adolescents is needed to determine the most effective length of medication treatment.

Lilly-SAT3-5
SSRIs IN THE TREATMENT OF PMDD: AN UPDATE

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The recent inclusion of research diagnostic criteria for premenstrual dysphoric disorder (PMDD) in the DSM-IV recognizes the fact that some women in their reproductive years have extremely distressing emotional and behavioral symptoms premenstrually. Through the use of these criteria, PMDD can be differentiated from premenstrual syndrome which has milder physical symptoms such as breast tenderness, bloating, headache and minor mood changes, as well as from premenstrual magnification which occurs when physical and/or psychological symptoms of a concurrent psychiatric and/or medical disorder are magnified during the premenstruum. Epidemiological surveys have estimated that as many as 75% of women with regular menstrual cycles experience some symptoms of premenstrual syndrome. PMDD, on the other hand, is much less common. It affects only 3 to 8% of women in this group, but it is much more severe and exerts a much greater psychological toll. These women report premenstrual symptoms that seriously interfere with their lifestyle and relationships. The etiology of PMDD is largely unknown but the current consensus seems to be that normal ovarian function (rather than hormone imbalance) is the cyclical trigger for PMDD-related biochemical events within the CNS and other target organs. The serotonergic system is in close reciprocal relationship with the gonadal hormones and has been identified as the most plausible target for interventions. Thus beyond the conservative treatment options such as lifestyle and stress management and the more extreme interventions that eliminate ovulation altogether the serotonin re-uptake inhibitors (SSRIs) are emerging as the most effective treatment options for this population. Results from several randomized placebo-controlled trials in women with PMDD, with predominantly psychological symptoms of irritability, tension, dysphoria and lability of mood, have clearly demonstrated that the SSRIs have excellent efficacy and minimal side effects. More recently several preliminary studies indicate that intermittent (premenstrually only) treatment with SSRIs is equally effective in these women and thus may offer an attractive treatment option for a disorder that is itself intermittent.

The Lundbeck International Psychiatric Institute

Lundbeck-IPI-SAT. Evidence-based medicine in depression

Chairs: H van Praag (NL), N Sartorius (CH)

Lundbeck-IPI-SAT-1
THE DEBILITATING BURDEN OF DEPRESSION

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Depressive disorders are a major public health problem. They are frequent and severe in their consequences if left untreated.

Recent studies have demonstrated that people suffering from depressive disorders make up a significant proportion of all those seeking help from general and primary health care services. Depressive disorders are poorly recognized, and patients suffering from them often exposed to costly somatic examinations and treated for a variety of somatic diseases. Antidepressant treatment is provided to only half of those who were diagnosed as suffering from depression and the doses prescribed are often low.

It is highly probably that the prevalence of depressive disorders will increase in the years to come. The reasons for this include the ageing of the population, the increasing expectancy of life of people who suffer from chronic illness (who often have co-morbid depressive disorders) as well as the extended life expectancy of people suffering from depressive disorders.

There are also some indications that the incidence of depressive disorders is increasing. As a consequence it is of great importance to undertake measures likely to help in the control of depressive disorders. These include additional training for general practitioners and other health workers, the improvement of the undergraduate education about depressive disorders, and the education of the general public.

Lundbeck-IPI-SAT-2
EVIDENCE BASED MEDICINE IN DEPRESSION: THE DIFFERENCE BETWEEN THEORY AND PRACTICE

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There is a large literature on the epidemiology of care which shows many differences between treatment guidelines and routine treatment in depression. Examples are high rates of non-recognition, inappropriate diagnostic specificity, no treatment or application of inadequate drugs, insufficient daily doses of antidepressants, early treatment termination, or insufficient psychological interventions.

Additionally there are large differences between areas or medical specialties in the way how depressive disorders are treated.

The conclusions from such data are twofold: Firstly, physicians must be better trained and informed about available evidence about optimal treatment of depression. Secondly, reasons for this therapist-non-compliance with guidelines have to studied. Available data suggest, that many guidelines may not be valid for treatment problems in routine care or do not address crucial points in medical decision making.

Lundbeck-IPI-SAT-3
QUALITY IMPROVEMENT IN THE TREATMENT OF DEPRESSION THROUGH EDUCATION

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In the years 1983–1984, the Swedish Committee for Prevention and Treatment of Depressions (PTD) offered an educational program to all general practitioners (GP:s) on the Swedish island of Gotland. The education has been shown to lead to a significant decrease in inpatient care, morbidity, mortality and costs caused by depressive illness on the island. Unspecific medication decreased and specific antidepressive medication increased.

A scrutinizing of all suicides on Gotland during the 1980:ies showed that the overall decrease in suicides due to the educational program mainly was caused by the decrease in suicides committed by female suicidants with recognized major depression and in contact with general practitioners. This was expected. However, the number of male suicides was almost uneffected by the educational program and the GP:s improved ability to diagnose and treat depressions.