the prevention of recurrent mood events (manic, mixed, or depressed) in patients with bipolar I disorder.

Methods: Patients with bipolar I disorder (DSM-IV, most recent episode manic, mixed or depressed) received open-label quetiapine (400–800 mg/day; flexible, divided doses) plus Li/DVP (target serum concentrations 0.5–1.2 mEq/L and 50–125 μg/mL, respectively) for up to 36 weeks to achieve at least 12 weeks of clinical stability. Patients were subsequently randomized to double-blind treatment with quetiapine (400–800 mg/day) plus Li/DVP or placebo+Li/DVP for up to 104 weeks. Primary endpoint was time to recurrence of any mood event defined by medication initiation, hospitalization, YMRS or MADRS score ≥20 at two consecutive assessments or at final assessment if the patient discontinued, or study discontinuation due to a mood event.

Results: 1461 patients entered the stabilization phase and 703 (48%) were randomized to double-blind treatment receiving at least one dose of study medication (ITT population). A markedly lower proportion of patients had a mood event in the quetiapine+Li/DVP versus placebo+Li/DVP group (18.5% vs 49.0%, respectively), with a risk reduction of 72% (hazard ratio 0.28; P<0.0001). The incidence of adverse events was similar between the two treatment groups.

Conclusions: Maintenance treatment with quetiapine+Li/DVP significantly increased the time to recurrence of any mood event compared with placebo+LI/DVP. Long-term treatment with quetiapine was generally well-tolerated.

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P0157

Why clinicians maintain antidepressants in some patients with acute mania? Hints from a large, observational study (EMBLEM)

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Aim: Antidepressants are recommended to be withdrawn during a manic episode. This analysis explored the characteristics of patients receiving antidepressants during an acute manic episode in the context of a large, observational study.

Method: EMBLEM (European Mania in Bipolar Longitudinal Evaluation of Medication) is a 2-year prospective observational study of acute mania/mixed mania. Of 2416 patients, 345 (14%) were taking an antidepressant (AD) and 2071 (86%) were not (NAD) during acute mania. Demographic and clinical variables were collected at baseline and at outpatient visits up to 2 years. Illness severity was measured using Clinical Global Impressions–Bipolar Disorder (CGI-BP), 5-item Hamilton Depression Rating Scale (HAM-D-5), and Young Mania Rating Scale (YMRS). Logistic regression analysis was used to identify variables associated with AD use.

Results: AD use varied across countries (p<0.05), more use with mixed episodes (p<0.001), rapid cyclers (p=0.02), more previous depressive episodes (p<0.001) and higher HAM-D-5 severity at baseline (p<0.001) but less use with higher education (p=0.029), YMRS (p=0.022), CGI-BP overall (p=0.006) severity and inpatients at baseline (p<0.001). There were no differences in alcohol abuse or suicide attempts. Depression recurrence rates were significantly higher with AD (p<0.001).

Conclusions: The EMBLEM study suggests that patients with mania receiving antidepressants are more likely to be outpatients with mixed mania or rapid cycling, and have a higher risk of depressive recurrence during follow-up. Clinicians seem to maintain antidepressants in manic patients to address depressive features during mania and prevent further depressive episodes.

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P0158

Aripiprazole in combination with Lithium/Valproate in bipolar mania (CN138-134)

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Background and Aims: To evaluate the efficacy, safety and tolerability of aripiprazole plus valproate/lithium in the treatment of patients with bipolar I mania partially non-responsive to lithium or valproate monotherapy.

Methods: This multicentre, randomized study included patients with bipolar I disorder (manic/mixed episode, with/without psychotic features). Partial non-responders with therapeutic lithium (0.6–1.0 mmol/l) or valproate (50–125 μg/ml) levels were randomized (2:1) to double-blind combination aripiprazole (aripiprazole [15–30 mg/day] + lithium/valproate; n=253) or placebo + lithium/valproate (n=131). The primary endpoint was mean change from baseline in YMRS Total Score at Week 6 (LOCF).

Results: The aripiprazole combination therapy demonstrated significant improvement from baseline in the YMRS Total score versus placebo + lithium/valproate at Week 1 and all subsequent visits (all p<0.05) up to Week 6 (−13.3 vs. −10.7, p=0.002; LOCF). Significant improvements from baseline to Week 6 were observed with aripiprazole vs. placebo + lithium/valproate in CGI-BP-S (mania) score (−1.9 vs. −1.6; p=0.014; LOCF) and the LIFE-RIFT score (−1.76 vs. −0.99; p=0.046; LOCF). At endpoint, aripiprazole plus lithium/valproate was associated with significantly greater remission rate (YMRS Total score ≤12) and response rate (≥50% improvement from baseline in YMRS Total) than placebo + lithium/valproate. Similar percentages of patients had clinically relevant weight gain (aripiprazole + lithium/valproate vs. placebo + lithium/valproate: 3.0% vs. 3.9%; p=0.718, Week 6, LOCF). Aripiprazole combination therapy was well tolerated.

Conclusions: In patients with bipolar mania, aripiprazole in combination with lithium/valproate is an effective and well-tolerated treatment that improves psychosocial functioning.

