Table 1 Description of the sample, demographic and clinical data.

Table 1: Description of the sample, demographic and clinical data

VARIABLE	PATIENTS (n=103)	CONTROLS (n=91)	STATISTICS
Age	41.96 ± 10.231	36.23 ± 13.40	Mann Whitney test; MW U= 3519; **p<0.0005**
Gender (M: F)	41:62	36:55	Fisher exact test; ns.
Age of disease onset	26.12 ± 8.974		
Lifetime duration of treatment	15.38 ± 9.519		
Number of hospitalizations	4.13 ± 3.968		
Psychiatric heredity			
Same disorder	15 (14.6%)		
Other disorder	39 (37.9%)		
Without	47 (45.6%)		
Education:			
elementary	9 (8.7%)	1 (0.9%)	Pearson chi-square; ns.
vocational training	25 (24.3%)	3 (2.8%)	
secondary school	52 (50.5%)	38 (34.9%)	
university	16 (15.5%)	9 (8.3%)	
not completed	1	40	
Marital Status:			
single	61 (59.0%)	28 (25.7%)	Pearson chi-square; ns.
married	24 (23.1%)	21 (19.3%)	
divorced	15 (14.3%)	1 (0.9%)	
widowed	1 (0.9%)	1 (0.9%)	
not completed	3 (2.7%)	40	
Employment Yes/No	33/70		
objCGI severity	4.14 ± 0.971		
subCGI severity	2.75 ± 1.392		
objCGI-subCGI severity	1.67 ± 1.56		
Q-LES-Q			
Physical health (max 65p)	41.81 ± 9.74	43.53 ± 10.43	unpaired t-test: t=4.098 df=180; **p<0.0001**
Feelings (max 70p)	46.33 ± 10.63	52.36 ± 9.70	unpaired t-test: t=4.107 df=192; **p<0.0001**
Work (max 65p)	27.82 ± 18.13	37.78 ± 19.47	Mann Whitney test: MW U= 3377; **p<0.001**
Household (max 50p)	34.99 ± 9.04	33.84 ± 13.72	unpaired t-test: t=0.6997 df=192; ns.
School / study (max 50p)	13.47 ± 8.77	20.05 ± 12.97	Mann Whitney test: MW U= 3451; **p<0.005**
Leisure (max 30p)	20.15 ± 5.42	25.22 ± 4.05	unpaired t-test: t=7.290 df=191; **p<0.0001**
Social activities (max 55p)	35.69 ± 9.22	43.02 ± 8.24	unpaired t-test: t=5.808 df=192; **p<0.0001**
General (max 80p)	51.49 ± 12.08	56.88 ± 9.69	unpaired t-test: t=3.400 df=192; **p<0.001**
SUM O-LES-Q (max 465p)	271.5 ± 58.03	312.68 ± 46.11	unpaired t-test: t=5.419 df=192; **p<0.0001**
SUM Q-LES-Q in percent	58.42 ± 12.47 %	67.24 ± 9.91 %	unpaired t-test: t=5.401 df=192; **p<0.0001**
ISMI			
Alienation	13.31 ± 3.89		
Stereotype agreement	14.01 ± 3.42		
Perceived discrimination	11.01 ± 3.30		
Social withdrawal	13.03 ± 3.77		
Stigma resistance	12.63 ± 2.34		
Overall score	63.98 ± 13.74		

Table 2 Relation between Q-les-Q domains and facets of ISMI.

Domain	Overall score of ISMI	Alienation	Stereotype agreement	Perceived discrimination	Social withdrawal	Stigma resistance
Physical health	-0.496***	-0.397***	-0.509***	-0.372***	-0.454***	-0.349***
Feelings	-0.633***	-0.535***	-0.588***	-0.469***	-0.561***	-0.413***
Work	-0.261**	-0.202*	-0.246*	-0.141	-0.258**	-0.106
Household	-0.355***	-0.278**	-0.350***	-0.294**	-0.311***	-0.268**
School / study	-0.099	-0.069	-0.073	-0.078	-0.103	-0.100
Leisure	-0.457***	-0.430***	-0.411***	-0.347***	-0.410***	-0.293**
Social activities	-0.507***	-0.391***	-0.438***	-0.390***	-0.555***	-0.235*
General	-0.550***	-0.487***	-0.487***	-0.444***	-0.504***	-0.316***
SUMA O-LES-Q	-0.581***	-0.477***	-0.540***	-0.429***	-0.548***	-0.355***

