part of the assessment of patients with any unexplained acute psychosis to detect this potentially curable disease. In this way, this article analyzes the psychiatric, physical and laboratory findings associated with hyperthyroidism and treatment.
Objectives To report a case of psychosis in a patient with endocrine disease.
Methods Clinical records. Research on PubMed and Medscape using the Mesh Terms "hyperthyroidism", "psychosis" and "thyroid and psychiatric manifestations".
Results We present the case of a male patient, previously followed on our ambulatory psychiatric service for drug-induced psychosis. He was hospitalized due to psychotic symptoms, without substance abuse. Inpatient evaluation diagnosed hyperthyroidism. The patient did not present any somatic changes, except for psychosis. The patient was effectively treated with antipsychotics. He was referred to further evaluation and started antithyroid therapy.
Conclusions Thyroid disease should be considered in the differential diagnosis of a broad spectrum of psychiatric symptoms. Psychosis is a rare complication of hyperthyroidism, ranging between 1–20%. The typical psychosis is reported to simulate manic-depressive psychosis. This association reinforces the need of a careful clinical evaluation in patients presenting with psychosis. Such psychiatric symptoms remit successfully with concomitant administration of antipsychotics and normalization of thyroid levels.
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EV0205

Alcohol use and bipolar disorder comorbidity: Synthesis and perspectives

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Objective Alcohol use disorders and bipolar disorder commonly co-occur and both are associated with more pejorative outcomes, thus constituting a major public health problem. We undertook this synthetic review to provide an update on this issue in order to clarify the nature of the relationship between the two disorders, improve clinical outcomes, prevent complications and therefore optimize management of patients.
Methods We conducted an electronic search by keywords in databases MEDLINE, EMBASE, PsychINFO, published in English and French from January1985 to December 2015.
Results The AUD prevalence is important among BD patients in whom the effects of alcohol are more severe. However, in terms of screening, it appears that the comorbidity is not systematically sought. The concept of co-occurrence finds its clinical interest in the development of specific screening and therapeutic strategies. To date, there are only few recommendations about the management of dual diagnosis and the majority of them support "integrated" approaches.
Conclusions Recommendations should emphasize this strong co-occurrence and promote systematic screening and offered integrated cares.
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EV0206

Prevalence of psychiatric comorbidities in epilepsy

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Introduction Epilepsy is a chronic disease defined as a brain disorder, characterized by a predisposition to present seizures, generating cognitive, psychological, and social consequences.
Objective To determine the prevalence of psychiatric comorbid disorders in patients with epilepsy (PWEs) and its associated factors.
Methods We conducted a cross-sectional study involving 30 PWEs who were treated in the neurology department of Habib Bourguiba Hospital in Sfax, Tunisia. We used the Mini International Neuropsychiatric Interview for the diagnosis of Axis I psychiatric disorders.
Results The half of patients had psychiatric comorbidities: 4 had major depressive disorder (MDD), 2 had MDD with generalized anxiety disorder, 4 had MDD with social phobia, 1 had bipolar disorder type I, 1 had panic disorder, 1 had agoraphobia and 2 had generalized anxiety disorder.
Twenty-five PWEs had seizure-onset below 30 years old and among them, 40% had psychiatric comorbidities. Among patients who had seizure-onset above 30 years old, none had psychiatric comorbidities. Psychiatric comorbidities were found in 71.5% of patients with seizure frequency >2 per year. Psychiatric comorbidities were more common in patients with generalized seizures compared to whom with partial seizures (53% versus 45%). It was also more common in patients treated with polytherapy compared to whom with monotherapy (64% versus 37.5%).
Conclusion The prevalence of psychiatric comorbidities is relatively high among PWEs. The most frequent diagnoses found were mood and anxiety disorders. It is very important to identify them and treat them to enhance seizure control.
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EV0207

Cancer, depression symptoms and quality of life: The role of creativity

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The diagnosis of cancer is associated with the occurrence of psychopathological symptoms, which cause even more difficulties to patients. Scientific research demonstrates that creativity could help increase the general population's quality of life and regulate their negative emotions, but only a few studies are available on the link between creativity and the regulation of patients' respective experience. This study aims at (1) measuring the impact of creativity on the patient's level of depression and quality of life and (2) evaluating the psychopathological profile of the creative person. Thirty-five subjects undergoing chemotherapy treatment (age: 61 + 11) took part in this study. The experimental protocol is composed of creativity, depression and QoL tests. The results show that creativity is negatively correlated with depression level and positively with QoL ($r = -45$; $P = <.05$ and $r = .54$; $P = <.01$ respectively). The linear regressions show that creativity is a variable, which predicts a high QoL ($F = 13.83$; $P = .001$). Also, 29.5% of the QoL variability is explained by creativity. A cluster analysis sorted out three different groups:

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very creative persons (VCP); mildly creative persons (MCP); slightly creative persons (SCP). VCPs have a significantly lower level of depression and have a better QoL compared to SCPs. MCPs have a level of depression between the other groups and a similar level of QoL than VCPs. These results suggest that creativity could have a noticeable influence on how patients experience their cancer. Further studies on this phenomenon will be necessary for creativity to be taken into account for psychological follow-up in oncology.
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EV0208

Temporal tumor as a cause of bipolar-like disorder?

