Objectives: Through the presentation of the case of a patient with Bipolar Affective Disorder who manifests, during a manic episode, a Capgras delusion, we intend to approach the heterogeneity of the manifestation of some symptoms that tend to be specific of concrete psychiatric syndromes.
Methods: Clinical case presentation and non-systematic literature review using Pubmed plataform.
Results: AB, female, 49 years old, diagnosed with Bipolar Affective Disorder. Hospitalized for a manic episode with dysphoric mood, increased energy levels and delusional activity of grandiose and persecutory content. During hospitalization, a Capgras delusion centered on the husband emerged: he was replaced by a stranger, I was able to detect him by smell.
Capgras delusion is a delusional misidentification syndrome characterized by the belief that someone close has been replaced by an imposter. Despite being a rare syndrome, vastly more common in schizophrenia, affecting about 73% of cases, it can also occur in other psychiatric conditions such as dementia syndromes and, less often, mood disorders (16.7%).
Additionally, there are several examples that demonstrate the versatility of psychiatric symptom occurrence in different diagnoses, with first-rank symptoms serving as an example. Described in 1959 by Kurt Schneider, they were considered specific symptoms of schizophrenia, assuming this diagnosis based on the recognition of only one symptom. Over time, its pathognomonic character has become extinct, and its detection in mood disorders and acute psychotic disorder is relatively common.
Another example is the overlap between depressive and anxious symptoms. In fact, anxiety symptoms occur in about 85% of patients diagnosed with depressive disorder and, in turn, the presence of depressive symptoms in about 90% of patients diagnosed with anxiety disorder. This evidence has allowed, over time, a review of the diagnostic criteria for these disorders, leading to a progressive blurring of the threshold between them.
Conclusions: Psychiatric diagnosis is still a delicate task, totally dependent on the clinical interview. The lack of analytical and imaging tests, as well as the absence of pathognomonic symptoms, constitute a particular challenge in diagnosis. For this reason, we highlight the importance of recognizing combinations and patterns of symptoms rather than the specificity of just one symptom.

Disclosure of Interest: None Declared

EPV0818

A very musical psychopathology – from intrusive musical imagery, to musical obsessions and hallucinations

A. S. Morais*, F. Martins, P. Casimiro, V. Henriques, N. Descalço and R. Diniz Gomes

Psychiatry, Hospital Garcia de Orta, Lisbon, Portugal
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.2122

Introduction: The semiological spectrum that encompasses musical imagery is a very confusing field, as it is often difficult to understand the nature of the underlying psychopathological phenomenon from the patient's description.
Objectives: The purpose of the authors is to explore reviewing, distinguishing and organizing the concepts such as Intrusive musical imagery, musical obsessions, musical hallucinations, pseudohallucinations and musical palinacousis.
Methods: A brief non-systematized review is presented, using the literature available on PubMed and Google Scholar.
Results: Intrusive musical imagery (earworms, *ohrwurms*, or involuntary musical imagery) occur in more than 85% of general population, without pathology or ear disease. It involves the involuntary repetition of 15-30 seconds of a fragment of music/tune, persisting like a looping soundtrack, not being aversive.
Musical obsessions are a rare form of intrusive imagery, occurring either with other symptoms of Obsessive Compulsive Disorder or isolated ("The stuck song syndrome"). It is recurrent, persistent, intrusive, unintentional, time consuming and causes distress or functional impairment (although not as ego-dystonic and aversive as usually intrusive visual imagery are); preserved insight.
Musical hallucinations occur only in 0,16% in a general hospital; they can be linked to psychiatric diseases, but they are more common in neurological diseases (cerebral lesions, Parkinson's disease, delirium, drug induced…). They are reported to with less controllability, less lyrical content, and lower familiarity, than other forms of inner music; are perceived to arise from an external source and are interpreted as veridical.
Musical Pseudohallucinations can arise after severe hearing loss, in hallucinogen intoxication and in psychotic or non-psychotic disorders (as dissociative states or in borderline personality disorder). They occur in inner/subjective space, but insight can fluctuate.
Musical palinacousis is associated with electroencephalogram and neuroimaging abnormalities, linked to structural brain pathology. There is perseveration (echoing) of an external auditory stimulus occurs after cessation of the stimulus.
Conclusions: A rash classification can lead to misdiagnosis (for e.g. interpreting obsessive symptoms as hallucinatory phenomena or rendering an organic pathology undiagnosed) and the institution of inappropriate therapy. It is important to carefully explore these musical imagery phenomena when patients present these complaints, taking some time to characterize them.

Disclosure of Interest: None Declared

EPV0819

Delusions of body control: Psychopathological description of a case.

C. M. Gil Sánchez[1]*, J. A. Salomón Martínez[2] and E. Fernández García[1]

[1]Psychiatry, Sistema Andaluz de Salud (SAS), ALGECIRAS and [2]Psychiatry, Sistema Andaluz de Salud (SAS), Cádiz, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.2123

Introduction: A considerable number of patients with schizophrenia suffer from somatic passivity or delusions of control. So much so, that Schneider considered them as part of the first-rank symptoms.
In these cases, patients can think that feelings, impulses, thoughts, or actions are controlled or imposed by an external force.
Objectives: The objective is to make a psychopathological description of this symptomatology, based on a case report with Anomalous bodily experiences.

