Methods: 296 youths, ages 10-17 year-old with a DSM-IV diagnosis of bipolar I disorder were randomized to receive either placebo or aripiprazole (10mg or 30mg) in a 4-week double-blind trial. Completers continued assigned treatments for an additional 26 weeks (double-blind). Efficacy endpoints included mean change from baseline to week 4 and week 30 on the Young Mania Rating Scale; Children's Global Assessment Scale, Clinical Global Impressions-Bipolar version severity scale, General Behavior Inventory, Attention Deficit Hyperactivity Disorders Rating Scale, and time to discontinuation. Tolerability/safety assessments included incidence and severity of AEs, blood chemistries and metabolic parameters.

Results: Over the 30-week course of double-blind treatment, aripiprazole (10 mg and 30 mg) was superior to placebo as early as week 1 (p< 0.002) and at all scheduled visits from week 2 through week 30 on mean change from baseline in the Y-MRS total score (p<.0001; all visits). Significant improvements were observed on multiple endpoints including the CGAS, GBI, CGI-BP, ADHD-RS-IV total score, time to discontinuation, and response and remission rates. The 3 most common AEs were somnolence, extrapyramidal disorder, and fatigue. Mean change in body weight z-scores over 30 weeks was not clinically significant.

Conclusions: Over 30-weeks of treatment, both doses of aripiprazole were superior to placebo in the long term treatment of pediatric bipolar patients. Aripiprazole was generally well tolerated.

P0140

Age at onset in bipolar disorders

A. Ortiz-Dominguez [1], C. Slaney [2], J. Garnham [2], M. Alda [1,2]. [1] *Deparment of Psychiatry, McGill University, Montreal, QC, Canada* [2] *Department of Psychiatry, Dalhousie University, Halifax, NS, Canada*

Background: The underlying genetic heterogeneity in Bipolar Disorder (BD) has led to the search of potential markers associated with subtypes of the disorder; as such, age at onset (AAO) could be considered as a factor that defines more genetically homogeneous subgroups.

Objective: To analyze the modal distribution of a BD population according to the AAO of the disorder, as well as the clinical characteristics related to the distribution findings.

Methods: 357 patients with a BD diagnosis were included in the study. AAO was defined as the age when the patient first met DSM-IV criteria for a major mood episode. Using an admixture analysis, patients were distributed among different parameters; and parametric analyses were conducted in order to compare the demographic and clinical characteristics between groups.

Results: The model that best fit the observed distribution was a mixture of three Gaussian distributions (mean ± SD): 17±3.7 years, 26±8.8 years, and 35.5±12.54 years. Statistically significant differences were found with respect to social status, course of illness, suicidal behavior, rapid cycling, medical co-morbidities and lithium response (p<0.05).

Conclusions: Our results support the existence of a tri-modal distribution in BD defined by AAO, each one with different clinical characteristics; and suggest that early-onset and late-onset BD reflect an underlying genetic heterogeneity in bipolar disorder, being early-onset BD implicitly a more serious subtype of disorder.

P0141

Delayed diagnosis of the bipolar disorder

F. Oueriagli [1], R. Chagh [2], S. Bouaouda [2], F. Manoudi [2], F. Asri [2], I. Tazi [2]. [1] *Academic Military Psychiatric Unit, Ibn Sina Hospital, Marrakesh, Morocco* [2] *Academic Psychiatric Unit, CHU Mohamed VI, Marrakesh, Morocco*

The delayed diagnosis of patients with bipolar disorder is a significant problem. These Patients will necessarily receive an inappropriate therapeutic and an inadequate management.

The objective of this work is to value the delay diagnosis of the bipolar trouble, to determine the factors of risk and its impact on the evolution of the disorder and on the life of patient.

It is a retrospective study of 101bipolar patients, according to the DSM IV criteria, that have been seen in consultation or hospitalized to the psychiatric unit of Marrakech, during a period from February 1st to September 2007.

The middle age of the patients was of 29,5 years with a masculine predominance (60,4%), the patients were unmarried in 61,4% and without profession in 44,6%.

The personal antecedents of hippomania were present in 61,4% , the familial antecedents of psychiatric disorder in 55,4%.

