Methods: Collection of clinical information from the patient described below. Review of the literature about SS.
Results: A 21-year-old woman presented to the Psychiatry Emergency Department in November 2021 for complaints of sadness, anhedonia and emotional lability, with one month of evolution. She also had insomnia and confusional periods, so she stopped driving and quit her work as a storekeeper. She was given sertraline 50mg/day and trazodone 50mg/day. In the past two weeks, the patient had episodes of headache and vomiting, with 8 kg weight loss. She started a fever (38.5ºC) two days before observation. The patient had a prior history of depressive symptomatology four years earlier related to her father's grief and her medical and surgical history was unremarkable. She was brought in a wheelchair by her mother and was using diapers because she was confined to bed for the past week. Objectively, the patient was somnolent, tearful and confused, with scarce speech and psychomotor slowing. No focal signs were found on neurological examination. Collaboration of Neurology was asked. Routine laboratory studies showed a slight increase in leucocyte count (12 500/mm3) and CRP (17mg/dL). Cerebrospinal fluid analysis showed 15 cells/uL and protein of 2.64 g/L. Cerebral MRI showed multiple striatocapsular periventricular lesions involving the thalamus, the left midbrain, and the medulla oblongata, as well as focal bilateral hemispherical and cerebellar subcortical lesions. The lesions presented high signal in T2 and showed restriction in the diffusion study. She was admitted to the Neurology inpatient department and treated with pulse methylprednisolone 1000 mg/day for five consecutive days, after which cognitive function improved. Ophthalmology observation found cotton-wool exudate and arteriolar interruption in the right eye, supporting the diagnosis of SS.
Conclusions: This syndrome represents the importance of diligent cooperation among different medical specialties to improve diagnosis-making, treatment and recovery. Psychiatric symptoms are frequent in neurological syndromes, so a high degree of suspicion is needed.

Disclosure of Interest: None Declared

EPV0810

Features of the immune status in patients with functional disorders of the gastrointestinal tract with non-psychotic mental disorders.

N. P. Chernus[1]*, A. S. Sivkov[2], R. V. Gorenkov[3,4], S. I. Sivkov[5] and ?. ?. Золотовицкая[1]

[1]the Outpatient Care Department, the I.M. Sechenov First Moscow State Medical University, Москва; [2]the Department of Clinical Pharmacology and Internal Diseases Propaedeutics, Первый МГМУ им. И.М. Сеченова: Москва, Россия; [3]Scientific substantiation of health preservation of the population of the Russian Federation, The N. A. Semashko National Research Institute of Public Health; [4]Higher Healthcare Organization Management, the I.M. Sechenov First Moscow State Medical University, Москва and [5]the Department of Clinical Pharmacology and Internal Diseases Propaedeutics, the I.M. Sechenov First Moscow State Medical University, Moscow, Russian Federation
*Corresponding author.
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Introduction: Актуальность исследования накопления данных о исключении иммунологического статуса у больных с выраженными расстройствами желудочно-кишечного тракта (ФЖКТ), характерных непсихотических заболеваний легких.
Objectives: изучение взаимосвязи и появление признаков иммунологического и психовегетативного статуса больных у ФЖИР
Methods: Проанализированы и рассчитаны результаты ПВ-А-обследования (тест MMPI) с иммунологическим статусом 57 больных (средний возраст 35,36 ± 14,43 года, мужчины-18, женщины-39) с ФАД в динамике с группой здоровых лиц 34 человека, среднего возраста 28 ,63±9,54 года
Results: У больных с тревожной депрессией [средний профиль: пик по шкале 2 + ⊠ 7-8 и ⊠ 9 шкал] оценочное увеличение относительного значения Т-хелперов CD3+CD4+ (58,0 и 55,0% p = 0,015) при снижении относительного количества Т-цитотоксических лимфоцитов CD3+CD8+ (0,312 и 0,372, p=0,023; 14,0 и 19,0, p=0,001) соответственно, увеличение иммунорегуляторного индекса: Т-хелперы/Т-цитотоксические CD3+ CD4+/CD3+ CD8+ (4,143 и 2,600 , p=0,001); снижение относительного количества NK-клеток CD3-CD16+CD56+ (6% и 8%, p=0,01).
У больных с преобладанием соматизированной анестезии [ведущий пик по шкале 1]: основные выявлены в относительно сниженном CD3+ Т-лимфоцитов (53,0 и 60,0, p=0,001); снижение Т-хелперов: CD3+CD4+ (28,0% и 31,0%, p=0,001); повышение ЭКГ: CD3-СД16+СД56+ (34% и 26,0%, p=0,01; 1153 и 470, p=0,01) по сравнению со здоровыми людьми.
Выявленные изменения показателей иммунитета выявлялись в период обострения заболевания и носили транзиторный характер.
Conclusions: Анализ данных с позиций клинико-динамического выявления вклада иммунобиологических регуляторов организма в клиническое затяжное течение и участие иммунной системы в механизме реализации психоэмоционального контроля стресса. .

