Department of Geriatric Psychiatry, *Centro Hospitalar Psiquiátrico de Lisboa* (CHPL), Lisbon, Portugal

Background: Very-late-onset obsessive-compulsive disorder (VLO-OCD) is rather rare. Although VLO-OCD should prompt a thorough workup, most cases do not evidence an underlying medical illness nor structural brain abnormality. A subset manifests somatic obsessions, bringing about diagnostic challenges.

Objective: Critical literature review based on a case study.

Case presentation: A 73-year-old male patient, was hospitalized for intrusive, repeated, distressing mental images and thoughts about hell, describing difficulty to disengage from these obsessions, alongside secondary mystical and ruin delusion-like ideas, modulated by the pathoplastic effect of core religious beliefs, and inflated sense of responsibility. He had previously experienced those intrusive mental images, yet not in a recurrent nor uncontrollable manner.

Preceding the OCD, he presented mild depressive symptoms triggered by financial hardships. After the emergence of OCD, depressive disorder aggravated, with psychomotor retardation, hopelessness, insomnia, anorexia. Obsessive hyperawareness of autonomic processes, distressing body-focused preoccupations raised by interoceptive stimuli, became noticeable, with overestimation of threatening consequences, day-long swallowing rituals/compulsions, avoidance of nutritional intake, general unease, and even panic. Yale-Brown Obsessive Compulsive Scale (*Y-BOCS*) scored 25. Ancillary tests were unremarkable. Transglutaminase antibodies were negative, ruling out gluten-sensitive enteropathy, hence tryptophan-serotonin metabolism impairment. Neuroimaging did not evidence structural disruption of cortico-striatal circuitry. Therapeutic regimen comprised sertraline 200 mg/day, augmented with mirtazapine 45 mg/day, aripiprazole 15 mg/day. Additionally, trazodone, buspirone and benzodiazepines were used to manage anxiety and insomnia. At the fourth week of treatment the anxiety burden driven by religious obsessions ameliorated. Meanwhile lamotrigine 100 mg/day and gabapentine 200 mg/day were added with further improvement (60% *Y-BOCS score reduction*, at seventh week).

Discussion: This case highlights the clinical relevance of the OC spectrum concept, wherein at the compulsive end are OCD-related disorders which feature high degrees of harm avoidance, intolerance to uncertainty, anticipatory anxiety, engagement in repetitive behaviors. We hypothesize that somatoform variant of OCD constitutes a distinct phenotypic subtype, stemming from a complex interplay of neurobiological substrates, psychosocial, and genetic factors, shared with hypochondriasis. This assumption might be addressed in future studies.

Furthermore, this case illustrates the fact that VLO-OCD might exhibit prodromic periods of subclinical OC symptoms before the manifestation of full-blown OCD.

P88: Individuals with Mild Cognitive Impairment (MCI) have poorer social networks than cognitively normal individuals from rural India

Authors: Jonas S. Sundarakumar, Pooja Rai, Albert Stezin, Thomas G. Issac and SANSCOG Study Team Centre for Brain Research, Indian Institute of Science, Bangalore, India

Introduction: In recent years, the significance of robust social networking is being increasingly recognized due to its association with better cognitive performance. On the other hand, social isolation is linked to higher risk of developing dementia in mid-life and in older age groups. Only few studies have examined social networking in

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individuals with Mild Cognitive Impairment (MCI). The lack of social connectedness could increase the chances of these individuals progressing to dementia.

Methods: We cross-sectionally assessed social networking among 122 subjects with MCI and 2403 cognitively healthy subjects, aged 45 years and above, from the Srinivaspura Aging, NeuroSenescence and COGnition (SANSCOG) study cohort in rural southern India. Cohen's Social Network Index (SNI) was used to assess social networking, wherein three dimensions are assessed: network diversity, number of people in social network, and number of embedded networks. The diagnosis of MCI was made using the Clinical Dementia Rating (CDR) instrument. This is an extensively validated 5-point scale, wherein six cognitive and functional domains are assessed: Memory, Orientation, Judgment & Problem Solving, Community Affairs, Home & Hobbies, and Personal Care. The overall CDR score of '0' was interpreted as cognitively normal and CDR score of '0.5' as MCI. The SNI dimension scores were compared between subjects with MCI and cognitively healthy subjects using t-test and a p-value of <0.05 was considered significant.

Results: The mean scores of all three SNI domains were significantly lower in MCI compared to cognitively healthy subjects: network diversity (5.30 ± 1.54 vs. 5.94 ± 1.60, $p < 0.001$), number of people in social network (18.4 ± 8.61 vs. 20.3 ± 8.87, $p = 0.023$), and number of embedded networks (1.80 ± 1.26 vs. 2.03 ± 1.14, $p = 0.038$).

Conclusion: Aging rural Indians with Mild Cognitive Impairment (MCI) have poorer social networks than their cognitively normal counterparts. Hence, social connectedness should be routinely evaluated in individuals with MCI and prompt social interventions should be instituted to enhance their social functioning. Social isolation may indeed be a contributory risk factor for developing cognitive impairment. However, causal relationships and reverse causality should be evaluated in further longitudinal studies.

P90: The indirect role of supportive dyadic coping in the association between self- perceptions of aging and depression

Authors: Jose A. Fernandes-Pires, Andrés Losada-Baltar, María del Sequeros Pedroso-Chaparro, María Márquez-González, Isabel Cabrera, Laura García-García, and Guy Bodenman.

Objective: it has been shown that having negative-self perceptions of aging significantly predicts depressive symptomatology. Although the partner relationship may have an impact on the effects of perception of aging on distress, the number of studies assessing the effect of partner on negative self-perception of aging and mental health is limited. The stress of one partner may elicit dyadic coping (DC) responses in the other partner. The stress of one partner may elicit dyadic coping responses in the other partner. Depending on whether the responses are positive (supportive) or negative (hostile)a close relationship can go along with additional stress or resources and benefits. The present study analyzes the relationship between negative self-stereotypes and depressive symptomatology, considering the partner's dyadic coping as a moderator variable in this association.

Method: Participants were 365 individuals (59.3% women) 40 years or older (M= 60.86, SD=10.66) involved in a marital/partner relationship. Participants completed a questionnaire that included the variables: negative self-perception of aging, positive DC (e.g., "My partner shows empathy and understanding to me"), negative DC (e.g., "When I am stressed, my partner tends to withdraw"), and depressive symptomatology. Two moderation models were tested by linear regression: the first considered positive DC and the second negative DC as a moderator in the relationship between negative self-perception of aging and depressive symptoms.

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