individuals with personality disorders and to a lesser extent in patients with schizophrenia. True suicides in drug users include only episodes with depressive symptoms.

Disclosure of Interest: None Declared

EPV0242

Anxiety disorder and depressive disorders in teens

I. Belabbes

arazi hospital, sale, Morocco
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Introduction: Anxiety and mood disorders are frequent causes of consultation in child psychiatry. In pediatrics, they can be the cause of life-threatening or psychological complications, such as suicidal ideation, anxiety attacks, scarification or suicide attempts.
Objectives: Discuss the clinical and therapeutic features of anxiety-depressive syndromes.
Methods: We shed light on anxiety-depressive syndromes through the study of complex clinical cases encountered in child psychiatric hospitalization.
Results: We report a case series of 10 patients, the majority of whom were female. The age range was 12 to 17 years. Clinical features included emotional manifestations such as sadness, tantrums and anxiety, as well as cognitive symptoms such as memory and concentration problems, with dark or suicidal ideation, and occasional endangerment behaviors such as scarification or suicide attempts.
Treatments range from psychosocial interventions, including therapeutic mediation, psychotherapy and social support, to pharmacological treatment with antidepressants, hypnotics, neuroleptics and, rarely, mood regulators.
Conclusions: The frequency and severity of anxiety-depressive syndromes in the absence of adequate care underlines the importance of screening, early diagnosis and treatment of children with these disorders.

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EPV0244

Adult Attention-Deficit/Hyperactivity Disorder and Borderline Personality Disorder: diagnostic and management challenges

M. Barbosa* and A. R. Fonseca

SPSM, Centro Hospitalar de Leiria, Leiria, Portugal
*Corresponding author.
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Introduction: Borderline Personality Disorder (BPD) and Attention-Deficit/Hyperactivity Disorder (ADHD), relatively common psychiatric pathologies (5% and 1-2% respectively), share several characteristics, specially impulsivity and emotional dysregulation. With different therapeutic approaches, it is therefore important to distinguish the entities for a correct approach to the patient. Clinical evidence has also demonstrated high comorbidity between two entities, and therefore this recognition is of equal relevance.
Objectives: Analyze the clinical evidence, in order to better understand the dynamics between the two pathologies as comorbid or differential diagnosis, for an appropriate approach to the patient.
Methods: Authors used the Medline database through the Pubmed search engine, with the keywords: "PBP", "PHDA".
Results: These two pathologies share impulsive and spontaneous actions with poor thinking about the consequences; nonetheless, ADHD individuals tend to show this impulsivity by being more impatiente when they have to wait, talking over other people, interrupting others; on the contrary, in BPD impulsivity can be showed more as self-harm behaviors.
As for the emotional dysregulation, that both entities share, in the comorbid case it is known that it is the most severe form. This characteristic is part of the central characteristics of BPD where these individuals experience intense and unstable emotions. They have difficulty regulating their emotions which can lead to rapid changes in mood, and they report feelings of emotional emptiness and difficulty in establishing stable relationships. As for ADHD individuals, despite present, it's not a core symptom, as they have more control over their emotions, and have more adaptative cognitive strategies.
Attention deficit can be a core symptom of a subtype of ADHD and has not yet been reported in patients with PBP, except in comorbid situations. According to studies, 30-60% of patients with PBP report and score on attention deficit scales. Truth is both entities have intelectual disfunctionalities.
Results of genetic studies are very inconsistent, however epigenetic research and reseach focusing on hypothetized vulnerability genes or sites have been promising.
Conclusions: A complete clinical history is particularly important in these cases and sometimes difficult, as so, clinicians should be aware to prevent misdiagnosis and provide the best care for both disorders and the comorbidity. Given that treatment differs between both pathologies, psychotherapy in BPD, and the multimodal approach in ADHD, it is imperative to distinguish the two entities. In comorbid cases, a combination of the two therapies has demonstrated effectiveness but much more studies are needed.

Disclosure of Interest: None Declared

EPV0245

"Unraveling the Diagnostic Dilemma: Unusual Presentation of Huntington's Disease with Predominant Psychiatric Symptoms and Late-Onset Motor Manifestations"

M. I. M. M. N. Ibrahim* and M. Iderapalli

Essex Partnership University NHS Foundation Trust, Basildon, United Kingdom
*Corresponding author.
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Introduction: Huntington's Disease is a neurodegenerative disease inherited in an autosomal dominant fashion.The underlying genetic defect is unstable CAG trinucleotide repeat expansion with a repeat length longer than 36 resulting in pathological aggregation of abnormal protein causing cell death.
The clinical symptoms encompass 3 main domains-motor,cognitive and psychiatric.The psychiatric symptoms often in atypical form appear decades before other symptoms causing significant impact on patient's functioning and quality of life.

