

and supervised process of reducing or stopping medications that may no longer be of benefit or may be causing harm. Clinically relevant aspects and considerations of this deprescribing process in elderly patients with affective disorders will be discussed. Woodford HJ, Fisher J. New horizons in deprescribing for older people. *Age and Ageing* 2019;48:768-775. Hiance-Delahaye A, et al. Potentially inappropriate prescription of antidepressants in old people: characteristics, associated factors, and impact on mortality. *Int Psychogeriatr* 2018 May;30(5):715-726. Bobo WV, et al. Frequency and predictors of the potential overprescribing of antidepressants in elderly residents of a geographically defined U.S. population. *Pharmacol Res Perspect* 2019;e00461.

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Keywords: Affective disorders; Elderly

W0062

Deprescribing process in demented patients: What is the rationale?

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Polypharmacy is rather a rule than an exemption in the elderly. This applies also to the demented population, whether they live in private homes or in nursing homes. The application of multiple drugs increases the risk to develop delirium, to promote falling and to hasten cognitive decline. What can be done to reduce these risks? First of all, drugs should be given on the basis of an appropriate assessment. Pain e.g. may be misunderstood as challenging behaviour. Side effects might be misunderstood as newly occurring symptoms. Drugs should be prescribed with a written protocol, what the drug is expected to do. If this does not occur, the drug should be deprescribed. In addition, antidepressants should be deprescribed. Many demented patients receive more than two of them, mostly for years. Deprescription follows the evidence, that antidepressants are not much helpful in dementia. They may induce hyponatremia, too. The deprescription of benzodiazepines requires patience and a long tapering-out. And overall, what about the antipsychotics? They shall be given at a minimum dosage and duration. That means, that drug pauses should be established regularly. And finally, what about the antibiotics, antihypertensive drugs and more? Having in mind, that severe dementia is mostly a state, where the principles of palliative medicine should be applied, also many of these drugs can be deprescribed.

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Keywords: Deprescribing; dementia; polypharmacy; delirium

W0063

Antipsychotics for elderly with psychosis: Deprescribe or continue?

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Maintenance treatment with antipsychotics remains the key principle in the long-term management of psychotic disorders. For some patients, it means life-long use of medication. Continuous drug administration helps to prevent relapses, maintain remission, and achieve functional recovery. Moreover, epidemiological data suggest that antipsychotic treatment significantly reduces mortality rates of schizophrenia patients. On the other hand, some authors argue that antipsychotic drugs may lose its efficacy over time, their long-term exposure results in more harm than benefit. Especially elderly patients are more sensitive to side effects. Several studies which followed-up patient cohorts over the span of several decades found that there are schizophrenia patients who can achieve good functional outcome and full recovery without antipsychotic treatment. Therefore, it is paramount to identify those individuals, particularly among elderly psychotic patients, who can thrive and benefit from timely antipsychotic discontinuation.

Disclosure: No significant relationships.

Keywords: Antipsychotics; schizophrenia; drug discontinuation

Research

Birth asphyxia: Is this an area of primary prevention in schizophrenia?

W0065

Birth asphyxia and its implications for neuropsychology and brain volume in schizophrenia

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Introduction: Newborn infants can suffer permanent brain damage as a result of birth asphyxia (ASP), a severe obstetric complication (OC). However, effects of OCs on cognitive abilities and brain structure in schizophrenia (SZ) are unknown.

Objectives: The main goals of this study were to investigate putative effects of a history of OCs on adult cognition and brain structure in SZ.

Methods: We utilized prospective data from the Medical Birth Registry of Norway to identify incidences of severe OCs in adult healthy controls (HC; n = 622) and patients with SZ (n = 607). IQ was assessed, and a subset of participants (n = 414) underwent magnetic resonance imaging.

Results: Severe OCs (27%) and ASP (14%) were equally common in SZ and HC. SZ patients with OCs had lower IQ than patients without OCs, a difference not found in HC (p = .023). Having experienced more than one co-occurring severe OC was associated with lower IQ in both groups, wherein 81% of co-occurring OCs involved ASP. ASP was related to smaller intracranial volume and brain volumes in both groups. Smaller caudate volumes were found