- The collection of anamnestic and clinical data was established using a pre-established form

Results: Our study included 24 patients aged between 16 and 18 years, with a mean age of 17 years, comprising 13 males and 11 females.

Patients presented voluntarily in 42% of cases, were brought in by law enforcement in 25%, and were referred by a private psychiatrist in 17% of cases. The reasons for consultation were as follows: behavioral disturbances in 63% of cases, a suicide attempt in 21%, and incoherent statements in 8% of cases. 60% of cases used medication ingestion as the method during the suicide attempt. A family history of psychiatric disorders was found in 50% of cases, as well as a family history of suicide attempts in 13% of cases. Additionally, 71% of cases had prior follow-up with a private psychiatrist, 21%of cases had previously attempted suicide, and 33%of cases had personal somatic histories.

The onset of disturbances was progressive in 71% of patients. Upon hospitalization, anxious symptoms were noted in 25% of cases, while depressive symptoms with suicidal ideation were recorded in 29% of patients. hallucinations and delusions were noted in 50% of cases, and behavioral eccentricity was observed in 25% of cases. Instinctual disorders were present in 75% of cases, with sleep disturbances observed in 71%of cases, sexual disorders in 25%of cases, and appetite disorders in 13 %of cases.

Verbal hetero-aggression was identified in 83% of cases, while physical hetero-aggression was noted in 67%of cases. Self-harming behaviors were recorded in 48% of patients.

The diagnoses made according to DSM-5 criteria were distributed as follows: bipolar disorder in 29% of cases, schizophrenia in 17%of cases, and 13%of cases related to a life stage.

Conclusions: Adolescent psychiatric hospitalizations are rising, emphasizing the need to understand clinical characteristics of this population. This study analyzes clinical aspects of adolescents admitted to a psychiatric unit over one year. The findings aim to enhance treatment strategies and patient outcomes.

Disclosure of Interest: None Declared

EPV0309

Treatment of Catatonia Associated with Xp11.22 Duplication Syndrome and Comorbid Autism Spectrum Disorder: A Case Report

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Introduction: Xp11.22 duplication syndrome, a rare genetic condition first identified in 2009, has fewer than 100 documented cases in the literature. To date, little is known about the genotype-phenotype relationship in this rare genetic syndrome and there is a paucity of data specifically regarding catatonia in this condition.

Objectives: The primary aim of this case report is to provide a comprehensive description of the clinical presentation, diagnostic approach, and management strategies employed in a case of catatonia occurring in the context of Xp11.22 duplication syndrome and ASD.

Methods: Methods of this case report include assessment of the patient via thorough psychiatric and medical evaluation, as well as additional information obtained through chart review and collateral sources.

Results: Our patient, a 15-year-old Caucasian male, was diagnosed with Xp11.22 duplication syndrome at age 3 due to speech and motor delays. At 14, he experienced sudden behavioral and motor changes, including withdrawal, repetitive speech, slowed gait, and repetitive motor behaviors like “rewind” actions. Over 3 months, symptoms included emotional lability, self-injurious behaviors, and significant disruption to daily functioning. Outpatient management with olanzapine and quetiapine worsened agitation. Referred to a specialist, he was started on lorazepam up to 12 mg daily for suspected catatonia. ECT was considered, but further workup ruled out seizure disorder and autoimmune encephalitis. Pediatric neurology found no alternative etiology and recommended ECT. On admission, BFCRS score was 14, showing catatonic symptoms like automatic obedience, mutism, and immobility. Lorazepam was reduced to 2 mg three times daily, and amantadine 100 mg twice daily was continued. An acute ECT course of 12 bilateral treatments over four weeks reduced catatonic symptoms, improving mutism, motor speed, and daily activities. During a 56-day hospitalization, he received 7 maintenance treatments. Upon discharge, BFCRS decreased to 7, and he continued lorazepam and amantadine.

Conclusions: This case report underscores the complexity of managing catatonia in patients with Xp11.22 duplication syndrome and ASD, highlighting the potential need for multimodal treatment approaches. The significant improvement observed with the addition of ECT to the treatment regimen emphasizes the importance of considering this option in cases of refractory catatonia, even in patients with complex genetic and neurodevelopmental backgrounds. This case raises important questions about the underlying neurobiological mechanisms of catatonia in the context of Xp11.22 duplication syndrome and ASD.

Disclosure of Interest: None Declared

EPV0310

The impact of institutionalization and adoption on ADHD diagnosed children

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Introduction: Adoption is a process which aspires to protect the children and provide them a secure home. Nevertheless these minors present very often in their new environment a wide range of different difficulties, that enhances them to adapt in their personal and academic spaces. ADHD is one of the most prevalent neurodevelopment diseases among adopted children (Mulas et al., 2016; Doom et al., 2016).

Objectives: The objective of this review is to shed light on the association between ADHD and adoption.

Methods: A literature review has been carried out of scientific studies on the prevalence and risk factors for developing ADHD among adopted children from different countries of origin. Systematic reviews of papers and studies on new developments in the etiology of ADHD were also consulted.

