



Objective: to determine the prevalence of various psychiatric conditions in association with migraine; describe the patterns of association of these comorbidities with a variety of health-related outcomes.

The prevalence of physician-diagnosed migraine was 15.2% for females and 6.1% for males. Migraine was most common in those between ages 25 and 44 years and in those of lower income. Migraine was associated with major depressive disorder, bipolar disorder, panic disorder, and social phobia, all occurring more than twice as often in those with migraines compared with those without. Migraine was not associated with drug, alcohol, or substance addiction. The higher prevalence of psychiatric disorders in migraineurs was not related to sociodemographic variables. Psychiatric disorders were less common in those over 65 years, in those who were in a relationship, and in those of higher income whether migraine was present or not. Health-related outcomes were worse in those with both migraines and a psychiatric disorder and moderate in those with either condition alone.

Migraine is associated with major depressive disorder, bipolar disorder, panic disorder, and social phobia. Migraine in association with various mental health disorders results in poorer health-related outcomes compared with migraine or a psychiatric condition alone. Understanding psychiatric correlations of migraine is important in order to adequately manage this patient population and to guide public health policies regarding health services utilization and health-care costs.

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DEPRESSION AND ANXIETY WITH MULTIPLE SCLEROSIS

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The aim of the present study was to investigate the relationship between involvement of specific areas of the brain and occurrence of depression and anxiety in patients with multiple sclerosis (MS). 55 patients were examined (32 women and 23 men, mean age 39.5 years) with definite MS, 47 patients (25 women and 22 men, mean age 40.7) suffering from chronic rheumatoid diseases and 50 healthy subjects (31 women and 19 men, mean age 40.1). Disability, independence, cognitive performances, depressive and anxiety symptoms were assessed. The diagnosis of major depression was made according to the DSM-IV.

The patients with multiple sclerosis underwent a 1.5 Tesla magnetic resonance examination including T1 and T2 weighted images. Calculation of regional and total lesion loads and brain volumes were performed. The number (%) of subjects with the diagnosis of major depression was 11 (20) among MS cases, 8 (17) among controls with chronic disease ($p=NS$), and 2 (4) among healthy volunteers ($p < 0.0001$). The Hamilton Depression and Anxiety rating scales median scores were 5 and 18, respectively in the MS patients, 5 ($p=NS$) and 14 ($p=NS$) with chronic rheumatoid diseases controls, and 3 ($p < 0.0001$) and 6 ($p < 0.0001$) in the healthy controls.

Both severity of depressive symptoms and diagnosis of major depression correlated with right frontal lesion load ($r=0.22$, $p=0.035$, and $r=0.23$, $p=0.026$, respectively) and right temporal brain volume ($r=0.22$, $p=0.005$ and $r=0.22$, $p=0.036$, respectively). The severity of depression was related significantly also with total temporal brain volume ($r=0.26$, $p=0.012$), right hemisphere brain volume ($r=0.25$, $p=0.015$), disability ($r=0.30$, $p=0.003$) and independence of MS cases ($r=-0.26$, $p=0.01$).

Anxiety did not correlate significantly with any of the measures of regional and total lesion loads and brain volume or with any of the considered clinical variables. The similar frequency of depression and severity of depressive symptoms in MS patients and in chronic disease patients, a significant difference in this respect with the normal controls, and a significant correlation between depression and the disability measures would suggest a psychological reaction to the impact of the disease but the relationship between depression and the alterations in the frontal and temporal lobes of the right hemisphere supports, on the contrary, a causative role of organic brain damage.



The lack of any significant association between symptoms of anxiety and either MRI abnormalities or clinical variables led us to the opinion that anxiety is a reactive response to the psychosocial pressure experienced by patients.

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CHARACTERISTICS OF CLINICAL MANIFESTATION AND THE COURSE OF MENTAL DISORDERS AND CONCOMITANT CARDIOVASCULAR DISEASES

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A high comorbidity between psychiatric disorders and cardiovascular disease (CVD) has received growing attention in recent scientific literature. One explanation for this comorbidity is that chronic disease, such as CVD, leads to depression and anxiety, through restriction of activities, fear of impending mortality, and other consequences of debilitating disease. Patients suffering from schizophrenia and related psychoses, run a substantial risk of developing hypertension and cardiovascular diseases. Moreover, stress has been linked to higher rates of morbidity and all-cause mortality and is recognized as a risk factor for numerous health conditions, including cardiovascular diseases. During acute stress, a number of cardiovascular changes occur, including accelerated heart rate and high blood pressure. Consequently, those experiencing stress more frequently or to a greater degree would be at greater risk for hypertension, myocardial infarction, and other cardiovascular disorders.

The objective of the research is to study clinical and psychopathological, pathopersonological and psychosocial features of the formation of mental disorders (MD) associated with cardiovascular disease, to develop the principles of their diagnosis.

The research was conducted using socio-demographic, clinical-anamnestic, clinical and psychopathological, psychodiagnostic, clinical-catastrophic, statistical methods and was implemented in two main stages.

At the first stage a patient supervision, experimental-psychological, psychodiagnostic research, diagnosis and comparative characteristics of the main and control groups; determination of features of nonpsychotic mental disorders depending on the duration of the disease by rheumatoid arthritis were carried out. At the second stage a correction of mental disorders using psychotropic drugs and psychotherapy was conducted out.

The proposed program is a comprehensive approach to the treatment of MD against CVD with the use of psychopharmacotherapy and integrative psychotherapy approaches (rational psychotherapy, elements of cognitive behavioral and gestalt therapy).

The patients with the diagnosis of MD, according to the criteria of International Classification Disease 10 (ICD), who attended mental hospital for follow-up visits, were included in this study. The study was approved by the ethics committee of the hospital, and signed informed consents were obtained from patients. Patients with the diagnosis of RA and aged between 20 and 60 years were included.

Experimental-psychological techniques included: Hamilton's Depression and Anxiety Scale (HDRS, HARS) – which were used to detect the level of depression and anxiety. Patients' quality of life was assessed using the four subscales of Quality of Life Index by Mezzich. HRSD and HRSA are both 35-questioned multiple-choice self-report inventories. For depression, 21 points and more are significant; for anxiety, 14 points and more are significant. Quality of Life Index by Mezzich includes questions for each subscale was individually scored from 1 to 10 (0-10 points). Higher scores indicated the best quality of life.

The targets of a complex influence (psychopharmacological and psychotherapeutic) are a pathological emotional state with concomitant cognitive imbalance, individual-psychological deviations, social interaction. The positive dynamics of the level of depression, anxiety and quality of life on the HRDS, HADDs and Quality of Life Index by Mezzich estimates was established.