

or 10/16) met responder criteria at endpoint (CGI-I \leq 2) and 7 (43.75%) met remission criteria (CGI-S \leq 2). Adverse events were generally mild and included tiredness (5 patients), sedation (5), dry mouth [3], lightheadedness [1], and diarrhea [1]. 2 patients discontinued levetiracetam due to side effects (tiredness and/or sedation).

Conclusion: These preliminary data suggest that levetiracetam may be an effective adjunctive treatment for patients with PTSD who remain symptomatic despite initial antidepressant therapy. Levetiracetam was generally well-tolerated. Further controlled and larger studies are warranted.

References

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P.4.a.013 Patients with “pure OCD” incur higher 2-year psychotropic costs than patients with “pure depression”

C. Hankin^{7*}, L.M. Koran¹, L. Culpepper², J.D. Dunn³, D.W. Black⁴, E. Hollander⁵, J. Knispel⁶, Z. Wang⁷, A. Bronstone⁸, D.D. Dougherty⁹, A. Levin¹⁰.
¹Stanford University, Department of Psychiatry, Standord, USA;
²Boston University School of Medicine and Boston Medical Center, Department of Family Medicine, Cambridge, USA;
³SelectHealth Inc., Formulary and Contracts, Salt Lake City, USA;
⁴University of Iowa, Department of Psychiatry, Iowa City, USA;
⁵Mt Sinai School of Medicine, Department of Psychiatry, New York City, USA;
⁶Humana, Florida Commercial Markets, Singer Island, USA;
⁷BioMedEcon, Biostatistics, Moss Beach, USA;
⁸BioMedEcon, Medical Writing, Moss Beach, USA;
⁹Massachusetts General Hospital, Psychiatric Neuroimaging Group and Obsessive-Compulsive Institute, Boston, USA;
¹⁰Health Plus, Medical Management, New York City, USA

Purpose: Little is known about the healthcare burden of patients with obsessive-compulsive disorder (OCD). We compared healthcare use and costs of newly-diagnosed patients with “pure OCD” (P-OCD) to a matched sample of patients newly-diagnosed with “pure depression” (P-D).

Methods: We examined 9 years (1997–2006) of Florida Medicaid claims. Among adults (age > 18) with \geq 1 OCD diagnosis (ICD-9 300.3), we identified their first occurring (“index”) OCD claim and selected those with 2 years of preceding data. Of these, P-OCD patients were identified as having no diagnoses of depression (ICD-9 296.2, 296.3, 296.9, 300.4, 309.0, 309.1, 311), psychoses (ICD-9 295, 298), bipolar disorder (ICD-9 296, 297), organic mental disorders (ICD-9 290, 291, 292, 293, 294), pervasive developmental disorder (ICD-9 299), nonpsychotic brain damage (ICD-9 310), development delays (ICD-9 315), or mental retardation (ICD-9 317, 318, 319) in the 2 years preceding and following their index claim. P-D patients were identified similarly, except that the index claim was depression and the exclusion diagnoses included OCD rather than depression. Each P-OCD patient was matched to \geq 1 P-D patient on sex, race/ethnicity,

medical illness severity (Charlson Comorbidity Index), and age and year at index diagnosis. P-OCD patients without a match were excluded from analysis. We examined inpatient and outpatient primary diagnoses to classify medical versus psychiatric care, and NDC codes to classify pharmacy claims. We assumed that the following psychotropics classes were prescribed for psychiatric illness: antidepressants, antimanics, antipsychotics, anxiolytics, sedatives and hypnotics, mood stabilizers, and stimulants; other medications were assumed to be prescribed for medical illness. Numbers and costs of inpatient stays, outpatient visits, and pharmacy claims were calculated over the 2 years following each patient’s index claim. We compared mean total, medical, and psychiatric healthcare use and costs. When data were skewed, data were log transformed.

Results: Among 2,924,412 Medicaid enrollees, 99 met criteria for P-OCD and 14,906 for P-D. Of these, 85 patients with P-OCD were matched to 963 patients with P-D (14 P-OCD patients could not be matched). Although there were no significant differences between groups with respect to overall healthcare costs, or inpatient utilization or costs, in the 2 years following index diagnosis, patients with P-OCD incurred significantly fewer outpatient medical claims ($p=0.006$) and costs ($p=0.007$) and significantly greater total pharmacy claims ($p=0.009$) and costs ($p=0.009$) than patients with P-D. Specifically, compared to those with P-D, patients with P-OCD had significantly more pharmacy claims ($p < 0.0001$) and costs ($p < 0.0001$) for psychotropics but not for other types of medications. During this 2-year period, P-OCD patients were 6 times more likely (OR = 5.85, 95% CI 3.27 to 10.46, $p < 0.0001$) than those with P-D to fill prescriptions across 3 or more psychotropic classes (e.g., stimulants, antipsychotics and antidepressants).

Conclusions: Patients with P-OCD incurred similar total healthcare costs, on average, to those with P-D, but significantly higher psychiatric pharmacy costs, particularly for psychotropics. Greater use of combined psychotropic classes seen among patients with P-OCD may reflect the greater complexity of these patients or a tendency for this group to receive inappropriate treatment.

P.4.a.014 Serum cortisol and DHEA-S levels in PTSD patients versus controls: correlations to panic-agoraphobic spectrum symptoms

C. Carmassi^{1*}, E. Da Pozzo¹, C. Martini¹, R. Paggini¹, S. Tonini¹, F. Mundo¹, D. Cesari¹, L. Amendola¹, A. Ciapparelli¹, L. Dell’Osso¹. ¹University of Pisa, Department of Psychiatry Neurobiology Pharmacology & Biotechnologies, Pisa, Italy

Introduction: Alterations in the Hypothalamic-Pituitary-Adrenal (HPA) axis, the network coordinating hormonal metabolism during physiological and stress responses, have been ascertained in Post-traumatic stress disorder (PTSD) (De Kloet et al., 2006). Reduced cortisol levels were linked to PTSD vulnerability and hypothesized as a risk factor for PTSD development in adult offsprings of Holocaust survivors (Yehuda et al., 2007). These findings suggest that HPA axis anomalies, could have a relevant role in the development of the disorder. Steroids, in fact, play an important role in several neurophysiological and psychiatric disease processes and elevated circulatory levels of DHEA-S, negative or positive modulators at the GABAA receptor in concentration-dependent manner, have been detected in patients with combat related PTSD (Spivak et al., 2000).