

response. As a result, we can infer through a hypothesis-free approach potential pathways whose alterations may estimate treatment. At the time of writing the analyses are still undergoing, the final results will be presented and discussed at the congress.

Disclosure of Interest: None Declared

EPP0535

Organic affective disorder due to meningioma, case report

M. Garcia-Moreno^{1*}, A. de Cós Milas², L. Beatobe Carreño², P. del Sol Calderón¹ and Á. Izquierdo de la Puente¹

¹HOSPITAL UNIVERSITARIO PUERTA DE HIERRO MAJADAHONDA and ²HOSPITAL UNIVERSITARIO DE MÓSTOLES, MADRID, Spain

*Corresponding author.

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Introduction: Brain tumors can be associated with psychiatric symptoms in up to 50% of cases. The most frequent primary is meningioma and the clinic will depend on its location. Since surgical treatment does not always guarantee complete resolution of the condition, concomitant psychopharmacological treatment is usually recommended.

Objectives: To review about organic mania and its differential diagnosis.

Methods: We carry out a literature review about organic affective disorder accompanied by a clinical description of one patient with organic mania.

Results: A 50-year-old woman admitted due to psychotic symptoms. She had a diagnosis of frontal and parietal meningioma treated with surgical treatment 10 years ago. In this context she had a diagnosis of Organic Affective Disorder and 3 previous psychiatric admissions due to affective or psychotic symptoms. Current episode consisted in dysphoria, magalomanic ideation, delusional ideation of harm and mystical-religious content, high speech pressure and insomnia with little awareness of the disease. Cranial magnetic resonance showed postoperative right frontal changes and stability in parietal meningioma, with no significant differences compared to the previous study. Diagnosis of Organic Affective Disorder is maintained and reintroduced treatment with aripiprazole withdrawn by the patient weeks before. Because of adverse effects and persistence of the symptoms described, it was changed to olanzapine with good response and tolerability. The behavior was progressively adapted with improvement of the dysphoria and without psychotic symptoms at discharge.

Conclusions: Affective symptoms due to organic disorders such as brain tumors can be treated surgically and with psychopharmacological treatment.

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EPP0536

A family history of suicide in bipolar disorders: powerful, powerless

M. Sagué Vilavella^{1*}, G. Fico¹, G. Anmella¹, A. Giménez¹, M. Gómez Ramiro², M. T. Pons Cabrera¹, S. Madero¹, A. Murru¹ and E. Vieta¹

¹Department of Psychiatry and Psychology, Hospital Clínic, Barcelona and ²Department of Psychiatry, Hospital Álvaro Cunqueiro, Vigo, Spain

*Corresponding author.

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Introduction: When completing the medical record of a patient with bipolar disorder (BD), hardly anything is more impacting than a family history of completed suicide (FHS). In fact, FHS is a main risk factor for personal suicide attempts and death in this population. There are few modifiable protective factors against suicide in BD, such as lithium treatment and absence of substance abuse.

Objectives: We aimed to explore the relationship between a FHS and clinical characteristics in patients with BD. Given the impact that FHS has on the individual and on healthcare professionals, we hypothesized that it would modify behaviors towards a higher prevalence of the modifiable protective factors against suicide, namely more treatment with lithium and less drug addiction.

Methods: This is a cross-sectional study that included all patients with BD that were followed up in a specialised unit between 1998 and 2020. Only subjects with complete information on FHS were retained for the analysis. We assessed sociodemographic and clinical data and described it with measures of frequency, central tendency and dispersion. Differences between subjects with and without FHS were calculated with χ^2 , Fisher's exact test and Student's t-test as appropriate. We set the significance level at $p \leq 0.05$. All tests were two-tailed.

Results: The sample consisted of 480 subjects with a mean age of 45.9 years (standard deviation 14.4, range 18-88), of which 54.4% (n=261) were women. 69.2% (n=332) had a diagnosis of BD type I and 30.8% (n=148) of BD type II. 77 subjects (16%) had a FHS. Regarding differences between groups, those with relatives who had committed suicide did not show statistically significant differences in terms of sociodemographic variables (age, gender, civil status, employment) or key clinical features (type of BD, illness duration, psychotic features, predominant polarity, rapid cycling, number of lifetime manic and depressive episodes, comorbid personality disorder), neither did they have a higher use of lithium (55.8% vs 59.3%, $p=0.572$) nor lower substance use disorder (10.9% vs 15.5%, $p=0.34$). Predictably, people with FHS had a higher prevalence of family history of mental and affective disorders (96.1% vs 70.9%, $p<0.001$; 86.3% vs 56.3%, $p<0.001$) and of stressful life events (71.6% vs 58.9%, $p=0.05$). Personal lifetime suicide attempts also tended to be higher (36.4% vs 26.7%, $p=0.088$).

Conclusions: Contrary to our hypothesis, in our sample of subjects with BD a FHS was not associated with a higher prevalence of the modifiable protective factors against suicide. Therefore, although suicide has a major impact both in families and healthcare professionals, our results suggest it does not modify attitudes towards prevention in a real-life scenario. The main limitation of our study is its cross-sectional design, which does not allow for causal inference. In conclusion, there is room for improvement in the fight against suicide.

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