

Additionally, the development of dementia in these patients may exacerbate the clinical manifestations associated with PTSD, complicating proper management and treatment.

Objectives: To describe a clinical case of a patient with a history of PTSD presenting with cognitive impairment, and to provide a brief review of the literature.

Methods: Case description and literature review.

Results: A 65-year-old male patient, originally from Colombia, with a documented history of PTSD secondary to kidnapping and armed conflict, presented to psychiatric services in Spain for initial assessment and treatment. The family reports neglect of self-care, persistent hypervigilance, nightmares, and night screams, as well as multiple attentional failures, learning difficulties, and memory impairments. The patient was referred for a neurological consultation where the evaluation included a Mini-Mental State Examination (MMSE) scoring 16/30. Cranial MRI showed no abnormalities, and amyloid PET was negative. An FDG PET scan revealed discrete hypometabolism of the medial prefrontal cortex, which could be indicative of possible frontotemporal dementia.

Conclusions: The prevalence of dementia is rising globally. PTSD has been identified as a modifiable risk factor for developing dementia. Furthermore, studies show that the relationship between these conditions is bidirectional, with late-onset PTSD also potentially developing in patients with a diagnosis of dementia. The mechanisms underlying this relationship are poorly understood. It is hypothesized that both conditions share common pathophysiological pathways. PTSD manifestations in patients with dementia are often difficult to recognize, which is believed to result in an underdiagnosis of the condition. Additionally, these clinical manifestations can be confused with neuropsychiatric symptoms associated with dementia, further complicating diagnosis. The relationship between PTSD and dementia may be modifiable if patients with PTSD are provided with appropriate diagnosis and treatment, thereby improving their quality of life and prognosis.

Disclosure of Interest: None Declared

EPV1433

Aggression, autoaggression and stress in people with a heart attack

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Introduction: A human represents wholeness of biological, psychological and social nature and below impact of psychosocial stress preserves the homeostasis of the organism manifests a complete biopsychosocial response is therefore necessary in professional practice to be taken psychoneuroendocrine immunological approach in treating certain somatic and psychological.

Objectives: Determining emotions, various types of aggression in people who have experienced a heart attack and is currently under the influence of chronic psychosocial stress of moderate intensity.

Methods: The examination was conducted on an outpatient basis on 14 subjects aged 51 to 72. age of male and female who experienced a heart attack. Applied: Azingerova aggression scale, PSQ stress test, Zung anxiety scale, Zung depression scale.

Results: The respondents show a stress reaction at the level of moderate stress (30-60) with dominant feelings of: fatigue, tension, dissatisfaction, overload. Anxious symptoms are at the level of mild to moderate (45-59). Depressive symptoms are at the mild level (50-59). They have higher values on the aggression test. In both sexes (male and female) they have the highest values in self-aggression. Somewhat lower is verbal aggression while emotional aggression has average values. In the female gender, aggression is the lowest through physical force, while the use of aggression through physical force is occasional for men. Both sexes show little aggression towards objects around them.

Conclusions: In people with somatic diseases, in the case of a heart attack, emotions are high an important factor for their stability, especially the negative ones, and therefore it is necessarily needed an integrative approach to treatment, taking into account the mental state as a whole especially when they are in a state of psychosocial stress.

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EPV1434

Systematic Assessment of Stellate Ganglion Block in Post-Traumatic Stress Disorder: Exploring Clinical Utilization and Significance

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Introduction: Post-traumatic stress disorder (PTSD) is a chronic condition resulting from exposure to traumatic events. The utilization of stellate ganglion block (SGB) as a potential treatment for PTSD has garnered increased interest in recent years. SGB acts by blocking sympathetic outflow, offering promise in alleviating autonomic dysfunction associated with PTSD symptoms. However, the evidence supporting SGB's efficacy compared to established recommendations remains limited.

Objectives: To bridge this knowledge gap, a systematic review was conducted following PRISMA guidelines to assess the clinical applications and implications of stellate ganglion block (SGB) in the management of post-traumatic stress disorder (PTSD). The study aimed to identify pertinent literature, synthesize findings from diverse sources, evaluate outcomes of SGB therapy for PTSD, analyze factors such as anesthesia preferences and procedural methods, scrutinize symptom alleviation post-SGB sessions, explore reported side effects and symptom recurrence, and shed light on existing limitations within the current discourse on SGB's utility in treating PTSD.

Methods: The systematic review involved the evaluation of 14 studies meeting predetermined inclusion criteria, incorporating a total of 550 participants. Notably, the majority of participants were military service members and veterans, with a median age of 36.9 years. The review focused on anesthetic practices, procedural techniques, timing of SGB administration, and symptom progression post-SGB therapy sessions.

