Introduction: Traumatic brain injury (TBI) is a rare, yet possible cause of psychosis (Fujii D *et al.* Psychiatr Clin North Am. 2014; 37(1):113-24), with one of the main challenges being distinguishing between Psychosis secondary to traumatic brain injury (PSTBI) and schizophrenia (SZ).
Objectives: To discuss the diagnostic challenges in patients with psychosis and history of TBI.
Methods: In addition to describing a case report of a male with psychotic symptoms presenting after a severe traumatic brain injury, research was undertaken in PubMed and other databases using the keywords "traumatic brain injury", "psychosis" and "schizophrenia".
Results: Our patient is a 36 year-old male who suffered a severe TBI at age 22, with consequent frontal and temporal encephalomalacia. Initially he presented with persecutory delusions, delusional perceptions associated with colors, social isolation and decline in academic performance, which were attributed to Post-Concussion Syndrome. However, these symptoms would remain for years to come, leading to the new diagnosis of SZ, at age 25. This way, he started intramuscular antipsychotic medication, which reduced psychotic symptoms and improved his academic performance. This amelioration, at age 30, led to the belief in another diagnosis: Brief Psychotic Episode (after brain trauma). Consequently a reduction in antipsychotic dosage was tried but a resurgence of psychotic symptoms was observed at age 33, which led to the reintroduction of antipsychotic medication, and the reconsideration of the diagnosis of SZ. When we examined him, at age 36, he presented similar symptoms to those observed after the brain injury, intensified by years without antipsychotics. We also found that he had regular use of cannabinoids since age 16 and that his brother was diagnosed with Schizoaffective disorder.

Image:



Image 2:



Conclusions: PSTBI usually occurs after a TBI with frontal and temporal lesions, and psychotic symptoms like persecutory delusions, with the frontal lesions being a possible explanation for the decline in cognitive function by causing deficits in attention, executive functions and memory (Fujii D *et al.* Journal of Neuropsychiatry Clinics in Neuroscience 2002;14:130-140). SZ can similarly explain many of the findings presented, like psychotic symptoms, social isolation and decline in cognitive function due to negative symptoms, specially considering the use of cannabinoids and genetic vulnerability present in this patient and the fact that TBI is also a risk factor for the development of SZ. This case highlights the difficulty in the differential diagnosis between PSTBI and SZ, given that it presents aspects that can point in both directions.

Disclosure of Interest: None Declared

EPV1284

First Episode Psychosis: A Neurodevelopmental Crossroads

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Introduction: Autism spectrum disorder (ASD) and schizophrenia (SZ) are neurodevelopmental disorders that, although unfolding in

different ways, can present with overlapping symptoms, both negative symptoms like deficits in social–emotional reciprocity and engagement (Trevisan *et al.* Front.Psych; 2020;11:548), and positive symptoms like delusions and hallucinations (Ribolsi *et al.* Front Psychiatry; 2022;13:768586).
Objectives: To discuss the diagnostic challenges between ASD and SZ in patients presenting with both positive and negative symptoms.
Methods: In addition to describing a case report of a man with negative symptoms and presumptive psychotic symptoms, research was undertaken in PubMed and other databases using the keywords "autism spectrum disorder", "schizophrenia" and "multiple sclerosis".
Results: A 26 year-old man was involuntarily admitted to the in-patient unit due to persecutory delusions, irritability, social isolation and cognitive symptoms. He had also been recently diagnosed with Multiple Sclerosis (MS). These symptoms had begun 5 years prior, intensifying over time, leading to the hypothesis of First Episode Psychosis, with a probable recent escalation secondary to the flairing up of MS. Through a detailed clinical history, we discovered that, in fact, the patient exhibited conduct changes since early adolescence: restricted and repetitive behavior, social isolation, reduced tolerance to opposition, cognitive rigidity, circumscribed interests and puerile contact. This lead to the development of great hostility towards his family members, whenever his wants weren't met (most of them mismatched with reality), resulting in isolation from the family and the sending of aggressive messages and emails, even though his parents always tried to provide the patient with everything he wanted, explaining the assumption of persecutory delusions. Intramuscular risperidone and clozapine were initiated for irritability and cognitive symptoms, respectively, with minimal improvement in both, mainting however every other symptom described.
Conclusions: Despite the current distinction between ASD and SZ, they still share many similarities, increasing the difficulty of determining an exact diagnosis. We present a case with negative and cognitive symptoms, that can fit in both conditions, and positive symptoms that fit in SZ. It's possible to understand that the delusions may not be primary, but secondary to social interpretation bias, common in ASD patients, and that part of the cognitive symptoms can be due to MS. The suboptimal response to antipsychotics also makes us lean more to the presence of ASD with temporary psychotic symptoms instead of a primary psychotic disorder.

Disclosure of Interest: None Declared

EPV1285

Diagnostic delays in schizophrenia with catatonic symptoms mimicking conversive disorder

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Introduction: Notwithstanding the drastic reduction in the prevalence of catatonic symptoms in schizophrenia with the development of anti-psychotic treatment regimens since the 1950's, a subgroup of patients still presents mostly such symptoms, associated with worse long-term prognosis.
Objectives: Discuss the challenges surrounding the diagnosis and clinical management of patients with schizophrenia with catatonic symptoms.
Methods: In addition to describing a case report of a male with catatonic symptoms mimicking conversive disorder, research was undertaken in PubMed and other databases using the keywords "conversive disorder, "catatonia" and "schizophrenia".
Results: A 29-year-old male patient, a former Geology BA student followed by Psychiatry in our hospital for conversive symptoms – namely mutism and sudden episodes of motor paralysis with no changes in the neurological examination or imaging exams - and admitted twice for that reason in the prior 6 months, was brought to the ED by police after an attempted self-injury with a knife. The family reported for the past week sleep-wake inversion, social isolation, compulsive smoking, refusal to eat any homemade food, soliloquies, staring at the walls for no reason and, in the last 3 days, post its with messages such as "I sinned" or "I disappointed God". In the ER, the patient engaged in mutism, with negativism in his posture. Considering the high suicide risk and the presence of psychotic symptoms, including persecutory, poisoning and mystical delusions as well as likely auditive-verbal hallucinatory activity, he was admitted again, this time in involuntary regime. To exclude secondary causes, both blood samples and imaging techniques (first head CT and later MRI) were ordered. The bloodwork revealed increased levels of CK without any other significant findings, and imaging techniques also had negative results. In the psychiatric ward, the patient engaged in selective mutism towards the medical team, likely in a context of persecutory delusions. Due to the prominence of negative symptoms and lack of adhesion to treatment, we choose to treat with intramuscular paliperidone and sertraline, 50 mg. With this treatment, the patient started feeding himself again, resumed a daily routine and ceased his mutism. Yet, he remained highly defensive psychopathologically, with very poor speech content and severe affective blunting. He was discharged with the diagnosis of schizophrenia and has been followed in outpatient visitations, remaining clinically stable.
Conclusions: Catatonic schizophrenia in its first presentation can be confused with conversive disorder, given the fact both may share movement disorders, in psychotic patients who collaborate very little with psychiatrists, requiring a careful combination of anamnesis, mental state examination and gathering of information with family members or others close to the patient.

Disclosure of Interest: None Declared

EPV1286

On the issue of psychopathological analysis of a work of fiction using the example of Dostoevsky's "The Double"

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Introduction: Vladimir Chizh, who replaced Emil Kraepelin in the Department of Psychiatry at the University of Dorpat in 1891, counted no fewer than 30 characters with psychoneurological