Results: All of them they receive appropriate neurological, psychiatric, psycological and rehabilitation support and treatment. They managed to have a good outcome after 36 months follow up.
Conclusions: The development of depressive disorders after such traumatic events remains a strong predictor of a variety of difunctions (social, personal, work etc). The emergence of depressive disorders in many cases remains unexplored and poorly understood. The effect into the the overall health remains a very important factor to investigate. The combination and collaboration of the various medical disciplines is essential in order to help young people.

Disclosure of Interest: None Declared

EPV0680

Depressive disorders after mild craniocerbral injuries in professional athletes

?. Syrmos[1]

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Introduction: Craniocerebral injuries are serious traumatic situations with negative effects in the overall health and also in sports performace and health
Objectives: Aim of this study is to present cases of deppresive disorders after mild craniocerebral injuries in professional athletes
Methods: 6 cases are presented. Range of age between 20 and 30 years old. All of them reported depressive disorders during the post traumatic period after craniocerebral injuries mainly during professional athletic activities
Results: All of them they receive appropriate neurological, psychiatric, psycological and rehabilitation support and treatment. They managed to have a good outcome after 24 months follow up.
Conclusions: The development of depressive disorders after such traumatic events remains a strong predictor of a variety of difunctions (social, personal, work etc). The emergence of depressive disorders in many cases remains unexplored and poorly understood. The effect into the the overall health remains a very important factor to investigate. The combination and collaboration of the various medical disciplines is essential in order to help young people and mainly professional athletes.

Disclosure of Interest: None Declared

EPV0682

Thirteen-Year Trajectories of Depressive and Anxiety Symptoms in Individuals with and without Migraine: Insights from the NESDA Cohort

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Introduction: Migraine is strongly associated with depressive and anxiety disorders, as migraine patients have over a twofold higher risk of major depressive disorder and nearly a threefold higher risk of anxiety disorders compared to non-migraine individuals.
Objectives: This study investigates the 13-year trajectories in individuals with a depression or anxiety disorder with and without comorbid migraine. Additionally, the time to recovery of the depressive or anxiety disorder was compared.
Methods: The NESDA cohort consists of participants with an affective disorder at baseline, according to the Composite International Diagnostic Interview (CIDI). Depressive symptoms were measured using the Inventory of Depressive Symptomatology (IDS) and anxiety symptoms with the Beck Anxiety Inventory (BAI). The participants were divided at baseline into three subgroups: migraine, non-migrainous headache and non-headache. The individual symptom trajectories were evaluated over 13 years with linear mixed models. Additionally, the time to recovery of the affective disorders with or without migraine were compared with a Cox-proportional hazard analysis.
Results: In total 1,448 participants had either a depressive or anxiety disorder or a combination of both at baseline, 327(23%) had additional comorbid migraine, 518(36%) non-migrainous headache. Participants with comorbid migraine consistently reported higher severity of depressive and anxiety symptoms than non-headache participants over the 13-year follow-up, with an estimated higher IDS sum score of 0.22 (p<0.001) and a higher BAI sum score of 0.28 (p<0.001) (see Figure 1 and 2). The time to recovery of an affective disorder was similar for migraine and non-headache individuals (HR: 1.13 (p=0.17)).

Image:

