happiness, ecstasy, and placidity, mystical-religious delusions, and preoccupation with death, which may comprise a different psychotic debut.

Disclosure of Interest: None Declared

EPV0949

100 years of recovery and prognosis in schizophrenia

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Introduction: Recovery in schizophrenia is both widely accepted and commonly misunderstood. Researchers have described favorable outcomes for schizophrenia for the last 100 years. Nevertheless, many patients, relatives and clinicians view schizophrenia as a disease with an inevitable chronic course, as described by Kraepelin in 1889. The definition and measurement of recovery in schizophrenia have proven to be a difficult task. If defined by the remission of clinical symptoms, we have criteria that are operational, but is symptomatic remission sufficient to describe recovery? If looking at social recovery, outcomes related to recovery e.g., social life, employment or social engagement are not easily measured by reliable independent metrics. Thirdly, recovery can be described as a personal journey rather than a clinical endstate.
Objectives: The aim is to present a historical and global overview of 100 years of research in recovery in schizophrenia.
Methods: We conducted a systematic review and meta-analysis. We included prospective studies with at least 20 years of follow-up on patients with a diagnosis of schizophrenia, and the studies must include face-to-face clinical evaluation. We examined outcome in three nested groups: 'recovery', 'good or better' (i.e., good and recovery), and 'moderate or better' (i.e., moderate, good, and recovery). We used random-effects meta-analysis and meta-regression to examine mean estimates and possible moderators.
Results: The overview will start with Bleuler, who described that approximately one third have a good outcome, and end with the most recent meta-analyses on recovery in schizophrenia, presenting both data from our own research and others on the recovery of schizophrenia. Ultimately, we will discuss whether recovery have improved in the last 100 years.
Conclusions: It is a myth that schizophrenia inevitably has a deteriorating course. Recovery is certainly possible. Schizophrenia remains, however, a severe and complex mental disorder, exhibiting a limited change in prognosis despite more than 100 years of research and efforts to improve treatment.

Disclosure of Interest: None Declared

EPV0950

Fate of the first Brief Psychotic Disorder in hospitalised patients

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Introduction: Brief Psychotic Disorder (BPD), defined according to the DSM-5 by the presence of delusions and/or hallucinations and/or disorganised speech persisting for at least one day and less than one month, the disturbance not being due to a bipolar disorder or a schizophrenia spectrum disorder or to the effect of a substance. Classically, the prognosis of a BPD is considered to be divided between restitution ad integrum (30%), progression to bipolar disorder (30%), progression to schizophrenia (30%) or repetition of the same form (10%).
Objectives: The objectives of our study were to evaluate the evolutionary modalities after the first hospitalization for BPD after a follow-up of at least one year and to compare them with the data in the literature.
Methods: Our study was retrospective and descriptive. We reviewed the records of patients hospitalised in our department from 1 January 2014 to 31 December 2018 for a first BPD and assessed the subsequent course over a minimum period of one year.
Results: We included 70 records of patients hospitalized. Twenty-five patients (35.71%) were lost to follow-up after their first hospitalisation. The remaining patients (64.29%) were divided into 3 groups according to the above-mentioned evolutionary modalities (recovery, recurrence of BPD, progression to schizophrenia, progression to bipolarity). Results were in favour of an evolution towards bipolar disorder (35.55%), towards schizophrenia (44.44%), a relapse of the BPD (4.44%), while 13.33% of the BPDs had no future after an aftercare of at least one year. In addition, one case of evolution towards a chronic delusional disorder of the persecution type was observed.
Conclusions: In the present study, our results tend to be in line with the law of one-third described by some authors despite a slight discrepancy partly explained by the limitations of our study. Although, the outcome of BPD remains unpredictable. The minimum five years of evolution are decisive in assessing the subsequent prognosis.

Disclosure of Interest: None Declared

EPV0951

Aggressive behavior in patients hospitalised for a psychotic relapse

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Introduction: Patients in psychotic relapse may exhibit violent behavior towards objects, themselves or others. These behaviors,