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

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

http://dx.doi.org/10.1016/j.eurpsy.2016.01.642

EW525

Cognitive function in early psychosis patients from a low-income country

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Background Cognitive impairments are well established findings in schizophrenia and are associated with significant impairment of social functioning. Episodic memory, working memory and executive function test scores are typically 1 standard deviation below healthy controls. There are reports suggesting the presence of neurocognitive deficits prior to illness onset, opening the possibility of using cognitive profiles as disease markers. Interest in exploring cognitive functioning in early stages schizophrenia has continued to grow, as earlier treatments could possibly lead to improved outcomes.
Methods This is a cross-sectional assessment of cognitive profiles in patients with early psychosis. A total of 51 patients suffering from psychosis in the age group of 18–65 years were recruited and matched with 51 healthy controls. A wide range of neurocognitive domains were assessed using standardised neuropsychological tests.
Results There was evidence of statistically significant impairments in cognitive functioning across a broad range of cognitive domains in early-psychosis patients, as compared to healthy controls. More pronounced deficits were seen in executive function tests.
Conclusions To our knowledge, this is the first study to report cognitive deficits across a range of domains in patients with first episode psychosis from a low-income country. This study found deficits across multiple domains, including language, memory, attention, executive function, and visuospatial function in patients with early psychosis. Evidence of neuropsychological deficits in the early course of the disease may highlight crucial therapeutic windows for both pharmacological treatments and cognitive rehabilitation. This may improve functional outcomes in this patient group in the longer term.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.643

EW526

Short-term compliance in first-episode psychosis

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Introduction Non-compliance is a significant problem in patients with first-episode psychosis (FEP), representing a challenge for mental health professionals due to the heterogeneous course and functional outcomes.
Objectives The aim was to describe the short-term compliance in FEP and analyze the demographics, clinical features, and management issues potentially associated with non-compliance.
Methods This observational and retrospective study included all consecutive FEP admitted to our psychiatry unit from January to June 2015, belonging to our catchment area. To be categorized as compliant, patients had to attend month-1 and month-3 follow-up visits. Characteristics of compliant and non-compliant were compared using a bivariate analysis.
Results We included 18 patients whose characteristics are shown in the table. Overall, 8 (44.4%) were non-compliant. Patients who were non-compliant had a significantly shorter length of stay (10.3 [6.3] vs. 18.5 [8.9] days). Most patients (66.7%) had cannabis abuse, being slightly more frequent among non-compliant (75% vs. 60%, P = NS); in addition, the diagnosis of substance-induced psychotic disorder was also more common among non-compliant (50% vs 20%, P = NS). There were 2 patients who were readmitted, both in the non-compliant group (Table 1).
Conclusions Short-term non-compliance is high among patients with FEP. Despite the limitations of our study, our results suggest that, beside other factors (e.g. substance abuse), non-compliance could be associated with management-related factors.

Table 1

Characteristic	Compliant (n=10)	Non-compliant (n=8)	p-value
Age, mean (SD)	30.7 (12.7)	26.8 (14.8)	0.559
Sex (male), n (%)	7 (70)	6 (75)	0.814
Involuntary admission, n (%)	0 (0)	0 (0)	-
Drug abuse (cannabis), n (%)	6 (60)	6 (75)	0.421
Admission length (days), mean (SD)	18.5 (8.9)	10.3 (6.3)	0.036
Diagnosis at discharge, n (%)			0.258
- Brief psychotic disorder	1 (10)	0 (0)	
- Substance-induced psychotic disorder	2 (20)	4 (50)	
- Schizophreniform disorder	3 (30)	1 (12.5)	
- Schizophrenia	2 (20)	0 (0)	
- Bipolar disorder	1 (10)	0 (0)	
- Psychotic disorder NOS	1 (10)	3 (37.5)	
Treatment at discharge, n (%)			0.575
- Aripiprazole vo	2 (20)	2 (25)	
- Olanzapine vo	4 (40)	2 (25)	
- Paliperidone vo	1 (10)	0 (0)	
- Risperidone vo	0 (0)	2 (25)	
- Depot	2 (20)	1 (12.5)	
- Politherapy (oral)	1 (10)	1 (12.5)	
Referral, n (%)			0.178
- Community treatment	6 (60)	7 (87.5)	
- Day Hospital	3 (30)	0 (0)	
- Short stay psychiatric unit	1 (10)	0 (0)	
- Voluntary discharge	0 (0)	1 (12.5)	
Readmission, n (%)	0 (0)	2 (25)	0.094

