

18 years-old, finding that males presented an earlier start of the ED and not appreciating differences in the duration of the disease, income, episodes of purgation and psychiatric comorbidity of anxiety, behaviour disorders or impulsivity.

**Objectives:** The aim of this study was to evaluate gender differences in clinical characteristics, levels of depression, previous obsessiveness and personality dimensions in eating disorders (ED) compared with controls.

**Methods:** A total of 80 participants was divided into 4 groups, 20 men and 20 women with ED and 20 men and 20 women without ED (healthy control), matched by age and socioeconomic status. The design of the study was case-control, and data was collected through clinical interview and a battery of questionnaires.

**Results:** Men with ED only differ in vigorous physical activity (measured by IPAQ) from controls and women with pathology. Regarding personality traits, men and women with ED do not differ among them, although they do differ in novelty search and harm avoidance respect to their controls.

**Conclusions:** Behaviors such as physical activity in males frame a slightly different way of reducing their discomfort, however, clinical implication indicates that the treatment may be similar according to gender.

**Disclosure of Interest:** None Declared

## EPV0469

### Eating disorders. What about males?

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**Introduction:** Eating disorders (ED) historically been addressed as illnesses that only affect young adolescent females. ED's in males have been documented in literature as early as the 1960's; yet men continue to be under represented on research on the topic. For decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) perpetuated the invisibility of males by including amenorrhea as a diagnostic criterion. It was not until 2013 that male inclusion was endorsed through the removal of that criterion. It is estimated that one in four people affected with an ED is male. It is estimated that one in four people affected with an ED is male. The proportion of males reporting lifetime prevalence of Binge eating disorder (BED) was far greater than for Anorexia nervosa (AN) or Bulimia nervosa (BN); the female versus male ratio of BED prevalence was 3:1. AN is the most life-threatening ED, but is least frequently seen in male populations; researchers suggest this is because most men are not interested in the emaciated, thin look.

**Objectives:** This poster aims to recognize the presence of ED's in males and raise awareness on this topic.

**Methods:** Case report and literature review

**Results:** We present the case of a 50-year-old man with longstanding AN, who had never undergone mental health follow-up. He is referred to psychiatrist by his primary care provider (PCP) due to depressive symptoms. His medical history included vitamin D insufficiency and osteoporosis. At the age of 19 he was obese

(BMI 35) and from the age of 23 he started to present dietary restriction after a social event. He had never self-induced vomiting, use of laxatives, binge eating or compulsive exercise. He reported no history or current substance use disorder. BMI at first consultation was 17,6 and showed fear of weight gain. Antidepressant therapy was started and patient was referred to a specialized therapist, nutritionist and nurse.

**Conclusions:** Overall, the findings demand clinicians develop awareness about ED in males to advance illness management and enhance long-term prognosis. In our case, the delay in receiving treatment has probably led to greater morbidity and chronicity. PCP's play a key role in detection of ED's as the often act as a first point of contact for men accessing the health care system. While assessing and ED, the PCP should include general questions on eating habits in their intake interview. Once an ED is suspected, the first few minutes of the encounter are crucial to gain trust and buy-in from the patient. Once buy-in from the patient is gained, a complete physical exam and diagnostic work-up is required. Priority referrals to the following professionals are critical: psychiatrist, therapist, dietician or nutritionist, and ED specialist if available.

**Disclosure of Interest:** None Declared

## EPV0470

### Gastric bezoar in a patient hospitalized in an eating disorder unit. Case report

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**Introduction:** It is well known that eating disorders are related to comorbidity. At least, half of these patients have other mental disorders and, in addition to it, the presence of physical comorbidity (cardiovascular, kidney, nervous system, digestive tract, metabolic or endocrine disorders) comes with a decline in life expectancy.

**Objectives:** Description of a patient with a diagnosis of anorexia nervosa (AN) who developed a gastric bezoar during hospitalization.

**Methods:** Case treated in a specific Eating Disorder Unit in a Third-Level Hospital.

**Results:** 26 years old woman with a diagnosis of AN hospitalized in General Psychiatric Unit with BMI of 11,78 kg/m<sup>2</sup>. Nasogastric tube was necessary and, after 1 month with a progressive weight recovery (BMI 13,84 kg/m<sup>2</sup>), the patient was transferred to the Eating Disorder Unit in order to follow specific psychological therapy. No incidence related to physical exploration or clinical analyses happened during this month apart from pancytopenia due to malnutrition.

However, 8 days after, patient developed nausea and had 3 vomit episodes, constant abdominal pain at hypogastrium (moderate intensity), dizziness, instability and constipation. The patient refused possibility of pregnancy. The physical exam showed bowel

sounds augmented but no mass or peritoneal irritation appeared. Blood test results were normal. Abdominal X-Ray showed gastric dilatation with small bowel faeces sign, which suggested diagnosis of gastric bezoar.

