EPV0483

Triage mistakes in the Psychiatry Emergency Room: do we really know how to rule out organicity?

H. Andreu*, A. Giménez-Palomo, L. Bueno, E. Cesari, O. De Juan, J. I. Mena, I. Ochandiano, L. Olivier, S. Salmerón and M. Sagué-Vilavella

Psychiatry and Psychology Department, Institut Clínic de Neurociències, Hospital Clínic de Barcelona, Barcelona, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1179

Introduction: In Spain and other European countries, patients coming to the emergency room (ER) are usually classified as "organic" or "psychiatric" on arrival, but this may be complicated when psychiatric history is present as the focus can be misplaced (Leeman. IJPM 1975;6(4):544-40; Alam et *al.* Psychiatr. Clin. North Am. 2017;40(3):425–33).
Objectives: To describe three cases seen in the psychiatric emergency room (PER) in which triage errors occurred and to review whether it is widespread for psychiatric patients with organic pathology or in need of medical care to be wrongly triaged.
Methods: We retrospectively reviewed three cases seen in the PER of Hospital Clínic in July 2023 in which triage errors happened. Triage error was considered when patients triaged directly to the PER presented symptoms that either needed medical treatment or required medical clearance before being considered purely psychiatric.
Results: Case 1: A 27-year-old woman with history of depressive syndrome was triaged for a speech disturbance that had occurred fifteen minutes after intercourse. After being evaluated, she was referred to neurology where she was diagnosed with an acute ischaemic stroke in left middle cerebral artery territory, requiring thrombectomy and posterior admission to neurology.
Case 2: A 50-year-old man with history of alcohol use disorder was brought to the PER after saying that "he was seeing people doing magic" at home. When evaluated, significant distal tremor, tachycardia and hypertension were observed, being compatible with withdrawal symptoms, so he was transferred to the ER. There he was monitored and treated, finally requiring admission to internal medicine due to persistent symptoms.
Case 3: A 26-year-old man with history of substance use disorder was triaged for loss of consciousness and "spasms". After evaluation, he was transferred to the ER, where organic screening was carried out, being oriented as a probable tonic-clonic seizure and discharged with outpatient follow-up.
Conclusions: The cases presented are instances in which somatic diseases in patients pre-labelled with psychiatric histories were wrongly assumed to be recurrences of their psychiatric disorders. In all cases, they needed to be re-examined by the corresponding medical specialty and required diagnostic tests, in two cases hospital admission was needed. Emergency physicians and emergency psychiatrists often disagree on how to medically clear patients (Alam et *al.* Psychiatr. Clin. North Am. 2017;40(3):425–33; Janiak et *al.* JEM. 2012;43(5):866–70), some authors have even proposed protocols for doing this in a more systematic way (Shah et al. JEM. 2012;43(5):871–5). To avoid a delay in diagnosis and treatment and the consequences that may result from it, establishing guidelines for proper triage of patients with psychiatric history should be considered.

Disclosure of Interest: None Declared

Epidemiology and Social Psychiatry

EPV0484

Towards an increased attention on ADHD symptoms and traits in young adults: prevalence data from screening tools in a psychiatric outpatient clinic

C. Sanguineti[1], V. Nistico'[1,2,3], I. Folatti[1], G. Santangelo[1], R. Faggioli[4], A. Bertani[5], O. Gambini[1,3,4] and B. Demartini[3,3,4,4,*]

[1]Health Science Department, University of Milan; [2]Department of Psychology, University of Milan Bicocca; [3]Aldo Ravelli Research Center for Neurotechnology and Experimental Brain Therapeutics, University of Milan; [4]UO Psichiatria 51 e 52 and [5]Centro Giovani Ettore Ponti, ASST Santi Paolo e Carlo, Presidio San Paolo, Milan, Italy
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1180

Introduction: Attention–Deficit/Hyperactivity Disorder (ADHD) is a heterogeneous neurodevelopmental disorder encompassing developmentally inappropriate inattentiveness, hyperactivity, and increased impulsivity (DSM-5). Symptoms presentation is different for different stages of life; moreover, individuals with ADHD symptomatology can develop abilities and strategies that help them adapt and mask the distinctive features of the condition, thus reducing the functional impairment usually seen in ADHD subjects, and ultimately not receiving neither a clinical diagnosis nor a proper therapeutic support. They might express their lack of well-being through other transdiagnostic symptoms, and finally reach psychiatric attention for potential comorbidities. Hence, it was argued that the existence of children and adolescents with subthreshold and underrecognized symptoms that subsequently develop into a full diagnosis suggests that ADHD should be significantly more considered in adult mental health settings.
Objectives: Here we aimed to analyse the prevalence of ADHD symptoms and traits in a heterogeneous clinical psychiatric sample of young adults (aged 18 to 24 years old), who referred to a specialized outpatient clinic for various psychiatric and psychological disturbances.
Methods: 259 participants completed three validated self-report screening questionnaires for ADHD: the Wender Utah Rating Scale (WURS), the Adult Attention-Deficit/Hyperactivity Disorder Self-Report Screening Scale for DSM-5 (ASRS-5), and the Conners' adult ADHD rating scale (CAARS).
Results: 12.4% of our sample scored above the cut-off at both the WURS and the ASRS-5 and was considered at risk of ADHD.
Conclusions: The prevalence rate in our sample is higher than the one found in the adult general population (6.76%), and in the lower range of the one found in the adult clinical population (6.9% to 38.8%). We discuss the potential role of sociodemographics (age, sex, gender identity, and employment) and comorbidity factors. Differences in the clinical presentation of ADHD according to sex assigned at birth and age should be considered during every psychiatric evaluation to minimize the risk of underdiagnosis. We advocate for further studies investigating the prevalence of ADHD in different psychiatric services for adults, and for a stronger presence of specialistic ADHD services and trained clinicians on the territory: this would increase diagnostic reliability, consequently providing a better treatment for ADHD in adults, and facilitate the transition from pediatric to adult's services.

Disclosure of Interest: None Declared