Table 1. BNSS TS correlation with other scores. MARDER-NEG – PANSS Marder negative symptoms factor; SNS-TS- SNS total score; MARDER-POZ- PANSS Marder positive symptoms factor; MADRS – MADRS total score; CDSS-TS- CDSS total score

Variable	Correlation coefficient	p-value
MARDER-NEG	0,755	<0,001
SNS-TS	0,304	0,001
MARDER-POZ	0,171	0,064
MADRS-TS	0,085	0,361
CDSS-TS	0,472	0,117

Conclusions: The Lit-BNSS is a valid and effective psychometric tool for evaluating negative symptoms in a Lithuanian-speaking sample.

Disclosure of Interest: None Declared

EPV1805

Are negative symptoms evaluated with a self-assessment tool or a semi-structured interview more strongly correlated to mental health-related quality of life?

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Introduction: Negative symptoms are one of the core symptom groups of schizophrenia. These symptoms are highly prevalent and are proven to have a strong correlation with mental health-related quality of life. Evaluating negative symptoms using the Brief Negative Symptoms Score (BNSS), a semi-structured interview, is recommended. BNSS can be supplemented with the Self-assessment of Negative Symptoms (SNS), a self-assessment scale. It is unclear whether a semi-structured interview or a self-assessment scale is more related to the mental health-related quality of life.

Objectives: To evaluate whether scores BNSS or SNS are more strongly correlated with the mental health-related quality of life.

Methods: We performed a cross-sectional study in an inpatient clinic of a university hospital in Lithuania. Inclusion criteria were a diagnosis of schizophrenia spectrum disorder according to ICD-10, age between 18 and 65. Exclusion criteria were acute and/or severe comorbid psychiatric or somatic disorders. BNSS and SNS were used to evaluate negative symptoms. The 36-item Short Form survey (SF-36) was used to evaluate quality of life. Three independent psychiatrists evaluated the participants of the study. The first psychiatrist evaluated the negative symptoms with BNSS. The second psychiatrist handed out, collected, and scored SNS. The third psychiatrist handed out, collected, and scored SF-36. Afterward, the statistical correlation analysis was performed. Only the energy/fatigue and mental health subscores of SF-36 were included in the study to limit the correlation analysis to only the mental health-related quality of life.

Results: The study included 93 participants. We found that SNS scores significantly correlated with mental health-related quality of life compared. SNS had higher correlation indexes with the energy/fatigue subscore than the mental health subscore of SF-36. The strongest correlation was seen between the total score of SNS and the energy/fatigue subscore of SF-36 (r=-0,508, p<0,001). BNSS had no statistically significant correlations with either the energy/fatigue or the mental health subscore of SF-36. All of the correlation coefficients can be seen in Table 1.

Variable	Correlation coefficient MH	p-value	Correlation coefficient EF	p-value
SNS SI	-0,294	0,04	-0,358	<0,001
SNS A	-0,258	0,13	-0,251	0,015
SNS AV	-0,26	0,012	-0,398	<0.001
SNS AN	-0,354	<0.001	-0,434	<0.001
SNS TS	-0,348	<0,001	-0.508	<0,001

Table 1. Correlation coefficients of SNS and SF-36 scores. MH – SF-36 mental health subscore; EF- SF-36 energy/fatigue subscore; SNS SI – SNS social isolation subscore, SNS A- SNS alogia subscore; SNS AV – SNS avolition subscore; SNS AN – SNS anhedonia subscore; SNS total score.

Conclusions: SNS, a self-evaluation scale, was more strongly correlated to mental health-related quality of life than scores of BNSS.

Disclosure of Interest: None Declared

EPV1806

Ekbom Syndrome: what do we know about it? A case report

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Introduction: Ekbom Syndrome or delusional parasitosis is a, usually monosymptomatic, somatic type of delusional disorder in which the patients are convinced they are being infested with animal parasites while no objective evidence exists to support this belief (Mumcuoglu KY, Leibovici V, Reuveni I, Bonne O. Isr Med Assoc J. 2018 Jul;20(7):456-460). It has also been described as a hypochondriacal psychosis that causes great suffering for the patient and those around them. (Campbell EH, Elston DM, Hawthorne JD, Beckert DR. J Am Acad Dermatol. 2019 May;80 (5):1428-1434.)

Objectives: To study this syndrome in depth and learn more about these patients.

