Image:

Variables	Mean or %		Statistic	p-value
	Relapse	No Relapse		
Cases (n)	9 (8.7)	94 (91.3)		
Women (%)	66.7	38.3		.154[a]
Age	37.22±9.88	36.70±11.74	U=402.5	.811
Onset age	25.89±7.28	22.84±6.97	U=299.5	.159
Diagnosis			χ^2 = 1.55	.213
SS	8 (88.9)	65 (69.1)		
BD	1 (11.1)	29 (30.9)		
Comorbidity	6 (66.7)	33 (35.1)		.079[a]
Substance abuse	2 (22.2)	25 (26.6)		1.0[a]
Family history (%)			χ^2= 1.07	.585
Any psychiatric diagnoses	1 (11.1)	16 (17.0)		
Schizophrenia	3 (33.3)	18 (19.1)		
Untreated illness: DUI (mos)	45.77±90.7	17.25±48.16	U= 359.5	.419
Treatments before LAI (%)				
Any antidepressant	2 (22.2)	17 (18.1)		.670[a]
Mood-stabilizer	4 (44.4)	54 (57.4)		.499[a]
First gen. antipsychotic	3 (33.3)	26 (28.0)		.711[a]
Second gen. antipsychotic	9 (100)	67 (72.0)		.107[a]
Hospitalized ≤12 mos before LAI	5 (62.5)	20 (21.7)		.022*
Hospitalized at start of LAI (%)	3 (33.3)	24 (25.8)		.696[a]
Suicide risk ≤12 mos before LAI (%)				
Ideation	3 (37.5)	5 (5.4)		.015*
Attempt	2 (25.0)	3 (3.2)		.049*
Suicide risk at start of LAI (%)				
Ideation	1 (11.1)	4 (4.3)		.373[a]
Attempt	0 (0.0)	2 (2.1)		1.0[a]
Side effects of LAI during 12 mos treatment			χ^2 =38.45	<.001***
Parkinsonism	2 (25.0)	1 (1.1)		
Tremor	2 (25.0)	0 (0.0)		
Hyperprolactinemia	0 (0.0)	3 (3.3)		
Metabolic disorders	0 (0.0)	2 (2.2)		
Post Injection Syndrome	0 (0.0)	1 (1.1)		

Conclusions: In conclusion, our observations confirm the importance of LAI therapy in real word. However, our results indicate that these drugs might not prevent subsequent exacerbations for a proportion of individuals whose illness is stabilised on continuous antipsychotic treatment. Extra pyramidal symptoms in particular might have pathophysiological implications for relapse.

Disclosure of Interest: None Declared

Sleep Disorders and Stress

EPP0730

Evaluation of daytime sleepiness and insomnia symptoms in OSA patients with a characterization of symptom-defined phenotypes and their involvement in depression comorbidity

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Introduction: Recent studies have emphasized the importance of clinical manifestations, such as insomnia and sleepiness, in defining phenotypes of obstructive sleep apnea (OSA), shifting from a focus on OSA severity and sleep structure.
Objectives: The study aimed to characterize insomnia and sleepiness associated with OSA phenotypes and assess their involvement in depression symptoms (DS) in OSA.
Methods: A total of 181 participants undergoing polysomnography (PSG) were asked to fill out questionnaires, including Epworth Sleepiness Scale (ESS), Insomnia Severity Index (ISI), Pittsburgh Sleep Quality Index (PSQI), and Back Depression Index (BDI). They were categorized into phenotypes: insomnia-sleepiness (I+S; ESS≥11; ISI≥15; n=20), sleepiness (S; ESS≥11; ISI<15; n=22), insomnia (I; ESS<11; ISI≥15) and asymptomatic (A; ESS<11; ISI<15; n=55).
Results: A linear regression model for BDI score (R^2=0.357, p<0.001) included ISI score and subjective to objective sleep latency ratio. ISI score was a predictive factor for mild and moderate DS (OR=1.226, p<0.001 and OR=1.392, p=0.002, respectively). I and I +S phenotypes are characterized by higher BDI scores (p<0.001 and p=0.015), longer subjective sleep latency (p=0.008 and p=0.041), and shorter subjective total sleep time (TST; p=0.049 and p=0.006), compared to A. Furthermore, the I and I+S groups had shorter subjective TST than S (p=0.028 and p=0.047). I and I+S had higher BDI scores than A (p<0.001 and p=0.015, respectively) and S (p<0.001 and p=0.017, respectively). I phenotype was associated with the risk of mild and moderate DS (OR=5.614, p<0.001 and OR=9.550, p=0.008 respectively). Moreover, the I+S phenotype presented an even greater risk for mild DS (OR=10.286, p<0.001).
Conclusions: The study suggests that using clinical features for OSA phenotyping holds promise for finding OSA individuals with increased risk for the occurrence of DS.

Disclosure of Interest: None Declared

Training in Psychiatry

EPP0732

Psychiatric brain gain in Switzerland. Competency-based onboarding.

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Introduction: In the last 30 years, Switzerland has been established as a destination country for psychiatric trainees. The needed competences for the work as a trainee deviate regarding colleagues from foreign countries though, hindering a viable solid development professional without specific on-boarding program. A similar approach to the figure of tutor anchored in the Spanish postgraduate medical training is still missing in the Swiss medical System. Hereby we performed a survey in the new colleagues who are part from the medical team in an observer status before beginning with the responsibilities as a trainee.
Objectives: Recognizing competences and needs of the onboarding in current trainees that are still allocating because of the work