Methods: In this study, we describe the case of a patient with disorder of self-experience. We have conducted a systematic review of the descriptions published to date, regarding this case.
Results: We present the case of a 21-year-old patient who had gone to the emergency services three times for somatic pathology (described as dysesthetic and algic sensations in the throat, stomach and testicles).
In the psychopathological exploration, a delusional narrative is observed, as he refers that these sensations are being provoked by external people, with the aim of harming him.
The patient reports that these people are causing an increase in salivation in his salivary glands, for which he spits repeatedly.
He explains that these people can control his organs using an influencing machine, which in this case consists of a microchip implanted at the retroauricular area, from which they give orders and insult him at the same time.
In this case, a good symptom response was achieved with intramuscular Aripiprazole.
Conclusions: In the experiences of passivity, the patient experiences one event as if it were not his, but inserted into his self from the outside.
In the case of somatic passivity, there is a belief that there are external influences acting on the body. In this case, there was probably a kinesthetic hallucination coupled with an experience of passivity.
Similar to other published cases, this patient complained of being controlled and impaired by some form of contemporary technology. Delusions of control are often associated with delusional explanations about how thought or body can be controlled, in this case, through a microchip.

Disclosure of Interest: None Declared

EPV0820

Case report: Diagnostic challenges in early onset Alzheimer's disease

E. Chabukovska[1]*, S. Todevska[1], O. Pashanko[2], M. Petrushevska[3], G. Novotni[4], A. Novotni[5] and V. Sukloska[6]

[1]Adult psychiatry, Psychiatric hospital Skopje, Skopje; [2]Adult psychiatry, PHI Clinical Hospital "Dr. Trifun Panovski", Bitola; [3]Adult psychiatry, PHI Health Center; [4]Neurology, University Clinic of Neurology; [5]Adult psychiatry, University Clinic of Psychatry, Skopje and [6]Adult psychiatry, PHI Psychiatric Hospital "Demir Hisar", Demir Hisar, North Macedonia
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.2124

Introduction: According to World Alzheimer Report 2021, more that 55 million of people in the world suffer from dementia. And although age is the strongest known risk factor for dementia, dementia does not exclusively affect older people. Early onset dementia is defined as the onset of symptoms before the age of 65 years. Considering that people with early onset dementia are in the most productive period of their life and often exposed to stress, when the symptoms of depression or psychosis can appear linked to other psychiatric diagnose it is hard to think of dementia when it is in early stage.
Objectives: We present a case of a woman at age of 55, mother of one child, widow, with secondary school degree, employed as textile worker.
She was already on psychiatric treatment for five years diagnosed at first as Mixed anxiety and depressive disorder and after that as Major depressive disorder, single episode, severe with psychotic features. Her past treatment include Sertraline up to 100mg per day or Escitalopram up to 10mg per day and Olanzapine up to 10mg per day. But her condition was worsening progressive with cognitive decline and during serial stressful events in the family (the death of her husband and severe corona virus infection of her son).
At present time she was hospitalized with psychotic symptoms, confusion, paranoid ideas and hallucinations, dysfunctional in everyday activities.
Methods: The neuropsychological testing showed global reduction in cognitive-behavior status. The results of extended laboratory tests were in normal range. Brain MRI showed global cortical reduction with more specified atrophy in fronto-temporal lobes bilateral. SPECT analysis showed significant hypoperfusion in both hemispheres in frontal, parietal and temporal lobes. Cerebrospinal fluid examination showed decresed level of beta-amyloid-42 (281,6 pq/ml).
Results: The results confirmed the diagnose of dementia with early onset, but because of advanced stadium and insufficient family history it was not possible to make clinical diagonose of the type. Diagnose in the end of hospitalization was: Early onset dementia, M. Alzheimer frontal variant.
Conclusions: With the presented case we suggest that the clinicians need to be very careful in the cases of psychosis treated independently and explore the possibility that psychosis can be a symptom of Alzheimer desease. Our case suggest that we should consider the possibility of early onset AD in middle-aged patients whose first symptoms are depressive with psychotic features. In this respesct, psychiatris need to consider proper completion of AD diagnostic protocol including biomarkers analysis.

Disclosure of Interest: None Declared

EPV0821

A clinical case of anosognosia in a CADASIL disease.

E. Talaya Navarro*, L. Gallardo Borge, E. Gómez Fernández, R. Fernández Díaz, L. Al Chaal Marcos and E. Rybak Koite

Psiquiatría, Hospital General de Segovia, Segovia, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.2125

Introduction: CADASIL (Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy) is a cerebrovascular disease, tht appears in 1.98/100,000. It´s caused by a mutation of the Notch3 gene and is characterized by accumulation of granular osmiophilic material in the middle layer of the small and median sized cerebral arteries.
Sypmtoms are migraine, recurrent cerebral ischemic episodes, dementia, neuropsychiatric disorders (anosognosia, character disorders, apathy and cognitive impairment). It usually appears between 30-60 years, although there is an important variability. There is no curative treatment, only palliative.
Objectives: Clinical review of anosognosia and its presence in CADASIL disease.
Methods: Clinical case and literatura review.