Results: Analysis of the selected studies highlighted the prevalent use of 0.5% ropivacaine as the preferred anesthetic for SGB, with the

right-sided technique being the most commonly employed. Timing of the initial SGB session varied widely, with symptom improvement typically observed immediately or within the first week post-procedure. Positive outcomes often coincided with reductions in alcohol intake, medication use, and enhanced mood. Recurrence of symptoms was noted, necessitating additional SGB sessions, while reported side effects were predominantly mild and transient in nature.

Conclusions: While promising, caution is advised when interpreting the benefits of SGB due to challenges such as the absence of standardized clinical trial data, variabilities in reported outcomes, and potential reporting biases. Addressing these limitations through standardized assessment and reporting in future studies is crucial to enhance comprehension of SGB's efficacy, safety, tolerability, and appropriate indications for treating PTSD. This endeavor is pivotal in advancing a more nuanced understanding of SGB's role as a therapeutic modality in PTSD management.

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EPV1435

Navigating Diagnostic Overlaps: A Case Report of Paranoid Schizophrenia, Borderline Personality Disorder, and Hidden PTSD in a Patient with an Orphanage Background

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Introduction: Diagnosing psychiatric disorders in individuals raised in orphanages is challenging due to symptom overlap. Trauma from institutional life can mimic symptoms of both Post-Traumatic Stress Disorder (PTSD) and paranoid schizophrenia (Hermenau et al. *J Trauma Stress* 2011; 24: 513-516). For example, PTSD symptoms like intrusive memories may resemble schizophrenia's delusions when trauma affects threat perception. Additionally, PTSD-related attachment issues can exacerbate paranoia (Patel et al. *J Trauma Dissociation* 2016; 17: 123-136). Accurate diagnosis requires careful assessment of trauma history and symptom differentiation (Robinaugh et al. *Depress Anxiety* 2011; 28: 305-311).

Objectives: Challenges of symptoms overlapping in schizophrenia, borderline personality disorder, and PTSD.

Effects of orphanage background and early trauma on psychiatric symptoms.

Diagnostic methods and evolving treatment plans.

Methods: Patient ZN, a 37-year-old female with paranoid schizophrenia and borderline personality disorder (BPD), has had 11 admissions over six years at our clinic. Despite treatment with DSM-5 criteria, PANSS, and BEST scales, using antipsychotics, mood stabilizers, and benzodiazepines, there was no significant improvement. This year, her hospitalizations increased, particularly after developing a strong attachment and maternal feelings toward a doctor who treated her three times consecutively. PTSD, relevant due to her orphanage background and initially unassessed, was later identified through screening. Data were recorded through clinical notes, informed consent was obtained, and the case study's single-case design limits generalizability.

Results:

Conclusions: In conclusion, diagnosing PTSD, paranoid schizophrenia and BPD in orphanage-raised adults is challenging due to trauma, overlapping symptoms, and disrupted attachment. This case highlights the complexities of diagnosis and treatment, emphasizing the need for a comprehensive and adaptable approach.

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EPV1436

Diagnosis and treatment of post-traumatic stress disorder (PTSD) through the analysis of two clinical cases

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Introduction: Ongoing global conflicts have significant implications for the mental health of affected populations, with PTSD being one of the most prevalent disorders among those exposed to active violence.

Objectives: To understand the importance of PTSD diagnosis and treatment in individuals exposed to active violence through the review of two clinical cases.

Methods: A clinical evaluation, diagnosis, treatment and follow-up of two patients (A and B) during their admission to our hospital and a literature review of diagnosis and treatment of PTSD.

Results: We studied two patients from Armenia, a country currently engaged in armed conflict, who sustained injuries from a bomb explosion. Patient A had burns covering 18% of Total Body Surface Area (TBSA) and three fingers amputated, while B had burns in 50% of TBSA. Both were admitted to the Intensive Care Unit, where psychiatric evaluations were conducted, and then they were transferred to the plastic surgery unit for further care until discharge. During the first week of admission, symptoms such as flashbacks, nightmares, emotional numbness, feelings of fear, hopelessness, excessive guilt, insomnia, hypervigilance and episodes of depersonalization or derealization began to appear. Patient A exhibited an externalizing profile of symptoms (nocturnal agitation, crying and verbalization of guilt-related ruminations), while B presented an internalizing profile (affective numbness and dissociative episodes). Both cases were diagnosed with PTSD after more than a month of persistent symptoms. Psychopharmacological treatment was initiated after 20 days of hospitalization. Patient A was treated with quetiapine 200 mg/day for nocturnal agitation and sertraline 100 mg/day; while Patient B started sertraline 100mg/day and mirtazapine 15 mg/day. According to literature, first-line pharmacological treatment for PTSD includes SSRIs such as sertraline or fluoxetine. As a second-line we found mirtazapine, antipsychotics and prazosin. Benzodiazepines are not a choice and should be used cautiously (Schrader et al. *MM* 2021; 118 (6), 546-551). First-line treatment for PTSD is trauma-focused therapy and eye movement desensitization and reprocessing (EMDR) (Mann et al. *TI* 2023). In our case, such therapy was not possible to start due to language barriers and the severity of patients'