evolution, currently admitted to a center specializing in Eating Disorders, who comes to the emergency department with psychotic symptoms.
Objectives: To know the prevalence of comorbidity of psychotic symptoms in people with eating disorders, as well as possible risk factors, severity and management of them.
Methods: Presentation of a case and review of the available literature on the presence of symptoms of the psychotic sphere in persons diagnosed with eating disorders.
Results: The literature reflects data of a prevalence of 10-15% of patients with eating disorders presenting psychotic symptoms. The presence of psychotic symptoms is not directly related to a greater severity of the eating disorder. Some genetic associations have been found, as well as alterations at the physiological, cognitive and brain structure level that coincide in both pathologies. In some cases, an improvement in eating behavior has been observed when the psychotic symptomatology is resolved. In the case of patients with bulimia nervosa, a higher number of psychotic symptomatology has been observed, such as paranoid ideations, which some studies relate to a greater emotional capacity and histrionic expressiveness of this patient profile.
Conclusions: The comorbidity of psychotic symptoms and eating disorders is relatively frequent and makes us face challenges in the diagnosis, as well as in the management of these patients. This comorbidity is especially important in patients with bulimia nervosa. Future research is necessary to know a more exact management of these pathologies.

Disclosure of Interest: None Declared

EPV0466

The psychodynamic role of the displacement defense mechanism in people with obesity and anorexia nervosa

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Introduction: Feeding plays a very important role in our lives. First of all survival, but in general it has a much wider and important social role. Through feeding, in addition to satisfying life's needs and basic instincts, we experience a sense of satisfaction through the investment of libido. Anorexia nervosa and obesity as the two extremes of eating disorders can be considered as a disturbed experience of the satisfaction of eating, and in the background there is usually a very weak, fragile personality structure. A fragile personality structure tends to use primitive defense mechanisms, but the use of healthier, neurotic defense mechanisms in people with eating disorders should not be neglected.
Objectives: To investigate the role of the psychological defense mechanism of displacement in people with obesity and anorexia nervosa.
Methods: Search of contemporary professional and scientific literature in the field of psychodynamics of eating disorders.
Results: Displacement is a defense mechanism in which, when faced with a problem, the problem is not solved with the initial object of aggression, but the problem is moved to another object or situation that the individual perceives as less dangerous. Thus, when faced with a stressful situation or sadness, obese people may have a need for emotional eating, which can be interpreted as displacement of the problem, which is temporarily "solved" by satisfying the basic instinct, but later the person becomes overwhelmed by internal and external shame. Equally so, a traumatic upbringing and disturbed interpersonal family dynamics, which are often present in people with anorexia nervosa, can cause anxiety drives that are displaced in the form of the need for a strong restriction of food intake.
Conclusions: In people with obesity and anorexia nervosa, the use of the defense mechanism of displacement is pointed out. Through psychodynamic psychotherapy it can be very useful to recognize and interpert the use of displacement and, thus to enable reaching a neurotic and healthier level of functioning in people with the aforementioned eating disorders.

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EPV0468

How do men differ from women? Case-Control study on clinic and personality characteristics of eating disorders

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Introduction: A review of the literature shows how female sex is a crucial factor in the development of ED, being the proportion of women and men 10 to 1 regardless of the location of the sample (Duncan, Ziobrowski & Nicol, 2017) and different clinical subtypes (AN, BN) (Swanson et al., 2011). However, male population has always been less studied, some works find that only 1% of the articles published in AN is aimed at the study of males (Galusca, 2012).
Nowadays it is accepted that the etiopathogenesis of these disorders is multifactorial and in addition to female gender other risk factors have been identified, such as neurobiological alterations, psychological predictors, personality traits, low self-esteem, extreme perfectionism or thinness values focused on body and figure. On the other hand, certain impulsive behaviours such as self-harm, substance use, physical activity or diets are factors that may be confused as predisposing or as symptoms of the pathology itself (Connan et al., 2003, Treasure, Stein and Maguire, 2015).
Recently, Kinasz, Accurso, Kass and Le Grange (2016) have compared the clinical characteristics that differentiate men (59) from women (560) in a sample of children and adolescents between 6 and

