results: Preliminary results show that the level of anxiety is higher in female than in male workers, while the level of depression and sum score is highest in male workers. Without adjusting for job and demographic characteristics, agricultural and fishery workers have the highest depression level and sum score. The results are consistent throughout the different levels of industrial and occupational classification.

Conclusion: Anxiety and depression are costly to the society, especially due to increased absenteeism and reduced productivity. Knowledge on the relationship between anxiety/depression and work life, including identification of occupations and industries with increased level of anxiety/depression, is important before deciding on strategies for reducing the mischief of these disorders.

P18.09

Dementia and cognitive disorders in an oldest old population: a neuropsychological and genetic study

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Epidemiological and genetic studies have demonstrated an high prevalence of the ApoE4 allele in the common late-onset form of AD. The hypothesis is that Apolipoprotein E4 does not protect key neuronal structures, thus leading to neuronal degeneration. On the other hand, person who inherit Apo E2 receive the needed neuronal protection and are much less likely to develop AD.

We started on January 2000 an epidemiology study on the people aged over 85 years. The aim of our research was to identify: a) the prevalence of dementia and cognitive disorders in an oldest old population and their relation with the APO E polymorphism; b) the bio-psycho-social characteristics of the demented group. The participants received a semi-structured interview assessing demographic data. Each subject underwent a general and neuropsychological assessment performed by physician. Dementia was clinically diagnosed using the DSM-IV diagnostic criteria. The neuropsychological battery included: Mini Mental State Examination (MMSE); Alzheimer's Disease Assessment Scale (ADAS); T.I.B. (Brief Intelligence Test); IQCODE; Global Clinical Dementia Rating (CDR). Functional abilities were assessed by ADL (Activities of daily living. We also valued the subjects by using the Yesavage's Geriatric Depression Scale (GDS), UCLA Neuropsychiatric Inventory and Modified Cumulative Illness Rating Scale for the assessment of organic diseases. Finally we determined the APO E genotypes of participant subjects.

115 subjects (mean age 89.91 years ranging between 85 and 101, 37M/47F) have been evaluated in the first phase; 27 of them with dementia, according to DSM-IV diagnostic criteria. Only 16% were institutionalised in rest home with the remaining 84% living in their own homes alone(40.9%) or with their spouse or with their relatives. 66.7% of patients subjects did not revealed negative indices in the depression symptoms. 45.5% of elderly were self-sufficient, 29.4% were slightly dependent and 25.1% completely dependent. A significant correlation was observed between cognitive disorders and disability and between cognitive state indices and a regular social life.

Our results could confirm the association between the APO E e4 allele and AD/SDAT dementia. In AD/SDAT the frequencies of the e4 alleles were higher than those found in the oldest old population. None of the subjects with dementia presented the e2 allele, which probably has a protecting value.

P18.10

The temporal association between fatigue and psychiatric morbidity

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Aim: The aim of the present research was to study the temporal association of psychiatric morbidity and fatigue in a culturally diverse sample in primary care.

Methods: We used data from the WHO collaborative study of psychological problems in general health care. 3201 subjects from 14 countries were interviewed with a modified version of the Composite International Diagnostic Interview at two times in 12 months.

Results: Cases of psychiatric disorder at Time 1 were more likely to report fatigue of a new onset at Time 2 after adjusting for sociodemographic variables and intercentre variability (odds ratio 3.16, 95% CI 1.88 – 5.31). In addition, cases of fatigue at Time 1 were more likely to fulfill criteria for a psychiatric disorder of a new onset at Time 2 (odds ratio 3.27, 95% CI 1.65 – 6.49)

Conclusions: Previous psychiatric morbidity predicts future fatigue but the same is true for previous fatigue and future psychiatric morbidity. These results do not support simple cause and effect models of aetiology and show the complexity of the relationship between fatigue and psychiatric disorder.

P18.11

The study of depression disorders' spreading among the ambulatory patients in Kyrgyzstan

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There are two main problems of depressive disorders' correction in Kyrgyzstan: the absence of statistical data of spreading and the lack of primary care physicians' experience in identification.

The objective of present research was the solving of these problems. Primary screening have been carried out among the ambulatory patients in Bishkek. Screening model included the using of standardized WHO questionnaires. Preliminary stage of research included the educational training in depressive disorders' identification and there were 118 trained in depressions' diagnostics primary care physicians.

The period of pilot population investigation consisted of 24259 screening patients (both genders, age of 17–65). Primary care physicians inspected ambulatory patients, psychotherapists were recruited as the consultants.

There were revealed 5175 cases of clinical recognized depression of different kinds of severity, which was 21,3% of all examined population. Our data corresponded with the analogous ones in other NIS regions, such as Moscow and Harkov. All revealed cases of depressive disorders were identified by the order of ICD-10 criterions and were considered as primary ones, because there wasn't any patient who got any psychiatric care.

The main conclusions were about high prevalence of depressive disorders in non-organized population in Bishkek and the necessity of specialized educational programs for primary care physicians in depressive disorders recognition.

(1) Treatment of patients with depression in the condition of primary medical care. Edition 2.2 ERB WHO, 1998.

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