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Introduction The relationship between brain tumours, temporal epilepsy and psychiatric symptoms are historically known.
Objectives To report a case of mania in a patient with previous diagnosis of bipolar disorder, temporal tumour and temporal epilepsy.
Methods Clinical records. Research on PubMed, using "lateral temporal epilepsy" or "brain tumour" and "mania".
Results A 52 years old man was conducted to the emergency department by the police. He was found with psychomotor agitation at the Sanctuary of Fátima. He was apparently hyperthimic with flight of ideas. He had a history of epilepsy and temporal tumour and two previous manic episodes. It was assumed as a maniac episode.
During inpatient evaluation, patient had memory for the occurrence. He described a sudden onset on the day before, after drinking wine. He described delirant atmosphere, persecutory and mystic delusional beliefs "this is the third secret of Fátima being revealed", followed by ecstasy and psychomotor agitation. Remission was obtained in one week on psychotropics. MRI documented the lesion. Electroencephalography performed one month later revealed "slow waves."
Conclusions Organic causes should be excluded before consider a psychiatric disorder. The hypothesis of epilepsy-related psychosis or mania and other effects of a temporal tumour should be considered in etiology. However, co morbidity with bipolar disorder cannot be excluded.
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EV0209

Misophonia and affective disorders: The relationship and clinical perspective

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Misophonia is characterized by aversive reactivity to repetitive and pattern based auditory stimuli [1]. Misophonic sufferers demonstrate autonomic nervous system arousal, accompanied by heightened emotional distress. Sufferers describe extreme irritation, anger, and aggressive urge with physiological reactions including hypertonia, diaphoresis and tachycardia [2]. Some studies have found comorbidity with psychiatric disorders. However, most of these studies used small samples and few experimental methodologies [3]. This study identifies the possible relationship between misophonia and affective disorders, and any difference between the severity of misophonia in male and female patients. Fifty misophonic patients (female = 25, mean age = 46.28) were evaluated with Amsterdam Misophonia Scale (A-MISO-S) for the diagnosis of misophonia and with the M.I.N.I International Neuropsychiatric Interview for the diagnosis of affective disorders. Among $n = 50$ misophonic patients, we found major depression (MDD) = 11, melancholic depression = 5, dysthymia = 11, suicidality = 10, manic = 3, panic disorder = 8, agoraphobia = , social phobia = , obsessive compulsive disorder (OCD) = 14, post-traumatic stress disorder (PTSD) = 15. Misophonia was associated with MDD ($U = 76$, $P = .001$), suicidality ($U = 67$, $P = .001$), OCD ($U = 115$, $P = .002$) and PTSD ($U = 142.5$, $P = .008$). There was an indication of a significant difference between men and women in severity of misophonia ($U = 160.5$, $P = .002$). The presence of these varying affective disorders suggests that the sufferers are at high risk for affective disorders. Investigation of the co-morbidity will assist researchers to better understand the nature of the symptoms and how they may be interacting.
Disclosure of interest The authors have not supplied their declaration of competing interest.
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EV0210

Therapeutic patient education: A solution to the treatment of obesity and metabolic syndrome in psychiatry

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Introduction/objectives Obesity and overweight are major public health issues. Obesity is a risk factor associated with many non-communicable diseases such as diabetes, certain types of cancers, musculoskeletal disorders and cardiovascular, dermatological or gastroenterological diseases. Patients with severe psychiatric disorders have a higher risk of developing overweight or obesity than the general population. The risk of obesity in schizophrenics patients can be multiplied by a factor ranging from 2.8 to 3.5. Patients suffering from mood disorder have sightly lower risk of obesity, however we still consider a factor ranging from 1.2 to 1.5. This significant weight gain can be partly explained by medication.
Methods The hospital centre Le Vinatier, in France, has developed a therapeutic patient education program in helping patients to self-manage their preventable disease. In order to tackle the multifaceted nature of obesity, the program used the expertise of many different professionals: general practitioners, dieticians, dentists, physical adapted education teachers, pharmacists, nurses and so on. This programme is provided for patients suffering from obesity or an overweight complicated by diabetes, or/and metabolic syndrome, and/or history of cardiovascular diseases or/and a failure of a dietary monitoring. The program includes individual care and collective workshops in nutrition, oral heath, body image, adapted physical education, and roundtable.