Notably, 64.3% of the veterans experienced both anxiety and depressive symptoms and were taking antidepressants, while only one veteran exhibited neither. The remaining had either anxiety or depressive symptoms.
In terms of ED severity, 46.4% had mild to moderate ED, followed by 28.6% with mild ED, 17.9% with severe ED and 7.1% with moderate ED.
Only 14.3% reported using sexual enhancers.
Conclusions: This study provides valuable insights into the unique profile of ED among Tunisian veterans, revealing a high prevalence of psychological comorbidities, particularly anxiety and depression, alongside physical health issues. The interconnection of these factors highlights the importance of a holistic approach adressing both psychological and physical aspects of ED. These results call for further research into the specific challenges faced by veterans for a more personalized and effective interventions.

Disclosure of Interest: None Declared

EPV1873

Transition regret and detransition: what went wrong?

A. Cardoso[1]* and M. Mota[1]

[1]Psychiatry Department, Unidade Local de Saúde de São João, Porto, Portugal
*Corresponding author.
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Introduction: The phenomena of regret and detransition in individuals undergoing *gender-affirming treatments* raise significant medical and bioethical challenges for professionals working in this area.
Objectives: This work aimed to gather the most current evidence regarding the approach to the issues of regret and detransition, characterizing the main factors involved and reflecting on possible prevention strategies.
Methods: A literature review was conducted through research on PubMed, using the keywords "gender dysphoria," "regret," and "detransition". Only articles in English were included. Additional bibliography was selected by consulting the references of the initially included articles.
Results: Regret and detransition are distinct concepts. In fact, there can be regret without detransition and detransition without regret, with the narratives and experiences of these individuals being very diverse. Detransition may be motivated by external or internal factors, depending on whether transgender identity is preserved or lost. Originally thought to be rare, it has been challenging to assess the actual prevalence of these phenomena, whose increase is expected in the future. In an effort to counter this trend, the literature emphasizes the importance of a multidisciplinary and comprehensive approach to individuals with gender dysphoria, based on effective and assertive communication, ensuring responsible and informed decision-making. Regular follow-up combined with psychosocial support throughout the entire transition process is also crucial. Therapeutic approach should be individualized and integrated into a continuing care plan, grounded in an empathetic and non-judgmental attitude.
Conclusions: Regret and detransition are not necessarily synonymous with medical error. Considering the complex spectrum of experiences involving these phenomena, a comprehensive approach that allows for an integrated view of each person and their needs is essential. Further research and development of guidelines regarding the approach and support for this group of individuals are needed.

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EPV1874

Irreversible antidepressant-induced sexual dysfunction: what do we know so far?

A. Cardoso[1]* and M. Mota[1]

[1]Psychiatry Department, Unidade Local de Saúde de São João, Porto, Portugal
*Corresponding author.
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Introduction: Serotonergic antidepressants, particularly Selective Serotonin Reuptake Inhibitors (SSRIs), have been known to cause relevant sexual adverse effects, which were originally thought to disappear after treatment course. In later years, an emergent condition concerning the persistence of sexual impairment following SSRI discontinuation has gathered increasing social and scientific interest. Post-SSRI sexual dysfunction (PSSD) is still underrecognized and understudied.
Objectives: Our aim was to gather available evidence regarding the pathophysiological mechanisms and contributing factors to PSSD, as well as current management options.
Methods: A literature review was conducted using PubMed, through research of the following MESH terms: "Selective Serotonin Reuptake Inhibitors", "Antidepressive Agents", "Sexual Dysfunction, Physiological" and "Sexual Dysfunctions, Psychological". Only papers published in English were included.
Results: PSSD has been described as an iatrogenic condition whose symptoms could persist indefinitely. Despite clinical heterogeneity and lack of robust literature surrounding PSSD, there is growing evidence of this concern. In order to diagnose PSSD, sexual dysfunction due to reemergence of depressive illness must be ruled out. Accurate incidence and prevalence rates of this condition are unknown, though it appears to be a rare phenomenon. Several potential etiological explanations for PSSD have been proposed. Some have highlighted a dysregulation in serotonergic activity induced by SSRIs, while others have tested the role of neuroregulatory agents and bioelectric circuits. Another theory involves a possible link between PSSD and other post-discontinuation syndromes. In contrast, some authors have theorized that sexual impairment induced by a long course of SSRIs could induce a negative conditioning effect towards sexual activity in some patients. Despite abovementioned hypotheses, sexual dysfunction is usually complex in nature and thus multifactorial. There is no established treatment to PSSD. Pharmacological and psychotherapeutic approaches have been tested and proposed to ameliorate symptoms of PSSD, but further investigation is warranted.
Conclusions: PSSD is a heterogenous and idiosyncratic syndrome that needs further characterization. It remains unclear why only certain individuals develop PSSD and treatment options are limited. Current evidence is still incipient and insufficient to justify adjusting current SSRI prescription patterns. However, clinicians must be aware of this condition and should monitor and address

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these issues with patients. Future research should provide further insights into underlying pathophysiological mechanisms, which in turn could help acknowledge possible preventive and therapeutic interventions.