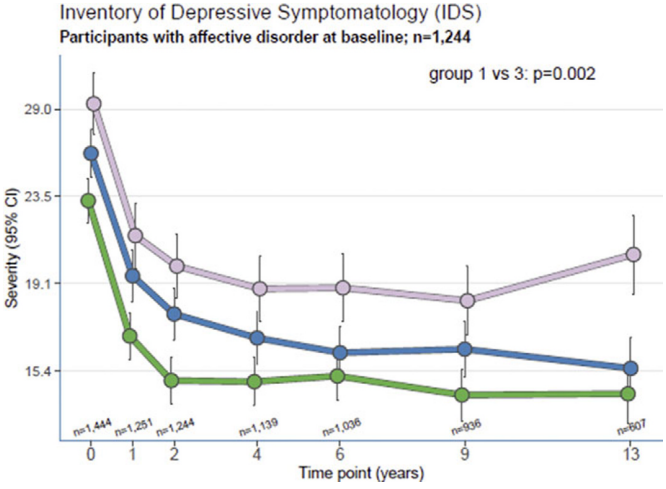
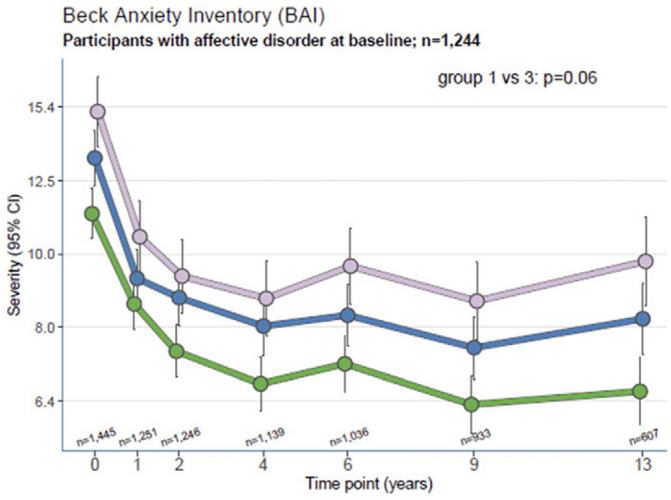


Image 2:



Conclusions: In this cohort, individuals with comorbid migraine showed consistently higher severity of depressive and anxiety symptoms than non-headache individuals over 13 years. Recovery time from an affective disorder was similar for migraine and non-headache individuals.

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EPV0683

Pharmacological management of late-onset major depression – Evidence-based approaches from the first episode to treatment-resistant cases

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Introduction: Depression in older adults may present itself as a recurring disorder originating from earlier life, as a new onset depression (late-onset depression, LOD), or as a depression due to organic diseases (e.g., vascular depression). An estimated 30% of all cases of depression in older adults are represented by LOD. Low tolerability due to the changes of the pharmacodynamic and pharmacokinetic profile (e.g., lower volume of distribution, reduction of renal clearence, longer half-time, different receptoral sensitivity and density), as well as low efficacy of antidepressants and high risk of completed suicide, have been reported in this population.

Objectives: To explore the current state of evidence for the pharmacological treatment of LOD through a narrative literature review.

Methods: This review included three databases (Web of Science/Clarivate, PubMed, and Cochrane), explored from their inception to June 2024, for papers published in English using the keywords "late-onset depression," "geriatric depression," "old age depression," and "antidepressants" or "treatment."

Results: Based on the results of 27 selected primary and secondary reports, selective serotonin reuptake inhibitors (SSRIs), especially escitalopram and sertraline, are considered the first line of treatment for LOD, with >50% rate of responsiveness being reported. SSRIs are followed by serotonin-norepinephrine reuptake inhibitors (SNRIs), and other new-generation antidepressants, mainly mirtazapine, vortioxetine, and bupropion. The therapeutic guidelines recommend the correct treatment of comorbid neurocognitive disorders; however, the available evidence shows that antidepressants have very limited efficacy in the presence of dementia. The number needed to treat (NNT) for LOD was between 6.7 and 14.4 (Alexopoulos *Transl Psychiatry* 2019;188 9). For treatment-refractory LOD (TRLOD), augmentation with lithium, aripiprazole, memantine, or methylphenidate, as well as switching to phenelzine, nortriptyline, desipramine, or a combination of antidepressants, such as bupropion and nortriptyline have been suggested as potential solutions, but the evidence to support such recommendations has low quality. Regarding the tolerability of antidepressants in this specific population, electrolyte imbalance, worsening of cognitive dysfunction, increased coagulation time, and falls should be considered.

Conclusions: SSRIs are the first-line pharmacological approach in LOD, with SNRIs and other new-generation antidepressants as the second-line. The pharmacological recommendations for TRLOD are based on low-quality data. Due to the tolerability and safety-specific aspects, special care should be given when monitoring these patients during the pharmacological treatment.

Disclosure of Interest: None Declared

EPV0685

Improvements in Functioning with Esketamine Nasal Spray versus Quetiapine Extended Release in Patients with Treatment Resistant Depression

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