Prevalence: percentage of patients in the clozapine treatment group with OSAS.
Results: No results at the moment of poster submission. In April 2018 results will be presented.
Discussion: Will be presented in April 2018.

F95. ASSESSING MANIC SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA USING THE YOUNG MANIA RATING SCALE

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Background: Van Os and Kapur have proposed that the discrete categorical dichotomy of schizophrenia versus bipolar disorder be changed to a dimensional conceptualization. It is also known that manic symptoms can contribute to the clinical course and prognosis of schizophrenia. Hence, a domain for mania has been included in the Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS) in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). However, the psychometric properties of the Young Mania Rating Scale (YMRS) have been little studied in subjects with schizophrenia.
Methods: One hundred and sixty-six inpatients with schizophrenia (diagnosed with DSM-5,2 age ≥ 18 years and ≤ 65 years, and length of hospital stay ≥ 2 weeks) were enrolled from two mental hospitals in Korea. The Institutional Review Board approved the study protocol, and informed consent was given by all study subjects before the start of the study. The Korean version of the YMRS was used to evaluate the severity of manic symptoms. In addition, the domain for mania in the CRDPSS was used to evaluate presence or absence of manic symptoms (0–1, absence; 2–4, presence).
Results: The average age and age-at-onset of the subjects were 46.5 (SD = 11.2) and 25.2 (SD = 13.2) years, respectively. Half were men (51.5%), and most were unmarried (79.1%), religiously affiliated (61.5%) and educated below high school graduate level (73.0%). The mean chlorpromazine equivalent dose of prescribed antipsychotics was 921.1 (SD = 952.0) mg. The mean total score on the YMRS was 7.3 (SD = 6.9) and the mean item scores were: 0.2 (SD = 0.4) for elevated mood, 0.1 (SD = 0.4) for increased motor activity, 0.1 (SD = 0.4) for sexual interest, 0.1 (SD = 0.4) for sleep, 0.4 (SD = 0.8) for irritability, 0.6 (SD = 1.2) for speech, 0.8 (SD = 1.1) for language, 2.0 (SD = 3.3) for content, 0.2 (SD = 0.7) for aggressive behavior, 1.0 (SD = 1.0) for appearance, and 1.8 (SD = 1.7) for insight. The Cronbach α for the 11 YMRS items was 0.66, which is considered an acceptable level of internal consistency. Moreover, only 4% (n = 7) of the 166 subjects had manic symptoms as assessed by the mania domain in the CRDPSS. A receiver operating characteristic curve (ROC) showed that the optimal cut-off score distinguishing schizophrenia patients with and without manic symptoms was 10 with a sensitivity of 88.3% and specificity of 75.6% (area under curve = 0.803, P = 0.012).
Discussion: Since a 10 point total score on the YMRS represents a mild level of Clinical Global Impression (CGI) severity of mania, we may conclude that our threshold on the YMRS for identifying manic symptoms in patients with schizophrenia is reasonable. Hence it may be useful to investigate the evaluation of manic symptoms in patients with schizophrenia from the perspective of deconstructing psychoses.

F96. AGE AND GENDER DETERMINED DIFFERENCES IN THE ONSET OF CHRONIC PHYSICAL MULTIMORBIDITIES AMONG PATIENTS WITH SCHIZOPHRENIA OR DEPRESSION AND THE GENERAL POPULATION

