psychotic. There is few literature regarding the latter, making it difficult to recognize, let alone to treat, since we do not have robust data on the incidence nor approved interventions.
Objectives: To get a better understanding on the standard of care for patients with psychotic denial of pregnancy.
Methods: We present a case report alongside a narrative literature review on the topic.
Results: We report the case of a 39-year-old caucasian woman, foreign, undomiciled, who was admitted to a Psychiatry unit due to psychotic symptoms. Her birthplace and prior medical records were unknown. She did not recognize being pregnant and showed great irritability when asked; her responses ranged from delusional attributions of symptoms related to the pregnancy to partially acknowledging her state but refusing to answer questions. Obstetric ultrasound revealed a low risk 35 weeks pregnancy. Treatment included quetiapine up to 700mg daily and psychological approach. A multidisciplinary team managed the case and arranged a plan for delivery. Eventually, delusional symptoms remitted and she accepted the gestation. She showed full collaboration during delivery, giving birth to a healthy female and presented transient recovery. After being separated from her daughter, her clinical situation worsened.
Psychotic denial of pregnancy is rather uncommon. It is usually seen in patients with prior history of major mental illness, most frequently schizophrenia, and important psychosocial vulnerability. It associates with several negative outcomes for mother and baby, including neonaticide. Most studies agree on the need of a multidisciplinary intervention including obstetrics, psychiatry, and others (social agents, ethical consultants…) to generate a plan for mother and baby. Biopsychosocial aspects should always be considered and each case individually formulated. Pregnant women must be given clear and concise information about the process. For some, seeing obstetric ultrasound might help them accept the pregnancy. Some authors propose labour induction prior to 39 weeks and performing a C-section, especially in cases of uncontrolled psychosis or risk of noncompliance. Most studies also recommend antipsychotic treatment. In cases of persistent denial or acute crisis, especially during the third trimester, patients should be admitted to a psychiatry unit with easy access to obstetric care. Supportive psychotherapy and psychosocial intervention should try to identify precipitating stressors for denial, such as prior or anticipated custody loss, which has been linked to psychotic denial.
Conclusions: Psychotic denial is a serious illness which requires a multidisciplinary treatment including biopsychosocial and obstetrical aspects.

Disclosure of Interest: None Declared

EPV1112

Psychotic denial of pregnancy: case report and narrative literature review.

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Introduction: Denial of pregnancy is the phenomenon where a woman fails to recognize or accept her pregnancy at >20 weeks gestational age. It associates with increased morbidity and mortality of mother and child, and can be classified as non-psychotic or psychotic. There is fewer medical literature regarding the latter, making it difficult to recognize, let alone to treat, since we do not have robust data regarding incidence nor approved interventions or treatment.
Objectives: To describe this unfamiliar entity in order to be able to perform a proper diagnosis and thus prevent possible negative outcomes.
Methods: We present a case report alongside a narrative literature review on the topic.
Results: We report the case of a 39-year-old caucasian woman, foreign, undomiciled, with an advanced pregnancy, who was admitted to a Psychiatry in-patient unit due to psychotic symptoms such as mistrust and delusions. She showed scarce collaboration during assessment and did not give any plausible information about her identity. Her birthplace and prior medical records were therefore unknown. Apparently, she had no family nor social support network. Despite the obvious signs, she did not recognize being pregnant and showed great irritability when asked; her responses ranged from claiming she was suffering from a gastric tumor and making delusional attributions of symptoms clearly related to the pregnancy to partially acknowledging her state but refusing to answer any questions on the matter. Blood work showed no significant abnormalities and obstetric ultrasound revealed a low risk 35 weeks pregnancy.
With an estimated prevalence of 1:475 in general population, denial of pregnancy is not as rare as it may seem. The psychotic variant, however, is rather uncommon. Typically, women with psychotic pregnancy denial have prior history of major mental illness, most frequently schizophrenia, and suffer from extreme psychosocial vulnerability. They usually present previous or anticipated child custody loss, which hampers the process of developing antenatal attachment behaviours. Psychotic denial does not associate with concealing, since these women are mentally detached from the gestation and tend to create delusional explanations to their pregnancy symptoms. Not all of them show complete denial, some being able to acknowledge it, though mostly in an inconsistent way. These patients often fail to seek prenatal care or are noncompliant, they are at greater risk of drug exposure, and some are unable to recognize symptoms of labour, all of which increases the rate of negative outcomes for mother and baby, including neonaticide.
Conclusions: Psychotic denial is a rare diagnosis which should be properly assessed due to its clinical implications and the need to prevent potential negative outcomes for mother and baby.

Disclosure of Interest: None Declared

EPV1113

PERINATAL GRIEF, EMERGENCY EVALUATION. ABOUT A CASE

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