affective symptoms), this topic remains controversial. Another difficult aspect about ATPD seems to be its low diagnostic stability, with diagnosis changing mostly to Schizophrenia, Schizoaffective disorder and Bipolar disorder. Duration of treatment after complete remission of symptoms is another controversial aspect of this disease.

Conclusions ATPD seems to have low diagnostic stability and poor research investment, and so it represents a challenge for psychiatrists on managing these patients in terms of treatment and follow-up plan. Further studies should be held regarding prognosis and treatment.

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EV322

Folie à deux through a case report

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Introduction The first reference to the shared delusions emerged in France in the nineteenth century. Shared delusions can be classified in three frames with different nosological value: simultaneous *folie à deux*, imposed *folie à deux* and communicated *folie à deux*.

Objectives A review of the structures of presentation of this psychiatric disorder through a case report and checking the categorization of the classic *folie à deux* in the current diagnostic manuals.

Methods Discussion through a case report of delusional disorder among twins. After several interviews with the patients we found that both have a complex delusional system, structured and bizarre at the same time. There was a clearly paranoid tinge in the narration which main theme is religion.

Results Delusional clinical appears identically and simultaneously in both subjects with equal readiness and doesn't give up after the admission of the patients in two different psychiatric hospitalization units.

Conclusions In the ICD-10 and DSM-5, diagnostics would be different depending on the kind of *folie à deux*. In simultaneous *folie à deux* and communicated *folie à deux* the dominant partner would receive a diagnosis of delusional disorder with ICD-10 and DSM-5. The acceptor partner would receive a diagnosis of delusional disorder induced with the ICD-10 and a diagnosis of unspecified schizophrenia spectrum and other psychotic disorder with the DSM-5. In a simultaneous *folie à deux*, both subjects would have a diagnosis of delusional disorder in both manuals. We think that this is the right choice.

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EV323

Presentation of the Comprehensive and Brief International Classification of Functioning, Disability and Health Core Sets (ICF-CS) for schizophrenia

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Objective The aim this presentation is present the results of the preparatory studies were presented at an international consensus conference, a multi-stage, iterative, decision-making and consensus process that took place 12–14 May 2015 in Barcelona, Spain. At this consensus conference, schizophrenia experts from different countries worldwide and working in a broad range of professions decided which ICF categories should be included in the first version of the ICF Core Sets for schizophrenia.

Method Four preliminary studies intend to capture the researcher's perspective, the patient's perspective, the expert's perspective and the clinician's perspective, respectively, on the most relevant aspects of functioning of persons living with schizophrenia. The final definition of ICF Core Sets for schizophrenia have been determined by integrating the results of preliminary studies in a consensus conference with international expert.

Result The experts included 97 categories in the Comprehensive ICF Core Set and 25 categories in the Brief ICF-CS. The specific categories of each ICF-CS are shown in this presentation. The Comprehensive ICF-CS can guide multidisciplinary assessments of functioning in persons with schizophrenia, and the brief version is ideal for use in both clinical and epidemiological research, since it includes a small and practical number of categories, but sufficiently wide for finding utility in clinical assessments.

Conclusion ICF-CS are being designed with the goal of providing useful standards for research, clinical practice and teaching, and it will stimulate research and will improve understanding of functioning, health and environmental factors in schizophrenia.

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EV325

Olfactory reference syndrome

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Introduction The term "olfactory reference syndrome" (ORS), introduced by Pryse-Phillips in 1971, is a persistent false belief and preoccupation with body odor accompanied by significant distress and functional impairment. Nowadays, it is not a distinct syndrome and it is currently classified as a delusional or obsessive-compulsive disorder.

Objectives and aims Review the history of ORSs classification and discuss why it should be considered as a separate diagnostic in the current health care classification systems.

Methods Description of a clinical case of a 36-year-old man and review the published articles on ORS by using PubMed database with the keywords: "olfactory reference syndrome", "chronic olfactory paranoid syndrome", "hallucinations of smell", "chronic olfactory paranoid syndrome", "delusions of bromosis" and "taijin kyofusho".

Results The published literature on ORS spans more than a century and provides consistent descriptions of its clinical features but nowadays is not explicitly mentioned in current classification systems as Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Statistical Classification of Diseases and Related Health Problems (ICD). ORS is overlap with different diagnostics such as delusional disorder, body dysmorphic disorder, obsessive-compulsive disorder, and hypochondriasis.

Conclusions Right now, it is not clear how the ORSs should best be classified so we consider interesting to include it as a separate diagnosis in our set classifications, since we understand that an adjusted