

patients receiving 1 mg/day of risperidone than placebo. On the Clinical Global Impressions scale, a rating of much or very much improved was received by 26% of placebo patients and 30%, 45%, and 40% of the risperidone patients. Differences were significant between placebo and risperidone at 1.0 mg/day ($p < 0.001$) and 2.0 mg/day ($p < 0.05$). It is concluded that, in elderly patients with dementia and psychotic symptoms at baseline, risperidone was efficacious in treating psychosis and behavioral disturbances.

P23.07

Psychiatric assessment after hip fractures – possible use of it

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Objectives: The authors investigated the psychiatric illness in older people with hip fractures. Previous studies suggested that older people with mental health problems are more likely to develop hip fractures and are at higher risk of suffering adverse consequence of such injury. Especially women are particularly vulnerable to such fractures.

Method: We conducted prospective longitudinal survey of hip fracture patients admitted to hospital in 6 months period. The authors studied 180 patient, with mean age 65 with underwent extensive clinical, psychiatric and orthopedic evaluation, the structured clinical interview for ICD10, SCIDI, BCRS, HAMD.

Results: 43% of 6-month survivors of hip fractures had psychiatric illness. Dementia 39%, depression 21%, cognitive dysfunction 31% and other psychiatric conditions 18%.

Conclusion: These findings suggest that higher proportion of patient with hip fractures suffer psychiatric illness. These injuries have high levels of currently untreated psychiatric morbidity which impact on the outcomes of treatment. This research has clinical implications for the treatment of hip fractures.

P23.08

Atypical symptoms in geriatric depression

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Objective: The study aimed to evaluate in Geriatric Depression the symptomatologic subtype with atypical symptoms on the basis of clinical and temperamental characteristics.

Methods: At this study was recruited a sample of 105 patients consecutively admitted in the Center for the study of Anxiety and Depression Disorder of the Psychiatry Clinic of the University of Parma with a DSM-IV diagnosis of Major Depressive Disorder. At baseline the patients are divided in two groups on the basis of presence (Atypical Symptoms, AS: n°45, 12 female=11.6% and 33 males=31.2%) or absence (No Atypical Symptoms, NAS: n°60, 41 females=39.8% e 19 males=17.4%) of atypical symptoms. The sample was assessed with the following instruments: HAMD+ atypical symptoms, HAMA, GDS, MADRS, CSDD, ADL, AIDL, BADL, QL-Index, SCL-90, MMS and CIRS for Comorbidity with general medical condition.

Results: Regarding the social demographic data there were significant differences about sample's mean age (AS=64,19±2 vs NAS=58,91±2,96; $p=0,005$). At symptomatologic gravity there were differences about presence of intellectual disorder (Ham-A item 5, AS=1,8±0,84 vs NAS=0,58±1,02 $p=0,004$); at HAMD higher depressive symptomatology (AS=15.44 vs

NAS=11,95±5,41; $p=0,004$) and higher hypochondria and atypical symptoms (item 15, AS=2.4±0,81 vs NAS=0,21±1,00 $p=0,002$; total score "atypical symptoms" AS=5.14±1.12 vs NAS=2.42±0.12 $p=0,002$); higher scores at GDS (AS=27,8±0,81 vs NAS=24,2±1,12 $p=0,005$). At SCL-90, AS scored significantly higher in the single subscales of Interpersonal Sensitivity (AS=12,12±6,05 vs NSA=7.21±5; $p=0,004$), Depression (AS=24,33±11,2 vs NAS=16,4±6,21; $p=0,002$). Comorbidity for general medical conditions, AS and NAS differed significantly in neurologic illness (AS=14,71±2,21 vs NAS=12,21±4,1; $p=0,004$), respiratory illness (AS=21,45±4,20 vs NAS=14,2±4,6; $p=0,002$). AT ADL, AS scored significantly lower (AS: 10,21 ±2,01 vs NAS=16,22±3.12; $p=0,002$). Regarding temperamental aspects, no statistically significant findings emerged from the two groups except for Harm Avoidance (AS=17,21±6,2 vs NAS=21,41±2,1; $p=0,011$).

Conclusion: The subtype with atypical symptoms results characterized by male patients, earlier onset, higher level of severity in depressive symptomatology, and intellectual disorders: memory and concentration deficit, scores significantly higher in the single subscales of interpersonal sensitivity and depression at SCL-90. The patients with atypical symptoms present higher comorbidity for general medical condition, statistically significant for neurologic and respiratory illness and higher level of disability. Regarding temperamental dimensions NAS presents significantly higher scores in Harm Avoidance.

P23.09

Psychotic symptoms in geriatric depression

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Objective: The study aimed to evaluate in Geriatric Depression the symptomatologic subtype with psychotic symptoms on the basis of clinical and temperamental characteristics.

Methods: At this study was recruited a sample of 105 patients consecutively admitted in the Center for the study of Anxiety and Depression Disorder of the Psychiatry Clinic of the University of Parma with a DSM-IV diagnosis of Major Depressive Disorder. At baseline the patients are divided in two groups on the basis of presence (Psychotic Symptoms, PS: n°28, 9 female=8.3% and 19 males=18.2%) or absence (No Psychotic Symptoms, NPS: n°77, 45 females=43.5% e 32 males=30%) of psychotic symptoms. The sample was assessed with the following instruments: HAMD+ atypical symptoms, HAMA, GDS, MADRS, CSDD, ADL, AIDL, BADL, QL-Index, SCL-90, MMS and CIRS for Comorbidity with general medical condition.

Results: Regarding the social demographic data, there were significant differences about sex (PS: 8.3% female and 18.2% males vs NPS: 43.5% female and 30% males; $p=0,005$), mean age (PS: 69,29±5,6 vs NPS: 61,05±1,55; $p=0,021$) and scolarity (PS: 4,78±4,56 vs NPS: 7,24±5,2; $p=0,026$). At SCL-90 Scale in both total score (PS: 105,3±24,3 vs NPS: 99,3±6,2; $p=0,002$), and in the subscales of somatization (PS: 13, 5±1,5 vs NPS: 9,21±4,3; $p=0,003$), obsessive-compulsive (PS: 12,9±3,9 vs NPS: 6,5±8,4; $p=0,002$) and psychotic (PS: 11, 5±1,2 vs NPS: 7,24±4,1; $p=0,003$) were statistically different between PS and NPS. At symptomatologic gravity there were differences about presence of intellectual disorder (Ham-A item 5, PS= 3,5±0,81 vs NPS=0,28±1,02 $p=0,002$); at HAMD higher depressive symptomatology (PS=17,41 vs NPS=12,91±5,23; $p=0,005$), initial insomnia and somatic anxiety (item 5, PS=3,2±0,85 vs NPS=0,41±1,02