The treatment was the dissolution of the bezoar by Coca-Cola, solving the symptoms completely.

The patient refused having eaten hair or any other kind of object or indigestible material but admitted to be following a strict vegan diet. Finally, after an endoscopy was done, the patient was diagnosed of phytobezoar.

**Conclusions:** Based on literature, bezoars are rare in AN, being phytobezoars the most common between the types of bezoars. Nevertheless, there are some risk factors, such as delayed gastric emptying, dehydration or, in the case of phytobezoar, ingestion of food containing high amount of cellulose, hemi-cellulose, lignin, and tannins (celery, pumpkin, grape skins, prunes, raisins and, in particular, persimmons). Some of the symptoms caused by phytobezoar can be similar to those of the AN (abdominal pain, intestinal obstruction, poor appetite, vomiting, malnutrition, weight loss). Therefore, gastric bezoar could be an underdiagnosed or even undiagnosed disease in this group of patients. Taking this into account could reduce time until diagnosis and treatment, decreasing the risks associated.

**Disclosure of Interest:** None Declared

## EPV0472

### Superior mesenteric artery syndrome: when vomiting are not voluntary

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**Introduction:** Superior mesenteric artery syndrome is a gastro-vascular disorder in which the third and final portion of the duodenum is compressed between the abdominal aorta and the overlying superior mesenteric artery. This rare, potentially life-threatening syndrome is typically caused by an angle of 6°–25° between the abdominal aorta and the superior mesenteric artery, in comparison to the normal range of 38°–56°, due to a lack of retroperitoneal and visceral fat (mesenteric fat). In addition, the aortomesenteric distance is 2–8 millimeters, as opposed to the typical 10–20. However, a narrow superior mesenteric artery angle alone is not enough to make a diagnosis with no symptoms.

Symptoms are fullness and epigastric tightness after meals, nausea and vomiting (often bilious) and pain in the middle of the abdomen that improves with the prone or knees flexed to the chest. The diagnosis is supported by imaging tests (esophagogastroduodenal transit or CT) showing dilation and stasis proximal to AMS in the third duodenal portion.

Relief from vomiting with feeding through a enteral probe placed beyond the obstruction to the proximal jejunum supports diagnosis.

Precipitating factors should be corrected first, whenever possible. Acute symptoms can be resolved with gastric decompression and intravenous fluids. Therefore, surgical correction should only be done in well-studied patients with chronic recurrent episodes of AMS syndrome. The most recommended surgical technique is a laparoscopic proximal duodenojejunostomy

**Objectives:** To describe a case of superior mesenteric artery syndrome and review in literature the organic complications and associated psychopathology of this disorder

**Methods:** Clinical case report and brief review of literature

**Results:** 17-year-old woman with a diagnosis of anorexia nervosa. Admitted for behavioral disorder, repeated self-harm and low mood. Presents a BMI of 16.6. Irregular rules. Progressive diet is started to which nutritional supplements are added with good initial tolerance. It presents a loss of 2kg and begins with nausea, vomiting and postprandial epigastralgia. Oral panendoscopy and abdominal ultrasound are performed showing possible mesenteric aortic clamp so naso-jejunal probe and exclusive enteral feeding is prescribed. She received enteral jejunal nutrition progressively with feedback syndrome prophylaxis that included parenteral vitamin B1. After a few days, oral supplementation began. He remained hemodynamically stable, with no signs of heart failure. It gained 3kg of weight up to 43.2kg, starting before discharge from the hospital successfully oral tolerance.

**Conclusions:** Superior mesenteric artery syndrome is a serious complication in anorexia nervosa with a low incidence and an estimated mortality of 33%. A multidisciplinary approach that addresses both the medical and psychological needs of these patients throughout their hospital stay is necessary.

**Disclosure of Interest:** None Declared

## EPV0473

### Relationship between orthorexia nervosa and self-esteem in Tunisian medical students

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**Introduction:** The effect of self-esteem in eating disorders has been investigated in several studies, but it's still not extensively investigated in orthorexia nervosa.

**Objectives:** To study the prevalence and factors associated with orthorexic eating behaviors in medical students and it's relation with self-esteem.

**Methods:** A cross-sectional study was conducted through an online survey among medical students of the faculty of medicine of Sfax (Tunisia). Participants completed an anonymous self-administered questionnaire. We collected their sociodemographic and clinical data. Orthorexia nervosa (ON) was assessed using the self-reported scale, ORTO-15. We used the Rosenberg's self-esteem scale to assess self-esteem.

**Results:** Ninety five medical students completed the survey. The mean age was 25.8±3.4 years and the sex ratio (F/M) was 3.75. The average body mass index was 23.64±3.53 kg/m<sup>2</sup>.