

family, and auditory hallucinations. His symptoms were worse at night after taking the donepezil, and he regularly requested to have a firearm for self-defense in the late hours of the night. His symptoms progressed for several weeks before his family brought him into the geriatric psychiatry clinic to address his psychosis. The family recognized that these new symptoms started shortly after the patient began taking donepezil and had already started decreasing the dose to half of what was originally prescribed.

**Results:** This patient experienced symptom remission from psychosis immediately upon discontinuation of donepezil. The patient and his family reported significant improvement with no continuation of hallucinations or paranoia. There was also reported improvement in mood and irritability, and the patient appeared significantly better upon follow-up with geriatric psychiatry. Due to this immediate improvement, the suspected causative factor in the precipitation of psychosis in this patient is the anticholinesterase activity of the donepezil. Although the prescribing information of donepezil details inadequate data proving an association between donepezil and psychotic symptoms, two other published case reports (Yorston GA *et al.* J Psychopharmacol 2000;14:303-4, Pozzi FE *et al.* Case Rep Neurol 2022; 14:359-365), along with this one, provide evidence of a causal relationship between the two. The patient was switched to memantine therapy and has remained free of psychotic symptoms thus far.

**Conclusions:** This case demonstrates the caution required among clinicians when prescribing donepezil for the treatment of Alzheimer’s disease. There needs to be a more focused risk evaluation of potential psychiatric adverse effects in patients treated with donepezil.

**Disclosure of Interest:** None Declared

**EPP0473**

**A study on demographic and psychiatric suicide risk factors and their correlation in the community dwelling elderly**

K. Lee

Psychiatry, Dongguk University Hospital, Gyeongju, Korea, Republic Of

doi: 10.1192/j.eurpsy.2023.779

**Introduction:** According to data from the National Statistical Office of the Republic of Korea, the number of suicides increased with increasing age, and the elderly over the age of 65 had a higher suicide success rate using lethal means.

Among mental disorders, depression is known to be the most associated with suicide, and suicidal thoughts help predict the risk of suicide. Dementia, depression, and sleep disorders, which are typical mental health problems of the elderly, require treatment, but only 10% of the elderly receive appropriate treatment at the right time.

**Objectives:** The purpose of this study was to identify suicide risk factors among the community dwelling elderly and to reveal their correlations. In addition, the differences of suicide risk factors were analyzed in the cognitively impaired group and the cognitively normal group.

**Methods:** We investigated 20,127 elderly over aged 65, from January 2019 to December 2019. The participants were asked to complete questionnaires. Cognitive function, depression, anxiety,

sleep disturbance, suicidal idea data was obtained by mini-mental status examination for dementia screening (MMSE-DS), short geriatric depression scale (SGDS), geriatric anxiety inventory (GAI), Athens insomnia scale (AIS), and scales for suicidal ideation (SSI). We used the Chi-squared test and logistic regression analysis for these data to examine the suicidal risk factors and to analyze the relationships. And differences in suicide risk factors according to cognitive function were also analyzed.

**Results:** Age, cognitive function, depression, anxiety, and sleep disturbance were identified as risk factors for suicide among the community dwelling elderly. Depression was the factor that increase the risk of suicide the most, followed by anxiety, impaired cognitive function, sleep disturbance, the late elderly (85 years or older), and the middle aged elderly (75-84 years old). In addition, depression increased the risk of suicide by 1.86 times in the cognitively impaired group.

**Image:**

Table 1. Sociodemographic and psychiatric symptom characteristics of subjects

Characteristics	Categories	N(%)	Total N
Gender	Male	4,372(21.7%)	20,127
	Female	15,755(78.3%)	
Age	65-74	6,474(32.2%)	20,127
	75-84	10,791(53.6%)	
	≥85	2,862(14.2%)	
Residence status	Live alone	9,132(45.4%)	20,127
	Living with other people	10,995(54.6%)	
Education status	0-1yr	6,437(32.0%)	20,127
	2-6yrs	9,865(49.0%)	
	7-12yrs	3,329(16.5%)	
	>12yrs	496(2.5%)	
Disease	None	5,364(26.7%)	20,127
	Have	14,763(73.3%)	
MMSE-DS	Normal	2,694(91.5%)	2943
	Cognitive function Impaired	249(8.5%)	
S-GDS	Normal	18,017(89.5%)	20,127
	Depressed	2,110(10.5%)	
GAI	Normal	16,711(83.0%)	20,127
	Anxiety	3,416(17.0%)	
AIS	Normal	4,573(61.8%)	7401
	Sleep disturbance	2,828(38.2%)	
SSI	None	19,333(96.1%)	20,127
	Suicidal ideation	794(3.9%)	

**Image 2:**

Table4. Correlation of variables with suicidal ideation

	SSI	Age	Gender	Educational status	Disease	Residence status	MMSE-DS	S-GDS	GAI	AIS
SSI	1	-0.007	0.021**	0.000	0.047**	-0.023**	-0.073**	0.458**	0.433**	0.266**
Age		1	-0.021**	-0.335**	0.093**	-0.206**	-0.346**	0.065**	-0.027**	0.015
Gender			1	-0.044**	0.021**	-0.016	0.013	0.035**	0.036**	0.032**
Educational status				1	-0.154**	0.258**	0.467**	-0.114**	-0.032**	-0.053**
Disease					1	-0.099**	-0.067**	0.141**	0.097**	0.077**
Residence status						1	0.159**	-0.098**	-0.029**	-0.038**
MMSE-DS							1	-0.143**	-0.052**	-0.055**
S-GDS								1	0.678**	0.399**
GAI									1	0.431**
AIS										1