18 years-old, finding that males presented an earlier start of the ED and not appreciating differences in the duration of the disease, income, episodes of purgue and psychiatric comorbidity of anxiety, behaviour disorders or impulsivity.
Objectives: The aim of this study was to evaluate gender differences in clinical characteristics, levels of depression, previous obsessiveness and personality dimensions in eating disorders (ED) compared with controls.
Methods: A total of 80 participants was divided into 4 groups, 20 men and 20 women with ED and 20 men and 20 women without ED (healthy control), matched by age and socioeconomic status. The design of the study was case-control, and data was collected through clinical interview and a battery of cuestionaires.
Results: Men with ED only differ in vigorous physical activity (measured by IPAQ) from controls and women with pathology. Regarding personality traits, men and women with ED do not differ among them, although they do differ in novelty search and harm avoidance respect to their controls.
Conclusions: Behaviors such as physical activity in males frame a slightly different way of reducing their discomfort, however, clinical implication indicates that the treatment may be similar according to gender.

Disclosure of Interest: None Declared

EPV0469

Eating disorders. What about males?

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Introduction: Eating disorders (ED) historically been adressed as illnesses that only affect young adolescent females. ED's in males have been documented in literature as early as the 1960's; yet men continue to be under represented on research on the topic. For decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) perpetuated the invisibility of males by including amenorrhea as a diagnostic criterion. It was not until 2013 that male inclusion was endorsed thorught the removal of that criterion. It is estimated that one in four people affected with and ED is male. It is estimated that one in four people affected with and ED is male. The proportion of males reporting lifetime prevalence of Binge eating disorder (BED) was far greater than for Anorexia nervosa (AN) or Bulimia nervosa (BN); the female versus male ratio of BED prevalence was 3:1. AN is the most life-threatening ED, but is least frequently seen in male populations; researchers suggest this is because most men are not interested in the emaciated, thin look.
Objectives: This poster aims to recognize the presence of ED's in males and raise awareness on this topic.
Methods: Case report and literature review
Results: We present the case of a 50-year-old man with long-standing AN, who had never undergone mental health follow-up. He is referred to psychiatrist by his primary care provider (PCP) due to depressive symptoms. His medical history included vitamine D insufficiency and osteoporosis. At the age of 19 he was obese (BMI 35) and from the age of 23 he started to present dietary restriction after a social event. He had never self-induced vomiting, use of laxatives, binge eating or compulsive exercise. He reported no history or current substance use disorder. BMI at first consultation was 17,6 and showed fear of weight gain. Antidepressant therapy was started and patient was referred to a specialized therapist, nutritionistand nurse.
Conclusions: Overall, the findings demand clinicians develop awareness about ED in males to advance illness management and enhance long-term prognosis. In our case, the delay in receiving treatment has probably led to greater morbidity and chronicity. PCP's play a key role in detection of ED's as the often act as a first point of contact for men accesing the health care system. While assesing and ED, the PCP should include general questions on eating habits in their intake interview. Once an a ED is suspected, the first few minutes of the encounter are crucial to gain trust and buy-in from the patient. Once buy-in from the patient is gained, a complete physical exam and diagnostic work-up is required. Priority referrals to the following professionals are critical: psychiatrist, therapist, dietician or nutritionist, and ED specialist if available.

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EPV0470

Gastric bezoar in a patient hospitalized in an eating disorder unit. Case report

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Introduction: It is well known that eating disorders are related to comorbidity. At least, half of these patients have other mental disorders and, in addition to it, the presence of physical comorbidity (cardiovascular, kidney, nervous system, digestive tract, metabolic or endocrine disorders) comes with a decline in life expectancy.
Objectives: Description of a patient with a diagnosis of anorexia nervosa (AN) who developed a gastric bezoar during hospitalization.
Methods: Case treated in a specific Eating Disorder Unit in a Third-Level Hospital.
Results: 26 years old woman with a diagnosis of AN hospitalized in General Psychiatric Unit with BMI of 11,78 kg/m2. Nasogastric tube was necessary and, after 1 month with a progressive weight recovery (BMI 13,84 kg/m2), the patient was transferred to the Eating Disorder Unit in order to follow specific psychological therapy. No incidence related to physical exploration or clinical analyses happened during this month apart from pancytopenia due to malnutrition.
However, 8 days after, patient developed nausea and had 3 vomit episodes, constant abdominal pain at hipogastrium (moderate intensity), dizziness, instability and constipation. The patient refused possibility of pregnancy. The physical exam showed bowel