SCL-90 sub scales (phobic anxiety, hostility, obsessive-compulsive behavior) and the total number of positive symptoms.

Conclusions: We discuss the importance of perceived threats at a physical or mental level, in the psychological adaptation process that is required in face of the disease.

Mon-P61

PHARMACOLOGICAL TREATMENT IN HIV-POSSITIVE PATIENTS WITH DEPRESSION

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Background: Depression is one of the most common psychiatric disorders found among HIV infected individuals, and it's a medical condition of serious morbidity. Antidepressant agents are frequently prescribed to treat depressive symptoms which often overlap with those of HIV infection.

Method: A Medline literature search was made covering the period 1992–1997 with systematic searching of citations from the articles identified. Representative articles were selected (Impact Factor > 1), focousing on those aspects which have not been thoroughly reviewed elsehere: kind of poblations under study, efficacy of new antidepressant and psycostimulants in cognitive and somatic symptoms, tolerability and interaccions with some of antimicrobial, antifungical, antiviral and protease inhibitors agents.

Results: All the antidepressant agents under study have showed clear and similar clinical efficacy on the treatment of depressive symptoms on HIV-affected individuals. In general, side effects due to psychopharmacological treatment are more frequent and more severe in HIV-infected patients. Additionally, some of them seem to interact with protease inhibitors agents. SSRI have demonstrated a better tolerance than the classical antidepressant agents, because of the lower level of secondary symptoms.

Conclussions: Antidepressants and stimulants appear to be effective in treating depression in HIV-affected individuals, specially in the cognitive-affective symptoms. HIV-possitive patients may better tolerate the tryciclic-induced side effects than HIV-negative patients. SSRI agents seem to be first choice antidepressants as they involve less secondary effects and a better tolerance. The number of subjects in trials under study are small (always n < 20) and basically include homosexual population. There are still not studies assessing the effectiveness of new antidepressant agents as citalopram, venlafaxine, mirtrazapine or nefazodone. The suspected interaccion of some antidepressant agents with protease inhibitors and the issue of new antidepressant agents with more representative trials should be further objects of research.

Mon-P62

COMPARISON BETWEEN THE HOSPITAL ANXIETY AND DEPRESSION SCALE AND THE BECK DEPRESSION INVENTORY IN DETECTING DEPRESSION IN HIV INFECTED PATIENTS

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Introduction: It's difficult for non psychiatric physicians to detect depression correctly. Psychopathological symptom rating scales could be very useful in these cases.

Objective: To compare the BDI. and the HADS as a screening tool for major depression in HIV positive patients.

Methods: HIV positive patients referred to our consultation/liaison psychiatry unit were interviewed using the Structured Clinical Interview for DSM-III-R (SCID) and completed the HADS and the BDI.

BDI scores were calculated for the complete 21-item measure (cutoff score of 15) as well as for the cognitive-affective (12 items) subscale (cutoff score of 10). For the HADS used the cutoff score of 10 and 8. We looked if the patients assessed as depressed using BDI or HADS got the diagnosis of major depression obtained by the SCID.

Results: Seventy-five HIV infected outpatients were evaluated. Most of them were in stages B and C of the CDC classification.

The prevalence of depression detected by each instrument and the resulting specificity and sensitivity are presented in the following table:

SCALE	prevalence	sensitivity	specificity
BDI-21 (21 items; cutoff = 15)	85.5%	100%	42.2%
BDI-12 (12 items; cutoff = 10)	64%	85.2%	47.9%
HADS-10 (cutoff = 10)	41.3%	80.1%	64.5%
HADS-8 (cutoff = 8)	52%	80.6%	51.3%

Conclusions:

1. The prevalence of depression in HIV infected patients detected by the BDI decreases when we use the cognitive-affective version.
2. The HADS with the cutoff score of 10 seems to be the most reliable instrument (best sensitivity and best specificity) in detecting depression in HIV positive patients.

Mon-P63

CAN SSRI INDUCE MANIA?

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Aim: The aim of this study was to assess the incidence of the risk of SSRI-induced mania in a series of the Authors' personal patients, and to detect any predictors.

Material and Methods: A sample of about 600 patients treated with SSRI was examined; it was split into subgroups according to: a) age; b) sex; c) diagnosis; d) personal or family history indicating mood disorders; e) response to TCAs in previous episodes.

The Authors detected 17 cases of induced mania in patients without a personal or family history of Bipolar Disorder.

These patients had been treated with SSRI for the following diagnoses (based on DSM IV): Obsessive-Compulsive Disorder, Panic Disorder, Schizophrenia, Body Dysmorphic Disorder, Personality Disorder.

Results: The patients who develop a manic episode were treated: a) 12 with Fluoxetine; b) 4 with Paroxetine; c) 1 with Citalopram.

These cases were compared to the cases reported in the literature in order to determine: a) clinical variables; b) doses of SSRI; c) lead-time to the onset of mania; d) duration of manic episodes.

(1) Rasmussen JCG, Manniche P: Incidence of Mania during treatment with Antidepressants with particular reference to the Selective Serotonin Re-uptake Inhibitor, Paroxetine. Proceedings of the V World Congress of Biological Psychiatry, Florence, 1991, 38–39.

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