The middle time between initial mental health diagnosis and bipolar diagnosis was 76 months with a maximum of 132 months.

The impact of the delay on the illness had been noted in 60% of the cases (length and severity of the episode, recidivisms), the suicidal risk was present at 32,7% of the patients.

The factors incriminated in the delayed diagnosis of the bipolar trouble are essentially represented by the minor or atypical shapes of mania.

The recognition of these shapes will permit a precocious diagnosis what will avoid the deleterious impact of the delay diagnosis on the evolution of the illness and the life of the patient.

P0142

Response to antidepressant treatment by suicidal major affective disorder patients

M. Pompili [1,2], M. Innamorati [3], A. Del Casale [1], C. Ferrara [1], A. Celentano [1], M. Angelone [1], S. Buffo [1], G. Manfredi [1], G. Giupponi [4], G. Di Veroli [1], I. Berry [1], P. Girardi [1], R. Tatarelli [1], E. De Pisa [1], C. Comazzetto [1], I. Falcone [1]. [1] *Department of Psychiatry, Sant'Andrea Hospital, University of Rome ''la Sapienza'', Rome, Italy* [2] *Department of Psychiatry, Harvard Medical School & International Consortium for Bipolar Disorder Research, McLean Division of Massachusetts General Hospital, Belmont, MA, USA* [3] *Università Europea Di Roma, Rome, Italy* [4] *Department of Psychiatry, Bolzano, Italy*

Objective: To test the prognostic value of suicidal status in depressed patients for responses to antidepressant treatment.

Methods: We evaluated treatment response and covariates in depressed patients diagnosed with DSM-IV major depressive (n=50) or bipolar disorders (n=32) treated initially in a day-hospital for 2 weeks, followed by 4 weeks of outpatient treatment with antidepressants, with or without a mood-stabilizer. Being suicidal was based on an item-3 of the 17-item Hamilton Depression Rating Scale (HDRS17) scored at ≥3 and verified by baseline clinical assessment; morbidity and improvement were based on the total of the remaining 16 nonsuicidal items (HDRS16).

Results: Suicidal (n=31) and nonsuicidal subjects (n=51) were similar in baseline ratings of depressive symptom-severity (HDRS16), but were depressed longer and less likely to be married. Suicidality ratings improved by 36% during 6 weeks of treatment among initially suicidal patients, but other depressive symptoms (HDRS16) improved (13%) only half as much as in nonsuicidal subjects (25%), independent of diagnosis and treatment. Fewer than half as many suicidal subjects showed ≥20% improvement in HDRS16 scores.

Limitations: Findings, based on diagnostically complex and relatively treatment-resistant subjects, may not generalize.

Conclusions: Being suicidal may limit response to treatment in depressed major affective disorder patients, independent of diagnosis or overall symptomatic severity.

P0143

Temperament in suicidal and non-suicidal psychiatric inpatients

M. Pompili [1,2], M. Innamorati [3], Z. Rihmer [4], H. Akiskal [5], A. Del Casale [1], C. Ferrara [1], G. Ardenghi [1], S. Volterri [1], F. Gentili [1], D Erbuto [1], E. De Marinis [1], G. Manfredi [1], A. Grispini [1], A. Celentano [1], M. Angelone [1], V. Narciso [1], P. Girardi [1], R. Tatarelli [1], I. Falcone [1], C. Comazzetto [1]. [1] *Department of Psychiatry, San'Andrea Hospital, Rome, Italy* [2] *McLean Hospital, Harvard Medical School, Cambridge, MA, USA* [3] *Università Europea Di Roma, Rome, Italy* [4] *National Institute for Psychiatry and Neurology, Budapest, and Department of Psychiatry and Psychotherapy, Semmelweis Medical University, Budapest, Hungary* [5] *International Mood Center, la Jolla, CA, USA*

