SLEEP DISTURBANCES AMONG INDIVIDUALS CONSULTING EMERGENCY DEPARTMENTS FOR NONCARDIAC CHEST PAIN AND HAVING PANIC DISORDER: PRELIMINARY RESULTS

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Introduction: Panic disorder (PD) is encountered in 20 to 30% of patients consulting emergency departments (ED) with noncardiac chest pain. In psychiatric settings, around two thirds of PD patients report sleep disturbances, and more than half have experienced nocturnal panic attacks (NPA). This study explored the nature and magnitude of sleep problems among PD patients consulting ED with noncardiac chest pain.

Methods: We present the data from 15 consecutive patients (8 women; mean age 37.20, SD = 11.34) consulting an ED 1) with noncardiac chest pain; 2) diagnosed as having PD by a research assistant; and 3) accepting to participate in a PD treatment study. Patients were assessed with the ADIS-IV, Insomnia Interview Schedule, and self-report questionnaires (Insomnia Severity Index, ISI; Dysfunctional Beliefs and Attitudes about Sleep Scale, DBAS). Sleep diaries were completed during one week.

Results: Data drawn from the Insomnia Interview Schedule indicated that, out of 13, 3 participants met criteria for Insomnia without experiencing NPA, 3 had NPA without reporting Insomnia, and 4 had both Insomnia and NPA. These results were confirmed by sleep diaries. Mean ISI scores were 3.00 for PD patients without Insomnia or NPA; 11.50 for PD patients with Insomnia; 8.00 for PD patients with NPA; and 17.00 for PD patients with both Insomnia and NPA. Mean DBAS scores were 0.83 for PD patients without Insomnia or NPA; 3.90 for PD patients with Insomnia; 3.90 for PD patients with NPA; and 5.43 for PD patients with both Insomnia and NPA.

Conclusion: The majority (77%) of patients consulting ED for noncardiac chest pain and having PD displayed sleep disturbances. There may be two distinct forms of sleep disturbances in this population, namely NPA and comorbid Insomnia. Data are currently being collected to increase sample size and test these hypotheses statistically.
Category O—Sleep in Psychiatric Disorders

served among individuals suffering from both comorbid Major Depres-
sion Disorder and one or more comorbid Anxiety Disorder in addition
to PTSD, and among those using psychotropic medication. Gender, age,
time interval since trauma, trauma type and alcohol use had no incidence
on sleep quality.

Conclusion: Sleep appears to have a unique contribution in accounting
for the severity of PTSD symptoms. Sleep also impacts how individu-
als with PTSD perceive their own mental health. Most individuals with
PTSD present significant sleep difficulties regardless of their clinical
presentation. Knowing the specific features of sleep in PTSD, as well
as assessing the need to address sleep problems in PTSD treatment will
help refine interventions with individuals suffering from this distressing
disorder.

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THE RELATIONSHIP BETWEEN POOR SLEEP QUALITY
AND PPMD RECURRENCE IS NOT MEDIATED BY IL-6
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Introduction: Postpartum major depression (PPMD) is a serious health
concern affecting approximately 14.5% of women. No risk factor has
proven superior at predicting who will develop PPMD. We recently
found that poor sleep quality, as defined by the Pittsburgh Sleep Qual-
ity Index (PSQI), was a better predictor of recurrence after 4 weeks
postpartum than traditionally assessed risk factors, including depressive
symptomatology. One mechanistic pathway that may mediate this rela-
tionship is inflammation, as evidence indicates that depression is linked
to dysregulation of inflammatory cytokines. We evaluated the mediating
role of IL-6, a pro-inflammatory cytokine, in the relationship between
sleep quality in late pregnancy and PPMD recurrence.

Methods: Participants were pregnant women (N = 33, 31 ± 4 yrs) with
past histories of PPMD but not depressed at enrollment. The PSQI was
completed at week 36 gestation and the 21-item Hamilton Rating Scale
for Depression (HRSD-21) at week 4 postpartum. Circulating IL-6 lev-
els were assayed from blood drawn at week 2, 3 or 4 postpartum. Re-
currence was determined by two consecutive HRSD scores ≥ 15 and
clinician interview.

Results: Eleven (33.3%) women recurred within 6 months postpartum.
No relationship was found between PSQI scores and IL-6 levels or be-
tween IL-6 levels and PPMD recurrence (p’s > .20). Poor sleep quality
in late pregnancy, but neither HRSD scores in late pregnancy nor IL6 at
week 4 postpartum, was related to a recurrence of PPMD.

Conclusion: The current relationship between poor sleep quality and
PPMD recurrence is not mediated by IL-6. Although these findings sup-
port previous reports that poor sleep quality is a prodrome for recur-
rent depression (Perlis et al., 1997), the biological mechanism mediat-
ing this relationship remains unclear. Further exploration of the degree
to which cytokine dysregulation is involved in this relationship and the
pathophysiology of PPMD is warranted.

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IMPROVED INSOMNIA SYMPTOMS AND DAILY
FUNCTIONING IN PATIENTS WITH COMORbid MAJOR
DEPRESSIVE DISORDER AND INSOMNIA FOLLOWING
ZOLPIDEM EXTENDED-RELEASE 12.5MG AND
ESCITALOPRAM CO-TREATMENT
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Introduction: This study evaluated the effect of zolpidem extended-
release (Ambien CR®), with concurrent escitalopram therapy, on sleep
and daytime functioning in patients with comorbid insomnia and major
depressive disorder (MDD).

Methods: Multicenter, double-blind, parallel-group, randomized, place-
bo-controlled trial in adults (n=385, age 21-64) with comorbid insomnia
and MDD. Patients received escitalopram 10mg/day (open-label) and
either nightly zolpidem extended-release, 12.5mg or placebo. After 8
weeks of treatment (Phase 1), depression responders (≥50% HAM-D17
reduction) entered 16 additional treatment weeks (Phase 2). Daily morn-
ing questionnaires for sleep and next-day functioning were evaluated
bi-weekly (Phase 1) and every 4th week (Phase 2). Safety was assessed
by AEs and evidence for rebound insomnia.

Results: 119/193 and 67/96 zolpidem extended-release/escitalopram,
and 125/192 and 60/95 placebo/escitalopram patients completed Phase
1 and Phase 2 respectively. Phase 1 sleep measures improved from base-
line for zolpidem extended-release/escitalopram patients versus pla-
cebo/escitalopram for total sleep time (TST; Wk. 8 primary endpoint:
+101.4 vs +64.0 min; P =< 0.0001), wake time after sleep onset (WASO),
nighttime awakenings (NAW) and sleep latency (SL; P =< 0.0003 each
measure/timepoint). Zolpidem extended-release/escitalopram also im-
proved next-day morning energy, morning concentration, sleep quality
and sleep impact on daily activities (Wk. 12, 16; NAW; Wk. 16, 20), sleep
quality (Wk. 12-24), morning energy (Wk. 12-24) and sleep impact on daily
activities (Wk. 12-24; P =< 0.05 each measure/timepoint cited), but not
for SL and morning concentration. Zolpidem extended-release did not
significantly augment depressive symptoms compared with placebo.
No evidence of rebound insomnia. Most frequent AEs (>10%) in zolpidem
extended-release/escitalopram vs placebo/escitalopram groups were
headache (14.1%/17.9%) and nausea (10.9%/8.4%).

Conclusion: Zolpidem extended-release and escitalopram co-therapy
was a well tolerated and effective treatment of multiple insomnia symp-
toms in patients with comorbid insomnia and MDD, over 24 weeks.

Support (optional): Funding for this study was provided by sanofi-
aventis