Results: 35 patients were recruted of who 65.7% were male. 68.6% were single. 51.4% had a low socio-economic level and 42.9% had an average level. 48.6% had a psychiatric history of which 22.9% had attempted suicide. Abuse was present in 34.3%, family separation in 22.9%, death of a parent in 20% while no patient reported sexual abuse. The most common method used was a razor blade in 57.1% of cases. The most mutilated site was the forearms in 65.7%, following a frustration in 60% and a conflict situation in 25.7%. 48.6% were hospitalised (34.5% in psychiatry, 5.6% in intensive care and 5.6% in otorhinolaryngology).
Conclusions: Self-harm is a frequent pathological behaviour whose incidence is increasing. Understanding the psychological and biological basis of self-harm will help to improve the management of these patients and prevent the recurrence of this dangerous behavior and its complication by suicide.

Disclosure of Interest: None Declared

EPV0275

About a case: affective psychosis and hyperthyroidism

J. Peñalver[1], A. Llimona[2], J. Mayans[1], L. N. Vargas[2], M. T. Campillo[3]*, C. Muro[2] and S. Oller[2]

[1]Psiquiatría, Parque de Salut Mar; [2]Psiquiatria, Parc de Salut Mar and [3]Psiquiatria, Parque de Salut Mar, Barcelona, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1625

Introduction: Hyperthyroidism due to Graves-Basedow disease is a common cause of neuropsychiatric manifestations, such as anxiety, psychomotor restlessness, mood disturbances, insomnia and psychosis. Hashimoto's encephalopathy rarely occurs in so-called autoimmune thyroiditis, which can present with hyperthyroidism and neuropsychiatric symptoms similar to Graves' disease. We add that the mystical-religious beliefs, present in all human cultures, and decisive in the case at hand, make us propose an evolutionary origin of them.
Objectives: Clinical case description
Methods: A clinical case based on medical reports is described
Results: We present the case of a 72-year-old woman, a member of the Seventh-day Adventist Church, well adapted to the Community. Known history of elevated antithyroid antibodies since 2019, brought to the emergency room involuntarily due to a mystical-religious delusional condition associated with behavioral disturbance. On examination, cachectic appearance, distal tremor, emotional exaltation and megalomanic speech were highlighted. Laboratory tests revealed primary hyperthyroidism with elevated antibodies. During admission, the differential diagnosis between Graves-Basedow disease and Hashimoto's encephalopathy was considered. Thyroid scintigraphy oriented the diagnosis to Graves-Basedow disease, not requiring lumbar puncture or corticosteroid treatment. Treatment was based on high-dose antithyroid and antipsychotic drugs, with clinical and analytical remission at 3 weeks. The patient was referred to a Social Health Center for functional recovery. The family refers to a similar episode in 2014, of less intensity and self-limited, which is proposed to be a hashitoxicosis.
Conclusions: Differential diagnosis between Graves-Basedow and Hashimoto disease is essential as they differ in treatment and prognosis. The continuity that the delusion presents with the previous beliefs of the patient, differing mainly in the affective-behavioral implication, makes us consider a predisposition to psychosis in our patient. Religiosity can be adaptive in certain environments, since mystical beliefs have existed throughout the history of the human species and seem to be part of our nature.

Disclosure of Interest: None Declared

EPV0276

MALIGNANT CATATONIA IN MEDICAL WARDS: A BROAD DIFFERENTIAL DIAGNOSIS

N. Arbelo

[1]Psychiatry, Hospital Clinic of Barcelona, Barcelona, Spain
doi: 10.1192/j.eurpsy.2023.1626

Introduction: Catatonia is an uncommon and heterogeneous psychomotor syndrome. It can be not only the manifestation of a psychiatric disorder but also a wide range of medical conditions. The malignant catatonia is a subtype of catatonia which includes dysautonomic signs such as hyperthermia or hemodynamic instability, and because most of the affected patients are taking antipsychotics or antidepressants previously, it can be confounded with medical conditions such as neuroleptic or serotonin syndrome.
Objectives: To present a case of malignant catatonia admitted in a medical ward
Methods: The present study is a case report of a patient admitted with initial diagnosis of serotonin syndrome in a medical ward of our hospital and referred to the consultation and liaison psychiatry (CLP) unit. We also searched previously case reports, series and systematic reviews about catatonia secondary to medical conditions and hyperthermia catatonia.
Results: Ms. TN is a 71-year-old woman, with prior history of major depressive disorder. One month ago she was admitted in a psychiatric ward of another hospital for a depressive episode with psychotics features, and was treated with escitalopram 10mg/day, vortioxetine 10mg/day, mirtazapine 15mg/day, trazodone 50mg/day, quetiapine 700mg/day and haloperidol 5mg/day. She had a worsening of depressive symptoms with suicidal thoughts, negativism and psychomotor retardation, and subsequently hyperthermia, rigidity, mydriasis, tachicardia and increased bowel sound. She was tranfered to our medical ward, and diagnosed of serotonin syndrome. She was stopped all the psychiatric drugs and was treated with dantrolene and support measures. After 10 days without antidepressants or antipsychotics she maintened the same symptomatology and was referred to our CLP unit. The psychopathological evaluation showed stupor, mutism, waxy flexibility and negativism, and she responded to a challenge test with intravenous clonazepam 0,5mg. She was diagnosed of malignant catatonia and was started oral clonazepam 2mg/day. Although there was a partial response, she did not tolerate higher doses because of sedation and finally was treated with electroconvulsive therapy (ECT). She dad a remission of catatonic symptoms after only two sessions of ECT.
Conclusions: Malignant catatonia can be confounded with other medical conditions such as serotonin or neuroleptic syndromes. All of them can have catatonic signs, and it is important to recognize them (a challenge test with a benzodiacepine can be helpful). The key to distingish malignant catatonia from them is that some of the

https://doi.org/10.1192/j.eurpsy.2023.1625 Published online by Cambridge University Press