can exacerbate motor symptoms. Pharmacological treatment should be guided by evidence; the drugs of choice are atypical antipsychotics such as Quetiapine or Clozapine, and in cases of affective symptoms, the inclusion of mood stabilizers like valproate, while lithium should be avoided to prevent the worsening of dyskinesia.

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EPV1540

Is pseudoneurotic schizophrenia still a clinically relevant concept?

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Introduction: Pseudoneurotic schizophrenia described patients with pervasive "neurotic" symptoms (anxiety, dissociation, obsessions, somatic complaints) alongside subtle disturbances of thought-form and affect regulation that concealed an underlying psychotic process. This term, similar to concepts like "borderline", "latent", or "ambulatory" schizophrenia, fell out of use and was absorbed into schizotypal and borderline personality disorder. However, an important clinical subset remains poorly captured by these labels, a gap that has been attempted to be filled with schizophrenia spectrum and other proposed categories such as schizo-obsessive disorder.
Objectives: To evaluate the clinical relevance of "pseudoneurotic schizophrenia".
Methods: A non-systematic literature review (keywords: pseudoneurotic schizophrenia; schizo-obsessive) was conducted, and a single case report is presented.
Results: A 29-year-old man with complaints of severe akathisia-like inner restlessness without overt manifestation of anxiety, unusual bodily sensations (skin burning, tingling/stinging, "licking," head pressure), dissociation, intrusive ego-dystonic obsessions with bizarre content, insomnia, and anhedonia. He was admitted to the day hospital where examination revealed multimodal hallucinations, somatic/persecutory/guilt delusions, thought interference and passivity phenomena, and a mild formal thought disorder. On admission, BPRS score was 65, and PANSS score was 90. MRI and EEG results were unremarkable. He reported the onset of psychiatric symptoms 10 years ago, and 3 years of persistent symptoms with preserved occupational functioning. History included 2 clearly delineated psychotic episodes with good antipsychotic response. Between episodes, he exhibited pervasive anxiety, marked inner restlessness, somatic complaints, intrusive obsessions, and atypical cutaneous/cenesthetic sensations, and was diagnosed with F41 and F60 and treated with SSRIs, with limited benefit. After antipsychotic treatment with partial remission (BPRS=38, PANSS=64), delusional ideation attenuated; reality testing was intact, and no formal thought disorder was elicited. Obsessive thoughts, burning cutaneous sensations, diffuse anxiety, and akathisia-like inner restlessness persisted with reduced intensity, and occupational functioning was preserved.
Conclusions: A subset of patients who present with anxiety, obsessive-compulsive, and mood symptoms may be masking a psychotic process. Careful assessment of neurotic symptoms and consideration of the "pseudoneurotic" concept are essential to avoid personality/anxiety mislabeling and delayed antipsychotic treatment. These cases may indicate progression to schizophrenia. This suggests that a clinically important phenotype remains inadequately captured by current DSM-5/ICD-11 categories and retains contemporary relevance within a dimensional schizophrenia-spectrum view.

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EPV1541

Sleep as a reflexion of well-being in schizophrenia

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Introduction: Sleep disorders affect between 30% and 80% of people with schizophrenia (Dule *et al.* TOPHJ. 2020;13(1):684-91). These disturbances have been linked to an exacerbation of psychiatric symptoms, a decline in cognitive function and a substantial reduction in quality-of-life (QoL) scores across various domains. These findings emphasize the importance of treating sleep disorders specifically to enhance the overall well-being of patients with schizophrenia (Chen *et al.* Schizophr Res 2024;264:407-15).
Objectives: Our objective was to assess the impact of sleep quality on the QoL in patients with schizophrenia and schizoaffective disorder (SAD).
Methods: This was a cross-sectional study including patients with schizophrenia and SAD, aged between 18 and 65 years, who were followed up at RAZI psychiatric Hospital in Tunisia. Sleep quality was assessed using the Arabic version of the Patient Sleep Quality Index (PSQI). Quality of life was assessed using the French version of the 12-item Short Form (SF-12) scale.
Results: Fifty patients with schizophrenia and SAD were included in our study. The mean age was 42 ± 12 years, 60% were men, and 82% were single. The median global PSQI score was 11 [4; 13], ranging from 0 to 17. The median physical health score (PCS-12) was 42.23 [31.08; 52.72], while the mean mental health score (MCS-12) was 42.91 ± 11.12. Both PCS-12 and MCS-12 scores were below the general population average of 50. According to the PSQI scale, 24% of patients were categorized as good sleepers, while 76% were identified as poor sleepers. A significant association was observed between the global PSQI score and PCS-12, with lower PSQI scores corresponding to higher PCS-12 scores ($\beta = -1.887$, $p = 0.001$). The PSQI score accounted for 68.2% of the variance in PCS-12 ($R^2 = 0.682$). Additionally, a significant association was found between the global PSQI score and MCS-12 ($p < 0.001$). Simple linear regression indicated that higher PSQI scores were associated with lower MCS-12 scores ($\beta = -1.835$, $p < 0.001$), with the PSQI score explaining 69% of the variance in MCS-12 ($R^2 = 0.69$).
Conclusions: Poor sleep quality significantly affects both physical and mental well-being of patients with schizophrenia or SAD. Therefore, systematic screening and management of sleep disturbances are crucial to optimize overall functioning and daily outcomes in this population.

Disclosure of Interest: None Declared

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