in a pilot study of patients with PDD. All interviews were audio recorded, with consent from the participant, and transcribed verbatim. Data were analyzed using Grounded Theory, with a constant comparative analysis method, using Atlas.ti version 9 software.
Results: Qualitative data are currently being analyzed. We expect to identify important themes relevant to the patient's and caregiver's personal experience and learn how they use and implement self-management in their lives.
Conclusions: PPEP4All may help patients with PDD and caregivers learn important self-management techniques to effectively cope with chronic depression and its consequences, and thus, it may help them meet their needs for care.

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EPV0419

Diagnostic and psychopharmacotherapy in the general practictioner practice

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Introduction: Due to the often long-standing and extensive doctor-patient relationship, family doctors have special access to the mental state of their patients. They are often the first point of contact, and consequently the treatment of depression often begins in the GP's practice or even takes place entirely there. This requires dedicated knowledge on the part of the general practitioner, especially with regard to diagnostic criteria and treatment.
Objectives: The aim of this article is to describe the basic diagnostic process for the general practitioner's practice, to give advice on the indication and implementation of psychopharmacological interventions, and to present the results. This overview summarises the most relevant connections to the diagnosis, assessment of the severity and psychopharmacotherapy of depression in general practice.
Methods: The following therapy algorithms and remarks are essentially based on the treatment recommendations of the Swiss Society for Psychiatry and Psychotherapy (SGPP) and the Swiss Society for Anxiety and Depression (SGAD) as well as the German S3 guideline of the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN).
Results: Family doctors play a central role in the treatment of depressive disorders. They are often the first point of contact for patients with depression and in about 40 percent of cases even the only contact point. The likelihood of developing a depressive episode in the course of a lifetime is 10 to 15 percent globally. Evaluations by the World Health Organisation WHO show that 9 to 23 percent of people with chronic illnesses have depression as a concomitant illness. A cross-sectional epidemiological study in Germany showed that 60 percent of patients in general medical care were not treated with antidepressants and/or psychotherapy in accordance with guidelines. In Switzerland, about half of the antidepressants are currently prescribed by general practitioners. Image 1 shows a detailled overview (in German) of the current medication.

Image:

Substanzklasse oder Wirkweise	Wirkstoff	Tagesdosis	Besonderheiten	Wichtige Nebenwirkungen
SSRI	Escitalopram	10 – 20 mg	Gutes Nutzen-Risiko-Verhältnis, aktivierend, auch bei Angststörungen und Zwängen	Appetitveränderungen, Unruhe, Schwitzen, Übelkeit, Schlaflosigkeit, sexuelle Dysfunktion
	Citalopram	20 – 40 mg, im Alter nur 20 mg		
	Sertralin	50 – 200 mg		
	Fluoxetin	20 – 80 mg	Gutes Nutzen-Risiko-Verhältnis, auch bei Zwangsstörungen, sehr lange Halbwertszeit [49]	siehe oben, jedoch weniger sexuelle Funktionsstörungen als andere SSRI
	Fluvoxamin	50 – 300 mg	Wie Fluoxetin, jedoch kürzere Halbwertszeit	
	Paroxetin	20 – 40 mg	Gutes Nutzen-Risiko-Verhältnis, aktivierend, auch bei Angststörungen und Zwängen	siehe oben, jedoch weniger Übelkeit, sowie Unruhe als andere SSRI
NaSSA	Mirtazapin	15 – 45 mg	Sedierend, wenig anticholinerg, nicht bei schweren Leber- oder Nierenschäden	Schläfrigkeit, Mundtrockenheit, Appetit- und Gewichtszunahme, Kopfschmerzen
	Mianserin	30 – 90 mg		Gewichtszunahme, Ödeme, Schläfrigkeit, erhöhte Leberenzyme
SNRI	Venlafaxin	75 – 225 mg	Gutes Nutzen-Risiko-Verhältnis, auch bei Angststörungen, aktivierend, auch bei neuropathischen Schmerzen	Unruhe, Agitiertheit sowie Blutdruckanstieg
	Duloxetin	20 – 90 mg		
Trizyklika	Amitriptylin	50 – 150 mg	Sedierend, auch bei neuropathischen Schmerzen, chronischen Spannungskopfschmerzen sowie zur Migräneprophylaxe	Anticholinerg, Hypotension, Gewichtszunahme, QTc-Zeit-Verlängerungen, hohes Rezidivprofil, nicht Mittel der ersten Wahl
	Clomipramin	50 – 75 mg	Sedierend, auch bei Panik, Zwängen und chronischen Schmerzzuständen	
Serotonin-modulatoren	Vortioxetin	5 – 20 mg	Geeignet bei kognitiven Symptomen im Rahmen der Depression, wirkt auch über noradrenerg/dopaminerger/glutamaterge Transmitter	Übelkeit, Juckreiz, Haarausfall
	Trazodon	Schlafanstossend 50 – 100 mg, antidepressiv 300 mg	Antihistaminerge Effekte mit schlafanstossender Wirkung, Retardpräparat vorhanden, keine Gewichtszunahme, weniger sexuelle Funktionsstörungen	Sedation, orthostatische Hypotonie, Schwindel
Melatonerge AD	Agomelatin	25 – 50 mg	Schlafanstossend, KI bei Demenz und eingeschränkter Leberfunktion	Kopfschmerzen, Schwindel, Übelkeit, Transaminasenerhöhung
Dopaminerge AD	Bupropion	150 – 300 mg	Aktivierend, auch für Nikotinentzug zugelassen, KI bei Anfallserkrankungen und Leberzirrhose	Kopfschmerzen, Herabsetzen der Krampfschwelle, Tachykardien
Monoaminoxidase-Hemmer Typ A	Moclobemid	300 – 600 mg	Keine Kombination mit serotonergen Substanzen, Einsatz bei schwerer Depression	Serotonerges Syndrom, insbesondere bei Tranylcypromin und tyraminhaltiger Diät
Pflanzliche AD	Johanniskraut	900 mg	Nur für leichte und mittelgradige Episoden	Wechselwirkungen durch Induktion Cyp450 und p-Glykoprotein
	Sitosan	80 – 160 mg	Leichtere gemischt ängstlich-depressive Zustände, subsyndromal	Dyspepsie, Aufstossen, allergische Hautreaktionen
Neue Entwicklungen	Esketamin	Nasenspray, Dosierung nach Plan des Herstellers	Zur adjuvanten Behandlung von TRD in der CH zugelassen, Durchführung spezialisierten ambulatorien und Praxen vorbehalten	Schwindel, Dissoziation, Übelkeit, Kopfschmerzen, erhöhter Blutdruck
	Zuranolon	30 mg	Klinische Studie in Phase III für schwere und postpartale Depression (50) (in CH nicht zugelassen)	Kopfschmerzen, Übelkeit, Schwindel, Schläfrigkeit
	Psilocibin	20 – 30 mg	Klinische Studie in Phase II für Behandlung von Angst und Depression in Kombination mit Psychotherapie (51) (in CH nicht zugel.)	Schwindel, Übelkeit, Erbrechen und Panikattacken
	Dextromethorphan-Bupropion-Kombination		Fast-Track-Zulassung in USA 2022 (in CH nicht zugelassen)	

Conclusions: Specialists in general internal medicine have a central role in recognition and treatment of depressive syndromes. Somatic causes can be ruled out by means of physical examination, laboratory and ECG/EEG/imaging. Mild and moderate depressive episodes can be treated by psychoeducation, counselling and medication. If the symptoms are mild, psychosocial support or psychotherapy alone can be considered. If acute suicidal tendencies or psychotic symptoms are identified, emergency symptoms, emergency admission to a psychiatric hospital should be considered.
The presence of other psychiatric comorbidities, resistance to therapy or complex psychiatric medication necessitate referral to outpatient specialists. Metabolic and cardiovascular side effects and interactions between psychopharmacological and internal medicine must be considered.

