describe depressive symptoms that appear in patients with history of psychosis. PPD unveils itself as a separate nosological entity, differing from the adverse effects typically associated with antipsychotics, the negative symptoms of psychosis, and other psychiatric disorders that present with both psychotic and depressive symptoms (e.g. bipolar disorder, schizoaffective disorder, or psychotic depression).
Objectives: The authors present a case of a 64 year-old man hospitalized due to inaugural psychosis with persecutory and grandiose delusions as well as auditory hallucinatory activity, who began to develop a depressive clinical picture whilst under treatment. A brief discussion on post-psychotic depression, from its clinical presentation to its treatment and implications in prognosis is also presented.
Methods: A brief non-systematized literature review using the *Pubmed* platform as well as presentation of a clinical case.
Results: Depressive complaints are a common complication of psychotic episodes, with the literature estimating that approximately a quarter of psychotic patients present with PPD. Although typically described in association with schizophrenia, recent literature describes PPD occurring alongside other psychotic presentations, including first-episode psychosis. A division between affect and psychosis has been attempted in terms of psychiatric classification, however, the blurred lines between the two continue to contribute to difficulties in differential diagnosis. This becomes a challenge when distinguishing between extrapyramidal symptoms associated with antipsychotics, negative symptoms (i.e apathy, abulia and alogia) and psychiatric disorders with affective-psychotic overlap. Having only recently been considered a distinct clinical entity in psychiatric classification systems, research on its etiology, course, treatment and prognosis are scarce. In regards to the previously described patient, a depressive disorder whilst in treatment for psychosis was identified, and through early recognition of the symptoms treatment with an antidepressant was initiated with favourable response.
Conclusions: PPD is a relatively common phenomenon which is gaining more attention in recent literature. As classifications have begun to consider PPD as a distinct clinical entity, as well as unifying defining criteria, further studies can be developed so as to clarify aspects which remain to be defined. The clinician should be aware of this entity as well as the potentially confounding symptom presentations, so as to provide adequate early treatment thus contributing to improved patient outcomes.

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EPV0454

Resistant depression. Clinical manifestations and diagnosis. Purposely a case

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Introduction: The term "depression" can be used in different senses: it can be a syndrome, a mood state, a mental disorder, and all of them are distinct clinical conditions…There are no pathognomonic features of bipolar/unipolar depression. A good medical history is the most important component of the evaluation. We have to use clinical variables and differential epidemiology for a correct diagnosis.
Objectives: They both analyze clinical, psychopathological and epidemiological characteristics of resistant depression and they review causes, incidence, prevalence, diagnostic, therapeutic tools and the importance of maintaining the treatment, because the abandonment of the treatment is a good predictor of possible relapses.
Methods: A literature Review of the last five years concerning resistant depression has been done: prevalence, incidence, pathogenesis and its relationship with other psychiatric disorders encoded in DSM-V.
Results: Unipolar major depression (major depressive disorder) is characterized by a history of one or more major depressive episodes and no previous history of mania or hypomania symptoms. A major depressive episode is presented with five or more of the following nine symptoms for at least two consecutive weeks; at least one of them must be either a depressed mood or a loss of interest or pleasure. In addition, the symptoms must cause significant distress or psychosocial impairment, and not be a direct result of a substance or general medical condition.
Conclusions: Symptoms of unipolar depression in adults can overlap with symptoms of other psychiatric and general medical disorders. Unipolar depression needs to be distinguished from these other disorders to prevent inappropriate treatment.

Disclosure of Interest: None Declared

EPV0455

DIVORCE AND DEPRESSION: A FORENSIC CASE OF OUR OBSERVATION AND PREVENTION STRATEGIES

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Introduction: Nearly 300 million people worldwide are affected by depression. According to the DSM-5, the depressive episode is characterized by a depressed mood, a marked decrease in interest or pleasure in all activities, insomnia, agitation or psychomotor slowdown. It occurs mainly in the female sex. Traumatic life events are associated with a depressive onset.
Objectives: It is well known that interpersonal relationships are foundations for human beings, especially emotional ones and that they have an important effect on mental health. Specifically, 60% of divorced people with a previous history of depression will develop a new depressive episode; this will develop in 10% of subjects without a previous history of depression. The recurring thought of death and suicide is also frequent, as well as the abuse of drugs and ethanol in cases of depression. The forensic pathologist often finds himself having to carry out complex inspections in order to trace the cause of death in these types of deaths.
Methods: We report the case of a lady, found dead at her home, in her bed.
Results: A medical prescription for benzodiazepines was found on the cabinet next to her bed with five bottles of benzodiazepines, one

