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#### EV428

### Incapacity to decide in liaison psychiatry: Analysis of sample of patients admitted in somatic departments of a general hospital

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**Introduction** Decision capacity (DC) is a complex construct, whose assessment poses huge challenges to Liaison Psychiatrist (LP).

**Objectives/aims** Assess factors related to DC in patients with somatic disorders admitted in medical and surgical departments of a general hospital.

**Methods** Clinical records of patients who were submitted to a DC assessment at Hospital Fernando Fonseca (Portugal), from 1st January 2012 to 31st December 2014 were retrospectively analysed. Collected data were statistically analysed with SPSS®. Univariable analysis was performed, in order to determine factors related to DC.

**Results** Data from 35 patients subject to DC evaluation were considered, of whom 42.4% were considered unable to give consent to medical and/or surgical procedures. Most of these assessments were related to patients who refused treatment. Patients unable to decide were predominantly male and mainly affected by organic mental or neurocognitive disorders ( $P < 0.05$ ). There were no statistical significant differences in the age of those considered able or unable to decide. After PL intervention, 40% of those considered unable to decide changed their decision. However, it was not significantly related to the ability to give consent.

**Conclusions** Neurocognitive disorders are common diagnosis found in patients admitted in somatic departments with no DC. Frequent change in decision after LP intervention may reflect not only cognitive fluctuations, but also a possible influence of LP intervention on patients' choices. Appropriate standardized measures are useful tools in assessing patients with cognitive impairment, reducing evaluation differences between professionals, and in order to increase LP decisions credibility.

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#### EV429

### Acute hypomania in systemic lupus erythematosus, differential diagnosis.

#### A case report

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**Introduction** It is well known that seizures and psychosis are diagnostic criteria for systemic lupus erythematosus (SLE), however, there could be many other neuropsychiatric symptoms. The American College of Rheumatology Nomenclature provides case definitions for 19 neuropsychiatric syndromes seen in SLE

(NPSLE), including cognitive impairment, psychosis, mood and anxiety disorders. Lack of specific manifestations difficult diagnosis and treatment.

**Objectives** To address the diagnostic difficulties that involve the appearance of hypomanic symptoms in the course of SLE treated with high doses of corticoids in a patient with a depressive episode history.

**Method** Description of case report and literature revision. We report the case of a 22-year-old woman who presented irritable mood, sexual disinhibition, insomnia and inflated self-esteem. The patient was recently diagnosed with SLE and was on treatment with 50 mg/d prednisone. She had familiar history for bipolar disorder and was taking 20 mg/d paroxetine since the last 6 months after being diagnosed with major depressive episode.

**Results** We proposed differential diagnosis between psychiatric symptoms secondary to central nervous system SLE involvement, a comorbid bipolar disorder or prednisone-induced mood symptoms. Fluctuation of hypomanic symptoms during hospitalization, poor relationship with variation in corticosteroid doses, findings on brain MRI compatible with vasculitis and positive antibodies, oriented this case to a neuropsychiatric manifestation of LES.

**Conclusions** We should keep in mind that symptoms of neuropsychiatric SLE may vary from more established manifestations of NPSLE to mild diffuse ones. More studies are needed to expand knowledge in the relationship between mood disorders and neuropsychiatric SLE.

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#### EV430

### Risk factors for a new cardiac event after a first acute coronary syndrome

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**Introduction** Depression is an established risk factor for acute coronary syndrome (ACS), nonetheless the mechanisms underlying this association are still unclear and literature disagrees on the role played by anxiety. Moreover, most of the studies included subjects with a long lasting history of heart disease or recurrent depressive episodes that could bias the results.

**Objectives** We performed serial assessments of anxiety, depression and new cardiac events in a cohort of never-depressed patients in the two years after their first ACS.

**Aims** Clarify the role of anxiety and depression in predicting new cardiac events.

**Methods** Two hundred and fifty-one consecutive patients completed the two-years follow-up. The presence of depression was evaluated with the Primary Care Evaluation of Mental Disorders (PRIME-MD) and its severity with the Hospital Anxiety and Depression Scale (HADS). Evaluations were collected at baseline, when GRACE-score was calculated, and at 1, 2, 4, 6, 9, 12 and 24-months follow-ups.

**Results** Forty-two patients (16.7%) developed a second cardiac event and, of these, eighteen (42.9%) had a previous depressive episode. At Cox Regression, controlling for confounding clinical variables (e.g. GRACE-score), developing a first-ever depressive episode was a significant risk factor (OR = 2.38; 95%CI = 1.11–5.14;  $P = 0.027$ ) whereas baseline anxiety was protective (OR = 0.56; 95%CI = 0.38–0.81;  $P = 0.002$ ). The latter, moreover, moderated the effect of incident depression on new cardiac events.

**Conclusion** Our results confirm the well-established detrimental effect of depression on cardiac prognosis and suggest clinicians to