Here, we discuss an unusual presentation of Huntington's Disease causing diagnostic dilemma.
Objectives: Case report discussing the unusual presentation of Huntington's Disease.
Methods: Case: Mr X is a 61 year old Caucasian male.He had an uneventful birth and early childhood attaining milestones appropriately. He experienced childhood adversity in the form of sexual abuse between ages 2-14 years. His mental health difficulties started following sexual abuse when he attempted to end his life by hanging and overdosing at age 15. He got married twice, both of which broke down. There is a history of significant alcohol abuse between ages 40-50. Following this, he had a myocardial infarction and a stroke requiring stenting.
He presented to Psychiatric Outpatient Services in 2011 with auditory hallucinations, social anxiety with panic attacks, OCD type rituals, claustrophobia and feeling hot all the time. He was started on an antipsychotic medication for psychosis ,but clinically deteriorated. He started having anger outbursts, marching on the spot ,and head banging. He was diagnosed with Huntington's Chorea in 2021 after he had developed chorea. He currently has low mood and is head banging for hours.
Results: Psychiatric symptoms in HD can span a variety of domains but most common are symptoms of frontal lobe dysfunction-disinhibition, poor attention, irritability, impulsivity and personality change. Apathy, emotional blandness and social withdrawal are also prominent features.
Mr X had strong family history of Paranoid Schizophrenia (aunt and cousin).There was no family history of HD. His mental health problems started early in life with DSH, Depression and Harmful use of Alcohol. He presented predominantly with psychotic symptoms like auditory hallucinations, social anxiety, paranoia. Motor symptoms started late which he incorporated into voluntary movements like head banging which made it difficult to differentiate from deliberate self harm.
Conclusions: Psychiatric symptoms constitute the core of HD. Studies have shown that though depression and personality change are typical of HD, there are number of other psychiatric symptoms that can impair quality of life. Early diagnosis and treatment of these symptoms will help patients and families to cope better with severe symptoms of this progressive disease.

Disclosure of Interest: None Declared

EPV0246

Concurrent Gender Dysphoria/Incongruence and Autism Spectrum Disorder, a literature review

N. Clementi[1,2]*

[1]General Adult Psychiatry/ Gender Identity Clinic, Royal Cornhill Hospital, NHS Grampian and [2]University of Aberdeen, School of Medicine, Aberdeen, United Kingdom
*Corresponding author.
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Introduction: Several studies have found that ASD (Autism Spectrum Disorder) and GD (Gender Dysphoria by DSM-V)/GI (Gender Incongruence by ICD-11) tend to co-occur, and in recent years the interest and publications on this comorbidity has increased rapidly.
Objectives: To review the prevalence of ASD in individual with a diagnosis of GD/GI.
To better tailor and improve care offered in the National Health Service (NHS) Gender Identity Clinics (GICs) throughout the UK.
Methods: Systematic literature review was conducted via Pub Med, MEDLINE and PsycINFO by the author, for all English-language articles published between 2018 and 2023, containing keywords as ASD, GD (Gender Dysphoria), GI (Gender Incongruence), transgender, autistic traits, autism, gender diversity, gender variance.
Results: Rate of people with ASD appear to be higher in people accessing Gender Identity Clinics (GICs) than in the general population. Results from this literature review show increased prevalence of GD and GI in ASD population.
Conclusions: This comorbidity has highlighted the importance of better tailor transgender healthcare services for people with neurodevelopmental conditions and neurodiversity, to avoid delay in ASD individuals accessing care and gender affirming medical treatments. Services should strive to provide an effective and equitable service. It is also important to better identify potential barriers for ASD people in accessing gender care. Literature also shows the people with ASD have more difficulties in communicating and describing their gender narrative and to express their wishes for gender treatments. Symptoms including problems in communications and social skills, obsession and rigidity can also impact their assessment of GD/GI in gender identity services. Some studies showed that for individuals who have concurrent ASD and GD/GI, assessment in GICs may be extended to better review their wishes for gender identity and for gender affirming treatment. Further research is needed to better investigate and understand factors explaining the relationship between ASD and gender diversity. There is still limited research in the real life experiences of gender diverse and autistic people. There is also a need to improve Gender reassignment protocol nationally to better care for individual with ASD and GD/GI throughout GICs in the UK.

Disclosure of Interest: None Declared

EPV0247

Osmotic demyelination syndrome (ODS), and psychiatric manifestations

P. Argitis[1]*, A. Karampas[2], M. Peyioti[1], A. Goudeli[1], S. Karavia[1] and Z. Chaviaras[1]

[1]Psychiatric, General Hospital of Corfu, Corfu and [2]Psychiatric, General Hospital of Ioannina, Ioannina, Greece
*Corresponding author.
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Introduction: Hyponatriemia can be potentially fatal if it is not corrected immediately. The rapid correction of chronic hyponatriemia can cause demyelinating brain lesions.
Objectives: A fifty-six year old female was brought to the emergency department of the psychiatric clinic by her daughter, with incomprehensible speech and psycomotor agitation. She was diagnosed several years ago with bipolar disorder, with valproic acid and quetiapine being her current medication. She has been living alone, in a small suburban city. Approximately twenty four hours