Disclosure of Interest: None Declared

EPV0811

Anti NMDAR encephalitis masked by symptoms of postpartum depression

S. Milanovic Hromin[1]*, A. Jelcic[2], R. Perincic[3], M. Komso[1], B. Barun[4], M. Grah[5], S. Zecevic Penic[6], S. Biloglav[7], I. Perincic[7], M. Juresko[7] and B. Skific[7]

[1]GENERAL HOSPITAL ZADAR, Zadar; [2]Ginekologija Dana d.o.o. for gynecology, obstetrics and consulting, Zagreb; [3]Private psychiatric office dr Robert Perincic, Zadar; [4]Department for neuroimunology of CNS, Clinical hospital center Zagreb; [5]Clinic for psychiatry Sveti Ivan, Zagreb, Croatia; [6]Neurological outpatient clinic, Clinic for psychiatry Sveti Ivan, Zagreb and [7]Department for psychiatry, GENERAL HOSPITAL ZADAR, Zadar, Croatia
*Corresponding author.
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Introduction: Anti NMDAR encephalitis is a relatively common autoimmune encephalitis characterized by complex neuropsychiatric features and the presence of Immunoglobulin G antibodies against the NR1 subunit of the NMDA receptors in the central nervous system. It causes psychiatric features, confusion, memory

loss and seizures followed by a movement disorder, loss of consciousness and changes in blood pressure, heart rate and temperature. Postpartum depression symptoms usually develop within the first few weeks after giving birth , but may begin earlier/during pregnancy / or later /up to a year after birth. They include: inability to sleep or sleeping too much, depressed mood or severe mood swing, difficulty bonding with your baby, withdrawing from family and friends, fatigue or loss of energy, feelings of shame, guilt or inadequacy, diminished ability to think clearly, concentrate or make decisions, anxiety and panic attacks, thoughts of harming yourself or your baby. Untreated may last for many months or longer.

Objectives: Recent studies have highlighted the possibility that a subset of patients with first-onset severe psychiatric episodes might suffer from undiagnosed autoimmune encephalitis. The acute onset of severe atypical psychiatric symptoms in young female patients should raise the index of suspicion for anti-NMDA receptor encephalitis, particularly in the setting of neurological symptoms, including side effects of antipsychotic treatment.

Methods: /

Results: /

Conclusions: Creating a therapeutic environment is an interdisciplinary clinical and theoretical approach to psychiatric treatment in hospital settings, the basic idea of which is that the entire environment has therapeutic potential. Psychodinamic knowledge and understanding of the process as well as principles of body-oriented psychotherapy may be of great importance in the treatment of these patients in addition to the use of pharmacotherapy.

Disclosure of Interest: None Declared

EPV0812

Differential diagnosis of cognitive dysfunction in a multi-morbid patient

S. Luna*, S. González, R. J. Cortés and O. Kawas

[1]Psychiatry, Hospital Universitario "Dr. José Eleuterio González", Monterrey, Mexico

*Corresponding author.

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Introduction: Patients with systemic lupus erythematosus (SLE) have cognitive dysfunctions as a neuropsychiatric manifestation, associated with disabling symptoms. However, the presence of other medical or psychiatric comorbidities can delay or lead to a misdiagnose.

Objectives: To present a case of a patient with diagnostic difficulty in the face of multiple medical and neurocognitive comorbidities.

Methods: Description of a case report.

Results: 19-year-old female, Mexican, unemployed, with incomplete high school, with medical history of preterm birth by cesarean at 30 weeks due to placenta previa, history of early puberty, 4 years evolution of focal epilepsy, 1 year evolution of hypothyroidism and mild depression.

She began her symptoms 4 years ago, characterized by an abrupt onset of memory disturbances, decreased concentration, poor academic performance, infantile behavior, need for affection, alternated with irritability periods, verbal and physical aggression, repetitive and erratic behavior. She went to multiple specialists with different therapeutic approaches without clinical improvement. In 2020, she was referred to our service for evaluation, evidenciating a mild depressive episode and psychotherapeutic treatment was started.

Mental and neurological examination without alterations, normal vital signs, at physical examination: malar rash, oral ulcers, alopecia. Labs: increased erythrocyte sedimentation rate, normocytic anemia, leukopenia, rest normal. An electroencephalogram was requested, without alterations. Simple brain MRI was performed (Figure 1).

Psychological (figure 2) and Neuropsychological tests (table 1) were performed, showing alterations in memory recall and inhibitory control.

Due to the symptoms presented by the patient, SLE was suspected, and rheumatology evaluation was requested, integrating a diagnosis of incomplete SLE, and started treatment. The patient presented symptomatic improvement in cognitive symptoms and systemic signs. Likewise, a genetic evaluation was requested, without meeting the criteria for a genetic syndrome. The patient continues with symptomatic improvement and multidisciplinary treatment.

Total scores	Natural	Normalized	Diagnosis
Orbitomedial	180	83	Mild alteration
Pref-Anterior	22	106	Normal
Dorsolateral	207	88	Normal
BANFE total	409	104	Normal

Image:

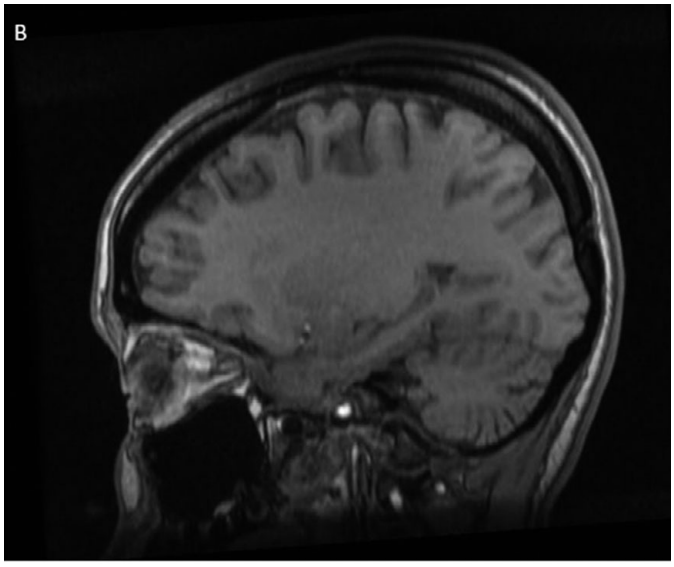

Figure 1. Simple sagittal MRI of the brain showing a generalized decrease in cortical and subcortical cerebral and cerebellar parenchyma.