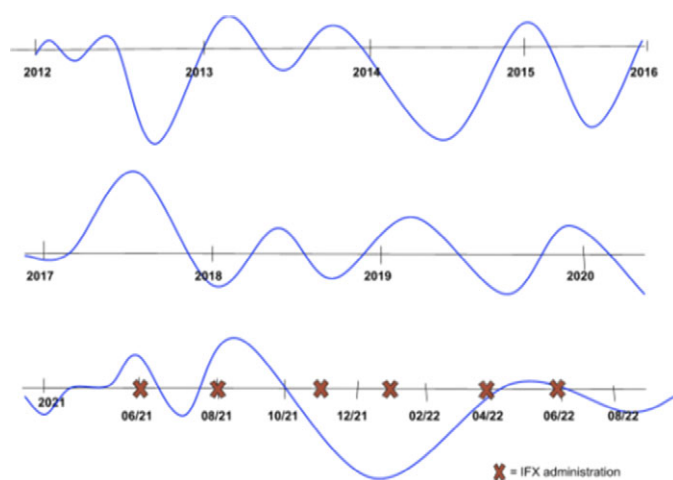


Image:

Conclusions: Although there is very scarce evidence that IFX causes psychiatric symptoms, there are few clinical trials too, showing evidence that TNF-alpha inhibitors may improve depressive symptoms. While we need more information and evidence to support the ideas of TNF alpha inhibitors effects on human neuropsychology, it is of great importance for especially patients with psychiatric history to be closely watched while administering the product, at least to minimize unintended adverse events.

Disclosure of Interest: None Declared

EPV0258**Associations between polysubstance use and psychiatric comorbidities**

R. Fernández Fernández^{1*}, P. del Sol Calderón², Á. Izquierdo de la Puente² and M. Vizcaíno da Silva³

¹Psychiatry, Hospital Universitario Infanta Cristina, Parla; ²Psychiatry, Hospital Puerta de Hierro, Majadahonda and ³Psychiatry, Hospital de El Escorial, San Lorenzo de El Escorial, Spain

*Corresponding author.

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Introduction: Polydrug use studies mention demographic and socioeconomic factors that may influence this problem. One of them is the existence of psychiatric comorbidity; Rentrop's study (Rentrop et al., 2014) finds in a sample of 50 patients that all patients had at least one axis I disorder, 90% at least one axis II disorder, which may compromise the outcome of detoxification and dehabitation treatments (Rentrop et al., 2014). Another study found that 44.9% of patients admitted to a psychiatric unit are polydrug users (Karam et al., 2002).

Objectives: To study the possible association of polydrug use with psychiatric comorbidity in patients admitted to a general hospital and presenting drug use.

Methods: We made a descriptive retrospective study through the use of electronic medical records. The drug use history was

obtained for all patients admitted to the inpatient service of a general hospital during a 3-year period.

Results: More cases of poly-consumption together with psychiatric comorbidity are found than expected in the χ^2 Test, with significant results ($\chi^2 = 27.2$; $p < 0.001$). The mean age of the patient with poly-consumption and psychiatric comorbidity is 34.9 years.

Psychiatric comorbidity	Polydrug use	No	Yes	Total
		No	Observed	296
	Expected	284	11.64	296
Yes	Observed	217	21	238
	Expected	229	9.36	238
Total	Observed	513	21	534
		513	21	534

Conclusions: Psychiatric comorbidity in patients with polydrug use may be overlooked (Kruckow et al. 2016). Identifying patients with dual diagnosis is important given that these patients suffer decreased treatment compliance and life expectancy compared with single-diagnosis patients (Kruckow et al., 2016).

References: Rentrop, M., Zilker, T., Lederle, A., Birkhofer, A., & Hörz, S. (2014). Psychiatric comorbidity and personality structure in patients with polyvalent addiction. *Psychopathology*, 47(2), 133–140. <https://doi.org/10.1159/000351784>

Kruckow, L., Linnert, K., & Banner, J. (2016). Psychiatric disorders are overlooked in patients with drug abuse. *Danish medical journal*, 63(3), A5207.

Disclosure of Interest: None Declared

EPV0259**Validation of the Thai version of the Neurological Disorders Depression Inventory for Epilepsy (NDDI-E): Screening for major depressive disorder in patients with epilepsy**

S. Kuladee^{1*}, T. Prachason¹, T. Buranapichet¹, P. Rodwanno¹ and A. Boongird²

¹Department of Psychiatry, Faculty of Medicine, Ramathibodi Hospital and ²Department of Internal Medicine, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok, Thailand

*Corresponding author.

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Introduction: Depression has been recognized as a common comorbidity in patient with epilepsy and is associated with low quality of life. Regular screening for depression may aid in early detection and enhance quality of life.

Objectives: To validate the Thai version of the Neurological Disorders Depression Inventory for Epilepsy (NDDI-E).