Methods: The Pubmed database was used to collect the available information about Ekbom syndrome since 2006. Using the search term "delusional parasitosis". We also present the following clinical case:

A 66-year-old woman, with no history of mental health or substance abuse, came to the dermatology department for multiple pruritic wounds all over her body. She reports that when she scratches herself there is a "small ball that crackles, like a living thing", she has tried to bring samples but has not been able to collect them, according to her. She is convinced that she is infested by parasites. In addition, in the last few weeks she has suffered significant hair loss. On physical examination she presents multiple

scabby plaques on the thorax, back, face and scalp. On the scalp she presents frontal alopecia and madarosis.
The patient was referred to Psychiatry.
On psychopathological examination the patient presented moderate ideational and somatic anxiety, reactive to hair loss and feeling of infestation, also admits difficulty in falling asleep. No affective symptoms were observed or described, nor were there any other accompanying psychotic symptoms (self-referentiality, delusions of harm, persecution, etc.).
Results: We started treatment with Olanzapine 5mg before going to bed, plus a rescue tablet if needed due to anxiety.
In the following reviews, the delirious clinic persists, although a notable reduction of the anxiety and improvement of the night rest is observed.
Conclusions: When it comes to treatment, one of the main difficulties we find is that the patient accepts to be evaluated by psychiatry, so it is important to establish a good therapeutic relationship with the patient, since this will determine the patient's therapeutic adherence to the treatment.
Treatment usually consists of antipuriginous and antipsychotic agents. In our case we selected Olanzapine for its sedative effect, with which we observed a significant reduction of symptoms. However, the available literature usually recommends starting treatment with risperidone. Even so, there is little evidence on its efficacy in Eckbom's Syndrome.
Treatment studies are scarce and the evolution varies from one case to another.

Disclosure of Interest: None Declared

EPV1807

Relation between childhood trauma and social vulnerability in adulthood in patients with first episode psychosis

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Introduction: The relationship between childhood adversity and psychosis has been the focus of extensive research in recent years. Studies suggest that individuals who experience significant adversity during childhood,such as abuse,neglect,or trauma, hava an increased risk of developing psychotic disorderser later in life.
Enviromental factor have been shown to play a signitficant role in the development of psychosis,often interacting with genetic predispositions.Nevertheless the relation between childhood trauma and social vulnerability in adulthood in patients with a first episode of psychosis (FEP) patients has not been studied.
Objectives: The aim of this work is to study social factors in patients with childhood trauma and their impact on the development of a FEP.
Methods: The sample was divided into 3 groups, controls,first episode psychosis patients with childhood trauma (FEP with CT) and first episode psychosis patients without childhood trauma (FEP without CT). 135 controls and 190 patients with FEP (58.42% with CT) were assesed through questionnaires on traumatic experiences, life stress events and a socio-demographic interviews. The likelihood of experiencing life stress events in the past year, social vulnerability,affective issues and substance use were examined using logistic regression models.
Results: Four covariates demonstrated a significant association with the clinical group with CT: being without a partner ($p < .01$), unemployment ($p < .01$), a history of psychiatric conditions ($p < .01$), and migration status ($p < .01$). However, stressful events in adulthodd were not found to be significant.
Conclusions: While childhood trauma does not seem to directly trigger re-traumatization in adulthood, it may contribute to place FEP patients in socially vulnerable circumstances that could lead to the development of psychotic symptoms.

Disclosure of Interest: None Declared

EPV1808

Clinical Differences Between Urban and Rural Populations in Adolescents with Clinical High Risk of Psychosis

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Introduction: Individuals at Clinical High Risk of Psychosis (CHR-P) show increased risk for developing psychotic disorders. The relationship between the risk of developing psychosis and urbanicity has been previously described; however, there are divergent results regarding the relationship between positive psychotic symptoms and urbanicity.
Objectives: The present study aims to analyze the clinical and sociodemographic differences between an urban and a rural population of youth with CHR-P.
Methods: The characteristics of the CHR-P program at La Fe Hospital (Valencia) are described and compared for the two populations in the study: a rural area comprising 10 towns with populations ranging from 200 to 29,000 inhabitants each, with an average of 12,600 inhabitants, and an urban area corresponding to the northern metropolitan area of Valencia. An analysis and comparison of the sociodemographic and clinical characteristics of the general population in both areas is also conducted.
Results: Preliminary results are provided: The sample consists of 46 patients, 21 from the rural area and 25 from the urban area. The average follow-up for both groups was 8 months, with a transition rate to psychosis during this period of 19% (n=4) for the rural area group compared to 0% for the urban area group (p=0.04). Patients in the rural area group exhibited greater severity of positive psychotic symptoms with a higher positive PANSS score (14.19 ± 4.32) compared to the urban area group (11.12 ± 3.67), and this difference was significant (p=0.032). No statistically significant differences were found between the two groups for the rest of the variables.
Conclusions: The preliminary results of our study show greater symptom severity in individuals from rural areas. Demographic factors, resource provision, or delays in care might be related to this finding.

Disclosure of Interest: None Declared