

**Objectives:** To illustrate the incipient phase of psychotic disorder through the presentation of a case.

**Methods:** A presentation of a clinical case.

**Results:** A 29-year-old man attends the emergency department due to anxiety of one month of evolution, that had debuted after a stressful event in the patient's life such as loss of employment. He suffered from intense morning-predominance anguish, depersonalization episodes, insomnia, hallucinosis, cognitive blocks that occasioned him great anxiety and apragmatic behaviors. Besides, he had language alteration and autolytic ideation with previous autolytic gestures. After evaluation, he was diagnosed with psychotic episode. He was hospitalized, and treatment with olanzapine and lorazepam was started.

**Conclusions:** With the exhibition of this case, we intended to point up the importance of a differential diagnosis with different disorders marked by anxiety as the main symptom. In our case, panic disorder should be taken in account as a differential diagnosis. Furthermore, as the evidence shows, the identification of prodromic phases in schizophrenia allows an early diagnosis and early intervention, improving the prognosis.

**Disclosure:** No significant relationships.

**Keywords:** trema; Anxiety; Psychosis; anguish

## EPV1412

### Anticholinergic syndrome in a patient with schizophrenia

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**Introduction:** Anticholinergic syndrome (AS) is a complication that can appear due to different drugs with antimuscarinic effects, such as antihistamines, alkaloids, antipsychotics, tricyclic antidepressives or anesthetics, and it is characterized by urinary retention, dry mouth and skin, mydriasis, low-grade fever, and confusion or coma.

**Objectives:** To describe a clinical case of AS admitted to our hospital.

**Methods:** We present a case report of a patient with schizophrenia who presented an anticholinergic syndrome. We also searched for previous studies of AS using a pubmed query.

**Results:** A 53-year-old male was admitted for a psychotic decompensation to another hospital in Barcelona. The usual treatment at home was amisulpride 1200mg/d, olanzapine 30mg/d and lormetazepam, and haloperidol 6mg/d and clonidine 40mg/d were added to treat the decompensation. Then, the patient started to present mydriasis, mucocutaneous dryness, low-grade fever, slight hypertension and tachycardia, repeated retentions of urine, confusion, unintelligible speech and agitation, so he was referred to our hospital. Once he was admitted, haloperidol was withdrawn and support measures (bladder catheterization, fluid therapy, etc.) were applied. After a few days, most of the mentioned alterations were stabilized, but the psychotic symptoms, such as thought and

behavioural disorganization, persisted and required electroconvulsive therapy, with subsequent improvement.

**Conclusions:** AS is a relatively frequent side effect of psychiatric medication, which diagnosis is clinical, so, we must be capable to identify it and initiate early treatment to prevent possible complications. The first step, as reflected in the case described, is to stop the causative drugs, and apply support measures. Additionally, physostigmine can be used, as it is an effective antidote.

**Disclosure:** No significant relationships.

**Keywords:** anticholinergic; physostigmine; schizophrenia; Antipsychotics

## EPV1414

### Psychotherapeutic intervention for treatment of psychotic symptoms in patients with paranoid development. About a case

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**Introduction:** Psychotic symptoms are not exclusive to schizophrenia, they can be due to paranoid development and can be treated differently.

**Objectives:** The objective of this paper is to study, from the following case, the effect of psychotherapeutic treatment in patients with paranoid development.

**Methods:** A bibliographic search was performed from different database (Pubmed, TripDatabase) about psychological intervention for the improvement of paranoid symptoms. 20-year-old man, born into a family with marital problems, without difficulties in psychomotor development, socialization or academic performance, who began with behavioral alterations from the age of 5 that he had begun to suffer abuse from his father, showing aggressiveness towards other children and progressively worsening over the years: consuming cannabis, isolating himself, listening to protective voices and distrusting of people, to whom he responded aggressively believing that they wanted to harm him.

**Results:** Initially, he was treated with antipsychotics that were later suspended when acute psychotic symptoms were ruled out, diagnosing a paranoid development secondary to trauma, for which he had felt fear and defenselessness, and had learned to be alert and respond aggressively to everything he considered threatening, showing anger that he did not know how to express. During therapy, abstinence to drugs was worked on, therapeutic link, mentalization-based therapy, emotions, narrative techniques, trauma and systemic family therapy.

**Conclusions:** To conclude, we need to pay attention to development of pathologies like this so as not to rush with antipsychotics, when it may be due to a development secondary to trauma that needs to be treated psychotherapeutically.

