prudent. The increase of intentional (i.e., suicidal) determined YFO is a major public health concern.

Disclosure of Interest: None Declared

EPV0137

Conversive and Factitious disorders: Differential diagnosis based on a case report

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Introduction: Conversive disorder is characterised by the presence of one or more involuntary neurological symptoms that are not due to a clear medical pathology. On the other hand, consciously simulated illnesses fall into two diagnostic categories: factitious disorders and malingering, which are differentiated by both the motivation for the behaviour and the awareness of that motivation. Factitious disorder behaviours are motivated by an unconscious need to assume the sick role, whereas malingering behaviours are consciously driven to achieve external secondary gains.
Objectives: Study of the differences between conversion disorder and factitious disorder and their repercussions from a case of difficult diagnosis.
Methods: Bibliographic review of scientific literature based on a relevant clinical case.
Results: We present the case of a 14-year-old male patient. Adoptive parents. Studying in high school. Social difficulties since childhood. He comes to the emergency department on several occasions referring stereotyped movements and motor tics in the four extremities with left cervical lateralization. Increase of these symptoms in the last month, so it was decided to admit him to the pediatric hospital. After observation and study of the patient's movements with normal complementary tests he should return home. The following day he returned to the emergency department after an episode of dizziness, mutism and emotional block. It was decided to admit him to Psychiatry for behavioral observation and differential diagnosis.
Conclusions: In the assessment of patients it is essential to make an appropriate diagnosis taking into account the patient's symptomatology and the patient's background and life context. Conversion disorder is the unintentional production of neurological symptom, whereas malingering and factitious disorder represent the voluntary production of symptoms with internal or external incentives. They have a close history and this has been frequently confounded. Practitioners are often confronted to medically unexplained symptoms; they represent almost 30% of neurologist's consultation. The first challenge is to detect them, and recent studies have confirmed the importance of "positive" clinical bedside signs based on incoherence and discordance. Multidisciplinary therapy is recommended with behavioral cognitive therapy, antidepressant to treat frequent comorbid anxiety or depression, and physiotherapy. Factitious disorder and malingering should be clearly delineated from conversion disorder. Factitious disorder should be considered as a mental illness and more research on its physiopathology and treatment is needed, when malingering is a non-medical condition encountered in medico-legal cases.

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Smith-Magenis Syndrome associated with Autism Spectrum Disorder with delayed diagnosis due to B12 deficiency: a case report

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Introduction: Smith-Magenis syndrome (SMS) is a complex genetic disorder characterised by distinctive physical features, developmental delay, cognitive impairment and a typical behavioural phenotype. SMS is caused by interstitial 17p11.2 deletions (90%) involving multiple genes, including the retinoic acid-induced 1 gene (RAI1), or by pathogenic variants in RAI1 itself (10%).
Objectives: In this case report, we present a case of Smith-Magenis syndrome with Autism Spectrum Disorder with karyotype 46,XX, 17p 11.2 gene deletion confirmed by Autism Spectrum Disorder, who was followed up in a paediatric neurology outpatient clinic with neuromotor developmental delay and whose diagnosis was delayed due to B12 deficiency. We also update scientific developments in Smith-Magenis syndrome.
Methods: We describe an 18-month-old male with Smith-Magenis syndrome and Autism Spectrum Disorder who was seen in our paediatric psychiatric outpatient clinic and who received B12 replacement with developmental delay.
Results: The patient was followed up in the paediatric neurology outpatient clinic with delay in neuromotor developmental milestones and this delay was thought to be due to B12 deficiency (B12<100 ng/L). The initial examination revealed delay in neuromotor and behavioural milestones, speech delay, wide and high nasal bridge and hypertelorism. Further physical examination revealed syndactyly of the second and third toes bilaterally and crossed lower teeth. Clinical and psychometric testing (Ankara Developmental Screening Inventory) by 2 consultants and 1 research assistant resulted in a diagnosis of intellectual disability and an additional diagnosis of Autism Spectrum Disorder due to social deficits that could not be explained by intellectual disability.
Conclusions: Smith-Magenis syndrome is a well-known disorder involving the deletion of chromosome 17p11.2, which contains the RAI1 gene. This condition is associated with neuromotor and behavioural delay, as well as distinctive dysmorphic features. Clinicians should consider Smith-Magenis syndrome in the differential

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