to others antipsychotics in terms of PANSS total score and CGI-S score and a similar effect as compared to placebo on all metabolic outcomes. The probability to have a lower impact than aripiprazole on weight increase and fasting glucose level was respectively 75.5% and 65.9%. Probabilities to have a lower impact on cholesterol level and triglycerides compared to olanzapine, quetiapine or riperidone varied from 98% to 100%. **CONCLUSIONS:** Efficacy has been demonstrated for all reviewed treatments vs. placebo, with a similar effect. Lurasidone had a similar effect as compared to placebo and a less negative impact than olanzapine, quetiapine and risperidone on weight increase, triglycerides, total cholesterol level and than olanzapine on fasting glucose level.

PMH10

RELATIVE EFFICACY AND ACCEPTABILITY OF VORTIOXETINE VERSUS MARKETED ANTIDEPRESSANTS

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OBJECTIVES: Vortioxetine (Lu AA21004) is an investigative multimodal antidepressant which demonstrated efficacy, safety and tolerability in Major Depressive Episode (MDE). The comparison of vortioxetine to marketed antidepressants guides decison makers and clinicians in their choice of treatment. The main study objective was to generate comparative evidence for the efficacy and acceptability of vortioxetine in MDE. **METHODS:** Indirect comparisons were performed by meta-regression analysis, an extension of classical random-effect meta-analyses, to compare vortioxetine to agomelatine, escitalopram, duloxetine, sertraline, venlafaxine IR/XR and vilazodone. To ensure comparability between studies, in terms of selection of patient population and exposure to treatment, only investigational drug and placebo arms from pre-registration placebo-controlled studies were included in the base case analyses. The main outcomes were efficacy, measured as the standardized mean difference between active treatment and placebo control in the change from baseline to 2 months of the primary endpoint (MADRS or HAM-D total score), and acceptability (the withdrawal rate due to adverse events) and expressed as the logarithm of the odds ratio (OR) between active treatment and placebo. Sensitivity analyses were performed with the inclusion of post-marketing authorization studies, adjustment for age/gender and on response and remission. **RESULTS:** For efficacy, treatment effect estimates and p-values for vortioxetine versus comparators were: -0.16(0.11) versus agomelatine (negative effect favours vortioxetine); 0.09(0.42) versus duloxetine; -0.05(0.70) versus escitalopram; -0.04(0.83) versus sertraline; 0.12(0.33) versus venlafaxine IR/XR and -0.24(0.11) versus vilazodone. For acceptability, all but one OR (<1) favoured vortioxetine: 1.77(0.03) versus agomelatine; 0.75(0.26) versus duloxetine; 0.67(0.28) versus escitalopram; 0.30(0.01) versus sertraline; 0.47(0.01) versus venlafaxine and 0.64(0.18) versus vilazodone. Meta-regression adjusted for age and gender demonstrated the robustness of the estimated differences between treatments, as did sensitivity analyses including post-marketing trials. **CONCLUSIONS:** Vortioxetine is a promising intervention with efficacy comparable to marketed antidepressants in MDE and a favourable acceptability profile.

PMH11

DRUG TREATMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) IN AUSTRIA

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OBJECTIVES: The therapy of Attention Deficit/Hyperactivity Disorder (ADHD) with methylphenidate or atomoxetine, formerly only related to children and adolescents, is now extended to the adult population. Little is known about treatment patterns in Austria. The aim of this study was to evaluate the medication patterns of ADHD in 2012 in Austria, stratified by age and sex. **METHODS:** The data analysis refers to the accounting data of the 13 major Austrian health insurance funds, covering more than 97% of the Austrian population. Provided in a pseudonymised manner, with availability of the individual patient parameters age and sex, all dispensed medication of methylphenidate or atomoxetine is included in the descriptive analysis. The prevalence of ADHD medication is evaluated regarding age and sex. Furthermore the prescribed daily dose in relation to the defined daily dose is pointed out. **RESULTS:** A total of 9120 patients with ADHD medication in 2012 are included in the analysis (22% female). One per cent of all patients with ADHD medication is in the age cohort of under 6 years, 47% are between 6 and 13, 22% are between 14 and 17, and 30% are adults (18+). The relation between the defined daily dose (ddd) to the prescribed daily dose (pdd) shows that 86% of children and adolescents have less than 366 pdd in the whole year and only 1% has more than 732 pdd. 81% of the adults have less than 366 pdd and 6% have more than 732 pdd. **CONCLUSIONS:** While the variety of prescribed daily dose per patient is homogeneous during childhood and adolescence, this parameter spreads widely in adults. This could be an indicator of overuse or misuse. As the results reflect the prescription reality they can be used as a solid basis for further discussions, future evaluations and interventions about ADHD medication in Austria.

