(1999–2004) (N = 7500). Participants filled in a questionnaire about abdominal symptoms experienced within the last 12 months. The definition used: "Subjects stating that they often experience both abdominal pain and distension and additionally, either altering stool consistency or borborygmus", where often is defined as once a month or more often (pain) and frequently or almost constantly (other symptoms). We defined the exposed individuals by dividing the population into IBS symptom groups according to degree of IBS definition fulfillment at baseline and/or at the follow-up study 5 years later. The two cohorts were followed until December 2013 in Danish Central Registries to assess all-cause mortality and development of severe GI disorders.
Results: The Results showed that the population could be divided into symptom groups, where 40% had symptoms but did never fulfill the IBS definition, 8% had fluctuating IBS and 2% had persisting IBS over a 5 year period. 50% reported no IBS symptoms at either baseline or follow-up 5 years later. The preliminary Results showed that none of the IBS symptom groups were associated with increased all-cause mortality. Further, none of the IBS symptom groups were associated with an increased development of severe GI disorders. The associations were adjusted for age, sex, mental vulnerability and the study cohort.
Conclusion: This longitudinal study is an example where the exposed individuals were not only defined as 'IBS' or 'non-IBS' individuals. The study supports that IBS symptoms in the general population do not increase mortality or development of severe GI disorders, which is of great clinical interest. Further research in prognosis of IBS should take fluctuation of symptoms into account.

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Is hyperglycemia associated with anxious-depressive symptoms? An Italian study in primary care setting

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Background: Recent researches exploring the relationship between impaired glucidic tolerance, hyperglycemia or frank type II diabetes mellitus and symptoms of anxiety and depression, mostly conducted on in-patients or highly selected samples and on foreign populations, have reported conflicting results. Nevertheless, these medical and mental conditions are often comorbid in clinical practice. Chronic and systemic inflammation could represent the trait d\'union between these conditions. Primary care represents an interesting setting for exploring this comorbidity, given the high prevalence of psychiatric symptoms displayed by patients. The aims of this research was to measure the association between hyperglycemia and symptoms of anxiety and/or depression in out-patients, and to fill the lack of studies on comorbidity between depression and anxiety disorders and medical conditions in Primary Care services.
Method: The present was a cross-sectional study. We evaluated all consecutive patients undergoing a GP consultation in a Northern Italy practice. Exclusion criteria: age <40 or >80; use of antidepressants or antipsychotics medication; psychosis (schizophrenia, schizoaffective, bipolar, organic, or tall as psychotic disorder by DSM IV-TR) or major depression; pregnancy; previous stroke or heart attack; type I diabetes mellitus. The psychometric assessment was done by HADS (Hospital Anxiety and Depression Scale). Blood Glucose measurements (BM) in the last 6 months were considered in our analysis. Hyperglycemia cut-off: blood glucose >100 mg/dl. The statistical analysis was performed using STATA with multiple linear regressions.
Results: 209 subjects were recruited in our study (84 men and 125 women). Of those, 48 (22.9%) were affected by hyperglycemia: 22 were men and 26 women. Hyperglycemia was related to HADS-D score in the men sample ($\beta = .44$, $p = .01$). No association was found between hyperglycemia and HADS-A, either in men or in women.
Conclusion: The presence of hyperglycemia, well-known cardiovascular risk factor, may have a clinical value in predicting the presence of depressive symptoms, especially in men. Further studies should examine whether our results are generalizable to other populations and whether they are applicable to clinical depression. Molecular researches could focus on clarifying the pathophysiological reasons for such association, also exploring reasons for sex differences.

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Is low blood pressure always healthy? Evidence of an inverse association between depressive symptoms and arterial blood pressure in a primary care sample

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Background: Common mental health problems, such as anxiety and depression, have been related to the imbalance of the autonomous nervous system, also involved in blood pressure regulation. Low blood pressure readings have mainly been regarded as positive, but recent studies suggest low blood pressure is correlated with depression. The aim of the present research was to investigate the relationship between symptoms of anxiety and depression and blood pressure measures in a primary care sample.
Method: We conducted a cross-sectional study that received the approval of the local Ethical Committee. All consecutive patients undergoing a GP consultation in a Northern Italy practice were evaluated, with the following exclusion criteria: age <40 or >80; use of antidepressants or antipsychotics medication; psychosis or major depression; previous stroke or heart attack; type I diabetes mellitus; obesity related to hereditary conditions; pregnancy. The psychometric assessment was done by HADS (Hospital Anxiety and Depression Scale). Arterial blood pressure was measured twice using a stethoscope and a sphygmomanometer at the right upper arm after 5 min of seated rest; the mean measure was considered. High Blood Pressure (BP) cut-offs: systolic BP ≥130 mm Hg and/or diastolic BP ≥ 85 mm Hg, according to IDF 2005 guidelines. The statistical multiple linear regression analysis was performed using STATA.
Results: 209 subjects were enrolled in the study (125 women and 89 men). 122 subjects (58.1% of the whole sample) suffered from high blood pressure, and 98 of them (46.7%) followed an antihypertensive pharmacological therapy. A statistically significant inverse correlation between high diastolic BP and symptoms of depression at the HADS-D scale ($\beta = -.28$, $p = .01$) was found in the whole sample. The association was maintained in the male subsample, also after stratification by age, especially in the 40–60 years' group of patients ($\beta = -.53$, $p = .04$). On the contrary, no significant association was found between anxiety and BP measures.
Conclusion: This study confirms an inverse association between high diastolic BP and depression at epidemiological level in an out-patients sample; longitudinal studies are needed in order to examine temporal occurrence and to explore the pathophysiology and the molecular mechanism at the basis of this association. Further