Methods: Case report and non-systematic review of literature: sources obtained from Pubmed database.
Results: A 69-year-old man, native of Syracuse (Italy), was admitted to the Psychiatry Unit in February 2022 presenting behavioural disturbances and irritability. In July 2021 he presented the same symptoms, being mistakenly diagnosed with Bipolar Disease type I. He has no previous psychiatric history. He started with changes in his personality, short-term memory loss, aggressiveness and disorganized behaviour at the age of 66. At admission he was talkative and hyperfamiliar, presenting delusions of grandiosity, exalted affectivity and insomnia. Neurological examination showed short-term memory problems, signs of frontal disinhibition and abnormal glabellar tap sign. Blood tests, CT brain and MRI were performed to rule out organic underlying causes. Neuro-imaging found bilateral and symmetric calcifications in globus pallidus, thalamus and corpus striatum, in favour of FD. Secondary causes (abnormalities in the PTH, vitamin disorders and infectious diseases such as HIV, brucellosis or neurosyphilis) where discarded, allowing us to conclude it was probably a primary case of FD. Valproate was started as a mood stabilizer and anticonvulsant. Genetic tests were indicated.
Conclusions: FD should be considered as a differential diagnosis in the evaluation of psychiatric symptoms, especially when atypical and/or presented with neurological symptoms. The role of neuroimaging is essential.

Disclosure of Interest: None Declared

EPV0273

Diagnostic Overshadowing of Post-ictal Psychosis in the ED– A Case Series

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Introduction: Diagnostic overshadowing is established as a mechanism by which physical symptoms are misattributed to mental disorder, hence under-diagnosing and under-treating medical pathology. We report a case series of adult males with established neurological disorders who presented to the ED with visual hallucinations in the postictal period. The phenomena of postictal psychosis is long established in neuropsychiatric literature, with reported rates of postictal psychosis in epilepsy of 2%. Patients vsual hallucinations resolve with anticonvulsant stabilisation and rarely require antipsychotic augmentation.
Objectives: To illustrate diagnostic overshadowing in a case series of postictal psychosis
Methods: Retrospective case series
Results: Case 1:
A 36year old man self-presented to the ED 24hrs post tonic-clonic seizure of 15minutes duration. Medical history was significant for hydrocephalus as an infant with 29 surgical revisions of in-situ ventriculoperitoneal shunt since initial placement. Secondary epilepsy was reported to be poorly controlled with an estimated 50 ED attendances in the past year for management of seizure activity. On assessment new symptomatology of non-threatening visual hallucinations with associated low mood was elicited. A diagnosis of postictal psychosis was advised following psychiatric assessment and medical admission with anticonvulsant titration recommended. Despite this characteristic presentation there were repeated requests to admit this patient to the psychiatric unit and a perceived lack of understanding of his acute medical needs.
Case 2:
A 45year old man self-presented to the ED <24hours post discharge following medical admission for management of seizure. Medical history was significant for a right parieto-temporal infarct one year prior, with acceptable return to functioning following rehabilitation. The man had recently been diagnosed with secondary epilepsy and titration of sodium valproate commenced. The patient presented as distressed in the context of new onset visual hallucinations and palinopsia. Medical admission with urgent neurology input and anticonvulsant titration was advised following psychiatric assessment. ED physician repeatedly stated this patients presentation was stress related and requested psychiatric admission. Following medical admission the patient was managed by neurology. Sodium valproate was augmented with clobazam and the patients psychopathology resolved in full.
Conclusions: Diagnostic overshadowing is prevalent in the ED. Despite established medical diagnoses there may be a reluctance for medical teams to acknowledge or treat organic psychopathology. Psychiatrists must keep abreast of medical comorbidities and physical treatment guidelines of neuropsychiatric disorders in order to advocate appropriately for due medical input. Postictal psychosis is effectively managed by neurological input for effective seizure control with collaborative neuropsychiatry input.

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EPV0274

Self-harming behaviour in liaison psychiatry : Case series and literature review

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Introduction: Self-harm (SH) is common, in particular among young people. It can be seen in a wide range of psychiatric disorders, ranging from anti-social personality disorders to schizophrenia and mood disorders. In the extreme, self-harm can be functionally life-threatening. Such is the case of phlebotomy, emasculations and self-amputation. The severity of certain damage and the urgency of an initial somatic treatment contribute to make self-harm one of the most frequent reasons for intervention in liaison psychiatry.
Objectives: Through our case series and a literature review, we tried to describe the socio-demographic and psychopathological characteristics of the self-harmers and to identify the specificities of their management in liaison psychiatry.
Methods: It is a descriptive cross-sectional study, in the psychiatric department of a general hospital in Rabat, concerning patients evaluated for SH with or without other psychiatric manifestations. The data collected are analysed using the statistical software 'JAMOVI'. Patients seen in psychiatric consultations, in medical-surgical emergencies or in liaison psychiatry for SH were included. Patients already hospitalized in psychiatry were excluded.

