

Introduction: Intentionally harming oneself with deliberate destruction of body parts without a suicidal purpose is defined as self-mutilative behavior. Genital Self-Mutilation is an extreme form of such action and usually seen as a result of an underlying psychiatric condition. Although schizophrenia spectrum disorders are the leading cause, substance use, personality disorders, and gender dysphoria may also result in GSM. Klingsor Syndrome, a rare clinical entity, was first described as GSM with religious delusions. Later, Schweitzer proposed expanding the term to include all psychotic disorders. (Veeder et al., *Gen Hosp Psychiatry* 2017;44:43-50)

Objectives: The aim of this piece is to report our case of a patient with psychosis performing genital self-mutilation in order to promote proper diagnosis and management of patients with similar conditions.

Methods: A 24-year-old male was brought to the psychiatric emergency unit after self-harming behavior causing numerous wounds throughout his face, trunk, and genital area. Penile and scrotal lacerations were prominent. The patient stated that he had inflicted these wounds upon command hallucinations. Examination also revealed disorganized speech, dysphoric mood, paranoid delusions. The wounds were healed and the patient was prescribed antibiotic medication. He was then admitted to the psychiatric ward. The patient's first psychiatric visit was dating back to four years prior to his inpatient admission. However, symptoms of paranoid delusions and auditory hallucinations had been more severe for about a year. Throughout his outpatient appointments during this time, olanzapine and aripiprazole were tried and a partial response was elicited but the patient generally was non-compliant with the treatment. Cannabis use history was also significant. On admission, the patient was put on amisulpride 800 mg daily, gradually increased to 1200 mg. Valproic acid 1000 mg/day was also added to the treatment in order to control impulsive behaviors. Care of the genital wounds was provided as per the recommendations of the urology department. Near total improvement of the psychiatric symptoms were achieved during the hospitalization. The final diagnosis of Klingsor Syndrome was concluded as the patient was discharged.

Results: The patient's remission sustained during outpatient follow-ups. About a year after discharge, asymptomatic prolactinemia was detected and managed by reducing amisulpride dose and addition of aripiprazole 5 mg/day.

Conclusions: GSM is a dramatic form of self-harm. The severity of psychotic illness of patients often facilitates the conduction of such behaviors. Appropriate antipsychotic treatment and effective care may prevent patients from inflicting severe damage to themselves. Also, In cases of GSM in patients with underlying psychiatric conditions, an interdisciplinary approach is required.

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Intelligence Quotient changes over 10 years: diversity of cognitive profiles in first episode of psychosis and healthy controls

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Introduction: The evidence on the course of the intelligence quotient (IQ) at the long term in individuals with schizophrenia spectrums disorders is inconclusive.

Objectives: We aimed to analyse whether IQ improves, declines, or remains stable over 10 years in a sample of patients with First Episode Psychosis (FEP) and healthy controls (HCs).

Methods: The FEP patients participated in a Program of First Episode Psychosis in Spain called PAFIP. At baseline, FEP patients provided demographic and clinical data, and completed a neuropsychological assessment that included an estimation of premorbid IQ through the WAIS vocabulary subtest. At 10-year follow-up, the participants were invited to complete the same evaluation and 10-year IQ was estimated. The group of HCs underwent the same neuropsychological battery at both moments. Cluster analysis was performed separately in the FEP patients and the HCs to determine their profiles of intellectual change.

Results: FEP patients (n=137) were grouped into five clusters (see Figure 1): "Improved low IQ" (9.49% of patients), "Improved average IQ" (14.6%), "Preserved low IQ" (17.52%), "Preserved average IQ" (43.06%), and "Preserved high IQ" (15.33%). Ninety HCs were grouped into three clusters: "Preserved low IQ" (32.22% of the HC), "Preserved average IQ" (44.44%), and "Preserved high IQ" (23.33%). Demographic data of FEP patients are presented in Table 1.

Table 1. Sociodemographic data of FEP patients

	Improved low IQ (C1) N= 13 Mean (SD)	Improved average IQ (C2) N= 20 Mean (SD)	Preserved low IQ (C3) N= 24 Mean (SD)	Preserved average IQ (C4) N= 59 Mean (SD)	Preserved high IQ (C5) N= 21 Mean (SD)	F	P
Premorbid IQ	71.15 (6.50)	84.50 (5.10)	88.96 (5.31)	100.76 (4.90)	117.14 (7.34)	180.87	<0.001
10-year IQ	85.38 (5.94)	103.25 (4.06)	90.00 (5.32)	105.76 (6.49)	114.52 (6.87)	77.47	<0.001
Age	26.44 (6.07)	24.85 (4.08)	25.99 (8.49)	30.86 (9.54)	33.20 (8.81)	4.350	0.002
Age of onset	25.54 (5.81)	24.11 (4.19)	25.46 (8.41)	29.68 (9.26)	32.14 (8.48)	3.993	0.004
Sex (male %)	53.85	80.00	62.50	49.15	42.86	X= 7.672	0.104
Years of education	8.31 (2.14)	9.00 (2.10)	9.00 (2.13)	11.63 (3.39)	14.38 (3.15)	15.818	<0.001
DUP (months)	10.77 (16.50)	8.94 (9.79)	6.42 (9.47)	14.08 (28.46)	12.77 (20.02)	0.628	0.643
Schizophrenia diagnosis (yes%)	53.84	70.00	70.83	59.32	57.14	2.096	0.718

Conclusions: The FEP patients showed intellectual improvement or stability, but no decline post-onset of psychosis. However, their profiles of intellectual change are more heterogeneous than that of HCs over 10 years. Particularly, there is a subgroup of FEP patients with a significant potential for long-term cognitive enhancement.

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