RECOGNITION OF DEMENTIA AND DEPRESSION IN PRIMARY CARE

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The objectives of this study were to investigate, whether dementia is diagnosed early, whether there are differential diagnostic considerations, and whether treatable causes of memory impairment are thought of in primary care.

We performed a representative survey (145 family physicians (FP), 14 primary care neuropsychiatrists (NP); response rate 83.2%) in southern Lower Saxony. Two different written sample case histories were presented to these physicians in a face-to-face interview. Case one described a slight unspecific memory and concentration problem in an otherwise healthy 70 y old woman, case two a moderate dementia of Alzheimer's type (Version B) or vascular type (Version A).

In case one, 24% of FPs and no NP considered "no disease", 50% of NPs and 55.9% of FPs a vascular encephalopathy though there were no cerebrovascular risk factors present. For primary and differential diagnosis depression was thought of by 78.6% of the NPs and 40.7% of the FPs, and incipient dementia was thought of by about 40% of all physicians. Other reasons for cognitive deteriorations were discussed by only 1 NP and 4.9% of the FPs. In case 2, depression was thought of only for differential diagnosis by 5.1% in the version A and by 14.8% in the version B. However, in the latter, only 25.9% considered Alzheimer's disease primarily and only 50.6% for differential diagnosis. Like in case 1 the "major" diagnosis was vascular encephalopathy (> 60%).

In conclusion, there is a striking under-diagnosis of dementia and an over-diagnosis of (presumed) vascular etiology. Treatable causes of dementia seem to be neglected.

PRESENILE DEMENTIA IN SCOTLAND: A CLINICAL AND GENETIC ANALYSIS

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Background. The study aims to identify the population of *live* patients in the Lothian region, with *presenile dementia* of *all aetiologies* and to describe the clinical profiles of each and the patterns of decline which occur, together with any genetic characterisation possible.

Methods. Cases have been identified using the Lothian Psychiatric Case Register. For the *demographic data,* the CAMDEX (The Cambridge Examination for Mental Disorders of the Elderly) informant interview was used. The *behavioural assessment* comprised the CAPE- BRS (Clifton Assessment Procedure for the Elderly, Behavioural Rating Scale), the Cornell Depression Scale and a new behavioural and psychopathological assessment (personal communication, Professor A. Burns). The subject was seen and where possible the *cognitive assessment* was completed using the NART (National Adult Reading Test) and CAMCOG (cognitive assessment of the CAMDEX). A physical and *neurological examination* was done and the Webster scale for Parkinsonian features included. 40 mls of blood was taken at the assessment interview for the genetic analysis. After an interval of approximately one year each case is reassessed using these instruments.

Results. Of 290 potential cases, 164 *(57%)* were excluded. Reasons: Death 50 *(31%)*, Unsuitable 40 *(24%)*, Refused 40 *(24%)*, Untraced 23 *(14%)*, Out of area 11 *(7%)*. Of the 126 *(43%)* seen, 112 *(89%)* met DSM3R (Diagnostic and Statistical manual of Mental Disorders, Third Edition, Revised) criteria for dementia. 63 *(56%)* of the 112 were rated as DSM3R severe type. 80 *(72%)* of the 112 fulfilled the McKhann criteria for Alzheimer's Disease. Full description of the group is available. The genetic testing is currently in progress, including Apolipoprotein E allele typing. Important data concerning the services provided and used by this group of patients and their carers has been collected and can be shared with organisations working to find funding for presenile dementia in the health service. The completion of the second assessments will allow the patterns of decline to be analysed.

Conclusions. This study will provide a thoroughly documented and clinically well worked-up sample. The analysis of the work will help to identify if subgroups exist, according to the patterns of decline of the illness and genetic variations. This will give a greater chance to plan appropriately for all those involved in caring for and managing these illnesses.

NR6. Neurosis: panic disorder/ obsessive-compulsive disorder/ post-traumatic stress disorder

Chairmen: J Lucey, E Bullmore

DOES BRIEF DYNAMIC PSYCHOTHERAPY REDUCE THE RELAPSE RATE OF PANIC DISORDER?

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Background: Although panic disorder can be effectively alleviated by drug treatment, the relapse rate is high. By adding brief dynamic psychotherapy — focused on the psychosocial vulnerability of patients with panic disorder — to an established drug treatment, we hypothesized that this would result in a lower relapse rate after pharmacotherapy.

Methods: Patients with panic disorder (DSM-III-R) were randomized to treatment with, either, clomipramine for 9 months (N = 20), or, clomipramine for 9 months combined with 15 weekly sessions of brief dynamic psychotherapy (N = 20). Measures of anxiety and depression were collected at intake and at regular intervals. The patients had blind follow-up interviews at 6, 12, and 18 months after treatment start.

Results: All patients in both groups became free of panic attacks within 26 weeks of start of treatment. On termination of pharmacotherapy, the relapse rate was significantly higher in the clomipramine only group during the follow-up period. There were significantly lower scores for most anxiety measures in the clomipramine plus psychotherapy group at 9-month follow-up.

Conclusion: The addition of brief dynamic psychotherapy to treatment with clomipramine significantly reduces the relapse rate of panic disorder compared to clomipramine treatment alone.

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