\*p<0.05, \*\*p<0.01

**Image 3:**

Table 5. Logistic regression analysis of factors affecting suicide risk

Factor	B	S.E	Exp(B)	p	95% CI
Age(75-84)	-0.436	0.216	0.647	0.043	0.424-0.987
Age(≥85)	-0.702	0.327	0.496	0.032	0.261-0.941
Cognitive function impaired	0.922	0.275	2.514	0.001	1.468-4.307
Depressed	1.519	0.219	4.566	0.000	2.971-7.019
Anxiety	1.416	0.233	4.119	0.000	2.610-6.499
Sleep disturbance	0.803	0.223	2.232	0.000	1.442-3.456
Chi-square (df) of model, p	251.35 (6), 0.000				

B: Regression coefficient, S.E.: Standard error, Exp(B): Odds ratio, CI: Confidential Interval

**Conclusions:** Among community dwelling elderly, depression was the most contributing suicide risk factor. Prevention and treatment of depressive symptoms should be more active in the cognitively impaired group.

**Disclosure of Interest:** None Declared

**EPP0474****Capgras Syndrome as a Manifestation of a Neurodegenerative Disease – What do we know?**

M. Matias\*, L. Lopes, I. Grenha, M. Marques and M. Alves

Unidade Local de Saude Alto Minho, Viana do Castelo

\*Corresponding author.

doi: 10.1192/j.eurpsy.2023.780

**Introduction:** The Capgras syndrome (CS), firstly described in 1899, is a delusional conviction that a person emotionally close has been replaced by an imposter or duplicate. It has been associated to primary psychiatric disturbances as well as neuropsychiatric syndromes. Its etiology and management have been debated throughout the years. We describe a case of a 75 years old male who was admitted to our psychiatric ward due to aggressiveness towards his spouse, believing she was an imposter.

**Objectives:** In light of this case, we aim to discuss its etiology and review the association between the Capgras syndrome and neurodegenerative diseases.

**Methods:** Classically, CS was associated to psychotic illnesses such as schizophrenia, schizoaffective disorder and substance abuse. However, recent studies shed light on other possible etiologies, such as neurodegenerative and nonneurodegenerative diseases. In older ages, it has been associated to Alzheimer's and, most commonly, Lewy body dementia subtype. Research also shows that other misidentification syndromes are frequently present in association with CS. Patients are more likely to be aggressive towards caregivers under these circumstances. Studies suggest there is a higher prevalence of right hemisphere lesions in CS, namely frontal and temporal lobes, that impair facial processing. Various brain circuits are being proposed as possible etiopathogenesis.

In this case, parkinsonian signs were observed in our patient, such as resting tremor, imbalance gait and rigidity. Those had not been described before his hospitalization. His family stated memory loss and difficulty in executive functions were present for at least a year. This patient had no previous psychiatric history. Brain CT scan showed cortical atrophy.

**Results:** A neurodegenerative cause was assumed, and the patient was started on a cholinesterase inhibitor and on a second-generation antipsychotic. Improvement was observed.

**Conclusions:** This case is an example of the heterogenous etiology of the CS. It is important to consider different diagnosis, especially in older ages. More studies are needed to improve the knowledge on CS etiopathogenesis as well as the brains circuits involved. Psychopharmacology tackling these syndromes is also a growing.

**Disclosure of Interest:** None Declared

**EPP0475****Negative symptoms and associated factors in older people with schizophrenia**

M. Karoui<sup>1\*</sup>, I. Kammoun<sup>2</sup>, R. Kammoun<sup>1</sup>, H. Nefzi<sup>1</sup> and F. Ellouze<sup>2</sup>

<sup>1</sup>Tunis, Faculté de médecine de Tunis, Tunisia and <sup>2</sup>Faculté de médecine de Tunis, Tunisia

\*Corresponding author.

doi: 10.1192/j.eurpsy.2023.781

**Introduction:** The evolution of schizophrenia with age remains poorly studied. The prevalence of negative symptoms in elderly people with schizophrenia is even less described in the literature.

**Objectives:** to evaluate the prevalence of remission of negative symptoms in the elderly and to study the sociodemographic and clinical variables associated with this remission.

**Methods:** The sample consisted of 83 subjects aged 55 years and over, followed at the psychiatry department "G" of the Razi hospital in Tunis and suffering from schizophrenia according to the DSM5 criteria. Global remission was defined as a score below 4 on the seven negative symptom items of the PANSS. A questionnaire was administered to each patient to collect epidemiological and anamnestic data.

**Results:** 59% of the sample showed remission of global negative symptoms. 84% and 60% were in remission on the emotional and cognitive subscales, respectively. The existence of remission was correlated with lower PANSS global score, more preserved cognitive functioning, later age of onset, more family and social support, and the absence of a concomitant somatic illness.

**Conclusions:** This study showed that measures to optimize treatment of positive symptoms and cognitive functioning may have an impact on negative symptoms. Similarly, quality of social network in later life impacts the level of negative symptoms.

**Disclosure of Interest:** None Declared

**EPP0476****Pseudodementia or depression? An unresolved issue. Cognitive alterations in a population of geriatric patients**

M. Violi\*, B. Buccianelli, M. Simoncini, L. Massoni, F. Pardini, L. Massa, S. Palermo, A. Arone, M. G. Carbone, D. Marazziti and L. Dell'Osso

DEPARTEMENT OF CLINICAL AND EXPERIMENTAL MEDICINE, UNIVERSITY OF PISA, PISA, Italy

\*Corresponding author.

doi: 10.1192/j.eurpsy.2023.782