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EPV1875

Erectile Dysfunction in Patients with Mental Disorders: Challenges in Diagnosis and Intervention from a Family Medicine Perspective

C. G. Coronell[1]*, L. E. De Miguel[2], I. J. Contreras[1], O. Pascual[3], L. R. Bello[4], A. Ferrandez[5] and P. Guerrero[6]

[1]Family Practice Department, CAP Vallirana, Vallirana (Barcelona); [2]Psychiatry Department, Hospital Sagrat Cor, Martorell (Barcelona); [3]Nursery Department, CAP Vallirana, Vallirana (Barcelona); [4]Family Practice Department, CUAP La Solana, Sant Andreu de la Barca (Barcelona); [5]Family Practice Department, Centro de Salud Guadarrama, Madrid and [6]Family Practice Department, Centro de Salud de Nájera., La Rioja, Spain
*Corresponding author.
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Introduction: In Spain, erectile dysfunction (ED) affects around 19% of men aged 25 to 70, with higher prevalence in older age groups. Family doctors are key for early ED detection, yet it is often underdiagnosed due to limited sexual health training and poor communication. Many patients hesitate to discuss sexual issues, and short consultation times worsen this problem. Early diagnosis is crucial for effective intervention, improving both quality of life and health outcomes.
Objectives: To evaluate the effects of chronic diseases and medications on ED and identify commonly used treatments.
Methods: This retrospective review focused on patients with late-diagnosed ED. We assessed the delay in reporting symptoms and contributing factors such as embarrassment and consultation constraints. The study also explored the impact of chronic conditions like diabetes and hypertension, and the role of psychotropic medications. Data were gathered from the Sexology Patient Database at Vallirana Primary Care Centre (CAP), covering 255 sexual dysfunction cases. The review aimed to understand diagnostic delays and the influence of chronic conditions and medications on ED.
Results: Of 255 sexual dysfunction diagnoses, 193 were ED, making up 75.69%. The average patient age was about 62, with an average delay of 1.95 years before seeking help. ED comorbidities included Cardiovascular and Metabolic Diseases: 33.3%, Musculoskeletal and Articular Diseases: 31.25%, Psychiatric and Sleep Disorders: 29.2%, Digestive Diseases: 20.83%, Respiratory Diseases: 18.75%, Urogenital Disorders: 18.75%, Dermatological Disorders: 12.5%, Neurological Disorders: 10.42%, Endocrine Disorders: 8.33%, and Harmful Habits: 8.33%. Common medications were Antihypertensives: 16.7%, SSRIs: 14.6%, Proton Pump Inhibitors: 12.5%, Benzodiazepines: 10.4%, Antidiabetics: 10.4%, Statins and Fibrates: 10.4%, Bronchodilators and Inhaled Corticosteroids: 10.4%, Antiplatelets: 8.3%, and Other Medications.
Conclusions: The high ED prevalence of 75.69% underscores major issues with timely diagnosis. The average 1.95-year delay highlights barriers to early treatment. Chronic conditions, especially cardiovascular and metabolic disorders, are closely linked to ED. The presence of psychiatric and sleep disorders indicates a complex interaction with sexual dysfunction. The variety of medications used, particularly antihypertensives and SSRIs, necessitates careful management to avoid adverse effects. Family doctors are crucial for diagnosing, managing ED, and referring to specialists. However, time limitations and lack of sexology training often result in underdiagnosis. Enhancing awareness can improve early detection and management, leading to better patient outcomes and timely specialist care.

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EPV1877

Gender dysphoria and psychosis - symptom or comorbidity?

B. V. Ferreira[1]*, C. Alves[2], J. F. Fontes[1], M. M. Serra[1], T. Pereira[1], R. R. Henriques[3] and M. Gonçalves[1]

[1]Clínica 5; [2]Clínica 3 and [3]Clínica 2, ULS São José - Hospital Júlio de Matos, Lisboa, Portugal
*Corresponding author.
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Introduction: Gender dysphoria (GD) refers to the marked incongruity between the experience of one's gender and the sex at birth. Psychiatric illness is one of the major negative prognostic features for the outcome of GD. In particular, much controversy exists regarding whether individuals with psychotic symptoms should receive gender affirmative treatment.
Objectives: The present review aims to provide an overview of the current literature of the occurrence of gender dysphoria symptoms during psychotic episodes and identify challenges in differential diagnosis and treatment and offering recommendations to overcome them.
Methods: Articles published on the last five years were searched on Medline, PubMed, Web of Science and Springer Link using the following keywords: gender identity, psychosis, gender dysphoria.
Results: Delusions about one's physical appearance and the desire to change the body can be observed in patients with schizophrenia or other psychotic disorders. Therefore, the differential diagnosis is critical for therapeutic planning and effort is required to carry out the necessary diagnostics when articulation of gender dysphoric feelings coincides with the onset of psychosis. It is crucial to evaluate the chronology and dynamics of the individual symptoms, their constancy, patient's criticism, and response to antipsychotic treatment.
Conclusions: Some presentations of GD can be created by life experience in individuals who have underlying mental or neurophysiological abnormalities. The experiences of practitioners indicate that coincidence of schizophrenia and gender identity disorder is possible, that is why the differential diagnosis needs time, careful observation, examination and cooperation of psychiatrist and sexologist.
This review addresses the significance of understanding each patient's individual circumstances, focusing specifically on proper physician training and direct patient care.

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