Suicide is a serious public health problem. In the international literature there is evidence to support the notion that certain temperaments and personality traits are often associated with suicidal behavior. In this study, 150 psychiatric inpatients were investigated using the TEMPS-A, the MMPI-2 and the Beck Hopelessness Scale (BHS) and evaluated for suicide risk through the critical items of the Mini International Neuropsychiatric Interview (MINI). Statistical analysis, including linear regression analysis and multiple regression analysis, showed that suicide risk contributed to the prediction of hopelessness. Among the temperaments, only the Hyperthymic temperament, as a protective factor, and the Dys/Cyc/Anx temperament contributed significantly to the prediction of hopelessness. Irritable temperament and Social Introversion were protective factors for suicidal risk. Hopelessness and depression were associated with higher suicidal behavior and ideation, but, unexpectedly, depression as measured by the MMPI did not contribute significant to the multiple regression.. The present study indicated that, although suicidal psychiatric patients have MMPI-2's profiles in the pathologic range, they exhibit several differences from nonsuicidal patients. Patients at risk of suicide have specific temperaments as well as personality and defense mechanism profiles. They are more social introverted, depressed and psychasthenic, and use hysterical and schizoid mechanisms more often. Generalizability of the findings was limited by the small sample size, mix of BPD-I, BPD-II, MDD and psychotic disorder patients.

P0144

The effect of repetitive transcranial magnetic stimulation on symptoms in obsessive compulsive disorder

J. Prasko [1,2,3], M. Bares [1,2,3], T. Novak [1,2,3], M. Kopecek [1,2,3], J. Horacek [1,2,3], B. Paskova [1,2,3], B. Tislerova [1,2,3], J. Vyskocilova [1,2,3], R. Zalesky [1,2,3]. [1] *Prague Psychiatric Centre, Prague, Czech Republic* [2] *3rd Faculty of Medicine, Charles University, Prague, Czech Republic* [3] *Center of Neuropsychiatric Studies, Prague, Czech Republic*

Background: Within a decade, the Repetitive Transcranial Magnetic Stimulation (rTMS) was being used to treat depression and schizophrenia. Antidepressant response has been reported in open and double-blind, sham-controlled studies of depression. Less is known about rTMS efficacy in the obsessive compulsive disorder.

Method: The aim of the randomized, double-blind, sham controlled study was to compare the 2 and 4 week efficacy of the 10 sessions rTMS with sham rTMS in serotonin reuptake inhibitor resistant OCD patient. Thirty seven right-handed patients were randomly assigned to either active rTMS or to sham. Active rTMS with the frequency of 1 Hz at 110% of motor threshold was administered over the left dorso-lateral prefrontal cortex. The same time schedule was used for sham administration. Thirty three patients finished the study, three patients' dropped out at the beginning. Psychopathology was assessed by CGI, HAMA, Y-BOCS and BAI before the treatment, immediately after the experimental treatment, and 2 weeks after by an independent reviewer.

Results: Both groups improved during the study period but the treatment effect did not differ between them in any of the instruments.

Conclusion: Low frequency rTMS administered over the left dorso-lateral prefrontal cortex during 10 daily sessions did not differ from sham rTMS in facilitating the effect of serotonin reuptake inhibitors in OCD patients.

P0145

Alcohol and bipolar disorder: Multiple sides of a frequent Addi(C)Tion

A.N. Ramos, P. Cintra, P. Varandas, I.C. Brito. *Hospital Miguel Bombarda, Lisbon, Portugal*

The comorbidity between bipolar disorder and alcoholism has been recognized since Kraeplin's work, in the beginning of the century.

Current epidemiological data refer to the Bipolar Disorder as the Axis I disorder most commonly associated with substance abuse, being alcohol the most frequent.

The aim of this work is to present a revision of the epidemiology, diagnostic issues, clinical course, physiology, genetics, prognostic and treatment options of comorbid bipolar disorder and alcoholism.

The method used consists of bibliographic research and medline related articles research.

After the research we can concluded that the comorbidity between alcoholism and bipolar disorder is a challenge as far as the diagnostic and treatment options are concerned.

The comorbidity between the two disorders has implications for diagnostic and treatment. On the one hand alcohol use worsens bipolar disorder and on the other hand this one can be a risk factor for alcoholism.

Although there are several hypotheses to explain the relationship between alcoholism and bipolarity, that relationship is complex, bidirectional and not well understood.

Treatment options range from psychopharmacological and psychotherapeutic interventions, adapted to the clinical context of each patient.