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Background: The links between schizophrenia (SCH) or major depressive disorder (MDD) and chronic physical multimorbidities (CPM) are well established. Patients diagnosed with these disorders have a higher prevalence of CPM than the general population (GEP). However, our knowledge of age and gender determined differences in the development of CPM between SCH, MDD, and GEP remains fragmented and inconsistent. This exploratory study intended to compare the onset of CPM in female and male SCH and MDD patients, and the general population (GEP).
Methods: This nested, single-centered, cross-sectional study was performed during 2016 at Psychiatric hospital Sveti Ivan, Zagreb-Croatia. Data were collected for a consecutive sample of 136 patients diagnosed with SCH, 290 diagnosed with MDD, and 861 participants from the general population of the city of Zagreb and Zagreb County. The primary outcome was the prevalence of CPM. The secondary outcome was the prevalence of CPM in the youngest age group ≤35 years.
Results: After adjustment for gender and education, the prevalence of CPM was significantly different between patients with SCH or MDD and GEP ($p<0.001$). In the oldest age group (≥65 years) the difference was not significant anymore. In the youngest age group, the prevalence was highest in SCH patients (33%) followed by MDD (26%) and GEP (15%) indicating the early onset of CPM in severe mental illness. In the male participants <35 years old, there were no significant differences in the prevalence of CPM between SCH (25%), MDD (23%) and GEP (15%) ($p=0.411$). However, in the female participants <35 years old the difference was significant and clinically relevant ($p=0.006$). Prevalence of CPM in female participants was 50% in SCH, 33% in MDD and 14% in GEP.
Discussion: This study finding indicated the earlier onset of CPM in SCH and MDD patients than in GEP. This difference is primarily caused by the high prevalence of CPM in young female patients diagnosed with SCH. More prevalent physical morbidity points to a substantial disadvantage of female SCH patients early in the course of the illness. Understanding the nature and biological basis regarding the risk and outcome of CPM might help to identify new therapeutic targets, allow more individualized treatment, and facilitate better risk prediction and application of healthcare resources.

F97. CHRONIC PHYSICAL MULTIMORBIDITIES, GENDER DISPARITIES AND TREATMENT OUTCOME IN SCHIZOPHRENIA

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Background: Increased physical morbidity in patients with schizophrenia (SCH) is well established. However, our knowledge on the role of gender in chronic physical multimorbidities (CPM) remains limited, and the evidence

about the effect of CPM on SCH treatment outcome is sparse. The present study explored the gender-dependent differences in the prevalence, and age of onset of CPM between SCH and the general population (GEP), as well as the effect of CPM on hospital readmission in patients with SCH.
Methods: This cross-sectional study was nested within the larger frame of a prospective cohort study conducted at Psychiatric Hospital "Sveti Ivan", Croatia. Data were collected for a consecutive sample of 136 (49 female and 87 male) patients diagnosed with SCH (ICD-10) and 861 (467 female and 394 male) participants from the general population. The primary outcome was the prevalence of CPM. A secondary outcome was the number of psychiatric readmissions since diagnosis.
Results: In the total sample we observed the significant difference in CPM prevalence between SCH and GEP in the youngest age group, <35 years old (p=0.006). Among the male participants <35 years old, there were no significant differences in the prevalence of CPM between SCH (25%) and GEP (15%) (p=0.216). However, among the female participants <35 years old, the difference was significant and clinically relevant (p=0.002). Prevalence of CPM was 50% in SCH patients, and 14% in GEP. After the adjustment for age, sex, a number of psychiatric comorbidities and duration of SCH, the number of physical illness comorbidities was significantly associated with the number of previous psychiatric hospital readmission. (multivariate, robust regression; B=0.98; β=0.24; p=0.022). Approximately, the number of rehospitalizations increases for one with each chronic physical illness.
Discussion: This study identified gender differences in the prevalence of CPM in SCH patients, and the significant association of CPM with psychiatric hospital readmission. Higher physical morbidity points to a substantial disadvantage of female patients early in the course of illness. Understanding the nature and biological basis of gender-determined differences in risk and outcome of CPM might help to identify new therapeutic targets, allow more individualized treatment, and facilitate better risk prediction and application of healthcare resources.

