anxiety (r=-0.167, p=0.040), anger management problems (r=-0.173, p=0.033), and novelty-seeking behavior (r=-0.209, p=0.010) subscales.
Conclusions: Identifying the specific factors associated with treatment retention and dropout/relapse can be valuable in developing more effective and personalized treatment plans for individuals with OUD.

Disclosure of Interest: None Declared

Bipolar Disorders

EPP0359

Exploring the role of the immune-neuroendocrine interplay during affective episodes and euthymia in bipolar patients to seek for a reliable biological signature of the disease

A. Berry[1]*, M. Di Vincenzo[2], B. Collacchi[1], L. Giona[1], A. Giannini[2], D. D'Amico[2], F. Cirulli[1], A. Cirino[2] and M. Luciano[2]

[1]Center for Behavioral Sciences and Mental Health, Istituto Superiore di Sanità, Rome and [2]Department of Mental and Physical Health and Rehabilitative Medicine, University of Campania "Luigi Vanvitelli", Naples, Italy
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.528

Introduction: Bipolar disorder (BD) is characterised by heterogeneous phenotypic manifestations that may affect the achievement of a timely diagnosis delaying its therapeutic management. Increased circulating levels of pro-inflammatory cytokines and cortisol (CORT) have been observed in BD patients in addition to decreased levels of Brain-Derived-Neurotrophic Factor (BDNF) suggesting that the interaction among these mediators may play a role in the occurrence of affective episodes overall disrupting brain plasticity. However, knowledge on BD etiopathogenesis is still limited, including the causal relationship with inflammatory and neuroendocrine markers.
Objectives: To assess whether variations in peripheral neuroendocrine and inflammatory markers during acute phases of the disease and euthymia might predict the occurrence of affective episodes; to evaluate whether the interplay among these biomarkers might be exploited as a signature of BD.
Methods: We are currently recruiting BD patients during depressive or manic/hypomanic phases together with age- and sex-matched healthy controls (CTRLs). Complete blood count, pro-inflammatory, anti-inflammatory cytokines and BDNF will be assessed in serum; salivary cortisol awakening response test will be used to evaluate hypothalamic-pituitary-adrenal axis activity. MADRS, YMRS and HAM-A will be used to assess psychiatric symptoms, PSP and C-SSRS for global functioning and suicidal risk, IPSS and SRRS for stress levels and CIRS to evaluate physical comorbidities. All assessments will be carried out at the time of recruitment (T0) and after 3 (T1) and 6 (T2) months.
Results: Data have been so far collected on 28 BD patients (18 males, 10 females, age: 48.31±11.3) and 26 CTRLs (16 males, 10 females, age: 46.82±10.86). At T0, BD were characterised by a greater total number of white cells (7.83±1.86 BD vs. 6.78±1.87 CTRL, p<0.05), mean number of neutrophils (4.89±1.49 BD vs. 3.92±1.45 CTRL, p<0.05) and neutrophil/lymphocyte ratio (NLR) (2.52±1.1 BD vs. 1.9±0.69 CTRL, p<0.05). Moreover, BD patients showed overall a greater BMI (30.5±6.6 BD vs. 24.45±3.86 CTRL, p<.001). No difference was observed among groups with respect to sex and age.
Conclusions: Although preliminary, these results suggest that the active phases of BD are associated with a low-grade inflammatory state, potentially related to a different metabolic set-point in BD patients. Ultimately, this study will allow us to evaluate whether the presence of affective symptoms is correlated with fluctuations in the levels of inflammatory mediators, salivary cortisol and BDNF and to establish a reliable and highly predictive BD signature.
"Funded by: Bando Ricerca Indipendente ISS 2021-2023 to A. Berry project code ISS20-9286e4091f8e"

