

severe impairment in social relationships and are not better accounted for by the presence of agoraphobia. In a previous study, we found platelet expression reduction of the 18 kDa Translocator Protein (TSPO) in patients with panic disorder with associated ASAD.

Aims: To explore whether separation anxiety might be a factor differentiating TSPO expression in a sample of patients with major depression.

Methods: The equilibrium binding parameters of the specific TSPO ligand [3H]PK 11195 were estimated on platelet membranes from 40 adult outpatients with MDD, with or without separation anxiety symptoms, and 20 healthy controls. Patients were assessed by SCID-I, HAM-D, the Structured Clinical Interview for Separation Anxiety Symptoms (SCI-SAS) and the Adult Separation Anxiety Self-report Checklist (ASA-27).

Results: A significant reduction of platelet TSPO density mean value was found in depressed patients with associated ASAD, while no significant differences were found between depressed patients without ASAD and the control group. Individual TSPO density values were significantly and negatively correlated with both SCI-SAS-A and ASA-27 total scores, but not with HAM-D total score or HAM-D anxiety/somatization factor score.

Conclusions: Reduction of platelet TSPO density in our sample of patients with depression was specifically related to the presence of ASAD. These data suggest that TSPO expression evaluation is a useful biological marker of ASAD.

P0089

External validation of the axis V of Kennedy by symptom rating scales in patients with anxiety disorders

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Introduction: Anxiety disorders are associated with impairment in social functioning and poor quality of life, with personal impairment affecting many areas. Instead of collapsing together symptoms and functioning, the Kennedy Axis V is designed to assess seven dimensions.

Methods: Thirty-five outpatients consecutively admitted to our Anxiety Disorders Unit were evaluated before starting treatment by a set of instruments including: Mobility Inventory for Agoraphobia (MIA), Self-rating Anxiety State (SAS), Anxiety Status Inventory (ASI), Penn State Worry Questionnaire (PSWQ), Symptom Check List 90 Revised (SCL-90-R), Brief-COPE, and Kennedy Axis V (K Axis).

Results: Sample characteristics: age 38.5 ± 10.9 , males 36.1%, current substance use 14.3%, previous drug treatment 82.9%, previous psychotherapy 28.6%. Symptom scores (mean \pm SD): MIA 7.41 ± 6.84 , PSWQ 46.59 ± 12.15 , ASI 58.97 ± 10.53 , SAS 59.43 ± 11.85 ; as for the SCL-90-R subscales and indexes: Somatization (SOM) 1.62 ± 0.76 , Obsessive-Compulsive (O-C) 1.48 ± 0.70 , Interpersonal Sensivity (I-S) 1.38 ± 0.85 , Depression (DEP) 2.02 ± 0.90 , Anxiety (ANX) 1.94 ± 0.79 , Hostility (HOS) 1.14 ± 0.84 , Phobic Anxiety (PHOB) 1.52 ± 1.11 , Paranoid Ideation (PAR) 1.33 ± 0.87 , Psychoticism (PSYC) 0.88 ± 0.72 ; General Symptomatic Index (GSI) 1.55 ± 0.59 , Positive Symptom Total (PST) 58.84 ± 15.42 , Positive Symptom Distress Index (PSDI) 2.19 ± 0.57 . The results of the K Axis subscale for psychological functioning (PSY) was 54.00 ± 4.97 ; all the remaining subscales scored 90 or more. Significant correlations between symptom scales and psychological functioning were (Spearman's Rho, $\alpha = .05$): PSY vs. PSDI -0.526

($p = .002$), PSY vs. PSYC -0.446 ($p = .008$), PSY vs. DEP -0.43 ($p = .011$), PSY vs. GSI -0.427 ($p = .012$), PSY vs. I-S -0.425 ($p = .001$).

Discussion: Scores on the self-rated symptomatic scales are inversely correlated with the clinician-attributed score of PSY, suggesting construct validity.

