(altered cytokines), metabolic and lipid abnormalities related to starvation, and serotonergic and neurotrophic changes (BDNF) affecting mood regulation, impulsivity, and cognitive control.
Integrative models propose that chronic malnutrition interacts with affective vulnerability, compulsivity, and increased pain tolerance to simultaneously heighten suicidal desire and capability, especially in restrictive phenotypes.
Overall, current evidence supports a multidimensional understanding of suicide risk in eating disorders, in which clinical severity, emotional processes, and biological stress and metabolic pathways jointly contribute to vulnerability, underscoring the need for multimodal assessment and prevention strategies. Improved knowledge of the cognitive mechanisms associated with suicide risk in this population could guide the development of tailored treatment and prevention approaches.

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SP043

Eating disorders are psychiatric illnesses heavily burdened by death risk

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Abstract: Eating disorders (EDs) are among the most lethal psychiatric illnesses, characterized by a markedly elevated standardized mortality ratio compared to the general population. Mortality arises from both severe medical complications—particularly in anorexia nervosa—and suicide, which accounts for a substantial proportion of deaths across diagnostic subtypes. Despite this well-documented risk, suicide vulnerability in EDs remains insufficiently integrated into routine clinical assessment and care pathways.
Recent work by Sébastien Guillaume and colleagues has significantly advanced our understanding of suicidal risk in ED populations. Their findings highlight the central role of affective dysregulation, impulsivity (especially in binge–purge phenotypes), depressive comorbidity, and history of suicide attempts as key drivers of mortality risk. Beyond categorical diagnoses, dimensional constructs such as emotional pain, cognitive rigidity, and stress sensitivity appear crucial in explaining why only a subgroup of patients progresses from ideation to suicidal behavior.
From a precision suicidology perspective, EDs represent a paradigmatic case of dual vulnerability: metabolic fragility interacting with psychiatric and psychological risk trajectories. Not all patients with EDs share the same death risk. Stratification models integrating clinical phenotype (restrictive vs. binge–purge), prior suicidal behavior, depressive severity, and potentially biological markers (e.g., inflammatory or stress-related indicators) may improve identification of high-risk individuals.
Importantly, weight restoration alone does not equate to reduced suicide risk. The post-hospitalization period may constitute a critical window for targeted intervention. Precision-based approaches combining careful medical monitoring, systematic suicide risk assessment, and tailored psychotherapeutic strategies are therefore essential.
Recognizing eating disorders as illnesses with heterogeneous but potentially extreme mortality risk shifts the clinical objective: from symptom management alone to proactive, stratified, and suicide-informed care. Such an approach may ultimately reduce preventable deaths in this vulnerable population.

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SP044

Cognitive dysfunctions in multiple sclerosis

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Abstract: Cognitive dysfunctions cause pervasive and significant disabilities in people with multiple sclerosis. This will increase the global burden of the disease. Different domains of cognition are not equally affected by multiple sclerosis. Among the vulnerable domains of cognition impaired by multiple sclerosis, it should be noted that information processing speed (IPS), verbal memory, visual memory, prospective memory, executive functions, visuospatial processing, language functions, and social cognition are affected. So far, studies have revealed that cognitive dysfunctions in people with multiple sclerosis negatively impact the quality of life, disease management, risk of falls, driving, financial management skills, employment, and attending social and leisure activities. Moreover, their caregiver partners' health-related quality of life is also diminished. Three batteries are widely used to objectively assess cognition in persons with multiple sclerosis: the Brief Repeatable Battery of Neuropsychological Tests (BRB-N), the Minimal Assessment of Cognitive Function in MS (MACFIMS), and the Brief International Cognitive Assessment for MS (BICAMS). There are a lot of other psychiatric comorbidities or complications of multiple sclerosis that should be identified and treated, such as anxiety, depression, apathy, organic personality disorder, psychoactive substance abuse, and even suicide. All these conditions may worsen the cognitive impairments in people with multiple sclerosis. Some of the psychiatric comorbidities could be a direct consequence of disease-modifying therapy in multiple sclerosis. Whatever the case, the management of this subclinical population of people with multiple sclerosis and cognitive dysfunctions needs specific management, consisting of specific social, psychological, and pharmacological interventions.
Keywords: cognitive dysfunctions, multiple sclerosis, disabilities
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