syndrome, deepening of cognitive inertness (when compared with the first episode of schizophrenia) was noted.
Conclusions: It was determined that NS is not a static phenomenon, but has a certain clinical dynamic, within which individual structural components of NS change their intensity, clinical and prognostic significance.

Disclosure of Interest: None Declared

EPV1536

Latent profile analysis of chronic physical illness effects on psychiatric treatment outcomes in severe mental disorders

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Introduction: Chronic physical illnesses (CPIs) are common in severe mental disorders (SMD) and may shape psychiatric trajectories, yet heterogeneity across multimorbidity patterns is rarely modelled explicitly. We used latent profile analysis (LPA) to identify CPI profiles and examined their association with treatment outcomes.
Objectives: To derive CPI-based latent profiles in SMD and compare psychiatric rehospitalisations and related outcomes across profiles.
Methods: We conducted a retrospective cohort study on 605 patients with SMD. Eighteen binary CPI indicators (European Health Interview Survey) were analysed. Principal component analysis on tetrachoric correlations yielded five CPI components (musculoskeletal; cardiovascular; respiratory–metabolic; metabolic/general health; cerebrovascular). LPA was then fitted to these component scores, comparing four variance–covariance structures and 1–8 classes. The optimal solution was chosen using information criteria, entropy and clinical interpretability. Profiles were compared on the number of rehospitalisations for relapse (primary endpoint) using robust MM-estimation, adjusting for age, sex, education, household income, disorder duration, number of other psychiatric diagnoses, and treatment with antipsychotics, benzodiazepines, mood stabilisers and antidepressants.
Results: We included 605 patients: 326 schizophrenia-spectrum, 223 recurrent major depressive disorder (moderate–severe) and 56 bipolar affective disorder. A four-profile solution provided the best fit and clinical coherence: (1) healthiest/low multimorbidity (mean 1.1 CPI); (2) cerebrovascular–metabolic (2.5 CPI); (3) cardiometabolic–musculoskeletal (3.8 CPI); (4) high-burden musculoskeletal/general health with multiple comorbidities (5.1 CPI). Rehospitalisations differed across profiles: the highest burden occurred in Profile 3, Profiles 1 and 4 showed lower counts, with Profile 2 intermediate; patterns persisted after covariate adjustment.
Conclusions: LPA identified clinically distinct multimorbidity profiles in SMD that were differentially associated with psychiatric rehospitalisations for relapse. Patients with combined cardiometabolic–musculoskeletal burden had the poorest course, whereas low-burden and concentrated high-risk profiles fared better. CPI profiling may support risk stratification and tailored integrated somatic–psychiatric care and inform service planning.

Disclosure of Interest: None Declared

EPV1537

Still and Silent: When Psychosis Looks Like Conversion

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Introduction: The differential diagnosis between conversion disorders and psychotic episodes can present a significant clinical challenge. Both conditions may share striking symptoms such as mutism, immobility, altered states of consciousness, and bizarre behavior, which can lead to diagnostic confusion—especially in emergency settings.
Objectives: This case study aims to analyze the atypical clinical presentation of conversive symptoms in a patient in the emergency room.
Methods: A review of the literature on conversive symptomatology which may occur in psychosis.
Results: A 50-year-old woman with a psychiatric history since age 16, including multiple episodes with psychotic and conversive features—four requiring hospitalization. Her relatives report previous diagnoses of schizophrenia and bipolar disorder, but no records are available due to her international relocation. She is taking quetiapine 50 mg and oxcarbazepine 300 mg.
She arrives at the emergency room with her husband due to mutism. Organic causes are ruled out. On examination: mutism, perplexed gaze, failure to follow commands, and oppositional rigidity that varies and decreases with distraction. She imitates guided movements without difficulty; Hoover's sign is positive. A conversion disorder is suspected. Diazepam 15 mg and lorazepam 2 mg are administered.
Her husband reports increased anxiety, insomnia, mutism, and immobility over the past week, alternating with periods of normal behavior. Two weeks prior, she became distressed about returning to work. He states that similar episodes have occurred under stress and resolved within days with benzodiazepines.
After 24 hours, she is able to speak and move, but appears confused, with no memory of the episode. She describes a sense of strangeness, makes interpretive remarks, and shows loose associations. Speech is vague and poorly structured. She is admitted and started on olanzapine 10 mg and amisulpride 800 mg.
Conclusions: This clinical case illustrates an acute presentation initially characterized by mutism and immobility, compatible with a possible conversion disorder. However, the partial response to benzodiazepines and the subsequent emergence of psychotic symptoms suggest a different or more complex etiology.
One possibility is a psychotic episode with pseudoconversion symptoms—behaviors that mimic a conversion disorder but are actually expressions of disrupted thought processes. Another potential diagnosis is a brief psychotic disorder with catatonic features. Additionally,

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a polymorphic acute psychotic disorder (as defined in ICD-10) could explain the abrupt onset, symptom fluctuations throughout the day, and the presence of atypical features.
This is a diagnostically challenging case in the emergency setting, due to its atypical presentation and lack of information regarding the patient's psychiatric history. Access to her medical records and longitudinal observation would be essential for reaching a clearer diagnostic conclusion.

