emotional and behavioral resonance of delirium. The treatment consists of indicating abstinence from alcohol and administration of neuroleptics.

Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.576

EV0247

A Clinical review about differential diagnosis and comorbidities on premenstrual dysphoric disorder

L. SÃ¡nchez Blanco[1,â'^], M. Juncal RuÃ-z[1], G. Pardo de Santayana Jenaro[1], R. Landera RodrÃ-guez[1], M. GÃ³mez Revuelta[2], O. Porta Olivares[1], N.I. NÃºÃ±ez Morales[2]

[1] *Hospital universitario MarquÃ(c)s de Valdecilla, psychiatry, Santander, Spain*

[2] *Hospital universitario de Ã'lava-sede Santiago, psychiatry, Vitoria-Gasteiz, Spain*

[â'^] *Corresponding author.*

Introduction Symptoms of premenstrual dysphoric disorder (PMDD) recur during the premenstrual phase of the cycle and disappear to the beginning or after last menstruation. The main symptoms are emotional liability, dysphoria and anxiety.

Objectives To review PMDD for helping in the differential diagnosis between this disease and classical anxiety disorders.

Methods It was made a clinical review about differential diagnosis and comorbilities on PMDD in specialized literature and Pub-Med.

Results PMDD causes significant distress and impairment in social or occupational functioning the first week following menstruation. In relation with differential diagnosis on PMDD, on the one hand, several organic diseases could produce the same symptoms than PMDD: for example gynecological pathology as dysmenorrhea or menopausal transition, endocrinological diseases as hypothyroidism and hyperthyroidism and some hormonal treatment including hormonal contraceptives. In addition, a variety of medical disorders are concomitant pathologies that could be associated with PMDD (eg, migraine; epilepsy, asthma, allergies, systemic exertion intolerance disease, chronic fatigue syndrome; irritable bowel syndrome). These pathologies are exacerbated just before or during menstruation. On the other hand, several psychiatric disorders as bipolar disorder, major depression, dystimia, and anxiety disorders could get worse on the premenstrual phase.

Conclusions In relation with the diagnosis of PMDD, it seems necessary to consider various differential diagnosis such as psychiatric, gynecological and endocrine disorders because of all of them share like symptoms. For this purpose it is very important to make both a good clinical history and a comprehensive physical examination to offer the most accurate diagnosis and treatment.

Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.577

EV0248

Adult ADHD diagnosis and binge eating disorder

J. Sevilla Vicente[1,*], I. Basurte Villamor[2], A. Sedano Capdevila[1], M. Migoya Borja[1], R. Navarro Jímenez[1], L. Serrano Marugan[1]

[1] *Fundación Jiménez Díaz, psychiatry, Madrid, Spain*

[2] *hospital universitario Gregorio Marañón, psychiatry, Madrid, Spain*

[*] *Corresponding author.*

The association between attention deficit hyperactivity disorder (ADHD) and eating disorders has not been yet clarified. The presence of ADHD was significantly correlated with more severe binge eating, bulimic behaviors, and depressive symptomatology. The aim of this work is to study the relationship between ADHD subtypes in adults and the risk of food addiction (binge eating disorder). The sample was collected on a specific program for adults with ADHD diagnosis in Madrid (Spain). In total, the sample was 110 patients, and we collected information about socio-demographic factors. All patients met DSM-5 criteria for ADHD in different subtypes. We used the conner's Adult ADHD rating scales and the Barrat impulsiveness scale. Also we used the Shorter Promise Questionnaire. This is a 16 scale self-report instrument to measure an individual's level of addictive tendency.

The 36.4% were at high risk of developing a food addiction. For binge eating disorder (BE), no statistically significant differences were found by gender within patients with ADHD.

Binge eating was significantly related to the impulsivity and emotional liability subscale of the CAARS ($P < 0.05$). The risk of develop BE in ADHD was 4.7 (CI 95% 1.8–12.07). Binge eating was significantly related to the total score on the Barrat scale ($P < 0.05$) Risk of 3,5 (CI 95% 1.5–7.9) and within the subtypes of impulsivity, motor impulsiveness was the one that was significantly related to BE ($P < 0.001$)

There is a clear relationship between impulsiveness symptoms and BE in patients with ADHD. It's important to note that there are no gender differences within ADHA patients to develop a BE disorder.

Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.578

EV0249

From psychiatric to critical care: Patient profile and predictive transfer elements

R. Trabelsi[1,*], N. Bram[2], I. Benromdhan[2], W. Homri[2], N. Staali[2], R. Labbene[2]

[1] *Razi hospital, departement psychiatry F, Mannouba, Tunisia*

[2] *Razi hospital, psychiatric department C, La Mannouba, Tunisia*

[*] *Corresponding author.*

Introduction Patients with mental illness have an increased risk of morbidity and mortality from somatic complications, with a reduction in life expectancy of 15 to 30 years. During hospitalization in a psychiatric setting multiple risk factors can combine and contribute to a severe deterioration in the general condition of patients who may require reanimation.

Aim Describe the profile of patients admitted to Razi who required transfer to an intensive care setting during hospitalization to more precisely determine the predictors of severe somatic decompensation.

Methodology A descriptive retrospective study of patients transferred from the Razi hospital to the emergency medical assistance center (CAMU) during the period between 1 January 2014 and 31 December 2015.

Results The average age of patients was 39.5 years; 64.2% of the patients were men, 60% had a low socio-economic level, 34.7% had a comorbid disease. Forty-one percent (41%) of the patients transferred had been diagnosed with schizophrenia, and 27% had bipolar disorder. Antipsychotics were the most prescribed psychotropic drugs. High doses were used with therapeutic combinations in 85% of the cases. A toxic cause was identified in 58% of cases, including neuroleptic malignant syndrome in 18%. Dehydration and ionic disorders are among the most frequent causes in 27% of cases. Conclusion; Identifying risk factors for deaths in psychiatric hospitals highlights needed changes in psychiatric management strategies taking into account the patient's characteristics as well as the drugs' safety profile.

Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.579

https://doi.org/10.1016/j.eurpsy.2017.01.579 Published online by Cambridge University Press