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Roest, A.; Iozzia, G.; de Miranda Azevedo, R.; van der Harst, P.; Rosmalen, J.; de Jonge, P.

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to be tested for feasibility in general practice: the Central Sensitization Inventory (CSI), pressure point thresholds (PPTs) and monofilaments.

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39

Central sensitization as explanatory model for GPs

C. Den Boer, B. Terluin, J. van der Wouden, N. Blankenstein, H. van der Horst
Amsterdam UMC location VUMC, the Netherlands

Objective: It is important for patients with medically unexplained symptoms (MUS) to get an acceptable explanation for their symptoms. Central sensitization (CS) is an explanatory model for MUS and chronic pain in, amongst others, physiotherapy and rehabilitation medicine but until now it is not often used by general practitioners (GPs). We wanted to assess the effect of CS as explanatory model both on GPs and on patients.

Methods: We trained 33 GPs with their mental health nurse practitioners and (psychosomatic) physiotherapists. In their practices, we provided a short training in explaining CS. We provided training materials like videos, drawings, a clinical lesson and books. After 0.5- 1.5 year applying the model, 26 GPs participated in focus groups and interviews to report and discuss their experiences with and thoughts on CS as explanatory model. Audio recordings were transcribed and thematically analysed.

Results: The model gave tools and insight, for both GP and patient. The GPs thought that the CS explanation was acceptable for patients and helped them to get motivated for treatment. GPs were still struggling with uncertainty about the working hypothesis MUS and the fear to miss somatic pathology and they found the model sometimes complex to explain.

Conclusion: Though the model is complex and the issue of diagnostic uncertainty remains, the model offers tools and insight for both patient and GP. Furthermore it increases motivation for accepting treatment in patients, possibly leading to reduction of symptoms.

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41

Association of recognized and unrecognized myocardial infarction with depressive and anxiety disorders in 125,988 individuals: a report of the LifeLines Cohort Study

A. Roest[a], G. Iozzia[b], R. de Miranda Azevedo[b], P. van der Harst[c], J. Rosmalen[b], P. de Jonge[a]
[a]*Department of Developmental Psychology, University of Groningen, the Netherlands*
[b]*Department of Psychiatry, University Medical Center Groningen, University of Groningen, the Netherlands*
[c]*Cardiology and Thorax Surgery, University Medical Center Groningen, University of Groningen, the Netherlands*

Background: No previous study examined the role of recognition of myocardial infarction (MI) and the presence of affective disorders in a large population sample. The aim of this study was to investigate the association of recognized MI (RMI) and unrecognized MI (UMI) with depressive and anxiety disorders.

Methods: Analyses included 125,988 individuals enrolled in the LifeLines cohort study. Current affective disorders according to the DSM-IV were assessed with the Mini International Neuropsychiatric Interview. UMI was detected using electrocardiography (ECG) in participants who did not report a history of MI. The classification of RMI was based on self-reported MI history together with either the use of antithrombotic medications or ECG signs of MI. Analyses were adjusted for age, sex, smoking, somatic comorbidities related to MI, and physical health-related quality of life as measured by the RAND 36-Item Health Survey.

Results: Participants with RMI had significantly higher odds of having any depressive and any anxiety disorder as compared with participants without MI (depressive disorder: OR= 1.86;95%CI: 1.38-2.52;p<.001, anxiety disorder: OR= 1.60;95%CI: 1.32- 1.94;p<.001). Participants with UMI did not differ from participants without MI (depressive disorder: OR= 1.60;95%CI:0.96-2.64;p=0.070, anxiety disorder: OR=0.73;95%CI:0.48- 1.11;p=0.14). The presence of somatic comorbidities and low physical health-related quality of life explained the association between RMI with any depressive disorder (OR= 1.18;95% CI:0.84- 1.65;p=0.34), but the association with any anxiety disorder remained statistically significant (OR= 1.27;95%CI: 1.03- 1.57;p=0.027).

Conclusions: Recognition of MI is important for the occurrence of depressive, and especially anxiety, disorders. Therefore, a psychological pathway appears to be responsible for the increased risk of anxiety in patients with MI.

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44

Temperament and character in patients with acute abdominal pain

E. Lexne[a], L. Brudin[b], J. Strain[c], P. Nylander[a], I. Marteinsdottir[a]
[a]*Linköping University, Department of Clincial and Experimental Medicine, Psychiatry section, Sweden*
[b]*Linköping University, Department of Medical and Health Sciences, Sweden*
[c]*Ichan School of Medicine at Mount Sinai Medical Center, New York, USA*

Background: Abdominal pain, a common cause for seeking health care, has been reported to be associated with personality factors in primary care. Up till today there are very few reports if this also holds for emergency clinics settings.

Objective: To study different personality factors among patients with abdominal pain in an emergency ward.

Methods: Consecutive patients (N=165) hospitalized at an emergency clinic for abdominal symptoms, performed the Temperament and Character Inventory (TCI). The abdominal diagnoses were clustered into three groups; specific abdominal diagnoses (N=77), non-specific abdominal diagnoses (N=67) and organic dyspepsia (N=21). The TCI results were compared between these three groups and a control group (N=122).

Results: Patients with organic dyspepsia were significantly more anxious (harm avoidance) compared with those with specific abdominal diagnoses (p=0.003) and controls (p=0.003) and had a lower ability to cooperate (cooperativeness), p=0.048 and p=0.004 respectively. Also patients with organic dyspepsia were significantly more unpretentious (self-transcendence) compared to patients with specific abdominal diagnoses (p=0.048), non-specific abdominal pain (p=0.012) or controls (p=0.004). Finally patients with organic dyspepsia had a lower matured character (sum of self-directedness