

inducer and the receptor, as described in this case. We considered that the sister is the active subject. The delusion is persecutory, the most common in this disorder. The patient kept her job until she was hospitalized and as described in the literature patients with folie a deux maintain their functionality, which is responsible for the underdiagnosis of this disorder. The fact that the current evidence is based on case reports reflects the underdiagnosis and rarity of this disorder.

Conclusions: This clinical case highlights the challenging diagnosis and difficulty in treating this condition. Patients can be diagnosed many years after the onset of symptoms, which may not resolve with treatment. Much information, as prevalence, natural history, and optimal treatment, is lacking on folie a deux, and the etiology remains unknown. As such, prospective studies should be carried out to help understand this disorder.

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EPV0904

LATE ONSET PSYCHOSIS AND VERY LATE ONSET PSYCHOSIS: WHAT ARE THE POSSIBLE ETHIOLOGIES?

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Introduction: Psychotic symptoms have long been known to show up earlier in life, typically during adolescence and early adulthood. Late Onset Psychosis (LOP), in which symptoms start between 40 and 60 years of age, and Very Late Onset Psychosis (VLOP), in which onset of symptoms happens after 60 years of age, although classically rare, have had a growing prevalence in the last decades. **Objectives:** To access the definition and main etiologies of LOP and VLOP, based on the current literature.

Methods: Non-systematic review of literature using the terms “late onset psychosis” and “very late onset psychosis”. Case report of a patient who was admitted and treated in our inpatient field.

Results: 51-year-old female patient. She is divorced (two previous marriages) and has two daughters (26 and 16, respectively). She was brought by police officers because of behavior problems at the shelter where she was living. She was evicted from the house she was living in because of delay in paying the rent. On observation, she verbalizes persecutory and prejudicial delusions and auditory hallucinations on the 2nd and 3rd person (commenting voices) with at least 5 years of duration. She was hospitalized for almost 3 months, with slow but progressive clinical improvement on haloperidol 7.5mg/day. At the date of discharge, she did not spontaneously verbalize her symptoms, although she did not recognize them as delusional. Recent studies have shown that the prevalence of Schizophrenia in the typical age range is 75-80%, which means that an important proportion of diagnosis is made after that age span. Primary causes of LOP and VLOP are schizophrenia (of late onset), schizophrenia-like very late onset psychosis, delusion disorder, unipolar depression with psychotic symptoms and bipolar

disorder. Secondary causes should also be considered, such as delirium, dementia (Alzheimer's, Lewi bodies and vascular), and substances abuse; even more rare, other conditions should be considered, as cerebrovascular accident, encephalitis, epilepsy, and multiple sclerosis.

Conclusions: LOP and VLOP have been a growing diagnosis in the past decades. In the assessment of these patients, we must consider the importance of secondary etiologies besides the primary psychiatric ones. Primary psychosis is a diagnosis of exclusion, and the clinician must rule out secondary causes. Recent data point out these symptoms as markers for an increased risk of dementia in these patients. Further research involving individuals with LOP and VLOPs is required to increase the evidence base for treatment and improve outcomes of care.

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EPV0905

Prevalence and nature of childhood trauma among patients with schizophrenia and bipolar affective disorder

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Introduction: Epidemiological studies shows that exposure to early stress in the form of abuse and neglect in childhood increases the risk for later development of severe mental illnesses such as schizophrenia and bipolar affective disorder.

Objectives: •Study the prevalence of childhood trauma in a sample of adult patients diagnosed with schizophrenia and bipolar disorder.

•Identify potential differences of types of childhood trauma between both groups.

Methods: This cross-sectional study was conducted on 200 patients admitted to the inpatient unit at Maamoura psychiatric hospital in Alexandria. Assessment of the history and nature of childhood trauma was done by Arabic version of childhood trauma questionnaire (CTQ).

Results: There was no statistically significant difference between the two studied groups regarding past history of childhood trauma ($p=0.397$). (Table 1) Regarding the nature of childhood trauma, the history of emotional abuse and physical neglect was more commonly associated with developing bipolar disorder whereas the history of physical abuse was significantly more common among schizophrenia patients. (Table 2)

Conclusions: History of childhood trauma is common among adult patients with schizophrenia and bipolar disorder with no significant difference between both groups. Nature of trauma may be different where physical abuse might be correlated with later development of schizophrenia.

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