Conclusions: Although pica behaviors can be associated with various psychiatric disorders, there is often an underlying organic substrate. In this patient, the initial diagnosis of personality disorders and generalized anxiety, coupled with the repetitive pica behaviors, might have initially pointed exclusively toward a psychiatric approach. The identification of a broader symptomatic pattern, led to the suspicion of adult chronic hydrocephalus (ACH). The triad of symptoms in ACH, though classic, may not always be evident, and neuropsychiatric manifestations such as pica could be indirect signs of brain involvement.
This case underscores the need to consider organic differential diagnoses in patients presenting with atypical or unexplained behaviors from a purely psychiatric standpoint.

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EPV0721

Case study of GBMT post-bariatric surgery with psychiatric co-morbidities

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Introduction: Gelatinous bone marrow transformation (GBMT) is a degenerative change in hematopoietic bone marrow, initially linked to anorexia nervosa (AN) and recently to bariatric surgery (BS) (Böhm *et al.* Am J Surg Pathol 2000; 24(1) 56-65). BS is associated to malabsorption, nutrient deficits, diets, and medical complications resembling eating disorders (ED) (Conceição *et al.* Int J Eat Disord 2023; 56(4) 831-834), complicating diagnosis and management. Treating the underlying cause is key for GBMT recovery.
Objectives: Review BS complications: malnutrition, GBMT and AN with normal Body Mass Index (BMI).
Methods: This case study highlight the emergence of GBMT and atypical AN following BS.
Results: A 55-year-old woman first sought treatment from the Community Mental Health Team (CMHT) over 30 years ago for marital issues and was given medication. In 2006, she underwent bariatric surgery (BS) due to morbid obesity (BMI 52.6 kg/m^2). Since 2007, she had 3 hospitalizations for cosmetic surgeries and 5 for medical complications, including oedema, hypoproteinaemia, pancytopenia, zinc deficiency, and sepsis requiring ICU admission. She also showed symptoms of depressive disorder (DD), AN, and purgative symptoms. In 2017, she was re-referred to CMHT and diagnosed with DD, anorexia was considered a symptom of DD.
In 04/2024 she was readmitted under Internal Medicine care with subacute multifactorial diarrhoea, severe malnutrition, pancytopenia, coagulopathy, vitamins A, E, D and Zn deficiency and lower limb oedema (likely contributing to a normal BMI).
Diarrhoea was managed by switching sertraline to citalopram and budesonide added to treat lymphocytic colitis. Moreover, ciprofloxacin and metronidazole were used for small intestinal bacterial overgrowth.
Psychiatric involvement confirmed DD, anxiety disorder (AD), and atypical AN. Topiramate, mirtazapine and olanzapine were stopped to possible myelotoxic effects. A bone marrow aspirate confirmed GBMT. Benzodiazepines and gabapentin were used to manage AD. Her malnutrition was managed with Total Parenteral Nutrition and she was transferred to a psychiatric ward where she received specific treatment for ED. Pancreatic enzymes were added to reduce malabsorptive impact of BS. The option of reversing the bypass was considered.
Once the vital risk decreased and she was consuming normalized intakes, she was discharged with a BMI=20.9.
One month later, she was euthymic, reduced anxiety and coagulopathy and nutritional parameters normalized with haematological improvement.
Conclusions: Given the high prevalence of malnutrition and ED post-BS, ED should be systematically assessed even in patients with normal BMI. Early diagnosis prevents worsening of symptoms, which only improve after nutritional recovery (Steinhausen *et al.* Am J Psychiatry 2002; 159(8) 1284-93). Multidisciplinary management is crucial to achieve optimal nutritional outcomes.

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EPV0722

Refeeding Syndrome and Its Interventions: A Literature Review

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Introduction: Refeeding syndrome is a severe metabolic condition seen in psychiatric patients, particularly those with anorexia nervosa or other eating disorders, after rapid nutrient reintroduction. It involves disturbances such as hypophosphatemia, hypokalemia, and hypomagnesemia, creating challenges in psychiatric and medical settings. Early identification and management are critical to prevent complications like cardiac and respiratory failure (1,2,3).
Objectives: This study analyzes the pathophysiological mechanisms of refeeding syndrome, focusing on key metabolic, psychiatric and electrolyte disturbances during the refeeding process in malnourished patients. It also discusses prevention strategies and clinical management, emphasizing the role of multidisciplinary teams in early diagnosis and treatment (1,2,3).
Methods: A literature review was conducted using Scielo, PubMed, Cochrane, and BMJ, focusing on studies about the pathophysiology, risks, and interventions related to refeeding syndrome. From 40 articles analyzed, 12 published between 2000 and 2023 were selected, focusing on clinical management and treatment guidelines for malnourished patients.
Results: The review highlights that refeeding syndrome (RS) is a serious metabolic condition in malnourished patients, especially those with psychiatric disorders like anorexia nervosa. Rapid nutrient intake can cause metabolic issues, such as hypophosphatemia and hypokalemia, alongside significant psychiatric stress. Anxiety and treatment resistance may increase, especially in patients fearing weight gain, raising the risk of relapse.
Physical discomfort from refeeding, such as fluid retention, can worsen anxiety and complicate treatment. This may lead to extended hospitalization and poor treatment adherence. In psychiatric settings, inadequate management of RS can lead to agitation or