P0090

Comorbid symptoms as assessed by Hamilton anxiety scale in outpatients with generalized anxiety disorders (GAD)

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Objective: analyse the presence of comorbid symptoms as assessed by Hamilton Anxiety scale in outpatients followed in Psychiatric clinics.

Methods: Multicentre, cross-sectional study enrolling subjects above 18 years-old with GAD according with ICD-10. Participants were chosen at random by quotes and weighted geographically, but patients were enrolled consecutively. HAM-A and CGI-S were administered to determine clinical status and comorbid symptoms (scoring > 3 in HAM-A). QoL was assessed by SF-36 questionnaire.

Results: A total of 792 patients; 15.7% naïves (GADn), 68.9% women, mean (SD) age of 40.0 (12.9) years were included. Symptoms of insomnia were presented in 30.1% of subjects; 42.3% in GADn vs 27.8% on-treatment (GADt), $p = 0.001$. Symptoms of cognitive function deterioration were showed in 21.1% (25.2% in GADn vs. 20.3% in GADt, $p = 0.220$) and depressive symptoms in 15.5% (15.4% in GADn vs 15.5 in GADt, $p = 0.991$). Moderate to excruciating pain was presented in 46.7% of subjects; 50.5% in GADn vs 46.1% in GADt, $p = 0.705$. Overall, psychic and somatic anxiety symptoms scoring were higher in GADn than in GADt; 26.8 (7.3) vs 22.4 (9.6), $p < 0.0001$, 14.2 (3.6) vs 12.0 (5.0), $p < 0.0001$, and 12.6 (4.5) vs 10.4 (5.2), $p < 0.0001$, respectively. No age or sex differences were found.

Conclusions: Pain, symptoms of depression and cognitive deterioration were comorbid conditions presented in a considerable proportion of GAD patients irrespective of time of evolution, age or sex. Frequency of insomnia was also high, mainly in naïve patients. This study shows that more attention should be devoted to comorbid condition associated with GAD.

P0091

Demographics and impact of depression comorbidity on clinical and self-perceived health status in outpatients with generalized anxiety disorders (GAD)

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Objective: analyse the impact of comorbid depression on clinical and self-perceived health status in outpatients with GAD in Spain.

Methods: Multicentre, cross-sectional study enrolling subjects above 18 years-old with GAD according with ICD-10. Participants were chosen at random by quotes and weighted geographically, but patients were enrolled consecutively. HAM-A and CGI-S were administered to determine clinical status and SF-36 and Sheehan disability scales for health status assessment.

Results: Seven-hundred-ninety-two patients; 15.7% naïves (GADn), 68.9% women, mean (SD) age of 40.0 (12.9) years were included. Ninety (11.4%) fulfilled criteria for comorbid depression with GAD. Depressive subjects were older [49.5 (11.3) vs. 43.7 (13.2) years, $p=0.0001$], female (78.7% vs 67.6%, $p=0.034$) and received lorazepam and lormetazepam more frequently (30.0% vs. 18.5%, $p=0.015$, and 15.6% vs. 5.0%, $p=0.0002$, respectively), but not antidepressants, and received higher number of drugs; 2.3 (0.8) vs. 2.0 (0.8), $p=0.011$. Overall, psychic and somatic anxiety symptoms scoring (HAM-A) were higher in depressive; 26.4 (8.2) vs 22.7 (9.5), $p=0.0003$, 14.1 (4.1) vs 12.1 (4.9), $p<0.0001$, and 12.3 (4.7) vs 10.6 (5.2), $p=0.0023$, respectively. Depressive showed more severe symptoms of anxiety; 62.2% vs. 43.0%, $p=0.0031$, and scoring in CGI; 4.2 (0.9) vs 3.7 (1.1), $p<0.0001$. Depressives also showed higher scoring of disability; 19.7 (6.0) vs. 15.6 (7.0)%, $p<0.0001$, and lower values in physical and mental summary subscales of SF-36; 38.6 (7.9) vs 43.9 (9.0), $p<0.0001$, and 26.6 (9.5) vs. 30.4 (11.6), $p=0.0008$.

