Methods: Case report and non-systematic review of literature: sources obtained from Pubmed database.
Results: A 69-year-old man, native of Syracuse (Italy), was admitted to the Psychiatry Unit in February 2022 presenting behavioural disturbances and irritability. In July 2021 he presented the same symptoms, being mistakenly diagnosed with Bipolar Disease type I. He has no previous psychiatric history. He started with changes in his personality, short-term memory loss, aggressiveness and disorganized behaviour at the age of 66. At admission he was talkative and hyperfamiliar, presenting delusions of grandiosity, exalted affectivity and insomnia. Neurological examination showed short-term memory problems, signs of frontal disinhibition and abnormal glabellar tap sign. Blood tests, CT brain and MRI were performed to rule out organic underlying causes. Neuro-imaging found bilateral and symmetric calcifications in globus pallidus, thalamus and corpus striatum, in favour of FD. Secondary causes (abnormalities in the PTH, vitamin disorders and infectious diseases such as HIV, brucellosis or neurosyphilis) where discarded, allowing us to conclude it was probably a primary case of FD. Valproate was started as a mood stabilizer and anticonvulsant. Genetic tests were indicated.
Conclusions: FD should be considered as a differential diagnosis in the evaluation of psychiatric symptoms, especially when atypical and/or presented with neurological symptoms. The role of neuroimaging is essential.

Disclosure of Interest: None Declared

EPV0273

Diagnostic Overshadowing of Post-ictal Psychosis in the ED– A Case Series

K. Keenan* and A. Moran

Department of Psychiatry, Connolly Hospital, Dublin, Ireland
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1623

Introduction: Diagnostic overshadowing is established as a mechanism by which physical symptoms are misattributed to mental disorder, hence under-diagnosing and under-treating medical pathology. We report a case series of adult males with established neurological disorders who presented to the ED with visual hallucinations in the postictal period. The phenomena of postictal psychosis is long established in neuropsychiatric literature, with reported rates of postictal psychosis in epilepsy of 2%. Patients vsual hallucinations resolve with anticonvulsant stabilisation and rarely require antipsychotic augmentation.
Objectives: To illustrate diagnostic overshadowing in a case series of postictal psychosis
Methods: Retrospective case series
Results: Case 1:
A 36year old man self-presented to the ED 24hrs post tonic-clonic seizure of 15minutes duration. Medical history was significant for hydrocephalus as an infant with 29 surgical revisions of in-situ ventriculoperitoneal shunt since initial placement. Secondary epilepsy was reported to be poorly controlled with an estimated 50 ED attendances in the past year for management of seizure activity. On assessment new symptomatology of non-threatening visual hallucinations with associated low mood was elicited. A diagnosis of postictal psychosis was advised following psychiatric assessment and medical admission with anticonvulsant titration recommended. Despite this characteristic presentation there were repeated requests to admit this patient to the psychiatric unit and a perceived lack of understanding of his acute medical needs.
Case 2:
A 45year old man self-presented to the ED <24hours post discharge following medical admission for management of seizure. Medical history was significant for a right parieto-temporal infarct one year prior, with acceptable return to functioning following rehabilitation. The man had recently been diagnosed with secondary epilepsy and titration of sodium valproate commenced. The patient presented as distressed in the context of new onset visual hallucinations and palinopsia. Medical admission with urgent neurology input and anticonvulsant titration was advised following psychiatric assessment. ED physician repeatedly stated this patients presentation was stress related and requested psychiatric admission. Following medical admission the patient was managed by neurology. Sodium valproate was augmented with clobazam and the patients psychopathology resolved in full.
Conclusions: Diagnostic overshadowing is prevalent in the ED. Despite established medical diagnoses there may be a reluctance for medical teams to acknowledge or treat organic psychopathology. Psychiatrists must keep abreast of medical comorbidities and physical treatment guidelines of neuropsychiatric disorders in order to advocate appropriately for due medical input. Postictal psychosis is effectively managed by neurological input for effective seizure control with collaborative neuropsychiatry input.

Disclosure of Interest: None Declared

EPV0274

Self-harming behaviour in liaison psychiatry : Case series and literature review

K. BENALLEL*, W. MANSOURI and M. KADIRI

psychiatry, Military Hospital Mohammed V - Rabat, Rabat, Morocco
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1624

Introduction: Self-harm (SH) is common, in particular among young people. It can be seen in a wide range of psychiatric disorders, ranging from anti-social personality disorders to schizophrenia and mood disorders. In the extreme, self-harm can be functionally life-threatening. Such is the case of phlebotomy, emasculations and self-amputation. The severity of certain damage and the urgency of an initial somatic treatment contribute to make self-harm one of the most frequent reasons for intervention in liaison psychiatry.
Objectives: Through our case series and a literature review, we tried to describe the socio-demographic and psychopathological characteristics of the self-harmers and to identify the specificities of their management in liaison psychiatry.
Methods: It is a descriptive cross-sectional study, in the psychiatric department of a general hospital in Rabat, concerning patients evaluated for SH with or without other psychiatric manifestations. The data collected are analysed using the statistical software 'JAMOVI'. Patients seen in psychiatric consultations, in medical-surgical emergencies or in liaison psychiatry for SH were included. Patients already hospitalized in psychiatry were excluded.