Results: The prevalence of ADHD in adopted children is estimated to be around 25-50% (Mulas et al., 2013; Enriquezet. al., 2017). However, this percentage varies considerably depending on the origin of the children (Eastern Europe (de Maat et al., 2018), versus China (van Ginkel et al. 2016)). However, adopted children are more easily referred to a mental health specialist, as a consequence of the fact that adoptive parents are often particularly focused on the adaptation of these children (Sánchez et al., 2012).
The postnatal environment of adopted and institutionalized childrenchildren is often marked physical, emotional, sexual or other types of abuse (Doom et al., 2016). The quality of these orphanages and foster homes contributes to the lack of stimuli that children should receive in the first 2 to 3 years of life (Mullas et al., 2015). Consequently, this social and emotional deprivation among adopted children has been related to attachment disorders and ADHD (Elovainio et al., 2015).
On the other hand, other pre- and perinatal risk factors that influence the etiology of this disorder are especially prevalent in adopted children: premature birth, low birth weight and exposure to alcohol during pregnancy (Macke et al., 2020).
The role of culture as a possible protective factor is supported by research, with immigrants showing lower rates of ADD than adopted children of the same age range (Tan et al., 2016).
Finally, early foster care in adoptive families and the promotion of family bonding and appropriate parenting strategies can help adopted children improve their regulatory skills and other typical ADHD symptoms (Barca et al.,2017).
Conclusions: The deprivation of affective care and the lacking opportunity to establish a relationship with a main caregiver experienced by institutionalized children can lead to the expression of this disease in genetically predisposed individuals. These fenomenon reveals the importance of connection to family and culture to promote better mental health.

Disclosure of Interest: None Declared

EPV0311

Autism Spectrum Disorder and Comorbid Eating Disorders: Case Presentation of a 14-Year-Old Male with Carotenemia

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Introduction: Atypical eating behaviors are more common in children and adolescents with Autism Spectrum Disorder (ASD) compared with neurotypical development. Cognitive inflexibility in ASD can result in rigid food-related rules and preoccupation with eating, similar to Eating Disorders (ED). Several studies have focused on cataloging these atypical eating behaviors, such as Zickgraf H. et al. (2019). [Figure 1].
Objectives: Case presentation attended at the outpatient clinic of the Hospital Universitario Nuestra Señora de Candelaria (Tenerife). Literature review on atypical eating behaviors in ASD patients and their comorbidity with EDs.
Methods: A 14-year-old male, with no prior mental health history, showed normal social and academic adaptation but had a notable deficit in social smiling and persistent food texture rejection. He lives with his mother and has a close relationship with his paternal uncle, a personal trainer and role model.
He was referred to mental health services after multiple episodes of agitation, triggered by disruptions in his eating and exercise routines. Over the past year, he developed an intense focus on physical training practicing calisthenics several times a day, in addition to rejecting high-calorie foods, opting for vegetables (carrots and pumpkins). A conversation with soccer teammates, where comments about his body were made, may have acted as a trigger.
Results: Physical Examination: Yellowish skin pigmentation, particularly on palms and nasolabial folds, not affecting sclera.BMI: 21.7.
Mental Status Examination: Aprosodic speech, limited eye contact. Marked rigidity with daily routines; severe anxiety when disrupted. Irritability related to eating and exercise. Food restriction focused on fruits and vegetables (carrots, pumpkins); interest in "being healthier" (muscle gain, fat loss).No purging or binge eating behaviors.
Psychometric Tests: ASSQ, ASAS, WISC-R suggest Autism Spectrum Disorder, Level 1, with average intellectual functioning.
Differential Diagnosis: Biochemical tests ruled out jaundice, liver disease, hypothyroidism, and diabetes. Diagnosis of carotenemia made by exclusion.
Diagnostic Interviews (EDI-III):Symptoms consistent with Avoidant/Restrictive Food Intake Disorder (ARFID).

Image 1:

Figure 1. Mayes S. D., Zickgraf H. (2019). Atypical eating behaviors in children and adolescents with autism, ADHD, other disorders, and typical development. Research in Autism Spectrum Disorders, 64, 76–83.
*Peculiar patterns of eating like rituals around food or selecting food by particular criteria (brand, color...)

Image 2:

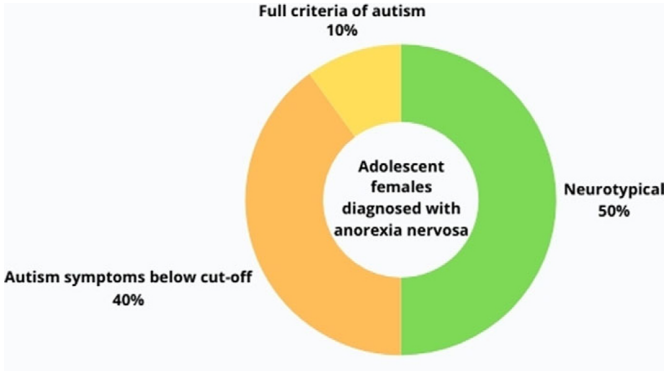

Figure 2. Westwood H., Mandy W., Simic M., Tchanturia K. (2018). Assessing ASD in adolescent females with anorexia nervosa using clinical and developmental measures: A preliminary investigation. Journal of Abnormal Child Psychology, 46(1), 183-192.