Table 1

Characteristic	Compliant (n=10)	Non-compliant (n=8)	p-value
Age, mean (SD)	30.7 (12.7)	26.8 (14.8)	0.559
Sex (male), n (%)	7 (70)	6 (75)	0.814
Involuntary admission, n (%)	0 (0)	0 (0)	-
Drug abuse (cannabis), n (%)	6 (60)	6 (75)	0.421
Admission length (days), mean (SD)	18.5 (8.9)	10.3 (6.3)	0.036
Diagnosis at discharge, n (%)			0.258
- Brief psychotic disorder	1 (10)	0 (0)	
- Substance-induced psychotic disorder	2 (20)	4 (50)	
- Schizophreniform disorder	3 (30)	1 (12.5)	
- Schizophrenia	2 (20)	0 (0)	
- Bipolar disorder	1 (10)	0 (0)	
- Psychotic disorder NOS	1 (10)	3 (37.5)	
Treatment at discharge, n (%)			0.575
- Aripiprazole vo	2 (20)	2 (25)	
- Olanzapine vo	4 (40)	2 (25)	
- Paliperidone vo	1 (10)	0 (0)	
- Risperidone vo	0 (0)	2 (25)	
- Depot	2 (20)	1 (12.5)	
- Politherapy (oral)	1 (10)	1 (12.5)	
Referral, n (%)			0.178
- Community treatment	6 (60)	7 (87.5)	
- Day Hospital	3 (30)	0 (0)	
- Short stay psychiatric unit	1 (10)	0 (0)	
- Voluntary discharge	0 (0)	1 (12.5)	
Readmission, n (%)	0 (0)	2 (25)	0.094

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EW527

Quality of care for medical comorbidities among patients with and without schizophrenia

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Introduction The association between schizophrenia and quality of care for medical comorbidities in universal health care systems remains unclear.
Objectives To elucidate whether equal access also implies equivalent and sufficient care.
Aims To compare the quality of care for heart failure, diabetes and chronic obstructive pulmonary disease (COPD) among patients with and without schizophrenia in Denmark.
Methods In a nationwide population-based cohort study, we used Danish national registries to estimate the risk of receiving guideline recommended disease-specific processes of care between 2004 and 2013.
Results Compared to patients without schizophrenia, patients with schizophrenia had lower chance of receiving high overall quality of care (≥ 80% of recommended processes of care) for heart failure (Relative risk [RR] 0.67, 95% CI: 0.48-0.92), diabetes (RR 0.84, 95% CI: 0.79-0.89) and COPD (RR 0.82, 95% CI: 0.72-0.93) as well as lower chance of receiving individual disease-specific processes of care including treatment with beta-blockers (RR 0.87, 95% CI: 0.79-0.96) in heart failure care and measurement for albuminuria (RR 0.96, 95% CI: 0.93-0.99), eye examination at least every second year (RR 0.97, 95% CI: 0.94-0.99) and feet examination (RR 0.96, 95% CI: 0.93-0.99) in diabetes care. Diabetic patients with schizophrenia also had lower chance of receiving antihypertensive (RR 0.84, 95% CI: 0.73-0.96) and ACE/ATII inhibitors (RR 0.72, 95% CI: 0.55-0.94). In COPD care, patients with schizophrenia had lower chance of receiving LAMA/LABA medication (RR 0.92, 95% CI: 0.87-0.98), however, higher chance of treatment with non-invasive inhalation (RR 1.85, 95% CI: 1.61-2.12).
Conclusions Quality of care for three medical comorbidities was suboptimal for patients with schizophrenia.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Efficacy and tolerability of switching to long-acting injectable (LAI) aripiprazole in outpatients with schizophrenia

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Introduction Switching antipsychotics is a therapeutic alternative for managing side-effects, or efficacy and compliance issues.
Aim To evaluate the efficacy and tolerability of switching to LAI-aripiprazole in patients who had insufficient response or were intolerant to the previous antipsychotic, or required a more convenient treatment regimen.
Methods This was a prospective, observational, 6-months study carried out in 45 outpatients with schizophrenia who were clinically stabilized but a switching to another antipsychotic was clinically indicated. Patients who required hospitalization, treatment discontinuation or adding another antipsychotic (including supplementation with oral-aripiprazole) were considered treatment failures. Switching was considered successful if the side-effect/symptom/adherence/convenience improved or, if applicable, disappeared.
Results Patients aged 38 years, 51% women, and previous antipsychotics comprised: LAI-paliperidone (42%), oral-aripiprazole (22%), oral-olanzapine (11%), oral-risperidone (7%), LAI-risperidone (4%) and others (14%). The efficacy results of the switching are presented in the table. Of the 45 patients, 7 (15%) were considered treatment failures: 3 patients were hospitalized due to recurrence of psychotic symptoms, 2 discontinued LAI-aripiprazole, and 2 required supplementation with oral-aripiprazole (Table 1).
Conclusions Our results suggest that switching to LAI-aripiprazole is an efficacious strategy for managing some antipsychotic-induced side-effects, persistence of negative symptoms and/or lack of treatment adherence.

Table 1

Reason por switching	Baseline, n(%)	Outcome (month 6), n(%)		
		Resolution	Improvement	Overall sucess
Hyperprolactinemia	10(21%)	8(80)%	2(20%)	10(100%)
Persistent negative symptoms	10(21%)	NA	8(80%)	8(80%)
Metabolic syndrome	9(20%)	1(11%)	7(80%)	8(91%)
Sexual dysfunction	5(12%)	1(20%)	4(80%)	5(100%)
Extrapyramidal symptoms	4(9%)	0(0%)	2(50%)	2(50%)
Lack of adherence	4(9%)	NA	3(67%)	3(67%)
Convenient regimen	3(8%)	NA	2(75%)	2(75%)

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