P01.059 RATES OF SEASONAL CHANGES IN CLINICAL STATUS OF BIPOLAR DISORDER PATIENTS IN THE STEP-BD 1000 DATA SET

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Statement of the Study: Patients with bipolar disorder are assumed to have an increased sensitivity to light. Evidence for this hypothesis includes changes in seasonal rates of mania (1), depression (2) and suicidality (3).

Methods: We examined the first 1000 patients enrolled in the Systematic Treatment Enhancement Program – Bipolar Disorder (STEP-BD) study. Patients who achieved Recovered status were examined for the prevalence of change, by month, to a new clinical status (Depression, Mania, Hypomania, Mixed) over the course of one year.

Summary of Results: There were 19,841 total reported changes in clinical status: 4,775 for bipolar II disorder (24.07%) and 14,017 for bipolar I disorder (70.64%).

Prevalence of change in clinical status from syndromal remission

	Month(s) of Highest Prevalence (%)	Month(s) of Lowest Prevalence (%)
Total Population		
Depression	April (9.56)	June (7.06)
Mania	March and December (10.48)	June (5.68)
Hypomania	April (10.81)	October (6.98)
Mixed	April and May (9.72)	August and September (7.71)
Bipolar I		
Depression	April and May (9.39)	June (7.08)
Mania	March (10.93)	August (5.46)
Hypomania	April and May (11.6)	December (6.44)
Mixed	April and May (9.75)	September (7.04)
Bipolar II		
Depression	May (10.41)	June (7.08)
Mania	April (10.82) and December (12.86)	August (5.46)
Hypomania	April (10.84)	September and October (6.40)
Mixed	April (10.43)	August (6.09)

Conclusion: This data in bipolar patients confirms patterns of peaks in prevalence of new onset episodes of illness in early spring, along with another peak of mania in December for bipolar II and in February for bipolar I. Interestingly, the summertime rates of depression, mania, and mixed status were troughs, with a fall-winter trough in the hypomanic patients. These results are consistent with the hypotheses of vulnerability to the illness around the solstices (March 21 and September 21) and the shortest photoperiod (December). The data also suggests seasonal influences affect mood stability rather than the polarity of the mood episode.

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P01.060 CYCLOTHYMIC TEMPERAMENT AND DEPRESSIVE DISORDERS: CLINICAL FEATURES AND FAMILY HISTORY

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Statement of the Study: Recent research on affective disorders suggest that a major depressive disorder (MDD) in patients with cyclothymic temperament (CT) might be included in a broad bipolar spectrum (Akiskal & Mallya, 1987), as well as MDD plus antidepressant-associated hypomania or superimposed on hyperthymic temperament (bipolar III and IV) (Akiskal et al., 2003; Cassano et al., 1992). Their likelihood to belong to the bipolar spectrum had previously been confirmed by an earlier age at onset of the affective disorder and by a higher rate of bipolar familiality, while such results had not been confirmed for MDD + CT as well. Aim of this study was to determine whether depressed unipolar patients with cyclothymic temperament were different from depressed patients that do not exhibit any dominant temperament, by comparing clinical and family history features.

Methods: A sample of unipolar outpatients (DSM-IV-TR, SCID), consecutively referred to our unit were administered the Semi-structured Clinical Interview for Temperament (TEMPS-I) (Placidi et al, 1998) and the Family History Questionnaire. Patients with dysthymic disorder and depressive disorder not otherwise specified were excluded from further data analysis. Age at onset of MDD and familial history for bipolar disorder were compared between patients with or without CT using respectively Student's t-test and c2 test.

Summary of Results: 87 out of 104 depressed patients were affected by MDD; of these, 60(69.0%) did not show any dominant temperament, while 13(14.9%) had cyclothymic temperament, 4(4.6%) hyperthymic, 2(2.3%) irritable, and 8(9.2%) depressed temperament. When clustering patients according to the presence/absence of CT, we found that the former group was significantly younger at onset of MDD (41.0± 15.2 vs. 51.5± 15.5 years; p=0.026); bipolar familiality was significantly higher in the MDD + CT group (15.4% vs 1.4%; p=0.011). Furthermore, in order to avoid the confounding effect of other temperaments on age at onset and on familiality, we decided to rule out those with temperament other than cyclothymic. Cyclothymic patients had a statistically significant earlier age at onset than depressives without any dominant temperament (41.0± 15.2 vs. 52.7± 14.5 years; p=0.011); furthermore they had significantly more bipolar family history (15.4% vs. 0%; p=0.002).

Conclusion: The earlier onset of MDD in patients with CT, as well as the high rate of familiality, strive for an inclusion in a broad bipolar spectrum, pointing towards the validation of the subtype of bipolar disorder that Akiskal has labeled as bipolar II. These preliminary data deserve further confirmation through better controlled studies.

P01.061 TREATMENT PSYCHOTIC SYMPTOMS IN CHILDREN WITH BIPOLAR DISORDER

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Statement of the Study: The purpose of this presentation to study secondary outcomes, specifically associated psychotic behavior, from our open label trials of atypical neuroleptics in the treatment of children and adolescents with pediatric bipolar disorder

Methods: This was a single-site, prospective, open-label, eight-week study of risperidone or olanzapine monotherapy in the treatment of youth with mania, aimed at evaluating short-term safety and efficacy, and time course of treatment response of the medication. Psychotic symptoms were evaluated with the Brief Psychiatric Rating Scale which was assessed at Week 0, 4 and 8.

Summary of Results: There were 30 males (13 on olanzapine and 17 on risperidone) and 18 females (5 on olanzapine and 13 on risperidone) with a mean age of 8.9± 2.7 years. There was a statically significant reduction of 12 points ($F(2,119)=34.1$, $p<0.0001$)on the BPRS over the course of the trial that did not differ between risperidone and olanzapine treated subjects ($t = -0.45$, $p=0.6$). There were significant improvements for the Thought Disorder ($p<0.001$), Anxiety/Depression ($p<0.009$), and Hostility ($p<0.001$) factors of the BPRS that did respond to one medication preferentially.

Conclusion: This study shows that, in addition to be effective in managing bipolar symptomatology, risperidone and olanzapine may also be effective in treating psychotic symptomatology.

P01.062 HYPOMANIA AND MANIA HAVE DIFFERENT SYMPTOM PROFILES

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Statement of the Study: According to DSM IV, manic and hypomanic episodes differ only in the degree of severity. Yet several lines of evidence, including family history, long-term diagnostic stability and linkage studies, point to bipolar I (BP-I) and bipolar II (BP-II) disorders as having distinct forms. This suggests that mania and hypomania, which are the hallmarks of the two disorders, might have different symptom profiles. To test this hypothesis we compared manic symptoms occurring in two BP-I and BP-II groups.

Methods: Two hundred and eighty bipolar inpatients were assessed using the Operational Criteria for psychotic illness checklist with a lifetime perspective. Manic or hypomanic symptoms were investigated and compared between BP-I (N=158) and BP-II (N=122).

Summary of Results: When compared with BP-II, BP-I disorder had a higher prevalence of reckless activity, distractibility, psychomotor agitation, irritable mood and increased self-esteem. These five symptoms correctly classified 82.8% of BP-I and 80.1% of BP-II patients.

Conclusion: These findings suggest that mania and hypomania can be differentiated in their clinical profiles and serve to address the question of bipolar