Disclosure of Interest: None Declared

EPP0360

Serum Lithium Concentration and the Risk of Chronic Kidney Disease

G. Gislason[1]*, Ó. S. Indriðason[2], R. Pálsson[1,2] and E. Sigurðsson[1,3]

[1]Faculty of Medicine, University of Iceland; [2]Division of Nephrology and [3]Mental Health Services, Landspitali–The National University Hospital of Iceland, Reykjavík, Iceland
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.529

Introduction: Lithium is an important treatment option for individuals with mood disorders, but its use has been linked to the development of chronic kidney disease (CKD). Existing studies on this association have reported conflicting results.
Objectives: The aim of this study was to examine the risk of developing CKD with lithium use adjusting for common comorbidities.
Methods: This was a retrospective cohort study that included all individuals in Iceland receiving lithium therapy between 2008 and 2018. Lithium use was defined as at least one dispensed prescription for Lithium or at least one serum lithium concentration above the detection limit. Patients with affective disorders (ICD-10 codes F30-F39) attending the outpatient clinics of Landspitali–The National University Hospital Mental Health Services in 2014-2016, without lithium exposure, served as controls. CKD stages 3-5 were defined according to the Kidney Disease Improving Global Outcomes (KDIGO) guidelines for CKD as estimated glomerular filtration rate (eGFR) less than 60 mL/min/1.73 m^2. The eGFR was calculated using the serum creatinine (SCr) based on the *Chronic Kidney Disease Epidemiology Collaboration* (CKD-EPI) equation. Acute kidney injury (AKI) was defined according to the SCr component of the KDIGO criteria for AKI, and other comorbid diseases were defined based on ICD-9 and ICD-10 codes. Individuals with fewer than 2 SCr measurements during the study period and those with CKD stages 3-5 prior to 2008 were excluded. Cox regression analysis with time dependent variables was performed to assess the risk of CKD.
Results: The study included 2046 individuals exposed to lithium, of whom 221 (10.9%) developed CKD in the study period. Among the 1220 control subjects, 39 (3.2%) developed CKD. Lithium use was associated with CKD (hazard ratio [HR] 1.93, 95% confidence

interval [CI] 1.37–2.74) after adjusting for sex, age, and comorbid diseases. Other significant risk factors were age (per year, HR 1.03, 95% CI 1.02–1.04), initial eGFR (per mL/min/1.73 m^2, HR 0.92-0.96, 95% CI 0.90–0.99), presence of diabetes (HR 1.73, 95% CI 1.15–2.48) and history of AKI (HR 1.89, 95% CI 1.32–2.70). When compared to the control group not exposed to lithium, the risk (HR) of CKD was 1.24 (95% CI 0.81–1.89), 2.88 (95% CI 1.97–4.20) and 5.23 (95% CI 3.31-8.26) for groups with a mean lithium concentration of 0.3-0.59, 0.6-0.79 and 0.8-0.99 mmol/L, respectively.
Conclusions: Long-term lithium therapy seems to increase the risk of CKD in a concentration-dependent manner in individuals with bipolar and unipolar mood disorders. To mitigate this risk, it is essential to monitor blood levels carefully and use doses of lithium as low as possible for adequate mood stabilization and treatment.

Disclosure of Interest: None Declared

EPP0361

Bipolar Disorder due to Cushing's Disease, with manic characteristics. Regarding a clinical case.

M. D. C. Blasco Fresco[1], S. Ciria Villar[1], L. T. Durán Sandoval[1], A. Perez Poza[1] and E. De La Fuente Ruiz[1]*

[1]Psychiatry, Miguel Servet University Hospital, Zaragoza, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.530