Conclusions: Comorbid depression enlarges deterioration in clinical status, level of functioning and quality of life of outpatients with GAD.

P0092

Clinical and self-perceived health status in outpatients with generalized anxiety disorders (GAD) followed in psychiatric clinics: A Spanish perspective

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Objective: analyse GAD impact on clinical and self-perceived health status in outpatients followed in Psychiatric clinics.

Methods: Multicentre, cross-sectional study enrolling subjects above 18 years-old with GAD according with ICD-10. Participants were chosen at random by quotes and weighted geographically, but patients were enrolled consecutively. HAM-A and CGI-S were administered to determine clinical status and SF-36 and Sheehan disability scales for health status assessment.

Results: A total of 792 patients; 15.7% naïves (GADn), 68.9% women, mean (SD) age of 40.0 (12.9) years were included. Time to effective diagnosis and start up of treatment were, respectively, 2.3 (4.9) and 2.6 (4.7) years. Severe symptoms of anxiety (HAM-A > 24) were presented in 45.2%; 56.9% in GADn vs 43.0% on-treatment (GADt), $p<0.001$. CGI-S was 3.7 (1.1) in GADn vs. 4.2 (0.8) in GADt, $p<0.001$. The 77.7% of GADt were receiving 2 or more drugs: 94.1% ansiolytics and/or antidepressants. The 39.3% of subjects showed high/extreme disability for work; 44.4% GADn vs 38.5%

GADt, $p=0.33$, 34.5% for daily-living domestic activities; 39.7% vs 33.7% respectively, $p=0.082$, and 41.8% for social life; 43.1% vs 41.7% respectively, $p=0.145$. Mental composite summary of SF-36 was below normal; 30,0 (11,4), much lower in GADn: 25,4 (8,5) vs. 30,8 (11,7), $p<0.001$. No gender differences were found.

Conclusions: This study showed that a considerable proportion of GAD patients still need for additional medical remedies which should improve the level of disability caused by the disease and counteract the deteriorated mental health observed in such patients.

P0093

Neuroticism does not influence the relationships between tobacco and panic features in the early phases of panic disorder

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Background and Aims: Tobacco consumption has been related to the onset of panic attacks (PA), panic disorder (PD) and agoraphobia, to panic symptoms and to features related to PD. The relationship that links tobacco and panic is not clear, and some models have been proposed to explain it (causal, neuroticism as a vulnerability factor).

Our aim was to study the relationship that tobacco consumption before the onset of PD has with some features of the disorder and to clarify the relationship that links tobacco and panic.

Methods: A sample of 82 naïve PD patients was included. Patients were extensively evaluated (Mini Neuropsychiatric Interview—MINI-, Panic Disorder Severity Scale—PDSS-, State-Trait Anxiety Inventory—STAI-, Beck Depression Index—BDI-, Anxiety Sensitivity Index—ASI-, Mobility Inventory of Agoraphobia—MIA-, Clinical Global Impression—CGI-, NEO-Five Factor Inventory—NEO-FFI). Tobacco consumption was retrospectively assessed by asking the patients the consumption they had the week before suffering the first panic attack.

Results: The condition of smoker before the onset of PA showed significant relationships with earlier age of onset of PD ($p=0.04$), less frequency of PA ($p=0.04$), and higher scores in BDI ($p=0.04$) and NEO-FFI neuroticism ($p=0.02$). After analysis with multiple logistic regression, neuroticism did not show considerably influence on any of these associations.

Conclusions: Being a smoker before the onset of PA is related, in the early phases of PD, to higher neuroticism and depressive symptoms, less frequency of PA and PD onset at a younger age.

Although proposed as a common vulnerability factor, neuroticism does not influence the observed associations.

P0094

Social anxiety disorder, panic disorder and mitral valve prolapse. Are there any relationships?

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Background: The association between Mitral Valve Prolapse (MVP) and anxiety disorders, particularly Panic disorder (PD) and Social Anxiety disorder (SAD), attracted considerable interest in the 1980