of which was empty, two semi-empty packs of antidepressants. Under the bed there was a photo album containing 58 pages to which the photographs of the lady's wedding were attached. In all the photographs the groom's face appeared torn. The hygienic-sanitary conditions of the house were precarious. The analysis of the medical record showed that the lady was being treated for major depressive disorder with psychotic manifestations, severe chronic insomnia disorder and abuse of ethyl alcohol and anxiolytics, which arose after separation from her husband five years before her. The toxicological examination performed on blood and urine confirmed the presence of massive doses of benzodiazepines and ethanol, causing death from respiratory depression.
Conclusions: In similar cases, the clinical and family history as well as the toxicological examination help the forensic pathologist in defining the cause of death. Depression leads to family and social isolation, affecting all aspects of a person's life. Divorce is not only a painful and expensive experience but also harmful to health. The subject is not only in a condition of marital and economic abandonment but also health because the resources currently used in this field are few. Together with the legal process, there should also be a health process with prevention strategies such as questionnaires, interviews, exercises in order to identify those at risk and treat them appropriately.

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EPV0456

rTMS efficacy in major depression disorder: comparing two reviews

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Introduction: Transcranial magnetic stimulation (TMS)is perhaps the most popular of the newbrain stimulation techniques because its clinical effects are produced without the need for a craniotomy (as with deep brainstimulation (DBS)) or seizure induction(as with electroconvulsive therapy (ECT)).Recently ,TMS is typically used to improve depression symptoms when other depression treatments haven't been effective.
Objectives: This is a review that discuss the efficacy of the antidepressant effect of TMS.
Methods: A narrative review was conducted basedon a search in pubmed using thekeywords: "rTMS" and "depression".
Results: One of the reviews studied proved the efficacy of rtms in the treatment of depressionbut there is still a clinical need for the complementary use of antidepressants.Although rTMS is more expensive than conventional antidepressants, it remains more interesting for patients who have not found benefits with pharmacological treatments.The other review also demonstrated the antidepressant effect of rTMS and that this effect, once completed, appears to be as long-lasting as that of antidepressants. TMS is also a promising new therapy and a powerful research tool. The body of TMS literature suggests that daily, left prefrontal TMS for 3–6 weeks has antidepressanteffects that are clinically meaningful (30% remission), with low side effects and nodrug-drug interactions. Furthermore, TMS shows promise in several other psychiatricdisorders, particularly treating acute and chronic pain.
Conclusions: Even though The Food and drug administration (FDA) has accorded RTMS' initial clearance of the first device in 2008 ,additional researches are still needed.The TMS coil location, stimulation intensity and frequency, and dosing strategy have to be more precise for better results.

Disclosure of Interest: None Declared

EPV0457

Open-Label placebo for the treatment of unipolar depression: Results from a randomized controlled trial

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Introduction: The response to placebo is robust in studies of various antidepressant treatments. The strong placebo response, combined with the absence of side-effects, has prompted suggestions to use the ethically sound open-label placebo (OLP) as a treatment for depression.
Objectives: The aim of the present study was to assess the efficacy of OLP in the setting of a randomized controlled trial for the treatment of unipolar depression.
Methods: Thirty-eight patients (28 females, 73.7%) were randomized to either an eight-week treatment with OLP (n=18) or four week of treatment as usual (TAU) followed by four weeks of OLP (n=20). Clinical and socio-demographic measures were assessed at baseline, after four weeks, and at the end of the trial. Response to treatment was determined using the Quick Inventory of Depressive Symptomatology (QIDS SR-16).
Results: There was an overall decrease in depression levels over time, $F(2,35) = 3.98$, $p = .028$). A significant *group* x *time* interaction was found only among non-geriatric patients (<65y) with an early onset of depression (<50y), $F(2,22) = 3.89$, $p = .036$]. Post-hoc tests indicated a significant decrease during the first four weeks, but only in the OLP group, $t(11) = 2.29$, $p = .043$.

Table 1: Demographic measures of OLP and TAU patients.

Measures	OLP (n = 18)	TAU (n =20)	Statistical analyses
Age (years) [Mean ± SD]	48.17 ± 16.86	51.65 ± 17.68	$t(36) = -0.62$, $p = .539$
Education level (years) [Mean ± SD]	15.61 ± 3.66	14.22 ± 2.62	$t(34) = 1.31$, $p = .200$
Gender (male/female) [no.]	4 / 14	6 / 14	$X^2(1) = 0.30$, $p = .587$
Age of onset (years) [Mean ± SD]	34.19 ± 15.82	32.45 ± 17.72	$t(36) = 0.32$, $p = .752$
Number of depressive episodes (no.) [Mean ± SD]	2.58 ± 2.61	6.64 ± 9.16	$t(21) = -1.47$, $p = .156$
Number of hospitalizations (no.) [Mean ± SD]	0.12 ± 0.33	0.17 ± 0.38	$t(33) = -0.40$, $p = .689$

Notes
OLP = Open label placebo; SD = Standard deviation; TAU = Treatment as usual.