to six days after the seizure(s). PIP frequently has a polymorphic presentation, tends to be affect-laden and symptoms often fluctuate. It is of limited duration and frequently responds very rapidly to low doses of benzodiazepines and antipsychotics. However, the propensity of the antipsychotics to provoke seizures and the risk of pharmacokinetic interaction with anti-epileptics are important considerations. Recurrence rates range 25% to 50%.
Conclusions Given the negative impact of PIP in morbidity and mortality among these patients, it is crucial that neurologists and psychiatrists are able to adequately recognize and treat this clinical condition.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.612

EV0283

Coordinating primary care and mental health

V.Martí Garnica [1,*], M.D. Ortega Garcia [2], M.A. Bernal Lopez [2], J.R. Russo de Leon [3], S. Marin Garcia [4]
[1] *Servicio murciano de slaud, csm San Andres, Murcia, Spain*
[2] *Servicio murciano de salud, csm Cartagena, Murcia, Spain*
[3] *Servicio murciano de salud, Hospital Reina Sofia, Murcia, Spain*
[4] *Servicio murciano de salud, csm Lorca, Murcia, Spain*
[*] *Corresponding author.*

Through the analysis of a case report to analyze the importance of the coordination between primary care and mental health service for a better management of an outpatient. It is known that primary care is the gateway to the patient in the health system. Therefore, the role of physicians headers is essential for diagnosis, for the start of drug treatment and referral to specialized care. It is known that one of every four patients have mental health problems. To meet the standards of primary care, physicians should ensure personalized assistance, integrated, continuous and permanent. Therefore, in relation to the accessibility of patients, it is essential to establish the diagnosis as soon as possible and initiate appropriate treatment to alleviate the symptoms of this type of psychiatric disorders and should track patients and their caregivers. For all this, it is essential that there is proper coordination between primary and specialty care in mental health. The interdisciplinary approach in these situations can assist the patient and family from a holistic perspective. This approach strengthens and reinforces the subsequent treatment, not only care but also evolutionary. Thus arises the interdisciplinary work as an opportunity to access the new and complex this social situation.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.613

EV0284

Association of blood pressure with anxiety and depression in a sample of primary care patients

A. Sacchetti [1], G. Mattei [1,2,*], S. Bursi [2], M.S. Padula [3,4,5], G. Rioli [1], S. Ferrari [1]
[1] *University of Modena and Reggio Emilia, Diagnostic-Clinical and Public Health Medicine, Modena, Italy*
[2] *Association for Research in Psychiatry, Castelnuovo Rangone, Italy*
[3] *University of Modena and Reggio Emilia, Department of Biomedical-Metabolic and Neural Sciences, Modena, Italy*
[4] *Società Italiana di Medicina Generale, Firenze, Italy*
[5] *Local Health Agency, Department of Primary Care, Modena, Italy*
[*] *Corresponding author.*

Introduction According to international scientific literature, and as summarized in the guidelines of the International Society of Hypertension, lowering of blood pressure can prevent cardiovascular accidents. Some studies suggest that hypertension, anxiety, and depression might be inversely correlated.
Objective To investigate whether blood pressure is associated with anxiety and depression.
Methods Cross-sectional design. Male and female primary care patients were enrolled, aged 40–80. Criteria of exclusion adopted: use of antidepressants or antipsychotics; previous major cardiovascular event; psychosis or major depression; Type 1-DM; pregnancy and hereditary disease associated to obesity. Anxiety and depression symptoms were assessed using HADS. Waist circumference, hip circumference, blood pressure, HDL, triglycerides, blood sugar, hypertension, albumin concentrations and serum iron were also assessed.
Results Of the 210 subjects, 84 were men (40%), mean age was 60.88 (SD ± 10.88). Hypertension was found to correlate significantly to anxiety (OR = 0.38; 95% CI = 0.17–0.84), older age (OR = 3.96; 95% CI = 1.88–8.32), cigarette smoking (OR = 0.35; 95%CI = 0.13–0.94), high Body Mass Index (OR = 2.50; 95% CI = 1.24–5.01), Waist-hip ratio (OR = 0.09; 95% CI = 0.02–0.46) and the Index of comorbidity (OR = 16.93; 95% CI = 3.71–77.29).
Conclusions An inverse association was found between anxiety and hypertension, suggesting the need to clinically manage these two dimensions in a coordinated way. Other findings are well known and already included in prevention campaigns. Further research is needed, also to better understand and explain the causative pathways of this correlation.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.614

EV0285

Impact of classification systems (DSM-5, DSM-IV, CAM and DRS-R98) on outcomes of delirium

G. McCarthy [1,*], D. Meagher [2], D. Adamis [1]
[1] *NUI Galway and HSE West, Sligo Leitrim Mental Health Service, Sligo, Ireland*
[2] *University of Limerick, Psychiatry, Limerick, Ireland*
[*] *Corresponding author.*

Introduction Previous studies showed different classification systems lead to different case identification and rates of delirium. No one has previously investigated the influence of different classification systems on the outcomes of delirium.
Aims and objectives To determine the influence of DSM-5 criteria vs. DSM-IV on delirium outcomes (mortality, length of stay, institutionalisation) including DSM-III and DSM-IIR criteria, using CAM and DRS-R98 as proxies.
Methodology Prospective, longitudinal, observational study of elderly patients 70+ admitted to acute medical wards in Sligo University Hospital. Participants were assessed within 3 days of admission using DSM-5, and DSM-IV criteria, DRS-R98, and CAM scales.
Results Two hundred patients [mean age 81.1 ± 6.5; 50% female]. Rates (prevalence and incidence) of delirium for each diagnostic method were: 20.5% ($n = 41$) for DSM-5; 22.5% ($n = 45$) for DSM-IV; 18.5% ($n = 37$) for DRS-R98 and 22.5%, ($n = 45$) for CAM. The odds ratio (OR) for mortality (each diagnostic method respectively) were: 3.37, 3.11, 2.42, 2.96. Breslow-Day test on homogeneity of OR was not significant x2= 0.43, df: 3, $P = 0.93$. Those identified with delirium using the DSM-IV, DRS-R98 and CAM had significantly longer hospital length of stay(los) compared to those without delirium but not with those identified by DSM-5 criteria. Re-institutionalisation, those identified with delirium using DSM-5, DSM-IV and CAM did not have significant differences in discharge destination compared to those without delirium, those identified