

Table 1 Referral source (n = 163).

Specialty	Number	%	Number/year
General Medicine	42	25.9	4.2
Surgery	13	8	1.3
Trauma and Orthopaedics	13	8	1.3
Intensive Care Unit	12	7.4	1.2
Infectious diseases	10	6.2	1
Haemato-Oncology	10	6.2	1
Respiratory Medicine	9	5.6	0.9
Hepatology	8	4.9	0.8
Cardiology	8	4.9	0.8
Neurology	7	4.3	0.7
Urology and Nephrology	7	4.3	0.7
Gastroenterology	6	3.7	0.6
Other	18	11.1	1.8

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### EV0310

#### A case report of mansonellosis with neuropsychiatric symptoms

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**Introduction** According to the WHO, tropical diseases affect 1/5 of the world population, being increasingly frequent in Europe. Most of these diseases produce mainly physical symptoms, but the appearance of accompanying neuropsychiatric symptoms are not uncommon.

**Objective** To present a clinical case of mansonellosis with neuropsychiatric symptoms.

**Clinical case** Twenty-two-year-old man from Equatorial Guinea, resident in the European Union for 3 years without psychiatric history. His medical history included recurrent malaria, syphilis treated with penicillin and he was HBsAg carrier.

He presented with a 10 month history of headache, pruritus, retrograde amnesia, episodes of anxiety and persecutory delusions. Previously he had gone to the emergency room several times. Cranial CT scan showed no abnormalities. Anxiolytic treatment with benzodiazepines was started, with partial response of the symptoms.

The blood tests revealed a WBC count of  $62 \times 10^9/L$  leukocytes with 11% eosinophils, IgE 5242 IU/mL and IgG 1740 mg/dL. Given the suspicion of filarial infection, a thick blood film was done, the result being positive for *mansonella perstans*. He was administered treatment with albendazole 400 mg/12 h for 10 days and ivermectin in single dose. One month after start of treatment the patient was asymptomatic with complete resolution of the neuropsychiatric symptoms and correction of eosinophilia.

**Results** The patient's origin, his medical history and the typical symptoms of parasitosis should raise the suspicion of an infectious origin of the neuropsychiatric symptoms.

**Conclusions** The patients from tropical regions with neurological and/or psychiatric symptoms should undergo comprehensive diagnostic workup to rule out an infectious disease as a possible cause.

**Disclosure of interest** The authors have not supplied their declaration of competing interest.

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### EV0311

#### Describing the assistance, the basis for improvement

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**Introduction** Consultation-liaison (CL) psychiatry is a branch of psychiatry that study and treat mental health of patients with other medical or surgical conditions. The assistance between hospitals and health services is heterogeneous.

**Aims and objectives** For this reason, the objective of our research is to define the clinical characteristics from our CL service and check out the quality relationship with the applicant service, for improving future assistance.

**Methods** We made a descriptive analysis of clinical variables from the patients who received assistance during 2 months by the CL service from the hospital del Mar, Barcelona. We got the frequencies and we used the Chi<sup>2</sup> test for the comparison between variables: Diagnosis, appearance in the report and treatment in the report.

**Results** Total of the sample: 42 patients, 61.9% women. Mean age: 55.1 years. Psychiatric diagnosis was present before the assistance on 57.1% of the patients. The most frequent diagnosis was Adjustment Disorder (47.6%) and more than one diagnosis was made in the 14.3%. Near the half of the patients required only primary care assistance after the discharge from the hospital. In the 68.3% of the reports appeared information about CL assistance and the indicated treatment didn't appear in all the reports. Statistically significant differences weren't found in the comparisons.

**Conclusions** Adjustment Disorder is supposed to be the most common psychiatric diagnosis in our CL psychiatry service, as we found in the reviewed literature. The results reveal that relationships between services can be improved. More studies must be done for completing information in this issue.

**Disclosure of interest** The authors have not supplied their declaration of competing interest.

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### EV0312

#### Neurocognitive profile of patients with early stages of HIV infection

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HIV-associated neurocognitive disorders (HAND) may include neurological disorders of various severities such as AIDS dementia complex (ADC) also known as HIV dementia and HIV-associated dementia (HAD), HIV encephalopathy, and Mild Neurocognitive Disorder (MND). As it seems HIV-associated neurocognitive disorders are associated with a metabolic encephalopathy induced by HIV infection and fueled by immune activation of macrophages and microglia. Despite of a group, evidences have described presence of cognitive alterations in HIV patients at different stages of HIV infection so far; little is known about the neurocognitive state of patients at very early stages of HIV infection. Here, we explored the neurocognitive profile of a group of cases of HIV patients at very early stages of HIV infection. We have analyzed of three groups of subjects, thus, we have studied a group of patients with early HIV infection, a healthy control group and a group of patients with mild cognitive impairment due to neurodegenerative causes. Our results suggested that cognitive processes are sensitive to very early neu-