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EPV0420

The antidepressant properties of ketamine (literature review)

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Introduction: Major depression is a common condition. Despite significant advances in psychopharmacology since the 1950s, the onset of action and drug resistance remain therapeutic challenges for traditional antidepressant agents, such as serotonin reuptake blockers. The recent discovery of the rapid antidepressant effect of ketamine, receptor antagonist, has revolutionized research in this field.
Objectives: demonstration of the antidepressant properties of ketamine

Methods: For this purpose, major search engines such as Pubmed, medline, Science Direct, and journals specializing in sociology were contacted, with the introduction of keywords (ketamine-Esketamine-resistant depression) and the selection of literature reviews but also articles deemed relevant for this review.
Results: The initial demonstration of ketamine's antidepressant effects was gradual, rather unusually in a treatment-resistant patient population. First administered in single doses in studies, ketamine showed a rapid and robust antidepressant effect, but not sustained over time. However, studies of repeated doses, spread over a period of a few weeks, then revealed that it was possible to prolong and even improve the clinical response. It is important to mention that the use of ketamine to treat depression still remains.
In 2000, the first randomized-controlled, double-blind clinical study used a crossover design, in which each participant received two infusions over 40 minutes, alternating between one week and one infusion of ketamine (0. 5 mg/kg) and a placebo infusion. A statistically significant antidepressant effect of ketamine compared to placebo was observed as early as 240 minutes after treatment and reached a maximum after 3 days; of the 8 patients treated with ketamine, 7 had an improvement in their symptoms of at least 30% and 4 of at least 50%
In 2006, Zarate et al. carried out the first replication study of the results obtained by the group from Yale University . In this study, 71% and 29% of the 17 patients who received ketamine achieved a response and remission, respectively ,the significant effect of ketamine was revealed after 110 minutes of treatment and until the end of the 7-day post-infusion follow-up.However, one week later, only 35% of patients had reached the clinical response threshold.
In 2010, Diazgranados et al. published the first study of ketamine treatment for bipolar depression. While the first two studies required patients to take no other psychotropic drugs, patients in this study had to show unresponsiveness to a therapeutic dose of lithium or valproic acid, two agents used in the treatment of bipolar disorder. Again here, 71% of patients who received ketamine achieved a clinical response
Conclusions: Finally, note that the discovery of the antidepressant action of ketamine has opened the door to the search for other molecules targeting the glutamatergic system, which will possibly provide an even greater

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EPV0422

"Keeping an eye on amylase". Side effects of antidepressants

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Introduction: Both in consultations with the general practitioner and with the psychiatrist, antidepressants are one of the most used drugs (1). These have multiple indications, and there are different groups according to their mechanism of action. In relation to this case, we are going to talk about Venlafaxine, a dual-type antidepressant, that is, it inhibits the reuptake of serotonin and norepinephrine. One of the most common side effects is digestive discomfort, which usually resolves after a few weeks (2). However, we should not ignore these symptoms, since they can hide something more serious.
Objectives: Presentation of a clinical case on a patient who presented an increase in pancreatic amylase after starting treatment with Venlafaxine.
Methods: Bibliographic review including the latest articles in Pubmed on side effects of antidepressant treatment, and more specifically at the gastrointestinal level (in this case we will talk about pancreatitis).
Results: We present the case of a 49-year-old woman, who was hospitalized 2 years ago, due to a first depressive episode. During this admission, psychopharmacological treatment was started for the first time, on that occasion with a selective serotonin reuptake inhibitor (SSRI), treatment of first choice (3). The patient had no side effects at that time, but the response was very modest, so it was decided to replace that antidepressant with Venlafaxine (with dual action), up to 150mg. The depressive symptoms improved markedly, however the patient began to feel digestive discomfort (which at first did not seem to be of great importance). A general analysis was performed, in which an increase in lipase (978 U/L) and amylase (528 U/L) was detected. An echoendoscopy, an abdominal scan, and a magnetic resonance cholangiography were performed; Pancreatitis secondary to drugs was suspected (a severe condition). Luckily, no significant lesions were found in the tests, and the levels of amylase and lipase decreased when Venlafaxine treatment was withdrawn (without reaching the normal range). The patient was discharged and continued to attend consultations. In the last control, amylase had dropped to 225 U/L. His abdominal pain disappeared. Treatment with Vortioxetine (a multimodal antidepressant) was started, however the amylase levels continue to be monitored, and the patient continues to see the gastroenterologist.
Conclusions: Gastrointestinal side effects are very common when taking antidepressant treatment, and in most cases they do not usually represent a serious problem.
However, it is described in the scientific literature that in some cases, acute pancreatitis secondary to some drugs, including Venlafaxine, can occur (4). In order to detect it, it is necessary to perform a blood test and sometimes also other complementary tests.
For its treatment, the fundamental thing is to withdraw the causing drug, trying to find other alternatives, and carry out a control to monitor possible complications

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