level was set at 0.10 for exploratory purposes. Statistical analyses included the Mann-Whitney U test and Kruskal-Wallis test to explore the effects of observer gender and relationship on the discrepancy in ADHD symptom reporting.

**Results:**

1. Gender of the patient did not influence self-reported ADHD scores (*U = 5057.500, p = 0.705)*, but observer gender significantly impacted their rating of the patient's symptoms (*U = 5312.500, p = 0.032).*
2. Female patients' ADHD symptoms were underrepresented more than male patients' (U = 3941.500, p = 0.019).
3. Male observers underreported symptoms more than female observers (U = 4772.500, p = 0.075).
4. Observer relationship to the patient did not significantly affect ADHD symptom score discrepancies (H(3) = 4.928, p = 0.177).
5. Female partners were less likely to underrepresent ADHD symptoms compared to female parents, female and male family members, and male partners *(p = 0.028, 0.002, <0.001).*

**Conclusions:** Female patients were more likely to have their ADHD symptoms underrepresented, particularly by male observers and male partners, indicating potential gender biases in perception. The findings suggest that clinicians should be cautious of possible underreporting of ADHD symptoms by male observers and particularly male partners. Future research should explore whether hyperactivity or inattentiveness is more frequently underrepresented and further validate these exploratory findings.

**Disclosure of Interest:** None Declared

## Addictive Disorders

### EPP076

### Increased risk of alcohol use disorder following bariatric surgery: literature review

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**Introduction:** In the last 50 years, obesity has become a leading cause of morbidity and decreased life expectancy, being associated with the development of cardiovascular disease, decreased mental health and overall decreased quality of life. The development of bariatric surgery as a treatment strategy in those in which attempts at conservative treatment yielded no satisfactory results has revolutionized treatment of refractory obesity. While short term gains in cardiovascular health are undeniable, long-term impact remains uncertain. More recently, there is emerging evidence of bariatric surgery being associated with *de novo* alcohol use disorder.

**Objectives:** We aimed to study the possible correlation between bariatric surgery and alcohol use disorder, specifically the individual risk factors that may promote such outcome. Moreover, we aimed to evaluate which surgical procedures are more eliciting of alcohol use disorder.

**Methods:** We performed a literature review using the database MEDLINE and obtained 241 results using the query terms "*bariatric surgery*" and "*alcohol*". Of these, we read all the summaries and subsequently selected 51 different scientific articles which we afterwards read in full. We then performed a literature review aiming to understand the maladaptive alcohol consumption patterns following bariatric surgery

**Results:** Most studies report maladaptive alcohol use following bariatric surgery. Outstandingly, this consumption pattern develops only at later follow up stages, usually over 3 years after surgery. Furthermore, not all types of bariatric surgery appear to pose the same iatrogenic risk. Gastric bypass poses the highest risk of new onset alcohol misuse, in comparison to sleeve gastrectomy or gastric band surgery. It is not yet fully understood the mechanism behind this pattern of alcohol misuse following surgery, but common reasons have been identified, including different social interaction patterns, addiction transfer, ambivalence towards bodily changes, increased mental vulnerability and different body response to the effects of alcohol.

**Conclusions:** The screening of alcohol misuse before and after bariatric surgery is of paramount importance to decrease the surgical iatrogenic risk and improve outcomes. Further research should be developed in understanding what are the risk factors and mechanistic pathways for alcohol misuse following bariatric surgery. Also, it should be investigated whether the treatment of alcohol misuse disorder differs between patients submitted to bariatric surgery or not.

**Disclosure of Interest:** None Declared

### EPP077

### Screening abstinent bariatric surgery patients for Behavioural Addictions using MMPI-2 data

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**Introduction:** Eating disorders comprise various conditions yet do not cover chronic overeating that may result in extreme obesity. Binge eating disorder with chronic somatic effects is not included in DSM-V; behavioural addictions do not comprise chronic overeating either. Neither do impulse control disorders. There are no actual screening tools for chronic overeating, and research is scarce on its chronic psychological effects

**Objectives:** This research aims to find the distinctive psychometric characteristics of addiction using MMPI-2 data taken from patients who underwent gastric surgery due to high-risk obesity or moderate-risk obesity with alarming comorbidities.

**Methods:** This study employed a consecutive patient cohort to evaluate complication rates and the efficacy of Single-Anastomosis duodeno-ileal bypass with Gastric plication (SADI-GP). Patient recruitment commenced in October 2018 and ceased in June 2019. The process involved preoperative assessment, surgery, and several postoperative follow-up appointments at 1, 3, 6, and 12 months. The Minnesota Multiphasic Personality Inventory

(MMPI-2) was administered during the 12-month follow-up. Participants aged between 18 and 65 years were included in the study, with body mass indexes (BMIs) exceeding 40 for individuals without comorbidities related to morbid obesity, and exceeding 35 for those with comorbidities related to morbid obesity, particularly related to glucose metabolism.
MMPI-2 scales previously confirmed to be related to SUD were analyzed, and common psychological comorbidities of SUD were searched for using these scales
**Results:** High scores on MAC-R, AAS, and APS scales are well-represented in the sample (Table 1).
The sample includes a high number of high scorers on Rc4 and a moderately high number of high scorers on Rc9 (Table 2).
Elevated individual scale scores form dual or triplet peak settings in the MMPI-2 results and may describe certain conditions, like SUD.
The majority of the subjects showed SUD-like personality settings (Figure 1). This study is constrained by limitations about sample size, a dropout rate exceeding expectations, stringent exclusion criteria, male-to-female ratio, short-term results, and the absence of longitudinal data on psychological characteristics.