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

http://dx.doi.org/10.1016/j.eurpsy.2016.01.644

EW527

Quality of care for medical comorbidities among patients with and without schizophrenia

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Introduction The association between schizophrenia and quality of care for medical comorbidities in universal health care systems remains unclear.
Objectives To elucidate whether equal access also implies equivalent and sufficient care.
Aims To compare the quality of care for heart failure, diabetes and chronic obstructive pulmonary disease (COPD) among patients with and without schizophrenia in Denmark.
Methods In a nationwide population-based cohort study, we used Danish national registries to estimate the risk of receiving guideline recommended disease-specific processes of care between 2004 and 2013.
Results Compared to patients without schizophrenia, patients with schizophrenia had lower chance of receiving high overall quality of care (≥ 80% of recommended processes of care) for heart failure (Relative risk [RR] 0.67, 95% CI: 0.48-0.92), diabetes (RR 0.84, 95% CI: 0.79-0.89) and COPD (RR 0.82, 95% CI: 0.72-0.93) as well as lower chance of receiving individual disease-specific processes of care including treatment with beta-blockers (RR 0.87, 95% CI: 0.79-0.96) in heart failure care and measurement for albuminuria (RR 0.96, 95% CI: 0.93-0.99), eye examination at least every second year (RR 0.97, 95% CI: 0.94-0.99) and feet examination (RR 0.96, 95% CI: 0.93-0.99) in diabetes care. Diabetic patients with schizophrenia also had lower chance of receiving antihypertensive (RR 0.84, 95% CI: 0.73-0.96) and ACE/ATII inhibitors (RR 0.72, 95% CI: 0.55-0.94). In COPD care, patients with schizophrenia had lower chance of receiving LAMA/LABA medication (RR 0.92, 95% CI: 0.87-0.98), however, higher chance of treatment with non-invasive inhalation (RR 1.85, 95% CI: 1.61-2.12).
Conclusions Quality of care for three medical comorbidities was suboptimal for patients with schizophrenia.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.645

EW528

Efficacy and tolerability of switching to long-acting injectable (LAI) aripiprazole in outpatients with schizophrenia

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Introduction Switching antipsychotics is a therapeutic alternative for managing side-effects, or efficacy and compliance issues.
Aim To evaluate the efficacy and tolerability of switching to LAI-aripiprazole in patients who had insufficient response or were intolerant to the previous antipsychotic, or required a more convenient treatment regimen.
Methods This was a prospective, observational, 6-months study carried out in 45 outpatients with schizophrenia who were clinically stabilized but a switching to another antipsychotic was clinically indicated. Patients who required hospitalization, treatment discontinuation or adding another antipsychotic (including supplementation with oral-aripiprazole) were considered treatment failures. Switching was considered successful if the side-effect/symptom/adherence/convenience improved or, if applicable, disappeared.
Results Patients aged 38 years, 51% women, and previous antipsychotics comprised: LAI-paliperidone (42%), oral-aripiprazole (22%), oral-olanzapine (11%), oral-risperidone (7%), LAI-risperidone (4%) and others (14%). The efficacy results of the switching are presented in the table. Of the 45 patients, 7 (15%) were considered treatment failures: 3 patients were hospitalized due to recurrence of psychotic symptoms, 2 discontinued LAI-aripiprazole, and 2 required supplementation with oral-aripiprazole (Table 1).
Conclusions Our results suggest that switching to LAI-aripiprazole is an efficacious strategy for managing some antipsychotic-induced side-effects, persistence of negative symptoms and/or lack of treatment adherence.

Table 1

Reason por switching	Baseline, n(%)	Outcome (month 6), n(%)		
		Resolution	Improvement	Overall sucess
Hyperprolactinemia	10(21%)	8(80)%	2(20%)	10(100%)
Persistent negative symptoms	10(21%)	NA	8(80%)	8(80%)
Metabolic syndrome	9(20%)	1(11%)	7(80%)	8(91%)
Sexual dysfunction	5(12%)	1(20%)	4(80%)	5(100%)
Extrapyramidal symptoms	4(9%)	0(0%)	2(50%)	2(50%)
Lack of adherence	4(9%)	NA	3(67%)	3(67%)
Convenient regimen	3(8%)	NA	2(75%)	2(75%)

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