although usually unconscious, are a common reason for hospitalization and a source of rejection and stigmatization by family and society.
Objectives: The objective of this study was to evaluate the presence of aggressive behavior in relapsed inpatients with schizophrenia in the F psychiatry department at the Razi Hospital in Tunisia.
Methods: This was a descriptive, cross-sectional study of fifty male patients hospitalized for a psychotic relapse who were naïve or discontinuing treatment for at least two months. Patients were assessed using a semi-structured questionnaire and the Overt Aggression Scale (OAS).
Results: The age of the patients included ranged from 17 to 65 years, with an average of 36.4±11.51 years. More than half of the patients were without occupation (58%, N= 29). For personnal history : Seven patients (14%) had attempted suicide ; Eight patients (16%) showed evidence of self-harm ; Thirteen patients (26%) had a history of arrests of which eleven (22%) were incarcerated.The OAS score ranged from to 0 to 35 with a mean at 9.7+/- 10.3. Twenty-seven patients were aggressive (54%).
Conclusions: Preventive strategies should focus more on predicting the aggressive potential of patients with schizophrenia and its socio-professional implication. Perhaps when using a less holistic approach to the disease and when approaching aggressive behavior as a symptom in its own right, we will be able to find other alternative options.

Disclosure of Interest: None Declared

EPV0952

Testostérone and Positive Dimension in Schizophrenia

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Introduction: Schizophrenia is characterised by a loss of contact with reality due to the presence in its symptomatology of a delusional and/or hallucinatory syndrome, also called positive symptoms and/or a dissociative syndrome, which reflects the negative component of the disease. Few studies suggest a probable link between testosterone and the symptomatic dimension of schizophrenia, but this subject remains poorly documented.
Objectives: The purpose of this study was to describe Testosterone profile in male patients with schizophrenia who are naïve to antipsychotic treatment or have been off it for at least two months and to investigate the relationship between testosterone levels and disease severity.
Methods: This was a descriptive, cross-sectional study of fifty male patients hospitalized for a psychotic relapse who were naïve or discontinuing treatment for at least two months. Patients were assessed using a semi-structured questionnaire and The Positive and Negative Syndrome Scale (PANSS). A blood sample was taken to measure testosterone level.
Results: The age of the patients included ranged from 17 to 65 years, with an average of 36.4±11.51 years. The PANSS score ranged from 50 to 195 with a mean of 116.76 +/- 31.817. Testosterone values ranged from 2.01 to 10.03 ng/ml with a mean of 4.74± 2.01 ng/ml. The majority had normal testosterone levels (94%) ; only 4% had high values and 2% had low values. A positive correlation was found between the positive component of PANSS and elevated testosterone (p=0.011). For the other subscales, no correlation with testosterone levels.
Conclusions: The present study is in favour of a testosterone aggravation of the mostly positive clinical signs of the disease in a significant way. Hormone assays could thus be a specific marker of certain patient profile with a particular evolution.

Disclosure of Interest: None Declared

EPV0953

The role of immune disfunction in schizophrenia pathogenesis

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Introduction: In the last years there has been increasing evidence that inflammation and autoimmunity may play a role in the pathogenesis of schizophrenia.
Although the brain has been considered an immune-privileged site, we understand now that infections and inflammation interfere with the blood-brain barrier, making the brain vulnerable to antibodies, cytokines and infectious agents.
Objectives: To understand the role of immune disfunction in schizophrenia pathogenesis, as well as the potential role of immunotherapy in its treatment.
Methods: We performed a narrative review of the evidence, using the following terms and their combinations “schizophrenia”, “autoimmunity” and “monoclonal antibodies”.
Results: It is widely known that prenatal, perinatal and childhood exposure to infections, nutritional deficits and other environmental insults, acting on a background of genetic vulnerability, may lead to schizophrenia. In such cases, we can observe potent and enduring inflammatory responses, such as cytokines dysregulations.
State markers, including IL-1β, IL-6 and TGF-β have increased levels during exacerbation of symptoms and stabilized levels when antipsychotics are administrated. Trait markers, such as IL-12, IFN-γ and TNF-α have systematically increased levels in acutely and chronically ill patients, even during clinical stability.
Moreover, patients with schizophrenia have been showing abnormalities of the blood-brain barrier, signs of central nervous system inflammation and elevated autoantibody levels and reactivity.
Several autoimmune diseases are associated with schizophrenia, such as celiac disease, Graves’ disease and psoriasis. On the other hand, it is known since the 1950’s that schizophrenia has a negative association with rheumatoid arthritis.
There are case reports of people with psychosis that were treated with immunosuppressive agents (for concurrent autoimmune diseases) that showed improvement in their psychotic symptoms.
NSAIDs, immunomodulators and several monoclonal antibodies have been tested as potential treatments for schizophrenia. The results were conflicting but promising. It is suggested that not every patient with schizophrenia may benefit from these treatments. Ideally, treatment targeting the immune system should be provided