

non-invasive RTG examinations and whether it is possible to pre-medicate these patients before such procedures with SSRI group medications.

Patients and method: The first hypothesis was related to MRI as precipitating factor, regardless of whether the patients had psychiatric diagnosis or somatic complaints. The second hypothesis was whether a good psycho-pharmacological preparation before the examination could reduce the negative experiences of the patients and facilitate the MRI. This was a pilot study with a small sample and we are planning to continue the investigation since the findings indicated that paroxetin may be very useful, if not with all patients investigated on MRI, then in patients with psychiatric diagnosis.

P35.08

Differential diagnostics of panic disorder and following treatment of the psychiatric policlinic

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Purpose of study: Many patients with vertigo, migraine, vestibrogenous polytopic algic syndrome are treated by GPs, or neurologists or another specialists, but not psychiatrists, We tried to learn if the right diagnosis/chronificated agoraphobia with panic disorder/ and the adequate psychiatric treatment can be successful.

Patients and methods: 52 patients have been chosen on the basis of 3 including criteria: DSM-IV and ICD-10: panic disorder, the disorder has not lasted less than 3 month and the up-to-now treatment and self treatment has not been successful.

Results and conclusion: The panic disorder is not a hard disease, but the diagnostics is very difficult and delicate. 44 women and 8 men at the age of 20 to 62 years with chronificating of panic disorder have often used to be tediously and hardly diagnosed and on the basis of that also inadequately treated. Thanks to psychopharmaca from SSRI and the rational therapy with benzodiazepins, the therapy of a diagnosed chronified panic disorder, or its comorbidity becomes treatable.

P35.09

Hypochondriasis or pseudo? Relationship with anxiety and its treatment

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Objectives: To differentiate hypochondriasis from the secondary pseudohypochondriasis.

Method: All patients met the diagnosis criteria of DSMIV for Anxiety Disorders and hypochondriasis. A Minnesota Multifacetic Personality Inventory (M.M.P.I), computerized EEG, a blood sample determining Platelet Serotonine, and Benzyl-amine-oxidase or plasmatic M.A.O immediately processed, was evaluated. After two years of follow-up, we divided the sample (N =163 into two groups (success N = 125 and failing N = 38)

Conclusion: Neither age nor sex had shown any significant difference of outcome. Poor educational level and single or divorced marital status shows a little higher rate of failure. There were any significant difference between groups of biochemical markers. Signs og good prognosis: Alternant MU rhythm and 14/6 rhythm in EEG as a sign of fear, the high rate of health concern in M.M.P.I clinical subscales, the M.M.P.I profiles like 2772, 1331, 6886 and 1881, the diagnosis of panic disorder with and without agoraphobia. Signs of bad prognosis: desynchronized EEG, low rate of fear or high rate of negative to treatment in M.M.P.I subscales, M.M.P.I.

profile 7887, the comorbidity with personalities disorders of axe II or with conversion disorder (300.11) .

P35.10

Comparison of paroxetine and reboxetine in panic disorder

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Objective: Compare the efficacy and the tolerability of reboxetine and paroxetine in the treatment of patients with panic disorder (PD).

Method: 34 outpatients with PD were treated with reboxetine 6 mg/day and 34 paroxetine 30 mg/day for 12 weeks in according to a randomized, single-blind design. Primary efficacy measures were the scores of Panic Associated Symptoms Scale, Sheehan Disability Scale and Fear Questionnaire. Side effects were collected.

Results: 7 patients in the reboxetine group and in 3 patients in the paroxetine group dropped from the trial due to side effects. After 12 weeks both groups showed significant decreases of panic-phobic symptomatology except for spontaneous panic attacks in the reboxetine group. Paroxetine was more effective on spontaneous panic attacks than reboxetine while no differences were found on anxious-phobic symptomatology. At the end of the trial, the rate of patients reporting sexual side effects were significantly ($p < .004$) higher in patients treated with paroxetine (17/31, 55%) than in those treated with reboxetine (2/27; 7%).

Conclusions: the results suggest that reboxetine have a good tolerability and efficacy in the treatment of PD however reboxetine seem to be less effective on spontaneous panic attacks that paroxetine.

P35.11

Paroxetine and respiration in panic disorder: preliminary results

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Objectives: Paroxetine reduces CO₂ induced-panic in patients with panic disorder (PD), however the precise mechanisms remains unclear. Since the irregularity of breathing pattern is the most consistent respiratory physiological abnormality found in PD we investigated the effect of paroxetine on this respiratory feature.

Method: Breathing pattern was assessed before and after one week of treatment with paroxetine (10 mg die) in 9 patients with PD. Respiratory physiology was assessed using a "breath by breath" Quarkb2 stationary testing system and irregularity of breathing pattern was measured calculating the Approximate Entropy Index (ApEn).

Results: After one week of treatment with paroxetine patients showed a significant decrease of the irregularity of tidal volume (TV) (from 1.43 ± 0.2 to 1.17 ± 0.3 , $p = 0.03$) and minute ventilation (MV) (from 1.54 ± 0.1617 ; 0.2 to 1.36 ± 0.1617 ; 0.3 , $p = 0.05$) patterns compared with pre-treatment condition.

Conclusions: Paroxetine decreases breathing pattern irregularity in patients with PD suggesting that a modulation of the respiratory function could be an important mechanism of the anti-panic effect of paroxetine.