**Image 1:**

*Table 1.* **Frequencies along the Supplemental Scales**

| | No. of patients with high score | % |
|---|---|---|
| Anxiety (A) | 5 | 31,25% |
| Repression (R) | 5 | 31,25% |
| Ego Strength (Es) | 1 | 6,25% |
| Dominance (Do) | 2 | 12,5% |
| Social Responsibility (Re) | 3 | 18,75% |
| College Maladjustment (Mt) | 5 | 31,25% |
| Post-Traumatic Stress Disorder Scale (Pk) | 6 | 37,5% |
| Hostility (Ho) | 6 | 37,5% |
| Over Controlled Hostility (O-H) | 3 | 18,75% |
| MacAndrews Alcoholism Scale Revised (MAC-R) | 9 | 56,25% |
| Addictions Acknowledgement Scale (AAS) | 4 | 25% |
| Addiction Potential Scale (APS) | 6 | 37,5% |
| Gender Role - Masculine Scale (GM) | 3 | 18,75% |
| Gender Role - Feminine Scale (GF) | 6 | 37,5% |

**Image 2:**

*Table 2.* **Frequencies along the Revised Clinical Scales (Rc)**

| | High score | % | Low score | % |
|---|---|---|---|---|
| Demoralization (Rcd) | 4 | 25% | 0 | 0 |
| Somatic Complaints (Rc1) | 2 | 12,5% | 0 | 0 |
| Low Positive Emotions (Rc2) | 7 | 43,75% | 0 | 0 |
| High/Low scores on Cynicism (Rc3) | 5 | 31,25% | 3 | 18,75% |
| Antisocial Behavior (Rc4) | 7 | 43,75% | 0 | 0 |
| Ideas of Persecution (Rc6) | 2 | 12,5% | 0 | 0 |
| Dysfunctional Negative Emotions (Rc7) | 4 | 25% | 0 | 0 |
| Aberrant Experiences (Rc8) | 1 | 6,25% | 0 | 0 |
| Hypomanic Activation (Rc9) | 4 | 25% | 0 | 0 |

**Image 3:**

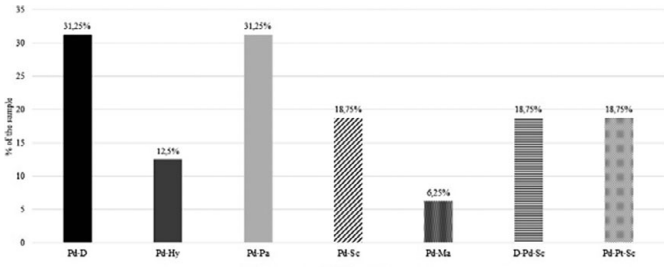



*Fig. 1:* **Co-occurence of the Clinical Scales**

**Conclusions:** We found the MacAndrews Revised (MAC-R) scale strong, with AAS and APS as intermediate indicators for non-substance-based behavioural addiction in our sample (Table 1). RC4 also seems to be a strong indicator (Table 2), along with Pd-D and Pd-Pa peaks (Figure 1).

**Disclosure of Interest:** None Declared

## EPP078

## Baclofen-Assisted Alcohol Detoxification with Minimal Diazepam Dosing: A Controlled Study at Corfu General Hospital Detoxification Unit

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**Introduction:** Alcohol withdrawal syndrome is a significant challenge in the management of alcohol use disorder, with traditional treatments often relying heavily on benzodiazepines like diazepam. This study aimed to explore the efficacy and safety of incorporating baclofen (30 mg/day) alongside minimal, tailored diazepam doses—adjusted according to alcohol intake and CIWA-Ar scores—to manage withdrawal symptoms more effectively than conventional diazepam protocols. By reducing the total diazepam needed and shortening detoxification time, the study highlights the potential of baclofen to offer a faster, safer approach to alcohol withdrawal treatment.
**Objectives:** To evaluate the efficacy and safety of combining baclofen (30 mg/day) with minimal diazepam doses—calculated based on alcohol consumption and adjusted by CIWA-Ar scores—in managing alcohol withdrawal symptoms more rapidly than standard diazepam protocols.
**Methods:** Sixty-nine patients with alcohol use disorder were enrolled and randomized into two groups. The baclofen group (n = 32) received baclofen 30 mg/day plus minimal diazepam, with initial diazepam doses based on average daily alcohol units consumed (1 mg diazepam per unit) and adjusted using CIWA-Ar scores. The standard group (n = 37) received a conventional diazepam-based detoxification regimen with fixed starting doses adjusted by withdrawal symptoms. Primary outcomes were the total diazepam dosage required and the duration of detoxification. Secondary outcomes included daily CIWA-Ar scores and incidence of adverse effects. Statistical analyses employed independent t-tests and chi-square tests, with $p < 0.05$ considered significant.
**Results:** The baclofen group required significantly less diazepam compared to the standard group (mean total dose: 30 ± 10 mg vs. 50 ± 15 mg; $p < 0.001$). They also experienced a shorter detoxification duration (mean: 15 ± 1 days vs. 19 ± 1 days; $p = 0.01$), indicating a faster withdrawal process. CIWA-Ar scores were consistently lower in the baclofen group throughout detoxification (mean: 6 ± 2 vs. 10 ± 3; $p < 0.001$), reflecting milder withdrawal symptoms. No significant adverse effects were observed in either group, including over-sedation, respiratory depression, or hallucinations.