**Disclosure:** No significant relationships.

**Keywords:** Trauma; mentalization-based therapy; Psychotherapy; psychotic symptoms

## EPV1415

## blind or schizophrenic but not both

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**Introduction:** Although visual impairment appears to be a risk factor for schizophrenia, early blindness may be protective. It's a phenomenon that has puzzled even the smartest scientific brains for decades. It might surprise you: no person born blind has ever been diagnosed with schizophrenia.

**Objectives:** The objective of this research is to discover the relationship between schizophrenia and congenital blindness: is there a protective gene? Is that visual perception constitutes an essential stage in the onset of the disease itself?

**Methods:** Case study of a family consisting of thirteen brothers and sisters, three of whom were blind at birth, three with schizophrenia. The study of the files of schizophrenic patients hospitalized in our structure since it opened in the 1970s

**Results:** Case study of a family consisting of thirteen brothers and sisters, three of whom were blind at birth, three with schizophrenia, but there is none with blindness at birth and schizophrenia. Plus on the basis of medical files there is no case of schizophrenia with blindness at birth. Preliminary observational analysis of this clinical case suggests the following hypothesis: the presumed protective role of congenital blindness against schizophrenia. The bibliographic research has objectified three recent studies in this direction in Australia, Denmark, and the USA.

**Conclusions:** The relationship between schizophrenia and congenital blindness is still unrecognized and controversial

**Several studies are done in this direction, but so far there is no assertion or confirmation of the hypothesis**

**Disclosure:** No significant relationships.

**Keywords:** congenital; blindness; schizophrenia; protect

## EPV1416

## Negative symptoms - a real unmet need

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**Introduction:** Schizophrenia is frequently a chronic and disabling disorder, characterized by heterogeneous positive and negative symptoms. Negative symptoms are a major health concern and a core component of schizophrenia that account for a large part of the long-term disability and poor functional outcomes in patients with the disorder. Adequate treatment would mean important progress and Distinguishing primary from secondary negative symptoms may inform about treatment options.

**Objectives:** Objective: to provide information that may be useful for clinicians treating patients with negative symptoms of schizophrenia.

**Methods:** We searched Pubmed and Cochrane Library database for english language articles.

**Results:** Negative symptoms are a core component of schizophrenia that account for a large part of the long-term disability and poor functional outcomes. Negative symptoms are common in

schizophrenia; up to 60% of patients may have prominent clinically relevant negative symptoms that require treatment. Negative symptoms can occur at any point in the course of illness, although they are reported as the most common first symptom of schizophrenia. Negative symptoms can be primary symptoms, which are intrinsic to the underlying pathophysiology of schizophrenia, or secondary symptoms that are related to psychiatric or medical comorbidities, adverse effects of treatment, or environmental factors. Negative symptoms clearly constitute an unmet medical need in schizophrenia, and new and effective treatments are urgently needed.

**Conclusions:** Clinically relevant negative symptoms of schizophrenia need to be recognized, assessed, and as well managed as possible in order to achieve improved outcomes for patients. More studies are needed to establish the better approach to negative symptoms.

**Disclosure:** No significant relationships.

**Keywords:** negative symptoms; schizophrenia

## EPV1417

## Ekblom syndrome: a case report

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**Introduction:** Ekblom syndrome is a clinical term for delusional parasitosis, a condition characterized by the belief that one's skin is infested by invisible parasites. Despite having no medical evidence, patients strive to prove their illness and interpret different sensations and symptoms as infestation with parasites.

**Objectives:** Our objective was to present a case report of a patient with Ekblom syndrome with detailed clinical information and treatment complications.

**Methods:** We included patient's history, psychiatric evaluation, complete diagnostic work-up, therapy and follow-up.

**Results:** A 60-years old female patient was admitted to her first hospital treatment in our psychiatric clinic. Upon admittance, she was extremely tense, preoccupied with the idea that bed bugs have infested her body. She showed extensive medical documentation, including numerous dermatologic reports regarding her condition, interpreting them in accordance with her delusions. In attempt to help herself and "release" the bugs, she harmed herself causing multiple skin lesions across her body and face. The treatment was complicated with secondary skin infections, ulcers, cellulitis and oedemas. Initial treatment with olanzapine was switched to risperidone due to side-effects (sedation, increase of appetite, weight gain). Gradually, with pharmacological treatment, psychoeducation and support, remission was achieved, but poor insight to her previous condition and psychiatric symptoms remained.

**Conclusions:** Ekblom syndrome presents a serious disorder that can be complicated with secondary somatic complications, often requiring involvement of different medical specialists. Moreover, lack of insight into the need for psychiatric treatment can lead to therapy discontinuation and relapse of symptoms.

**Disclosure:** No significant relationships.

**Keywords:** Delusional disorder; ekblom syndrome; parasitosis; dermatology