cessation. Clinical data were obtained through direct assessment, collateral history, and medical chart review. Treatment strategies included pharmacological stabilization, monitoring of vital signs, and supportive interventions.
Results: The patient presented with acute withdrawal symptoms within hours of last GHB intake, including tremor, diaphoresis, hypertension, agitation, anxiety, and episodes of disorientation. High-dose benzodiazepines were required for symptom control, with gradual clinical stabilization over several days. Adjunctive medications were necessary to address residual insomnia and anxiety. Psychoeducation regarding relapse risk and long-term consequences of GHB use was provided, and referral to an addiction treatment program was arranged.
Conclusions: GHB withdrawal constitutes a psychiatric and medical emergency that can mimic other withdrawal syndromes but requires rapid recognition and aggressive benzodiazepine-based management. Long-term care should combine pharmacological strategies for acute stabilization with psychosocial interventions to reduce relapse risk. This case underscores the importance of awareness among clinicians due to increasing prevalence of GHB use in nightlife and high-risk populations.

Disclosure of Interest: None Declared

EPV096

Addiction to Gambling and Antidepressants: Impact on Impulsivity and Compulsive Behavior

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Introduction: Pathological gambling disorder (PGD) is a psychiatric condition characterized by a loss of control over betting behavior, associated with dysfunctions in the dopaminergic and serotonergic systems. Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), are frequently used to treat psychiatric comorbidities in these patients. However, their effects on impulsivity and compulsive behavior remain controversial. While some studies suggest a beneficial effect in reducing compulsivity, others indicate a possible exacerbation of impulsivity, potentially increasing the risk of pathological gambling.
Objectives: To conduct a narrative literature review on the impact of antidepressants on pathological gambling behavior, discussing possible neurobiological mechanisms involved and implications for clinical management.
Methods: A narrative search was conducted in databases such as PubMed, Scopus, and Web of Science, including studies published between 2015 and 2024. The review analyzed research addressing the impact of SSRIs, SNRIs, and dopaminergic antidepressants on PGD, as well as their effects on impulsivity regulation and inhibitory control.
Results: Evidence suggests that SSRIs, such as fluoxetine and sertraline, may reduce compulsivity by modulating serotonergic neurotransmission and its interaction with the prefrontal cortex. However, their impact on impulsivity is variable, possibly due to the complex interaction between the serotonergic and dopaminergic systems within the reward circuitry. SNRIs and dopaminergic antidepressants, such as bupropion, have been associated with increased impulsivity in some studies, potentially exacerbating risk-taking behavior. The presence of psychiatric comorbidities, such as major depressive disorder and attention-deficit/hyperactivity disorder (ADHD), may influence treatment response, highlighting the need for a personalized approach.
Conclusions: The effect of antidepressants on pathological gambling is not yet fully understood and may vary depending on the patient's neurobiological profile and the class of medication used. Clinical management should consider individual differences and the presence of comorbidities, avoiding pharmacological strategies that may increase impulsivity. Future studies should further explore the underlying mechanisms of this relationship and guide more effective therapeutic approaches.

Disclosure of Interest: None Declared

EPV097

Short PQ interval in alcohol withdrawal: diagnostic challenge in a psychiatric setting

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Introduction: Chest pain in psychiatric inpatients often raises concern for acute coronary syndrome (ACS), particularly in those with alcohol use disorder, where somatic complaints and cardiological risks are common. Yet not all such pain reflects myocardial ischemia. Beyond the well-known "holiday heart syndrome," rare conduction anomalies like Lown–Ganong–Levine (LGL) syndrome may appear with paroxysmal supraventricular tachycardia. Alcohol withdrawal, marked by autonomic overactivity, can further unmask these arrhythmias and complicate the clinical picture.
Objectives: To demonstrate how alcohol withdrawal can mimic acute coronary syndrome and unmask rare conduction abnormalities such as LGL syndrome, emphasizing the importance of careful ECG interpretation in psychiatric settings.
Methods: Clinical observation of a 49-year-old inpatient undergoing alcohol withdrawal. The patient was assessed through physical examination, continuous monitoring of vital signs, and standard 12-lead electrocardiography. Supportive care was provided within a psychiatric ward setting, with cardiological consultation available if symptoms worsened.
Results: Electrocardiography revealed a short PQ interval (<120 ms), narrow QRS complexes, and no delta wave, consistent with a LGL conduction pattern. The episode was interpreted as a paroxysmal supraventricular tachycardia most likely triggered by autonomic flux during withdrawal. Symptoms subsided spontaneously with supportive care, without need for acute pharmacological or invasive intervention. An electrophysiological study would be required for definitive confirmation of the LGL syndrome.
This case illustrates how chest pain in psychiatric patients can easily be misinterpreted. In alcohol withdrawal, autonomic storm not only produces somatic sensations mimicking ACS but can also reveal pre-existing conduction anomalies. Misreading such ECG patterns as ischemic changes could unnecessarily prompt transfer

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to intensive care or invasive procedures. Previous reports in the literature have described arrhythmias unmasked by withdrawal, yet this remains under-recognized in psychiatric settings. Importantly, LGL syndrome may be overlooked because its ECG findings are subtle and may resemble normal variants. Differentiation from other pre-excitation syndromes, particularly Wolff–Parkinson–White, is essential to avoid misclassification. Careful ECG interpretation and awareness of such rare conditions can prevent misdiagnosis and reduce risk for the patient.

