

Methods: A bibliographic review of apathy as a behavioral symptom of NPH is carried out. Likewise, in addition to highlighting apathy as a possible diagnostic marker, the evidence of it as a prognostic marker of therapeutic response is discussed. For this, a review of publications in English and Spanish from the last 10 years was carried out in databases including Cochrane Library, EMBASE, MEDLINE/PubMed, SCOPUS. The MESH terms apathy, Hakims-Adams, idiopathic normal pressure hydrocephalus, chronic hydrocephalus, neuropsychiatric symptoms were used for the search.

Results: Sixteen articles were selected that verified the heterogeneity of the diagnostic criteria for apathy for its detection in patients with NPH. Likewise, it is identified that apathy is the most prevalent behavioral alteration with a prevalence of 60% of patients in this condition. Regarding its predictive value as a prognostic marker for shunt surgical treatment, the evidence is not conclusive either to confirm or to rule out the usefulness of apathy.

Conclusions: Apathy should be considered as another diagnostic key in NPH. Thus, the classic description of this condition as a motor-cognitive-urinary syndrome must be reconceptualized as a motor-cognitive-behavioral-urinary syndrome.

FC21: Clinical and therapeutic challenges in Geriatric Depression and Sleep Apnea Hypopnea Syndrome

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Objectives: Health professionals in our setting rarely ask adequately about sleep disorders beyond insomnia in depressive patients. This presentation aims to review the possible clinical situations between geriatric depression (GD) and sleep apnea and hypopnea syndrome (SAHS) and highlight the clinical impact of their adequate detection and treatment.

Methods: Presentation of a sample of 25 older adult patients from the Geriatric Neuropsychiatry Clinic and the Psychogeriatric Section of the Department of Psychiatry of the CEMIC (Buenos Aires, Argentina) with diagnoses of GD and SAHS.

Results: Presentation of different groups of patients with possible relationships in which these two entities interact: a) GD as a risk factor for developing SAHS; b) SAHS as a risk factor for developing GD; c) GD and SAHS as comorbidities; d) GD and SAHS as risk factors for morbidity and mortality for multiple diseases; e) SAHS as a cause of pseudo-resistance to antidepressant treatment in GD; e) GD as a cause of pseudo-resistance to SAHS treatment; f) the treatment of GD as a cause of pseudo-resistance to SAHS treatment; g) the treatment of SAHS as “a cause of” and/or “aggravate” of GD.

Conclusions: Mental health professionals must actively investigate in their older patients the possible relationships between GD and SAHS in order to ensure the diagnosis and appropriate treatments adapted to such clinical situations.