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EV975

Which type of management is most suited for patients with a diagnosis of false self personality (FSP) within a psychodynamically-oriented institutional day hospital? A study

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Introduction Our work team have already found that our Institutional Psychiatric Open Light Treatment (IPOLT) model allows the patient affected by severe mental illness (SMI) to more easily express her/his personal coping skills rather than behaving passively thanks to the "real free spaces" separating a structured intervention from another. Our work consisted in evaluating how patients with FSP respond to IPOLT.
Objectives This paper describes observations of psychotic patients operating from the position of FSP in order to evaluate how they respond to IPOLT compared with other patients according to three standards (day hospital attendance, psychotic episodes and hospital admissions).
Aims Identify the core factors for management of patients with FSP in the context of IPOLT.
Methods We isolated a sample including patients affected by severe mental illness (SMI); within this sample, we selected a small group of patients with FSP. During the last three years, we have been evaluating patients with FSP in terms of day hospital attendance, number of psychotic episodes and number of hospital admissions compared with data obtained from other patients with SMI without diagnosis of FSP.
Results The two data sets revealed no statistically significant differences in terms of the three standards.
Conclusions Our preliminary study showed a good effect for IPOLT treatment on patients with SMI. We expected that patients affected by SMI with FSP would have a different response to IPOLT, but it was not. We do not know whether such results depend on a too small sample of patients or inappropriate descriptors.
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EV977

Late onset psychosis. Review

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Introduction Several risk factors make older adults more prone to psychosis. The persistent growth in the elderly population makes important the necessity of accurate diagnosis of psychosis, since this population has special features especially regarding to the pharmacotherapy and side effects.
Objectives To review the medical literature related to late-life psychosis.
Methods Medline search and ulterior review of the related literature.
Results Reinhard et al. [1] highlight the fact that up to 60% of patients with late onset psychosis have a secondary psychosis, including: metabolic (electrolite abnormalities, vitamines defficiency...); infections (meningitides, encephalitides...); neurological (dementia, epilepsy...); endocrine (hypoglycemia...); and intoxication. Colijn et al. [2] describe the epidemiological and clinical features of the following disorders: schizophrenia (0.3% lifetime prevalence > 65 years); delusional disorder (0.18% lifetime prevalence); psychotic depression (0.35% lifetime prevalence); schizoaffective disorder (0.32% lifetime prevalence); Alzheimer disease (41.1% prevalence of psychotic symptoms); Parkinson's disease (43% prevalence of psychotic symptoms); Parkinson's disease dementia (89% prevalence of visual hallucinations); Lewy body dementia (up to 78% prevalence of hallucinations) and vascular dementia (variable estimates of psychotic symptoms). Recommendations for treatment include risperidone, olanzapine, quetiapine, aripiprazole, clozapine, donepezil and rivastigmine.
Conclusions Differential diagnosis is tremendously important in elderly people, as late-life psychosis can be a manifestation of organic disturbances. Mental disorders such as schizophrenia or psychotic depression may have different manifestations in comparison with early onset psychosis.
Keywords "Psychosis"; "Elderly"; "Late onset schizophrenia"
Disclosure of interest The authors have not supplied their declaration of competing interest.
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EV978

Late onset schizophrenia. A case report

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Introduction The presence of elderly people is more and more common in developed countries. Unlike other medical conditions, late onset psychosis includes organic and mental precipitants in its differential diagnosis.
Objectives To present a case of late onset schizophrenia.
Methods Medline search and review of the clinical history and the related literature.
Results We present the case of a 71-year-old woman with organic medical history of rectum adenocarcinoma in 2008 that underwent radiotherapy, chemotherapy and surgical resection with successful results. According to the psychiatric history, this patient has needed two admissions to the psychiatry ward, the first of them in 2012, (when the delusional symptoms started), due to deregulated behaviour in relation to persecutory delusions and auditory pseudo-hallucinations. In 2012, she was diagnosed with late onset schizophrenia. Blood tests (hemograme, biochemistry) and brain image were normal. Despite treatment with oral amisulpride and oral paliperidone and due to low compliance, delusional symptoms have remained. We started treatment with long-acting injectable papliperidone 75 mg/28 days having reached clinical stability.
Conclusions Late onset psychosis is due to a wide range of clinical conditions. In this case, our patient had no organic precipitants. The evolution and presentation of delusional symptoms in this patient made us think of late onset schizophrenia as main diagnosis.

