# Schizophrenia

## FC62

### Clinical symptomatology and facial emotion recognition in schizophrenia: Which relationship?

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*Introduction* Patients with schizophrenia show impairments in social cognitive abilities, such as recognizing facial emotions. However, the relationships between specific deficits of emotion recognition and with clusters of psychotic remain unclear.
*Objectives* To explore whether facial emotion recognition was associated with severity of symptoms and to which presentation of psychotic symptoms.
*Methods* Facial emotion recognition (FER) were evaluated in 58 patients with stable schizophrenia with a newly validated FER task constructed from photographs of the face of a famous Tunisian actress representing the Ekman's six basic emotions (happiness, anger, disgust, sadness, fear, and surprise). Symptomatology evaluation comprised the Positive and Negative Syndrome Scale (PANSS), the Calgary Depression Scale for Schizophrenia (CDSS) and the Clinical Global Impressions Scale Improvement and severity (CGI).
*Results* Patients who failed to identify anger had significantly higher scores in hyperactivity item ($P < 0.0001$). The patients who had a difficulty to identify sadness had more grandiosity ($P \leq 0.002$). The impairment in happiness recognition was correlated with hallucination ($P = 0.007$) and delusion ($P = 0.024$) items. Incapacity to identify fear was associated to lack of judgment and insight ($P = 0.004$).
*Conclusions* Deficits in recognition of specific facial emotions may reflect severity of psychiatric symptoms. They may be related to specific clusters of psychotic symptoms, which need to be confirmed in further studies.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.066

## FC63

### Differential serum acute-phase biomarker profile in schizophrenia and bipolar disorder

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There is a growing interest in inflammation and immune dysfunction in severe psychiatric disorders such as schizophrenia and bipolar disorder. This dysfunction seems to consist in abnormal blood levels of cytokines and acute-phase proteins, with increased levels of C-reactive protein (CRP), fibrinogen, homocysteine and erythrocyte sedimentation rate (ESR). Higher levels can be found in acute episodes and in patients with a higher cardiovascular risk. Acute-phase protein serum parameters were determined in a sample of 100 outpatients with schizophrenia ($n = 50$) or bipolar disorder ($n = 50$) so as to assess differences in pro-inflammatory state. Metabolic state was assessed through BMI, waist circumference, glucose, cholesterol and triglyceride levels.
The whole sample showed higher levels of fibrinogen (mean $4 \pm 0.9$ g/L), triglycerids (mean $2.9 \pm 8.5$ mmol/L), cholesterol-LDL (mean $3 \pm 0.9$ mmol/L), and homocysteine (mean $16.2 \pm 7.3$ umol/L) than our laboratory reference values from healthy individuals.
After correcting for gender and pharmacological treatment, patients with schizophrenia showed higher levels of ESR, fibrinogen, glucose and CRP, while homocysteine was not statistically different between patients with schizophrenia or bipolar disorder (see Table 1).
These results may suggest a different biomarker profile in bipolar and schizophrenic outpatients, with a more severe pro-inflammatory state in schizophrenia. Serum homocysteine levels could be a state marker in both disorders.

*Table 1*

| | ESR (mm) | Fibrinogen (g/L) | Glucose (mmol/L) | CRP (mg/L) | Homocysteine (mmol/L) |
|---|---|---|---|---|---|
| Schizophrenia | 6 ± 5.7 | 4.1 ± 0.85 | 5.7 ± 2.0 | 5.4 ± 4.2 | 17.1 ± 8.6 |
| Bipolar disorder | 3.1 ± 2.2* | 3.6 ± 0.76* | 4.4 ± 0.95* | 2.2 ± 2.0* | 15.9 ± 5.7 (NS) |

NS: not significant. *$P < 0.05$.

*Disclosure of interest* The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.067

## FC64

### Akathisia: Prevalence and risk factors in a community-dwelling sample of patients with schizophrenia. Results from the multi-center FACE-SZ Dataset

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The main objective of this study was to determine the prevalence of akathisia in a community-dwelling sample of patients with schizophrenia, and to determine the effects of treatments and the clinical variables associated with akathisia. Three hundred and seventy-two patients with schizophrenia or schizoaffective disorder were systematically included in the network of FondaMental Expert Center for Schizophrenia and assessed with validated scales. Akathisia was measured with the Barnes Akathisia Scale (BAS). Ongoing psychotropic treatment was recorded. The global prevalence of akathisia (as defined by a score of 2 or more on the global akathisia subscale of the BAS) in our sample was 18.5%. Patients who received antipsychotic polytherapy were at higher risk of akathisia and this result remained significant (adjusted odd ratio = 2.04, $P = .025$) after controlling the influence of age, gender, level of education, level of psychotic symptoms, substance use comorbidities, current administration of antidepressant, anticholinergic drugs, benzodiazepines, and daily-administered antipsychotic dose. Our results indicate that antipsychotic polytherapy should be at best avoided and suggest that monotherapy should be recommended in cases of akathisia. Long-term adminis-