F98. HYPOVITAMINOSIS D IN SCHIZOPHRENIA: ASSOCIATED CARDIOVASCULAR RISK

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Background: Vitamin D modulate the course of many neurologic diseases and conditions. Moreover, the prevalence of vitamin D deficiency might be higher in psychiatric patients, in particular with schizophrenia.
Likewise, there is an inverse relationship between vitamin D levels and several cardiovascular risk factors, including the metabolic syndrome, that patients with schizophrenia are predisposed to develop. It is within this framework that this study aims to explore the relationship between vitamin D levels in a cohort of Tunisian patients with schizophrenia and to determine the cardiovascular risk according to whether they had hypovitaminosis D or not.
Methods: A cross-sectional and retrospective descriptive study was conducted at the "F" psychiatry department at the Razi Hospital, Manouba over a twelve-month period from June 1st, 2015 to May 31st, 2016, including 80 patients with schizophrenia in period of clinical remission. The evaluation focused on anthropometric parameters and cardiovascular risk factors. A dosage of vitamin D was performed.
Results: The patients had an average age of 42.5 years and 70% were male. 25 patients had metabolic syndrome. 49% of patients had vitamin D insufficiency and 51% had vitamin D deficiency. Vitamin D levels had not been affected by the clinical characteristics of the disease. However, there was no significant association between vitamin D levels and metabolic syndrome. A significant negative correlation was found between the total sum of the various cardiovascular risk factors and the vitamin D deficiency (p <0.001).
Discussion: In our study, all patients had vitamin D levels below the recommended levels. 25 patients (31%) met the criteria for metabolic syndrome. All our patients had at least one cardiovascular risk factor. The majority (33% and 27%) had respectively three or four FRCV. 10% had more than five concurrent FRCVs. This result has been described in many studies. Indeed, in patients with schizophrenia, the cardiometabolic risk seems to increase continuously. Several European studies have reported a prevalence of metabolic syndrome ranging from 28% to 37% in patients with schizophrenia. Higher rates of 43% and 46% were reported respectively in the United States and Canada. Moreover, with schizophrenia have an increased risk of sudden death and are 2 to 4 times more likely to die prematurely compared to the general population. These results have been explained with a multicausal model focusing on genetics, lifestyle, smoking, diet and sedentary behavior as well as by the side effects of antipsychotics known to induce weight gain and aggravate symptoms. risk factors for cardiometabolic disease, although studies in naïve patients reflect various abnormalities early on. However, several studies confirm that certain metabolic abnormalities may occur in schizophrenic patients naive to any antipsychotic treatment.
This result is consistent with current literature data that highlight increased metabolic and cardiovascular risk in vitamin D deficiency. Indeed, in the general population, vitamin D deficiency is an important risk factor for cardiometabolic disease. The majority of cohort studies have reported an increase in the incidence of cardiovascular disease in people with low vitamin D levels.

F99. FIRST EPISODE PSYCHOSIS PATIENTS WHO USED CANNABIS DEVELOP THEIR ILLNESS AT A SIGNIFICANTLY YOUNGER AGE THAN THOSE WHO NEVER USED CONSISTENTLY ACROSS EUROPE AND BRAZIL

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Background: Patients presenting to psychiatric services with their first episode of psychosis (FEP) report higher rates of previous cannabis use than the general population (Donoghue et al., 2011; Myles, Myles and Large, 2016). Evidence suggested that patients suffering from psychosis with a history of cannabis use have an earlier age of onset of psychosis (AOP) than those who never used it (Di Forti et al., 2013).
We aim to investigate if the reported association between use of cannabis and AOP is consistent across different countries, once having taken into account different patterns of cannabis use (i.e. frequency of use and age at first use).
Methods: We analysed data on patterns of lifetime cannabis use and AOP from FEP=1,149 (61.7% males) from 5 European countries and Brazil part of the European network of national schizophrenia networks studying European Gene-Environment-Interaction (EUGEI) study.
Patients met ICD-10 criteria for psychosis, ascertained by using OPCRIT (McGuffin et al., 1991).
The CEQmv (Di Forti et al., 2009) further modified for the EUGEI study, was used to collect data on lifetime frequency of cannabis use (never used/ used at least once but less than daily/ everyday use) and age at first use in years (then dichotomized according to mean age at first use ≤15 years or ≥16 years).
We used two ANOVAs: age of onset was used as the outcome variable and frequency of cannabis use and age of first use were respectively entered as independent predictors, along with country, gender and self-ascribed ethnicity.
Results: 63.3% of our sample used cannabis at least once in lifetime. Among those who used cannabis in their lifetime, mean age at first use was 16.8 years (sd=4.6) and median age was 16 years, 42.3% tried first time cannabis at 15 years or before, 57.7% at 16 years or older.