Introduction: The increase in cortisol can be exogenous or endogenous. As etiologies of endogenous increase we find: Cushing's disease, 68% of cases, generally due to an ACTH-producing pituitary tumor; Adrenal Cushing syndrome (17%); Ectopic Cushing syndrome (15%) due to lung tumor most frequently. It is relevant since among its symptoms one of the most notable are the psychiatric alterations it produces, among them mood disorders, depression being the most common, as well as psychotic symptoms, delirium and anxiety disorder.
Objectives: To carry out a correct differential diagnosis of the pathologies that could present with symptoms of a manic episode.
Methods: Clinical case description of a 52-year-old woman, who presented with manic symptoms in 2020, requiring hospitalization. Upon discharge from the acute care unit, she consulted with the endocrinologist due to weight gain, revealing an increase in abdominal diameter, hyperpigmentation, a moon-like face, and a hump. Free cortisol was measured in 24-hour urine, with a high result, followed by brain MRI, and pituitary microadenoma was confirmed.
Results: The patient underwent surgical resection of the microadenoma, which was partially effective, so she maintained high cortisol levels, even despite oral retreatment. In 2023 she had a new manic episode, with a cortisol value of approximately 300 nmol/day.
Conclusions: The importance lies in the correct diagnosis to provide appropriate treatment and avoid the chronicity of the disease and the patient psychiatrization. In this case and as in many other diseases, which present with psychiatric symptoms, it is important to differentiate whether it is a primary psychiatric disorder or are component symptoms of another disease that, upon receiving treatment, would resolve the psychiatric symptoms.

Disclosure of Interest: None Declared

EPP0362

Affective temperament and emotional dysregulation in cyclothymia and adult ADHD: differential characteristics and clinical implications.

M. Moriconi[1]*, D. Bartolini[1], U. De Rosa[1], M. Barbuti[1], E. Schiavi[2] and G. Perugi[1]

[1]Clinical and Experimental Medicine, University of Pisa and [2]UO Psichiatria 2, Azienda Ospedaliero Universitaria Pisana, Pisa, Italy
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.531

Introduction: Emotional dysregulation is central to the problem of the overlap between attention-deficit/hyperactivity disorder (ADHD) and cyclothymia.
Objectives: We aimed to compare clinical characteristics, psychiatric comorbidity, affective temperament, and emotional dysregulation among subjects with attention-deficit/hyperactivity disorder (ADHD) and cyclothymia.
Methods: In this cross-sectional study, 187 participants were consecutively recruited between January 2018 and December 2019 at the outpatient clinic of the 2nd Psychiatry Unit of the University Hospital of Pisa. Eighty-one subjects were diagnosed with ADHD, 62 with cyclothymic disorder, and 44 with both conditions. Participating psychiatrists collected socio-demographic and clinical data, psychiatric comorbidities according to DSM-5 criteria, familiarity for psychiatric disorders, and any previous responses to antidepressant drug therapy. To study the temperamental characteristics of the participants, the short version of the Memphis, Pisa, Paris and San Diego Temperament Assessment (Brief-TEMPS-M) was administered, while emotional dysregulation was measured through the Reactivity, Intensity, Polarity, Stability questionnaire (RIPoSt-40).
Results: Cyclothymic subjects, both with and without ADHD, were more often female ($p<0.001$) than subjects with ADHD. Participants with ADHD showed significantly lower educational attainment than subjects without ADHD ($p<0.001$). In addition, participants with ADHD alone showed comorbid substance use disorder more frequently ($p<0.001$) than subjects with cyclothymia alone. On the other hand, the latter showed higher rates of eating disorders ($p=0.033$) and familiarity for major depressive disorder ($p=0.009$) and panic disorder ($p=0.029$). Depressive and anxious temperament was significantly more represented in cyclothymic subjects without ADHD, as was negative emotionality, while hyperthymic temperament showed an opposite trend. No significant differences were observed between groups for cyclothymic temperament and overall negative emotional dysregulation, but patients comorbid with both conditions had the highest scores in these subscales.
Conclusions: ADHD and cyclothymia show high and overall similar levels of emotional dysregulation. However, cyclothymic patients may be more prone to negative emotionality ("dark cyclothymia"). It is possible that individuals with "sunny" cyclothymic features may escape clinical attention if ADHD is not present in comorbidity.

Disclosure of Interest: None Declared