18 years-old, finding that males presented an earlier start of the ED and not appreciating differences in the duration of the disease, income, episodes of purgue and psychiatric comorbidity of anxiety, behaviour disorders or impulsivity.
Objectives: The aim of this study was to evaluate gender differences in clinical characteristics, levels of depression, previous obsessiveness and personality dimensions in eating disorders (ED) compared with controls.
Methods: A total of 80 participants was divided into 4 groups, 20 men and 20 women with ED and 20 men and 20 women without ED (healthy control), matched by age and socioeconomic status. The design of the study was case-control, and data was collected through clinical interview and a battery of cuestionaires.
Results: Men with ED only differ in vigorous physical activity (measured by IPAQ) from controls and women with pathology. Regarding personality traits, men and women with ED do not differ among them, although they do differ in novelty search and harm avoidance respect to their controls.
Conclusions: Behaviors such as physical activity in males frame a slightly different way of reducing their discomfort, however, clinical implication indicates that the treatment may be similar according to gender.

Disclosure of Interest: None Declared

EPV0469

Eating disorders. What about males?

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Introduction: Eating disorders (ED) historically been adressed as illnesses that only affect young adolescent females. ED's in males have been documented in literature as early as the 1960's; yet men continue to be under represented on research on the topic. For decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) perpetuated the invisibility of males by including amenorrhea as a diagnostic criterion. It was not until 2013 that male inclusion was endorsed thorught the removal of that criterion. It is estimated that one in four people affected with and ED is male.
It is estimated that one in four people affected with and ED is male. The proportion of males reporting lifetime prevalence of Binge eating disorder (BED) was far greater than for Anorexia nervosa (AN) or Bulimia nervosa (BN); the female versus male ratio of BED prevalence was 3:1. AN is the most life-threatening ED, but is least frequently seen in male populations; researchers suggest this is because most men are not interested in the emaciated, thin look.
Objectives: This poster aims to recognize the presence of ED's in males and raise awareness on this topic.
Methods: Case report and literature review
Results: We present the case of a 50-year-old man with long-standing AN, who had never undergone mental health follow-up. He is referred to psychiatrist by his primary care provider (PCP) due to depressive symptoms. His medical history included vitamine D insufficiency and osteoporosis. At the age of 19 he was obese (BMI 35) and from the age of 23 he started to present dietary restriction after a social event. He had never self-induced vomiting, use of laxatives, binge eating or compulsive exercise. He reported no history or current substance use disorder. BMI at first consultation was 17,6 and showed fear of weight gain. Antidepressant therapy was started and patient was referred to a specialized therapist, nutritionistand nurse.
Conclusions: Overall, the findings demand clinicians develop awareness about ED in males to advance illness management and enhance long-term prognosis. In our case, the delay in receiving treatment has probably led to greater morbidity and chronicity. PCP's play a key role in detection of ED's as the often act as a first point of contact for men accesing the health care system. While assesing and ED, the PCP should include general questions on eating habits in their intake interview. Once an a ED is suspected, the first few minutes of the encounter are crucial to gain trust and buy-in from the patient. Once buy-in from the patient is gained, a complete physical exam and diagnostic work-up is required. Priority referrals to the following professionals are critical: psychiatrist, therapist, dietician or nutritionist, and ED specialist if available.

Disclosure of Interest: None Declared

EPV0470

Gastric bezoar in a patient hospitalized in an eating disorder unit. Case report

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Introduction: It is well known that eating disorders are related to comorbidity. At least, half of these patients have other mental disorders and, in addition to it, the presence of physical comorbidity (cardiovascular, kidney, nervous system, digestive tract, metabolic or endocrine disorders) comes with a decline in life expectancy.
Objectives: Description of a patient with a diagnosis of anorexia nervosa (AN) who developed a gastric bezoar during hospitalization.
Methods: Case treated in a specific Eating Disorder Unit in a Third-Level Hospital.
Results: 26 years old woman with a diagnosis of AN hospitalized in General Psychiatric Unit with BMI of 11,78 kg/m2. Nasogastric tube was necessary and, after 1 month with a progressive weight recovery (BMI 13,84 kg/m2), the patient was transferred to the Eating Disorder Unit in order to follow specific psychological therapy. No incidence related to physical exploration or clinical analyses happened during this month apart from pancytopenia due to malnutrition.
However, 8 days after, patient developed nausea and had 3 vomit episodes, constant abdominal pain at hipogastrium (moderate intensity), dizziness, instability and constipation. The patient refused possibility of pregnancy. The physical exam showed bowel

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