The association between CADSS scores at 7 hours after first dosing and MADRS scores on day 4 was investigated with a statistical mediation analysis. The 7-hour timepoint was selected since it coincides with the average Tmax (time-to-peak) when the highest dissociation is expected. Depression scores at the first subsequent visit (on day 4) were selected for the analysis. It was also the time point where change in MADRS score from baseline differentiated the most between KET01 and placebo with a difference of 4.32 (p=0.006) to the benefit of KET01 – based on the model used in the mediation analysis.
Results: The antidepressant effect of KET01 that was mediated through dissociation was estimated to the negligible -1.28% (CI: (-28%) – (+11%)).
Conclusions: The antidepressant effect of KET01 was achieved with minimal to no dissociation and with no significant mediation through dissociation. Our findings challenge the commonly held clinical view that some degree of dissociation is necessary to guarantee ketamine's antidepressant effect. Instead, it appears that dissociative symptoms are merely adverse events associated with certain formulations of ketamine.

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EPP133

Impacts of childhood trauma on postpartum depression: prospective longitudinal study

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Introduction: Women who experience childhood trauma may be at a greater risk of developing postpartum depression (PPD), which can result in significant harm to both mothers and their children. Few studies have longitudinally evaluated the effect of childhood trauma on PPD.
Objectives: This study aimed to evaluate the impact of childhood trauma on PPD among Brazilian postpartum women.
Methods: This prospective longitudinal study was conducted with 153 women evaluated at two time points: T1 (immediate postpartum) and T2 (three months postpartum). PPD symptoms were assessed using the Edinburgh Postnatal Depression Scale (EPDS) and childhood trauma was assessed using the Childhood Trauma Questionnaire (CTQ). To verify the differences in PPD scores in the periods assessed and in relation to childhood trauma, generalized estimating equations (GEE) were used. EPDS scores were categorized with values ≥10 defined as the presence of PPD. Multinomial logistic regression analyses were performed to evaluate the influence of trauma on PPD risk subgroups as follows: early PPD (risk of depression at T1), late PPD (risk of depression at T2), and chronic PPD (risk of depression at T1 and T2).
Results: The results demonstrated that women who suffered trauma in childhood had significantly higher EPDS scores at both time points evaluated when compared to women who did not suffer from trauma. However, there was no significant difference in EPDS scores over time or in the interaction between time and childhood trauma, indicating that PPD scores and the impact of childhood trauma on PPD remained constant over time. All types of childhood trauma were significantly associated with late or chronic PPD. Emotional abuse, physical abuse, and emotional neglect are significantly associated with early PPD.
Conclusions: The present study demonstrated that women who experienced childhood trauma had significantly greater symptoms of PPD. However, PPD symptoms did not vary between the two assessments and remained stable. Mental health screening and interventions must be adopted during pregnancy monitoring and in the postpartum period.

Disclosure of Interest: None Declared

EPP134

Patterns of Sexual Dysfunction in Depression: A Population-Based Study in Sweden

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Introduction: Previous research suggests that sexual dysfunction (SD) can both contribute to and result from depression. Additionally, evidence indicates that antidepressants may cause SD as a side-effect. However, knowledge of SD patterns in depressed individuals at the population level remains limited.
Objectives: To describe and compare the prevalence and incidence of SD during a three-year period before and after a diagnosis of depression.
Methods: Nationwide health registers in Sweden were used to identify patients diagnosed with a new-onset depressive episode (ICD-10: F32 and F33) in specialized healthcare between 2006 and 2014. SD was defined as having an SD diagnosis (ICD-10: F52.0-52.3) or a filled prescription of a drug aimed against SD (phosphodiesterase 5 inhibitor) for women and men separately. First, the prevalence of SD was calculated for the three-year period before and after the depression diagnosis. Second, annual incidence rates of SD were calculated by only including the first-ever SD event for each year during the same periods. Finally, in men, the annual incidence rates of SD were stratified by age groups (18–29, 30–49, and 50–65 years).
Results: We identified 110,725 women (mean age 38 years) and 73,566 men (mean age 39 years) with newly diagnosed depression. Among the women, 117 had SD in the three years before the depression diagnosis, corresponding to a three-year prevalence of 0.12% (95% CI 0.10%–0.14%), whereas 192 had SD in the 3 years after the depression diagnosis, corresponding to a 3-year prevalence of 0.19%, 95% CI 0.17%–0.22%). The annual incidence of SD

ranged from 0.03%–0.09% with the highest incidence in the first year after depression. Among the men, 4,299 had SD in the 3 years before the depression diagnosis, corresponding to a 3-year prevalence of 6.4% (95% CI 6.2%–6.6%), whereas 5,716 had SD in the 3 years after the depression diagnosis, corresponding to a 3-year prevalence of 8.6% (95% CI 8.4%–8.8%). The annual incidence of SD ranged from 1.4%-2.2%, with the highest incidence in the first year after depression. When stratified by age, the annual incidence of SD in men was lowest in the youngest group (18-29 years: 0.2%–0.8%) compared to the older age groups (30-49 years: 1.4%–2.6%; 50-65 years: 2.2%–3.3%).

Conclusions: In this study of patients with specialist treated depression, SD was significantly more commonly diagnosed and/or treated in the three-year period after the depression diagnosis than before in both women and men. Furthermore, the incidence of SD was highest in the first year after the depression diagnosis. As expected, SD was more common among men, where it also increased with age.

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EPP135

Augmentation vs. switching medications in older patients with treatment-resistant depression: clinical moderators that matter

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Introduction: Older adults with treatment-resistant depression (TRD) can be treated with augmentation or switched to a different drug.

Objectives: We aimed to identify factors that moderate the effectiveness of these strategies on treatment outcomes to guide the selection of the optimal strategy for each patient.

Methods: We analyzed data from 742 older adults with TRD in the Outcomes of Treatment-Resistant Depression in Older Adults (OPTIMUM) clinical trial. All participants were randomized to one of two treatment strategies, which were augmentation with aripiprazole, bupropion, or lithium; or switching to bupropion or nortriptyline. Treatment outcomes were change in MADRS scores and remission after 10 weeks. Age, burden of comorbid physical illness, number of adequate previous antidepressant trials, presence of executive cognitive impairment, and clinically relevant comorbid anxiety were examined as potential moderators of the effect of the two treatment strategies (augmentation vs. switching) on treatment outcomes.

Results: Overall, augmentation produced more improvement in MADRS scores and produced a higher rate of remission than switching. For change in MADRS scores after 10 weeks of treatment, the number of adequate previous antidepressant trials was the only significant moderator of the superiority of augmentation over switching (b = -1.6, t = -2.1, p = 0.033, 95%CI [-3.0,-0.1]). There were no significant moderators for remission.

Conclusions: Older patients with TRD with less than three previous antidepressant trials benefit more from augmentation than from switching. Future studies validating this finding with different drugs in more diverse samples can facilitate their application in real world settings.

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