EPP1026

External and Internal Shame in people with migraines

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Introduction: Migraine often leads to reduction of social power and prestige of the patients, hence leading further emotions of shame.
Objectives: Exploring the role of external and internal shame in people with migraines.
Methods: The sample consisted of 180 people, more specifically 140 people from the general population and 40 people who have been diagnosed with migraine and receiving treatment for migraine, who completed the following questionnaires voluntarily and anonymously: a) Migraine Experience Questionnaire and Headache Impact Test-6 (HIT-6), b) the Other As Shamer scale (OAS) c) the Experience of Shame Scale (ESS), and socio-demographic and self-reported questionnaire.
Results: Patients scored higher level external Shame (OAS) rates (31.28 ± 6.98) than people from the general population who scored lower external Shame (OAS) rates (16.89 ± 10.00) with a statistically significant difference between them ($p = 0.000$). Also, patients scored lower-level internal shame (ESS) rates (45.58 ± 6.91) than people from the general population who scored higher internal shame (ESS) rates (53.36 ± 15.62) with a statistically significant difference between them ($p = 0.003$).
Conclusions: Patients with symptoms of migraine show statistically higher level of external shame and lower level of internal shame and further study is considered necessary.

Disclosure of Interest: None Declared

EPP1027

Where art thou? Reflecting on auditory hallucinosis

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Introduction: Hallucinosis has evolved out of classification systems but what about patients who present with exclusive or almost exclusive hallucinations? Auditory hallucinations are especially likely to swiftly be considered due to psychiatric illness.
An elderly patient with chronic auditory hallucinations without other significant psychopathology nor other symptoms prompted reflection and literature review.
Objectives: To review differential diagnosis of auditory hallucinosis.
Methods: Pubmed search for terms: auditory and hallucinosis.
Results: Hallucinations should be evaluated according to: type, onset and evolution, association with physical and /or neurological symptoms, association with other hallucinations and/or other psychopathology, characteristics.
Auditory hallucinations may present along a continuum from tinnitus, simple, verbal, musical.
The Pubmed search retrieved articles pertaining to auditory hallucinations associated with:
1. Sensory deprivation; 2. Hearing loss, auditory Charles Bonnet syndrome; 3. Dementia, neurodegenerative disorders; 4. Brainstem lesions; 5. Other central nervous lesions: thalamus, temporal, other; 6. Epilepsy; 7. Tic disorders; 8. Alcohol use disorders; 9. Borderline personality disorder; 10. Others.
Conclusions: Patients presenting with auditory hallucinosis should be carefully evaluated to exclude non-psychiatric disorders.
In some patients, such as the one who prompted the review, an identifiable cause may not yet be found.

Disclosure of Interest: None Declared

EPP1028

Diagnostic stability of 346 patients with borderline personality disorder based on retrospective clinical records

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Introduction: State-of-the-art research highlights that borderline personality disorder have high rates of comorbid Axis I disorders, which imply uncertainty in establishing an accurate diagnosis and can be some of the most challenging patients for clinicians and researchers.
Objectives: This study seeks to observe the diagnostic stability in borderline personality disorder patients, in order to increase empirical knowledge through a retrospective look at the historical line of diagnoses.
Methods: A twenty-year retrospective study at a psychiatric hospital, searching at the electronic clinical records for all patients with borderline personality disorder diagnosis, under the code 301.83 from World Health Organization's International Classification of Diseases, 9th Revision (WHO ICD9). A 346 patients' sample was identified aged between 18 and 83 years (M_{age}=44.14 years, SD=11.18; predominantly female 73.70%; $M_{schooling}$=9.31years; $M_{admissions}$=4.72$_{times}$, SD=9.21; 2nd-5th comorbid diagnosis, a 75.72% sample with three diagnosis); excluding organic cerebral syndrome and no comorbidity besides drug abuse, or no comorbidity at all.
Results: As a general observation, the following diagnoses are indicated: 44.09% major depressive disorder, 33.16% affective disorder, 13.05% schizophrenia, and 9.70% mania. As a spectrums

disorders analysis (Figure 1), differential percentage occurrences are identified in patients with borderline personality disorder.
Image:

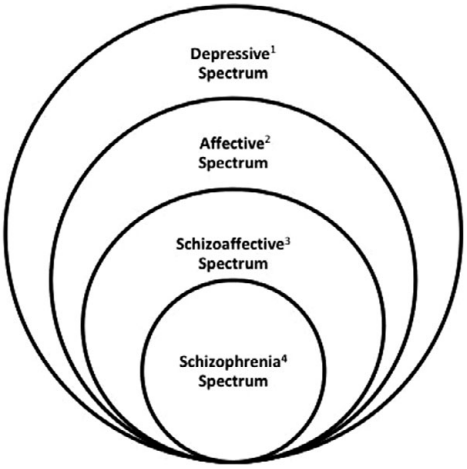

Figure 1. Percentage distribution of spectrums disorders diagnosis in patients with borderline personality disorders (n=346).

Note.
[1]$n_{diagnosis}$=250, %diagnosis$_{707}$=35.36, %patients$_{N=346}$=72.25
[2]$n_{diagnosis}$=188, %diagnosis$_{707}$=26.59, %patients$_{N=346}$=54.34
[3]$n_{diagnosis}$=104, %diagnosis$_{707}$=14.71, %patients$_{N=346}$=30.06
[4]$n_{diagnosis}$=74, %diagnosis$_{707}$=10.47, %patients$_{N=346}$=21.39

Conclusions: Based on clinical diagnoses records of borderline personality disorder patients, some spectrums disorders are highlighted, to be reported in descending order of incidence: depressive, affective, schizoaffective and schizophrenia spectrums.

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EPP1029

Delirious episode secondary to rotigotine: the psychotic patch

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Introduction: There is a fine line separating psychiatry and neurology. Most movement disorders can have psychiatric symptoms, not only those caused by the disease itself, but also those induced by the drugs used to treat them.

Objectives: Presentation of a clinical case about a patient diagnosed with Parkinson's disease presenting a several-month-long delirious episode due to dopaminergic drugs.
Methods: Literature review on drug-induced psychosis episodes in Parkinson's disease.
Results: A 57-year-old patient with diagnosis of Parkinson's disease for six years, who went to the emergency room accompanied by his wife due to delirious ideation. He was being treated with levodopa, carbidopa and rasagiline for years, and rotigotine patches whose dosage was being increased over the last few months.
His wife reported celotypical clinical manifestations and multiple interpretations of different circumstances occurring around her. He chased her on the street, had downloaded an app to look for a second cell phone because he believed she was cheating on him, and was obsessed with sex. He had no psychiatric background. It was decided to prescribe quetiapine.
The following day, he returned because he refused to take the medication since he thought he was going to be put to sleep or poisoned. It was decided to admit him to Psychiatry.
During the stay, rasagiline and rotigotine were suspended. Olanzapine and clozapine were introduced, with behavioral improvement and distancing from the psychotic symptoms which motivated the admission. The patient was also motorically stable. Although levodopa is best known for causing psychotic episodes, the symptons were attributed to rotigotine patches for temporally overlapping the dose increase.
Conclusions: Psychiatric symptoms are the third most frequent group of complications in Parkinson's disease after gastrointestinal complications and abnormal movements. All medication used to control motor disorders can lead to psychosis, not only dopaminergics, but also selegiline, amantadine and anticholinergics.
Excessive stimulation of mesocortical and mesolimbic dopaminergic pathways can lead to psychosis, which is the most common psychiatric problem related to dopaminergic treatment.
In the face of a psychotic episode, antiparkinsonian drugs which are not strictly necessary for motor control should be withdrawn. If this is not sufficient, levodopa dose should be reduced, considering the side effects that may occur. When the adjustment of antiparkinsonian treatment is not effective, neuroleptics, especially quetiapine or clozapine, should be administered. In a recent study, pimavanserin, a serotonin 5-HT2 antagonist, was associated with approximately 35% lower mortality than atypical antipsychotic use during the first 180 days of treatment in community-dwelling patients.
Medication should always be tailor-made to suit each patient and we usually have to resort to lowering or withdrawing the dopaminergic medication.

Disclosure of Interest: None Declared

EPP1030

An empirical staging model for schizophrenia using machine learning

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