Disclosure of Interest: None Declared

EPV1538

Off-label Augmentation with Cariprazine in a Patient with Schizotypal Disorder and Persistent Suicidal Rumination: A Case Report

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Introduction: Cariprazine, a D3/D2 and 5-HT1A partial agonist, is approved for schizophrenia, bipolar I disorder, and adjunctive MDD treatment. It's demonstrated efficacy across positive, negative, and transdiagnostic symptom domains , especially as an augmentative strategy for resistant negative symptoms (Barabassy et al. Pharmaceuticals 2025; 18:995). However its use in schizotypal disorder remains underexplored.
Objectives: To assess the efficacy of cariprazine augmentation to clozapine in a schizotypal disorder case, with focus on negative symptoms, suicidal rumination, and functional outcomes.
Methods: This case report was developed following an unsystematic literature review conducted via databases as PubMed and PsycINFO using keywords including: *cariprazine, clozapine augmentation, negative symptoms, schizotypal disorder*, and *suicidal rumination.* Clinical data were derived from a detailed patient evaluation and follow-up at the Day Hospital, University Clinic of Psychiatry in Skopje.
Results: A 40-year-old woman with a long-standing polymorphic psychiatric illness—marked by affective instability, poor interpersonal functioning, social withdrawal, and multiple suicide attempts and hospitalizations—was admitted for intensification of obsessive suicidal ideation despite high-dose clozapine (up to 400 mg/day) and previous adjunctive SSRIs and risperidone (discontinued due to hyperprolactinemia). On admission to the Day Hospital, clozapine (200 mg/day) was continued, and cariprazine 3 mg/day was initiated, while the patient was included in individual and group psychosocial treatment. Baseline assessment revealed: Positive and Negative Syndrome Scale (PANSS) – Positive 11, Negative 31, General Psychopathology 52; Suicidal Ideation Attributes Scale (SIDAS) 30 (high suicide risk); Personal and Social Performance (PSP) 25/100 (severe dysfunction).After 4 weeks, significant improvement was noted in regards to: PANSS – Positive (−18%), Negative (−42%), General (−27%) ; SIDAS 21 (−30%) reduction; PSP 65/100, indicating moderate recovery. Clinically, obsessive suicidal ruminations subsided, affective responsiveness improved, and the patient resumed self-care, parenting roles, and active participation in individual, group, and family therapy.
Conclusions: The rapid reduction in negative symptoms and obsessive suicidal ideation following cariprazine augmentation supports its broad efficacy, likely mediated by high D3 receptor affinity and serotonergic activity. While clozapine remains the gold standard for treatment-resistant psychosis, a substantial proportion of patients respond only partially. This case contributes to the limited evidence suggesting that cariprazine may enhance clinical and functional outcomes in schizotypal disorder, particularly where suicidality and negative symptoms predominate. Further research is needed to clarify its therapeutic role in this population.

Disclosure of Interest: None Declared

EPV1539

Psychotic manifestations as the first presentation of Huntington's disease: a case report

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Introduction: Huntington's disease (HD) is a neurodegenerative disorder characterized by motor, cognitive, and psychiatric symptoms that are often misdiagnosed. We present a case of a patient with a purely psychotic debut and a family history of the disease.
Objectives: To describe a clinical case of late-onset psychosis in the context of a family history of Huntington's disease, to highlight the importance of considering this pathology in the differential diagnosis, even in the absence of obvious motor symptoms.
Methods: A 44-year-old woman with a family history of Huntington's Chorea (father and sister) was admitted due to a clinical picture of psychomotor agitation and persecutory delusional ideas. The psychopathological exploration revealed auditory hallucinations and structured delusional ideas. The CT scan showed frontal atrophy. Initial treatment consisted of olanzapine. For diagnostic confirmation, tests are recommended, such as the genetic test for the HTT gene mutation (CAG repeat expansion), a brain magnetic resonance imaging (MRI) to evaluate caudate and putamen nucleus atrophy (an early sign in Huntington's disease), and a detailed neurological examination to detect subtle signs, such as alteration in oculomotor saccade, subtle dysarthria, or dystonia.
Results: The clinical picture was compatible with a paranoid type psychotic disorder. The treatment with olanzapine resulted in a behavioral improvement, allowing for pharmacological de-escalation and the removal of physical restraint. The evolutionary report of the admission established the diagnostic suspicion of Huntington's chorea as the basis of the clinical picture. The patient, a carrier of the HD gene, was discharged with follow-up in the parkinson's and abnormal movement unit.
Conclusions: This case report demonstrates the need for a comprehensive clinical history in patients with late-onset psychosis, as psychiatric manifestations can be the initial symptom of HD. It emphasizes the importance of close coordination between psychiatry and neurology for timely diagnosis and optimal therapeutic management. The approach should include symptomatic treatment, with a focus on avoiding typical antipsychotics like haloperidol and being cautious with some atypicals like Risperidone, as they