

Objective To describe the comorbidity between PD and substance abuse disorders.

Methods Systematic review of the literature on the subject. The databases consulted were Dialnet, Pubmed and Cochrane.

Results The various studies allow estimating that between 65% and 90% of subjects treated for substance abuse or dependence have at least one concomitant PT. Studies show a higher prevalence of Cluster C for alcohol consumption and Histrionic, Narcissistic, Boundary and Antisocial Disorders (Cluster B) for illegal drugs, mainly cocaine. Cluster B is the one that the literature has most related to substance use. It is also the group in which there is a greater predominance of impulsivity, which would be worth remembering its role as a vulnerability factor for addictions.

Conclusions What the research has shown is that a good deal of the problems that accompany substance use come from dysfunctional patterns of behavior that are maintained over time with high stability and can justify, in part, both the persistence of the addictive behavior as the difficulty of handling the patients who present them. At present, although the high comorbidity between TP and substance use is sufficiently documented, many questions still remain to be solved.

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Treatment difficulties in the pathology of the frontal lobe

A. Isac^{1,*}, B. Cristina¹, L. Viorel²

¹ Children's Emergency Hospital, Child and Adolescent Psychiatry, Cluj-Napoca, Romania

² "Iuliu Hatieganu" University of Medicine and Pharmacy Cluj-Napoca, Neuroscience Department- Psychiatry and Child and Adolescent Psychiatry Compartment, Cluj-Napoca, Romania

* Corresponding author.

Frontal lobe lesions may present as mood disorders, with apathy, emotional flattening and indifference towards the environment, referred to as "pseudodepression". A 14-year-old adolescent is transferred from a pediatric ward for frontal headaches, sleepiness, apathy, food refusal, irritability and marked weight loss (BMI = 14 kg/sqm). The patient has a history of Socialized Conduct Disorder, with extremely low compliance towards treatment. When admitted he is cooperating partially, has an influenced general state and refuses to drink liquids. He is sad, impulsive, with low frustration tolerance, negativist, oppositionist, with voluntary urine emissions and marked sleepiness. There are clinical signs of dehydration and an intermittent convergent strabismus in the left eye. Laboratory tests show an inflammatory syndrome, nitrate retention, dyselectrolytemia. Neurologically: exaggerated tendon reflexes, frust bipyramidal syndrome, slight ptosis of the left eye; electroencephalogram–slow activity (lesion?) in left deviations. A consult with the Infectious Disease unit renders a diagnosis of headache syndrome and frontal sinusitis. The MRI is suggestive for a left frontal infectious expansive process (abscess) and massive maxillary–ethmoidal–frontal sinusitis. Combined parenteral antibiotics and pathogenetic treatment are initiated and the patient undergoes neurosurgery with the evacuation of the tumor. A cystic formation of 6/5/1, 5 cm, containing an opalescent yellow liquid is found at the histopathological exam. Streptococcus spp. is identified by the bacteriological exam. The evolution is good under treatment, with a slight accentuation of the behavioural symptoms. This case illustrates the importance of correct differential diagnosis, the psychiatric diagnosis being one of exclusion.

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Psychiatric comorbidities in temporal lobe epilepsy: A case study

L. Jouini^{*}, U. Ouali, R. Zaouche, R. Jomli, Y. Zgueb, F. Nacef Razi hospital, "A" psychiatry department, Tunis, Tunisia

* Corresponding author.

Introduction Psychiatric disorders frequently occur in patients with temporal lobe epilepsy (TLE) (70%). This combination further reduces the quality of life of patients as diagnosis is difficult and therapeutic opportunities are often missed.

Objectives The aim of this case study is to show the possible association between TLE and psychiatric semiology and its therapeutic implications.

Methods Presentation of the clinical case of Mr BH who experienced psychosis like symptoms, was finally diagnosed with TLE and put under anti-epileptic drugs.

Results Mr BH, aged 22, with no family or personal history, was admitted for aggressive behavior, self-harm, pyromania, and depression. Three years prior to onset of psychiatric symptoms, he reports episodes of pulsatile–left–temporal headache followed by hypertonic movements of the neck. Symptoms were intermittently followed by total amnesia or impaired consciousness. The patient explained symptoms by an inner presence that he called "his twin" and to whom he attributed those behaviors contrary to his will. The discovery of bilateral hippocampal atrophy in magnetic resonance imaging with a normal electroencephalography suggested the diagnosis of TLE with post-ictal psychotic disorders. Patient was put initially on diazepam and olanzapine with partial improvement. Association of valproate led to progressive but then complete disappearance of symptoms and so confirmed our diagnosis.

Conclusions It is often difficult to attach psychiatric symptoms to epilepsy. The diagnosis should be done on a set of clinical, radiological and electrical arguments.

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Clinical features of PTSD in patients with TBI

O. Khaustova^{1,*}, O. Smashna²

¹ Bogomolets national medical university, psychosomatic medicine and psychotherapy, Kiev, Ukraine

² SHEI Ternopil state medical university named after I. Ya.

Gorbachevskyy MHC of Ukraine, psychiatry, Ternopil, Ukraine

* Corresponding author.

Objective Modern scientific researches about interaction between TBI and PTSD are characterized by few amounts and contradiction of conclusions.

Method Twenty-eight persons with TBI were examined by means of questionnaires and structured clinical interviews. 17 patients were suffering from PTSD. We compared clinical features in patients with isolated TBI and group with both disorders.

Results Four groups of symptoms were analyzed–sleep, emotions, cognition and personality features. Disorders of sleep were presented with violation of REM cycle, nightmares, hyperexcitation, increase watchfulness during the sleep. Emotional disorders were expressed as lability without external irritations; an excessive emotional reaction is on small events, agitation, irritability, inadequacy of emotional reactions and apathy (loss of desire to think, to feel, and/or to operate). Cognitive disorders included deceleration of psychomotor reactions, difficulties of searching of words in communication, problems of switching of attention, rigidity, difficulties in planning, decision of multistage tasks, violation of operative memory, executive dysfunction. Features of personality disorders were loss of initiation and self-control, decline of spontaneity, sur-