PMH12

TREATMENT DISPARITY AMONG PATIENTS DIAGNOSED WITH DEPRESSIVE DISORDER IN WORKING POPULATION BASED ON CLAIMS DATABASE IN JAPAN

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OBJECTIVES: Treatment disparity by gender and age among patients with depressive disorder in working population has not been examined in Japan. This study examined treatment disparity by gender and age among patients newly diagnosed with depressive disorder based on the claims database of health insurance societies between 2008 and 2011 in Japan. **METHODS:** Retrospective cohort database (N=600,000) was followed up for four years to identify patients (18 ≤ age ≤ 65) with newly diagnosed depressive disorder. The patients were followed up for one year after the index date (the first date of diagnosis). Psychotropic drugs used to treat depressive disorder included first- and/or second-generation antidepressant, benzodiazepine, sulpiride, and antipsychotics. The treatment duration and time to treatment by gender and age were evaluated by Cox regression model. **RESULTS:** A total of 5,464 patients (men: 3,483, mean age: 36.1±9.9) with depressive disorder was identified. Median treatment duration was 123 days (men: 150 days, women 92 days). 90.1% of patients was prescribed at least one psychotropic drug within 30 days from the first date of diagnosis (84.5% in women and 93.1% in men). The proportion of patients who were prescribed at least one psychotropic drug for the first time after 6 months from the index date was 5.6% (men: 3.8%, women: 9.1%). The result showed that older patients were more likely to be treated longer period. In addition, men tend to be prescribed at least one psychotropic drug in a shorter period of time from the index date compared to that in women. **CONCLUSIONS:** This study suggested the trend of treatment disparity between men and women as well as age in working population with regard to treatment duration and time to prescription. Further study is needed for generalizability.

PMH13

THE BURDEN OF TREATMENT CHANGE IN MAJOR DEPRESSIVE DISORDER: COMPARISON OF SWITCH VERSUS NON-SWITCH PATIENTS IN THE PERFORM STUDY

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OBJECTIVES: PERFORM (Prospective Epidemiological Research on Functioning Outcomes Related to Major depressive disorder) is a 2-year prospective observational cohort study conducted in Europe (France, Germany, Spain, Sweden and UK). Objectives are to describe the functioning of patients with major depressive disorder (MDD) and factors associated with functional impairment. Here we compare characteristics and outcomes of patients switching antidepressant treatment (ADT) with those initiating ADT at baseline, on an interim 1000-patient dataset. **METHODS:** Outpatients were recruited from primary or secondary care. Inclusion criteria were: DSM-IV-TR diagnosis of MDD, age 18-65 years, initiation or first switch to an ADT, in monotherapy. In addition to socio-demographics and disease history, data collection included clinician assessments (MADRS and CGI-S) and patient-rated scales evaluating depression (PHQ-9), functioning (SDS), work productivity (WPAI-SHP) and quality of life (QoL - EQ-5D). **RESULTS:** Of 947 analysable patients at inclusion, 213 (23%) patients were switching (76% for lack of efficacy), *versus* 716 (77%) initiating ADT. Switchers were slightly older (mean age 46 *versus* 43 years) and more often female (77% *vs.* 72% women). Switching patients had more severe symptom profiles: more had previous depressive episodes (34% *vs.* 24%) and previous suicide attempts (16% *vs.* 12%). Severity of current episode was greater for switchers (46% *vs.* 36% with a CGI-S score above "markedly ill"; 48% *versus* 38% with a PHQ-9 score above the severe depression threshold). MADRS scores were similar: 18.1 *versus* 17.6. QoL was poorer for switchers (EQ-5D: 0.449 *vs.* 0.567), as was overall patient functioning (47% *vs.* 36% with an SDS total score in the highest quartile), while no difference was found for absenteeism (35% *vs.* 34%) and presenteeism (49% vs. 50%) (WPAI-SHP). **CONCLUSIONS:** Patients switching ADT had more severe symptom profiles, lower quality of life and higher functional impairment, compared to non-switching patients.

PMH14

PATIENT-REPORTED COGNITIVE DYSFUNCTION NEGATIVELY IMPACTS FUNCTIONING IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER – PRELIMINARY FINDINGS FROM THE PERFORM STUDY

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OBJECTIVES: PERFORM (Prospective Epidemiological Research on Functioning Outcomes Related to Major depressive disorder) is a 2-year prospective observational cohort study conducted in Europe to describe the functioning of patients with major depressive disorder (MDD) and factors associated with functional impairment. Here we report the impact of patient-reported cognitive dysfunction (PRCD) on quality of life (QoL), work and overall functioning at baseline, on a preliminary 1000-patient dataset. **METHODS:** Outpatients were recruited from primary or secondary care. Inclusion criteria were: DSM-IV-TR diagnosis of MDD, 18-65 years old, initiation or first switch to an antidepressant, in monotherapy. Functioning was assessed by the SDS (Sheehan Disability Scale), work productivity by the WPAI-SHP (Work Productivity and Activity Impairment Questionnaire) and QoL by the EQ-5D (EuroQol-5 Dimensions) and SF-12 (12-Item Short-Form Health Survey). PRCD was assessed by the Perceived Deficit Questionnaire 5-item (PDQ-5). Descriptive analyses stratified on PDQ-5 quartiles were complemented with ANCOVA adjusted for severity of depression. **RESULTS:** At inclusion, over 947 analysable patients, mean PDQ-5 score (ranging from 0 to 20) was 11.5 (SD=4.4). PRCD was associated with impairment of overall functioning, QoL and productivity. SDS total scores were 14.4, 18.5, 20.2, and 23.6 (first to fourth PDQ-5 quartiles, respectively) (p<0.001). Similar patterns were observed for WPAI-SHP presenteeism scores (impairment while working: from 36.9% in first quartile to 64.4% in fourth quartile, p<0.001; overall work impairment: from 41.5% to 71.3%, p<0.001). These associations remained statistically significant after adjustment for baseline depression severity in multivariate analyses. A negative impact of PRCD was also observed on sick-leave length and on QoL. **CONCLUSIONS:** At inclusion, subjective cognitive dysfunction in depressed patients was associated with poorer functioning, work productivity and QoL. This is in addition to any negative impact of the