practice due to shortness of time and resources; tendency of colleagues from other disciplines to disregard setting features related to time and space (inadequate rooms, e.g. too busy or noisy); limited time for face-to-face discussion of cases or problems; conflicts with patients/relatives/colleagues, and fear of reciprocal manipulation.
Discussion Moving on the interface between psychiatry and the somatic disciplines, CL specialists need to develop special skills, not only those strictly technical, but also those "soft skills" including relational abilities and flexibility. Understanding the systemic aspects of referrals in the relationship between physician, staff and patients is usually essential in the process of consultation.
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W15

Psychotherapeutic interventions in consultation-liaison psychiatry implications for psychiatric trainees

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In clinical reality, psychiatric trainees working in consultation and liaison psychiatry (CLP) face a lot of obstacles to gain satisfactory results from their work on somatic wards. Specifically, the deliverance of psychotherapeutic interventions in every-day CLP is a topic of discussion. The talk will present a case of a young anorectic patient that will exemplify the difficulties in delivering psychotherapeutic treatment in every-day clinical work and will outline common difficulties, specifically in relation to interactions with staff of somatic units. The presentation will be wrapped-up by suggestions on how to deal with the most common problems.
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W16

Psychopharmacological treatments strategies in consultation-liaison psychiatry: Clinical vignette and pros and cons

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Introduction Multimorbidity and polipharmacotherapy are crucial features influencing the psychiatrist's prescription in the consultation-liaison psychiatry (CLP) setting.
Aims to provide an example of computer-assisted decision-making in psychotropic prescriptions and to provide hints for developing pharmacological treatment strategies in the CLP setting.
Methods Case report. A clinical vignette is presented, followed by a review of available online computer-assisted prescription software.
Results A woman in her seventies was repeatedly referred for psychiatric consultation. Eleven different medications were administered daily, because of multimorbidity. A diagnosis of distymia was established, with comorbid mixed pain (partly fulfilling the criteria of somatic symptom disorder) and substance use disorder (opioids). After the first assessment, six follow-up visits were needed during hospitalization. Mirtazapine and benzodiazepines were introduced. Beside the pharmacological intervention, conflict mediation was performed in the relationship with the patient, her relatives, the ward personnel and the GP, to develop a long-term rehabilitation project. Pros and cons of online computer-assisted prescription software were discussed together with the ward personnel, as well.
Conclusions Computer-assisted decision-making in psychotropic prescription is becoming more common and feasible. The use of available software may contribute to safety, effectiveness and cost-effectiveness of clinical decision-making. Risks are also possible: depending for example from regional differences in prescription indications, different guidelines, pharmacogenomics, frequency with which databases are updated, sponsorships, possible conflicts of interest, and real clinical significance of highlighted interactions – all issues the clinician willing to benefit from this modern tools should pay attention to.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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W17

Drugs pharmacokinetics interactions with cardiac and renal disease patients in consultation-liaison psychiatry

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The prevalence of psychiatric disturbances in patients with cardiovascular disease is elevated. For example the prevalence of major depression can reach 15–20% and of anxiety disturbances 5–20%.
When we treat psychiatric symptoms in cardiovascular disease we must have in mind four particular effects of psychiatric drugs: (1) disturbances of atrial-ventricular conduction; (2) QTc interval prolongation that can lead *to torsade de pointes* and ventricular fibrillation; (3) hypertension; (4) changes in platelet aggregation.
On the other hand, there is a great prevalence of psychiatric disease in patients with renal disease. For example, about 5–25% of the patients with advanced renal disease have major depression.
Renal disease patients can evidence changes in several pharmacokinetic parameters such as: (1) biodisponibility; (2) distribution; (3) metabolism; (4) excretion. Therefore, when we treat these patients we have to keep in mind the effect of psychiatric drugs over the renal functioning, but also the effect of the deficient renal function in the pharmacokinetics of the drugs.
I this presentation we intend to reveal what are the main concerns when we prescribe psychiatric drugs in patients with cardiovascular and renal disease.
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How should psychopharmacotherapy be learned by residents in psychiatry – proposals of psychopharmacology curricula

W18

The present situation of psychopharmacology teaching suggests the need for a European curriculum

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