Results: 35 patients were recruted of who 65.7% were male. 68.6% were single. 51.4% had a low socio-economic level and 42.9% had an average level. 48.6% had a psychiatric history of which 22.9% had attempted suicide. Abuse was present in 34.3%, family separation in 22.9%, death of a parent in 20% while no patient reported sexual abuse. The most common method used was a razor blade in 57.1% of cases. The most mutilated site was the forearms in 65.7%, following a frustration in 60% and a conflict situation in 25.7%. 48.6% were hospitalised (34.5% in psychiatry, 5.6% in intensive care and 5.6% in otorhinolaryngology).
Conclusions: Self-harm is a frequent pathological behaviour whose incidence is increasing. Understanding the psychological and biological basis of self-harm will help to improve the management of these patients and prevent the recurrence of this dangerous behavior and its complication by suicide.

Disclosure of Interest: None Declared

EPV0275

About a case: affective psychosis and hyperthyroidism

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Introduction: Hyperthyroidism due to Graves-Basedow disease is a common cause of neuropsychiatric manifestations, such as anxiety, psychomotor restlessness, mood disturbances, insomnia and psychosis. Hashimoto's encephalopathy rarely occurs in so-called autoimmune thyroiditis, which can present with hyperthyroidism and neuropsychiatric symptoms similar to Graves' disease. We add that the mystical-religious beliefs, present in all human cultures, and decisive in the case at hand, make us propose an evolutionary origin of them.
Objectives: Clinical case description
Methods: A clinical case based on medical reports is described
Results: We present the case of a 72-year-old woman, a member of the Seventh-day Adventist Church, well adapted to the Community. Known history of elevated antithyroid antibodies since 2019, brought to the emergency room involuntarily due to a mystical-religious delusional condition associated with behavioral disturbance. On examination, cachectic appearance, distal tremor, emotional exaltation and megalomanic speech were highlighted. Laboratory tests revealed primary hyperthyroidism with elevated antibodies. During admission, the differential diagnosis between Graves-Basedow disease and Hashimoto's encephalopathy was considered. Thyroid scintigraphy oriented the diagnosis to Graves-Basedow disease, not requiring lumbar puncture or corticosteroid treatment. Treatment was based on high-dose antithyroid and antipsychotic drugs, with clinical and analytical remission at 3 weeks. The patient was referred to a Social Health Center for functional recovery. The family refers to a similar episode in 2014, of less intensity and self-limited, which is proposed to be a hashitoxicosis.
Conclusions: Differential diagnosis between Graves-Basedow and Hashimoto disease is essential as they differ in treatment and prognosis. The continuity that the delusion presents with the previous beliefs of the patient, differing mainly in the affective-behavioral implication, makes us consider a predisposition to psychosis in our patient. Religiosity can be adaptive in certain environments, since mystical beliefs have existed throughout the history of the human species and seem to be part of our nature.

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EPV0276

MALIGNANT CATATONIA IN MEDICAL WARDS: A BROAD DIFFERENTIAL DIAGNOSIS

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Introduction: Catatonia is an uncommon and heterogeneous psychomotor syndrome. It can be not only the manifestation of a psychiatric disorder but also a wide range of medical conditions. The malignant catatonia is a subtype of catatonia which includes dysautonomic signs such as hyperthermia or hemodynamic instability, and because most of the affected patients are taking antipsychotics or antidepressants previously, it can be confounded with medical conditions such as neuroleptic or serotonin syndrome.
Objectives: To present a case of malignant catatonia admitted in a medical ward
Methods: The present study is a case report of a patient admitted with initial diagnosis of serotonin syndrome in a medical ward of our hospital and referred to the consultation and liaison psychiatry (CLP) unit. We also searched previously case reports, series and systematic reviews about catatonia secondary to medical conditions and hyperthermia catatonia.
Results: Ms. TN is a 71-year-old woman, with prior history of major depressive disorder. One month ago she was admitted in a psychiatric ward of another hospital for a depressive episode with psychotics features, and was treated with escitalopram 10mg/day, vortioxetine 10mg/day, mirtazapine 15mg/day, trazodone 50mg/day, quetiapine 700mg/day and haloperidol 5mg/day. She had a worsening of depressive symptoms with suicidal thoughts, negativism and psychomotor retardation, and subsequently hyperthermia, rigidity, mydriasis, tachicardia and increased bowel sound. She was tranfered to our medical ward, and diagnosed of serotonin syndrome. She was stopped all the psychiatric drugs and was treated with dantrolene and support measures. After 10 days without antidepressants or antipsychotics she maintened the same symptomatology and was referred to our CLP unit. The psychopathological evaluation showed stupor, mutism, waxy flexibility and negativism, and she responded to a challenge test with intravenous clonazepam 0,5mg. She was diagnosed of malignant catatonia and was started oral clonazepam 2mg/day. Although there was a partial response, she did not tolerate higher doses because of sedation and finally was treated with electroconvulsive therapy (ECT). She dad a remission of catatonic symptoms after only two sessions of ECT.
Conclusions: Malignant catatonia can be confounded with other medical conditions such as serotonin or neuroleptic syndromes. All of them can have catatonic signs, and it is important to recognize them (a challenge test with a benzodiacepine can be helpful). The key to distingish malignant catatonia from them is that some of the