

Results: There are 33 REMSs in Italy. As of 31st December 2021, 573 in-patients are hosted in REMSs. The most frequent diagnosis is schizophrenia (33%), followed by personality disorders (32%) and substance abuse (21.4%). 80% of the crimes committed involve violence towards human beings. As of 25th March 2022, the REMSs waiting lists include 605 individuals, 42 of whom were already imprisoned and 561 released. The average waiting time for admittance is about 10 months. Positioning on the waiting list follows the exclusive chronological criterion (date of sentence) and is not related to any clinical risk criteria whatsoever. It is estimated that one third of waiting patients remain without adequate care.

Conclusions: Rethinking the admittance criteria to REMSs is crucial. The use of alternative safety measures, the improvement of community mental health services and a real integration between both legal and health systems in terms of management of the offending psychiatric patient are among ways suggested to avoid breaking the dream of deinstitutionalisation.

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Guidelines/Guidance / Mental Health Policies

EPP0854

Hyperprolactinemia in patients taking antipsychotics: the importance of a shared approach between psychiatry and endocrinology

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Introduction: Hyperprolactinemia is a commonly encountered adverse effect of antipsychotic medication. Short and long-term repercussions of high prolactin, such as amenorrhea, sexual dysfunction, osteopenia and increased cardiovascular risk carry significant burden and may compromise therapeutic adherence. Despite its serious practical implications, hyperprolactinemia is still underscreened and its management neglected.

Objectives: To review current clinical guidelines regarding the management of hyperprolactinemia associated with the use of antipsychotics, reflecting upon the importance and need to share the management of this risk with an endocrinology expert.

Methods: We performed a literature review to identify clinical guidelines containing specific recommendations for antipsychotic-induced hyperprolactinemia (British Association of Psychopharmacology [BAP], NICE, Maudsley Prescribing Guidelines, Royal Australian and New Zealand College of Psychiatrists), published over the last ten years, with a particular focus on its physical risks.

Results: Most guidelines do not recommend routine monitoring of prolactin levels in asymptomatic patients. NICE and BAP guidelines have suggested measuring the baseline prolactin level, but have not specified follow-up monitoring, while Maudsley guidelines have. Management strategies depend on factors such as sex, age, as well as the clinical manifestations that ensue. Different treatment strategies have been described, such as decreasing the

dose of the antipsychotic, switching antipsychotics, adding aripiprazole or adding dopaminergic agonists. Referral to an endocrinology specialist should be made if the aetiology is unclear, prolactin levels continue to rise despite some intervention, the hyperprolactinaemia is severe (>3000 mIU/L) or there is suspected/confirmed pituitary adenoma. Further physical implications of having hyperprolactin are to be discussed by the endocrinology expert, namely those on bone metabolism, gonadal function and cancer risk.

Conclusions: Given the widespread use of antipsychotics and the need to have psychotic patients stabilized (sometimes with a lack of effective alternative), early detection and shared management of hyperprolactinemia are instrumental towards assisting both clinician's and patients' decision-making, be it towards lowering prolactin levels or managing its risk without compromising the antipsychotic's efficacy.

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What minimal detectable effect size is in your power – An inverted sample size formula for survival data

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Introduction: Power calculations are widely used in the conduct of clinical trials and are often required in funding applications and approvals. There is a recent debate on the role of power calculations in observational studies on existing data with (Hernán J Clin Epidemiol 2022; 144 203-205) and (Moris and Smeden J Clin Epidemiol 2022; 142 261-263) emphasizing the need for planning for all study types without risking discarding imprecise but otherwise relevant studies. In the current study, we construct a graph useful in the planning of a wide range of studies with survival data. We map the minimal detectable effect (MDE) for any possible number of events with a dichotome exposure varying the proportion assigned to the exposure groups.

Objectives: To provide a visual tool relating the sample size, more precisely the number of events, and the MDE for survival data in unbalanced designs.

Methods: The visualization is based on the formulas used by Stata's power logrank function by (Schoenfeld Biometrics 1983; 39 499-503) and (Freedman Statistics in medicine 1982; 1 121-129), and the MDE is mapped as a function of the number of events. Furthermore, we apply this to an ongoing project on data from the Danish national registers, comparing the risk of developing polycystic ovary syndrome (PCOS) associated with treatment with valproic acid in a population with bipolar disorder or epilepsy.

Results: Preliminary results (Fig. 1) show, as expected, that a larger sample size is required to obtain an MDE close to one. Also, the MDE increases when the assignment among groups is skewed. Moreover, we find a relevant minimal detectable HRR of 1.78 for developing PCOS in a population of 13,839 patients with bipolar disorder or epilepsy, exposed to valproic acid versus those not exposed to valproic acid, with a total of 203 cases of PCOS.