Image 1:

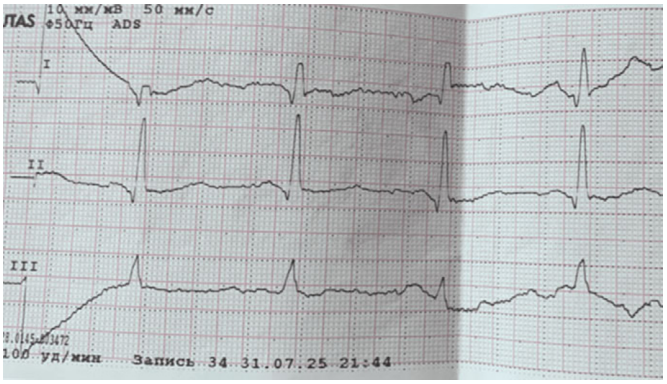
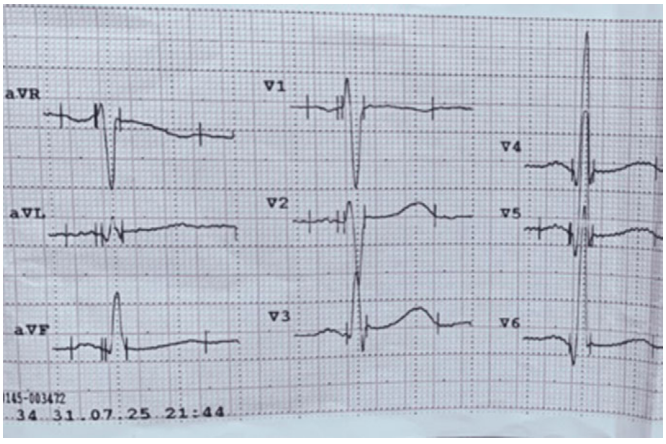


Image 2:



Conclusions: Even the possible presence of conduction abnormalities must be considered in psychiatric contexts, both to guide monitoring and to avoid misdiagnosis and harm. This case underscores the need for collaboration between psychiatry and cardiology in the management of alcohol withdrawal, ensuring that uncommon but clinically relevant conduction anomalies are not missed.

Disclosure of Interest: None Declared

EPV099

Emotional Childhood Trauma Predicts Poorer Adherence in Inpatient Addiction Treatment

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Introduction: Childhood traumatic experiences (CTEs) are highly prevalent among people with substance use disorders (SUDs). Most inpatient programmes screen for "any trauma," but different trauma domains (emotional, physical, sexual, general) may have distinct implications for treatment retention. Clarifying which domains predict non-completion could make trauma-informed care more targeted and effective.

Objectives:

1) To test whether specific CTE domains differentially predict completion of inpatient SUD treatment.
2) To compare the predictive value of a binary "any-CTE" screen versus domain-level screening.
3) To explore whether risk-behaviour burden and admission anxiety/depression contribute to adherence.

Methods: We conducted a cross-sectional study of consecutive inpatients at the Centre for the Treatment of Drug Addiction, University Psychiatric Clinic Ljubljana (13 January 2020–31 May 2021). During week 1, participants completed the Early Traumatic Inventory Self Report – Short Form, Alcohol Use Disorder Identification Test, and Zung Anxiety/Depression. Urine toxicology and hepatitis C virus serology were obtained; chart data captured comorbidities. The primary outcome was adherence, defined as completion of inpatient treatment according to the mutually agreed plan (yes/no). Associations between predictors and adherence were examined using multivariable logistic regression ($p<0.05$). Sample: N=217 (23.5% women; mean age 36±7 years).

Results: CTEs were common (78.8%). A binary "any-CTE" indicator did not predict adherence. In domain-level analyses, emotional CTE independently predicted lower odds of completion (OR 0.52, 95% CI 0.30–0.90, p=0.019), whereas general, physical, and sexual CTEs were not significant. Reporting a protective adult at the time of trauma (30.4%) was not associated with adherence (OR 0.75, 95% CI 0.42–1.35, p=0.339). Although CTEs correlated with a higher count of risk behaviours (OR 1.35, 95% CI 1.17–1.57, $p<0.001$), risk-behaviour counts themselves did not predict adherence (OR 1.01, 95% CI 0.91–1.11, p=0.897). Admission anxiety and depressive symptoms showed no significant associations with adherence after adjustment.

Conclusions: Retention risk in inpatient SUD care appears specifically linked to emotional childhood trauma rather than global trauma exposure, risk-behaviour burden, or baseline anxiety/depression. Routine domain-level trauma screening, flagging emotional CTE, could provide actionable "retention signals" to trigger early, individualized supports (e.g., enhanced alliance-building, stabilization, trauma-focused interventions). Prospective evaluations should test whether embedding such domain-level flags into admission workflows improves completion rates and post-discharge outcomes.

Disclosure of Interest: None Declared