Keywords "Schizophrenia" ;"Psychosis" ;"Late onset schizophrenia"
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further reading
Colijn MA et al. Psychosis in later life: a review and update. Harv Rev Psychiatry 2015;23(5):354-67.
Reinhard MM. Late-life psychosis: diagnosis and treatment. Curr Psychiatry Rep 2015;17(2):1.

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EV979

Major depressive disorder with psychotic symptoms in elderly. A case report

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Introduction The proportion of elderly people and affective syndromes are more and more common in developed countries. Elderly people have physiological conditions that may limit our intervention.
Objectives To present a case of a major depressive disorder with psychotic symptoms in a 72-year-old woman.
Methods Medline search and review of the clinical history and the related literature.
Results We present the case of a 72-year-old woman with psychiatric history of a major depressive disorder 14 years ago with ad integrum restitution after pharmacological treatment. In 2015, our patient was admitted to the psychiatry ward due to major depressive symptomatology (apathy, anhedonia, global insomnia, weight loss) that associated mood-congruent delusions (nihilistic, ruin, guilt, catastrophic) with deregulated behaviour. The patient was resistant to combined pharmacological treatment with aripiprazole, desvenlafaxine, mirtazapine and lorazepam, therefore, we decided to administer ECT, with successful results after 5 sessions. Brain tomography, blood and urine tests were normal. Clinical signs of dementia were not present.
Conclusions Inpatients with deregulated behaviour; it is important to rule out organic causes, especially in elderly, in whom dementia, brain tumors or metabolic disturbances may simulate psychiatric syndromes.
Keywords "Major depressive disorder" ;"Psychosis" ;"Late onset psychosis"
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further readings
Colijn MA et al. Psychosis in later life: a review and update. Harv Rev Psychiatry 2015;23(5):354-67.
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EV981

Obsessive versus delusional jealousy: Destruction in a form of creation – A review

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Introduction Jealousy is a complex emotional state and some degree is considered normal in mature love, but when does it become destructive in a relationship? There's a thin line between what is normal and what is pathologic. Pathological jealousy differs from normal by its intensity and irrationality. Obsessive and delusional jealousies are different types of pathological jealousy, difficult to distinguish, which is important, since they have different treatment. Despite the differences, both result in significant distress and carry the risk of homicide/suicide, so it's a matter deserving the psychiatrists' attention.
Objective Explore the psychopathological differences between obsessive and delusional jealousy and list the characteristics and difficulties in the approach to pathological jealousy.
Methods The results were obtained searching literature included on the PubMed and Google Scholar platforms.
Results Delusional jealousy is characterized by strong and false beliefs that the partner is unfaithful. Individuals with obsessive jealousy suffer from unpleasant and irrational jealous ruminations that the partner could be unfaithful, accompanied by compulsive checking of partners' behavior. This jealousy resembles obsessive-compulsive phenomenology and should be treated with SSRIs and cognitive-behavioral therapy. Delusional jealousy is a psychotic disorder and should be treated with antipsychotics.
Conclusion The common issue in pathological jealousy is the problem of adherence to treatment and bad prognosis. In order to achieve better treatment outcomes, we should follow-up the patient regularly. One key factor is to explore the psychopathology and motivate the sufferer for the proper pharmacological and psychotherapeutic interventions, trying to reduce the suffering caused by ideas of unfaithfulness.
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Differential diagnosis between schizophrenia and in major depression: The importance of abnormal bodily phenomena

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Introduction Anomalies of bodily experience have for long been described as relevant features of schizophrenia and major depression, yet such experiences are usually neglected in clinical examination. Bodily experience is the implicit background of our experiences against which we develop a coherent sense of self as a unified, bounded entity, naturally immersed in a social world of meaningful others. Such tacit experiential background is often perturbed in schizophrenia and major depression. Empirical research shows that patients with schizophrenia and major depression frequently present many different kinds of anomalies of bodily experience in the course of their illness.
Objective To characterize the abnormal bodily phenomena in both schizophrenia and major depression.
Aim To improve differential diagnosis based on the identification of typical features of abnormal bodily experiences in persons affected by schizophrenia and major depression and to provide supplementary diagnostic criteria.
Method Analysis of empirical and theoretical research published in the last 25 years.