EPV1418

blind or schizophrenic but not both

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Introduction: Although visual impairment appears to be a risk factor for schizophrenia, early blindness may be protective , It's a phenomenon that has puzzled even the smartest scientific brains for decades. It might surprise you: no person born blind has ever been diagnosed with schizophrenia.
Objectives: The objective of this research is to discover the relationship between schizophrenia and congenital blindness is there a protective gene ! is that visual perception constitutes an essential stage in the onset of the disease itself !
Methods: Case study of a family consisting of thirteen brothers and sisters, three of whom were blind at birth, three with schizophrenia. the study of the files of schizophrenic patients hospitalized in our structure since it opened in the 1970s
Results: Case study of a family consisting of thirteen brothers and sisters, three of whom were blind at birth, three with schizophrenia, but there is none with blindness at birth and schizophrenia. PLus on the basis of medicals files there is no case of schizophrenia with blindness at birth. Preliminary observational analysis of this clinical case suggests the following hypothesis: the presumed protective role of congenital blindness against schizophrenia. The bibliographic research has objectified three recent studies in this direction in Australia, Denmark, and the USA.
Conclusions: The relationship between schizophrenia and congenital blindness is still unrecognized and controversial
Several studies are done in this direction, but so far there is no assertion or confirmation of the hypothesis

Disclosure: No significant relationships.
Keywords: congenital; blindness; schizophrénia; protect

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Negative symptoms - a real unmet need

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Introduction: Schizophrenia is frequently a chronic and disabling disorder, characterized by heterogeneous positive and negative symptoms. Negative symptoms are a major health concern and a core component of schizophrenia that account for a large part of the long-term disability and poor functional outcomes in patients with the disorder. Adequate treatment would mean important progress and Distinguishing primary from secondary negative symptoms may inform about treatment options.
Objectives: Objective: to provide information that may be useful for clinicians treating patients with negative symptoms of schizophrenia.
Methods: We searched Pubmed and Cochrane Library database for english language articles.
Results: Negative symptoms are a core component of schizophrenia that account for a large part of the long-term disability and poor functional outcomes. Negative symptoms are common in schizophrenia; up to 60% of patients may have prominent clinically relevant negative symptoms that require treatment. Negative symptoms can occur at any point in the course of illness, although they are reported as the most common first symptom of schizophrenia. Negative symptoms can be primary symptoms, which are intrinsic to the underlying pathophysiology of schizophrenia, or secondary symptoms that are related to psychiatric or medical comorbidities, adverse effects of treatment, or environmental factors. Negative symptoms clearly constitute an unmet medical need in schizophrenia, and new and effective treatments are urgently needed.
Conclusions: Clinically relevant negative symptoms of schizophrenia need to be recognized, assessed, and as well managed as possible in order to achieve improved outcomes for patients. More studies are needed to establish the better approach to negative symptoms.

Disclosure: No significant relationships.
Keywords: negative symptoms; schizophrénia

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Ekbom syndrome: a case report

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Introduction: Ekbom syndrome is a clinical term for delusional parasitosis, a condition characterized by the belief that one's skin is infested by invisible parasites. Despite having no medical evidence, patients strive to prove their illness and interpret different sensations and symptoms as infestation with parasites.
Objectives: Our objective was to present a case report of a patient with Ekbom syndrome with detailed clinical information and treatment complications.
Methods: We included patient's history, psychiatric evaluation, complete diagnostic work-up, therapy and follow-up.
Results: A 60-years old female patient was admitted to her first hospital treatment in our psychiatric clinic. Upon admittance, she was extremely tense, preoccupied with the idea that bed bugs have infested her body. She showed extensive medical documentation, including numerous dermatologic reports regarding her condition, interpreting them in accordance with her delusions. In attempt to help herself and "release" the bugs, she harmed herself causing multiple skin lesions across her body and face. The treatment was complicated with secondary skin infections, ulcers, cellulitis and oedemas. Initial treatment with olanzapine was switched to risperidone due to side-effects (sedation, increase of appetite, weight gain). Gradually, with pharmacological treatment, psychoeducation and support, remission was achieved, but poor insight to her previous condition and psychiatric symptoms remained.
Conclusions: Ekbom syndrome presents a serious disorder that can be complicated with secondary somatic complications, often requiring involvement of different medical specialists. Moreover, lack of insight into the need for psychiatric treatment can lead to therapy discontinuation and relapse of symptoms.

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Keywords: Delusional disorder; ekbom syndrome; parasitosis; dermatology

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