P0159

Metabolic syndrome in patients with bipolar disorder

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Background: Previous studies on the prevalence of metabolic syndrome in patients with bipolar disorder have reported higher rates than in their respective general populations.

Objective: This study evaluates the prevalence rate and modal subcomponents of metabolic syndrome in 34 patients treated in University Hospital Centre Zagreb,Croatia.

Method: Naturalistic, cross sectional study. Patients were evaluated for the presence of metabolic syndrome according to NCEP ATP-III criteria.

Results: Mean age was 41.1(SD 12.9). Overall prevalence rate of MetS was 35.3%. Forty seven percent met the criterion for abdominal obesity, 58.8% for hypertrigliceridemia, 23.5 % for low HDL cholesterol, 50.0% for hypertension, and 23.5 for high fasting glucose. There was no diference in the prevalence rate by gender.

Conclusions: Clinical medical monitoring for these parameters is recommended. Psychotropic drugs use may confer differential risk for developing the metabolic syndrome.

P0160

A double-blind, placebo-controlled study with acute and continuation phase of Quetiapine and Lithium in adults with bipolar depression (Embolden I)

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Background and Aims: Evaluate the efficacy and tolerability of quetiapine and lithium monotherapy for major depressive episodes in bipolar disorder during an acute 8-week period and up to 52-week continuation phase.

Methods: 802 patients (499 bipolar I, 303 bipolar II) were randomized to quetiapine 300mg/d (n=265), quetiapine 600mg/d (n=268), lithium 600mg/d (n=136), or placebo (n=133) for 8 weeks. Primary endpoint was change from baseline to 8 weeks in MADRS total score. After 8 weeks, patients with MADRS $\leq$12 and YMRS $\leq$12 entered a 26- to 52-week continuation phase of quetiapine (300mg/d or 600mg/d) or placebo. Patients on lithium received 300mg/day of quetiapine (results of continuation phase not included here and to be presented separately).

Results: LSM MADRS score change at 8 weeks was -15.36 (quetiapine 300mg/d), -16.10 (quetiapine 600mg/d), -13.60 (lithium), and -11.81 (placebo; P<0.001 for both quetiapine doses, P=0.123 for lithium, versus placebo; LOCF ANCOVA). Quetiapine (both doses)-treated, but not lithium-treated, patients showed significantly greater improvements (P$\leq$0.05) in MADRS response and remission rates, HAM-D, CGI-BP-S, CGI-BP-Change, and HAM-A at Week 8 versus placebo; MADRS item 10 (suicidal thoughts) improved with quetiapine 600mg/d versus placebo (P=0.013). Most common adverse events considered drug-related included somnolence, dry mouth, and dizziness with quetiapine (both doses) and nausea with lithium.

Conclusions: Quetiapine (300mg/d or 600mg/d) was more effective than placebo for the treatment of acute depressive episodes in bipolar I and bipolar II disorder. Quetiapine treatment was generally well tolerated.

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P0161

A double-blind, placebo-controlled study with acute and continuation phase of Quetiapine and Paroxetine in adults with bipolar depression (Embolden II)

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Background and Aims: Evaluate efficacy and tolerability of quetiapine and paroxetine monotherapy for major depressive episodes in bipolar disorder during an acute 8-week period and up to 52-week continuation phase.

Methods: 740 patients (478 bipolar I, 262 bipolar II) were randomized to quetiapine 300mg/d (n=245), quetiapine 600mg/d (n=247), paroxetine 20mg/d (n=122), or placebo (n=126) for 8 weeks. Primary endpoint was change from baseline to 8 weeks in MADRS total score. After 8 weeks, patients with MADRS $\leq$12 and YMRS $\leq$12 entered a 26- to 52-week continuation phase of quetiapine (300mg/d or 600mg/d) or placebo. Patients on paroxetine received 300mg/d of quetiapine (continuation phase results not included here and to be presented separately).

Results: LSM MADRS score change at 8 weeks was -16.19 (quetiapine 300mg/d),-16.31 (quetiapine 600mg/d), -13.76 (paroxetine), and -12.60 (placebo; P<0.001 for both quetiapine doses, P=0.313 for paroxetine, versus placebo; LOCF ANCOVA). Quetiapine (both doses)-treated patients showed significantly greater improvements (P$\leq$0.05) in MADRS response rate, HAM-D, CGI-BP-S, CGI-BP-Change, HAM-A, and MADRS item 10 (suicidal thoughts) at Week 8 versus placebo; MADRS remission rates improved with quetiapine 600mg/d versus placebo (P=0.012). Paroxetine improved HAM-A scores versus placebo (P=0.033).

Most common adverse events considered drug-related included dry mouth, somnolence, sedation, and dizziness with quetiapine (both doses); dry mouth, sedation, headache, insomnia, and nausea with paroxetine.

Conclusions: Quetiapine (300mg/d or 600mg/d) was more effective than placebo for the treatment of acute depressive episodes in bipolar I and II disorder. Quetiapine treatment was generally well tolerated.

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Poster Session II: Cognitive Enhancing Drugs

P0162

Cognitive effects of acute Modafinil treatment in patients with sleep apnea

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