29.9%) vs 11.3% (11.1%–11.5%), adjusted OR = 2.09 (1.45–3.02, p < 0.001)], and low HDL [54.5% (46.9%–62.0%) vs 29.4% (29.1%–29.7%), adjusted OR = 2.77 (2.02–3.80, p < 0.001)]. **CONCLUSIONS:** Compared with the general population managed in BSA, MS prevalence was significantly higher in patients with BD, mainly due to higher prevalence of obesity; high triglycerides and low HDL levels. These findings strongly support the development of health policies addressing this health problem in BD patients.

PMH3

PREVALENCE AND COMORBIDITY BURDEN IN PATIENTS WITH BIPOLAR DISORDERS: CROSS-SECTIONAL ANALYSIS OF A HEALTH-PROVIDER ADMINISTRATIVE CLAIM DATABASE

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OBJECTIVES: To estimate the prevalence of any type Bipolar Disorder (BP) and comorbidity burden in a Health Management Organization. **METHODS:** Cross-sectional assessment of the Badalona Serveis Assistencials (BSA) administrative claim database. All subjects above 15 years, both sexes, included in BSA claim database were included in the analysis. Patients with BP, diagnosed according with DSM-IV criteria formed the study cohort. The control group was formed for the rest of individuals in the BSA database without BD. Prevalence of both BP disorder and comorbidities were assessed directly. Corresponding odds ratios to measure intensity of association were computed adjusted by age by using logistic regression techniques. The following comorbidities groups were assessed: diabetes, hypertension, dyslipidemia, cancer, coronary hearth disease, cerebrovascular disease, asthma, COPD, obesity, non-dementia neurological disorders, dementia of any type, and other psychiatric disorders. **RESULTS:** We identified 178 subjects with BD (53.4% women, 49.9 + 19.2 years old, mean + SD) out of 86.028 individuals [50,5% women (p = 0.494); 45.5 + 17.8 years (p = 0.001)] in BSA database; overall prevalence = 0.21% (0.18%–0.24%), men [0.20% (0.17%–0.23%)], women [0.22% (0.19%–0.25%)]. Patients with BD showed significant higher frequency of dislipidemia [25.8% (95% confidence interval: 19.6%–32.9%) vs 16.2% (15.9%–16.5%); age adjusted OR = 1.54 (1.07–2.23, p = 0.021)], non dementia neurological disorders [2.2% (0.6%–5.7%) vs 0.4% (0.3%–0.4%); adjusted OR = 4.17 (1.50–11.60, p = 0.006)], dementia [9.0% (5.2%–14.2%) vs 0.6% (0.5%–0.7%); adjusted OR = 14.00 (7.21–27.21, p < 0.001)], other psychiatric disorder [23.6% (17.6%–30.5%) vs 7.9% (7.7%–8.1%); adjusted OR = 3.29 (2.30–4.70, p < 0.001)] and obesity [41.4% (32.3%–50.9%) vs 27.1% (26.6%–27.5%); adjusted OR = 1.83 (1.24–2.68, p = 0.002)]. No other significant differences could be found. **CONCLUSIONS:** The observed prevalence of Bipolar Disorders was comparable to the one observed previously in other countries. Compared with general population managed by BSA, the comorbidity burden is higher in subjects with Bipolar Disorders, mainly any type neurological disorders and other psychiatric disorder.

PMH4

ASSOCIATION BETWEEN CHANGES ON THE NEGATIVE SYMPTOM ASSESSMENT SCALE AND MEASUREES OF FUNCTIONAL OUTCOME IN SCHIZOPHRENIA

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OBJECTIVES: To correlate changes in negative symptoms of schizophrenia, assessed by scores on the 16-item Negative Symptom Assessment scale (NSA-16), with changes in scores on various functional outcome scales. **METHODS:** Of 166 stable outpatients with schizophrenia or schizoaffective disorder participating in 1 of 3 medication or psychosocial intervention studies, 99 had data at baseline and 9 months, and were included in the analysis. The rating instruments used were the NSA-16, Brief Psychiatric Rating Scale, and several functional outcome rating scales: Quality of Life Scale (QLS), Multnomah Community Ability Scale (MCAS), Global Assessment of Functioning (GAF), Social and Occupational Functioning Assessment Scale (SOFAS), Frontal Systems Behavioral Scale (FrSBe), Functional Needs Assessment (FNA), and Life Skills Profile (LSP). The association between change scores was assessed using Pearson's correlation coefficients. **RESULTS:** Changes in negative symptoms showed moderate to fairly strong correlations with changes recorded on all functional outcome rating scales. The associations were statistically significant for all functional outcome measures, including structured assessments (QLS: r = −0.423, P < 0.0001; MCAS: r = −0.338, P = 0.0008), global assessments (GAF: r = −0.521, P < 0.0001; SOFAS: r = −0.497, P < 0.0001), performance-based assessments (FrSBe: r = 0.414, P = 0.0003; FNA: r = −0.231, P = 0.0247); and observational assessment (LSP: r = −0.367, P = 0.0003). This pattern of association between reductions in negative symptoms and improvements in functional outcome ratings was evident even after controlling for the effects of treatment-related improvements in positive symptoms. **CONCLUSIONS:** Reductions in negative symptoms, as rated with the NSA-16, are associated with improvements in clinician- and patient-assessed functional outcomes measures. This association is particularly strong when functional outcome is measured on the QLS, GAF, and SOFAS. These findings suggest that treatments that decrease negative symptoms may reduce the considerable functional disability associated with schizophrenia.

PMH5

A 3-MONTH ASSESSMENT OF TREATMENT PRESCRIBED TO PATIENTS WITH ADHD AND ITS IMPACT ON CLINICAL SEVERITY AND QOL OUTCOMES ACROSS 10 EUROPEAN COUNTRIES. RESULTS FROM ATTENTION DEFICIT/ HYPERACTIVITY DISODER OBSERVATIONAL RESEARCH IN EUROPE (ADORE)

Mata Lorenzo MJ[1], Poole L[1], Spiel G[2], Dalsgaard S[3], Falissard B[4], Le Heuzey MF[5], Rothenberger A[6], Dopfner M[7], Baldursson G[8], Curatolo P[9], Pereira RR[10], Vlasveld L[11], Nøvik T[12], Hervas A[13], Preuss U[14], Steinhausen HC[15], Rasmussen P[16], Coghill D[17], Riley AW[18], [19]Forrest CB
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OBJECTIVES: To present three-months results on treatments prescribed and their impact on the clinical aspects and Quality