Methods: The English version of NDDI-E was translated into Thai. Patients with epilepsy were enrolled at the outpatient neurology clinic from May 2019 to September 2019. Demographic data and clinical characteristics were collected. Participants underwent a psychiatric structured interview using the Mini-International Neuropsychiatric Interview (M.I.N.I.) as a gold standard for the

diagnosis of major depressive disorder. Then, participants completed the NDDI-E. The internal consistency was measured by Cronbach's alpha coefficient. The validity of the Thai version of the NDDI-E was assessed using the receiver operating characteristic (ROC) curve analysis. Youden's index was used to determine the optimal cut-off score of the Thai version of the NDDI-E.

Results: A total of 115 patients with epilepsy completed the evaluation. Twenty-three patients (20%) had major depressive disorder according to M.I.N.I. criteria. The Cronbach's alpha coefficient of the Thai version of the NDDI-E was 0.826. The area under the ROC curve was 0.995. A cut-off score greater than 17 provided a sensitivity of 95.65%, a specificity of 97.83%, a positive predictive value of 91.67%, and a negative predictive value of 98.90%.

Table 1: Demographic and clinical characteristics of the study population.

	Non-depressed (N = 92)	Major depression (N = 23)	P-value
Age in years, median (IQR)	31 (22)	28 (30)	0.637
Female, N (%)	50 (54.3)	15 (65.2)	0.347
Comorbid medical illnesses, N (%)			0.009
Present	40 (43.5)	17 (73.9)	
Absent	52 (56.5)	6 (26.1)	
Years since onset of seizures, mean (SD)	19.4 (11.9)	16.4 (14.1)	0.297
Seizure free for the last 6 months, N (%)	55 (59.8)	10 (43.5)	0.158
NDDI-E score, median (IQR)	12 (5)	19 (4)	<0.001

Table 2: Corrected item-total correlation and Cronbach's alpha if an item is deleted from the NDDI-E.

	Corrected item-total correlation	Cronbach's alpha if item deleted
1. Everything is a struggle	0.554	0.807
2. Nothing I do is right	0.590	0.800
3. Feel guilty	0.573	0.803
4. I'd be better off dead	0.643	0.788
5. Frustrated	0.660	0.784
6. Difficulty finding pleasure	0.548	0.808

Conclusions: The Thai version of the NDDI-E is a valid screening tool for major depressive disorder in patients with epilepsy.

Disclosure of Interest: None Declared

EPV0260

Varenicline induced auditory hallucinations in a young female with bipolar disorder: a case report

S. Bhanot^{1,1*}, V. W. L. Tsang² and L. Jia²

¹Biochemistry and Biomedical Sciences, McMaster University, Hamilton and ²Department of Psychiatry, University of British Columbia, Vancouver, Canada

*Corresponding author.

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Introduction: Creating appropriate and sustainable treatment plans for patients with concurrent disorders presents a challenge to psychiatrists and addiction medicine specialists alike. Although varenicline has been found to be one of the most effective medications for smoking cessation and abstinence, caution is needed when starting patients on this medication. In this case, a young female provisionally diagnosed with bipolar I disorder was hospitalized for a manic episode in the context of substance abuse and medical noncompliance. She also endorsed a long history of smoking, alcohol, cocaine, cannabis and ketamine use. In addition to being stabilized for bipolar disorder, the patient was started on varenicline for smoking cessation on Day 14 of admission.

Objectives: This case report highlights the potential risk of de-stabilization in a vulnerable youth with newly diagnosed bipolar I disorder and precarious social circumstances, in attempts to further concurrent approaches to psychiatric care.

Methods: In addition to qualitative observations, the main objective exam used to track patient progress through the duration of her hospitalization was the mental status exam (MSE). This is standard practice for psychiatric care and qualitatively assessed factors related to a patient's behavioral and cognitive functioning. Important factors assessed for this patient include appearance and behavior, speech, affect and mood, thought form, thought content, perceptual abnormalities, insight and cognition.

Results: Perceptual abnormalities, including auditory hallucinations, were not recorded at admission and the patient's symptoms of mania were resolving clinically on Day 18. Two days after starting varenicline, the patient developed auditory hallucinations, paranoia and referential beliefs. However, her insight was intact, and she had minimal thought-form disorganization. The patient also reported hearing auditory hallucinations of a derogatory nature, with her mood appearing more distressed during varenicline use. Symptoms were found to be resolved shortly after the discontinuation of varenicline on Day 18 and the patient appeared to be less distressed on following days. In this case, these symptoms were not in keeping with her bipolar diagnosis and thought to be secondary to varenicline after the consideration of potential alternative contributors.

Conclusions: The occurrence of side effects as a result of varenicline use in patients with diagnosed mental health conditions is rare and underlying psychiatric illness is not labeled as an absolute contraindication in the prescription of varenicline. However, it is important to advocate for increased guidance and research on the treatment of substance use disorders in patients with bipolar I disorder.

Disclosure of Interest: None Declared