Background: Although the clinical high risk (CHR) for psychosis paradigm has become well-established over the past two decades, one key component has received surprisingly little direct investigative attention: the validity of the conversion to psychosis or transition criteria. This lack of evidence is surprising because many CHR treatment and prediction studies rely on the conversion measure as an outcome. In the absence of such evidence, some observers have raised the possibility that conversions from CHRs may be trivial.

The aim of this study is to evaluate the predictive validity of the transition to psychosis as measured by the Structured Interview for Psychosis-Risk Syndromes (SIPS) in CHR individuals. To our knowledge, this is the first study to examine the CHR conversion to psychosis at one-year follow-up. It is hypothesized that CHR participants whose conversion to frank psychosis was ascertained by SIPS (SIPS CV) will show similar diagnostic stability and severity of illness compared to the FEP sample and will differ significantly from SIPS Non-Converters (NCV) on clinical severity.

Methods: Participants included 33 SIPS Converters (CV) (met criteria for conversion to frank psychosis (COPs) on SIPS) and 399 CHR NCV both from the North American Prodromal Longitudinal Study (NAPLS 2), as well as a sample of 67 separately-ascertained first-episode psychosis (FEP) patients from the STEP Coordinated Specialty Care (CSC) program in New Haven, CT. Comparisons using Chi-square and ANOVA were made at baseline and one-year follow-up on variables from demographic, diagnostic stability (SCID) and available measurement domains relating to severity of illness (psychotropic medication and resource utilization).

Results: The principal findings of the present study are: 1) large majority of cases in both SIPS CV (n=27/33, 81.8%) and FEP (n=57/67, 85.1%) samples continued to have current psychosis diagnoses at one year follow up, 2) exposure to antipsychotic medication was higher in SIPS CVs (n=17/32, 53.1%) compared to SIPS NCVs (n=8/197, 40.4%), and similar as compared to FEP cases (n=39/65, 60%), 3) at follow up, SIPS CV had higher rates of resource utilization (any psychiatric hospitalizations, day hospital admissions, and ER visits) than SIPS-NCV and were similar to FEP in most categories.

Discussion: The results suggest that the SIPS definition of psychosis onset carries substantial validity in that those with SIPS-defined psychosis demonstrate similar diagnostic stability and severity of illness at one-year follow as a first episode sample and greater severity of illness as compared to a SIPS-defined CHR converting sample. Limitations include the lack of functional assessments at follow-up in the SIPS-CV. Additional studies are needed to further validate the CHR vs transition to psychosis distinction. Since many patients who come to baseline evaluation for CHR are discovered to have previously unrecognized frank psychosis, future studies should aim to obtain additional evidence by following this important group.

F62. EVOLUTION OF ANTI-NMDA RECEPTOR ENCEPHALITIS CLINICAL FEATURES IN ADULTS

Ronald Gurrera1,2
1Harvard Medical School and VA Boston Healthcare System

Background: Autoimmune encephalitis is a recently discovered illness caused by antibodies against neuronal cell-surface or synaptic proteins. Of the 11 immunologically distinct varieties currently known, anti-NMDA receptor (NMDAr) encephalitis is second in frequency only to acute disseminated encephalomyelitis, which primarily affects children. Early symptoms of NMDAr encephalitis can mimic psychiatric disorders, including schizophrenia, and most patients are initially referred to a psychiatrist and misdiagnosed, further delaying treatment. Autoimmune encephalitis can develop rapidly over days or weeks, sometimes beginning with a prodrome of headache, mild hyperthermia or symptoms of a viral illness. Observed mortality rates range from 4-10%, and the recovery course is often protracted with substantial disability, but a full recovery can be achieved in 50% or more of patients with prompt and effective treatment. This study focuses on the frequency and chronological sequencing of signs and symptoms in adults with anti-NMDAr encephalitis who are likely to be evaluated first by a psychiatrist, with the aim of identifying patterns of clinical features that should prompt active consideration of this diagnosis early in the illness course.

Methods: PubMed and EMBASE databases were searched systematically to identify published reports of anti-NMDAr encephalitis that were associated with prominent behavioral or psychiatric symptoms. This search strategy was designed to identify reports in which the clinical presentation was likely to have resulted in a psychiatric evaluation, rather than those with more typical neurological presentations such as delirium. The search yielded 354 PubMed citations and 78 EMBASE citations, and additional reports were found by manually searching bibliographies of the computerized search results; 385 distinct citations remained after eliminating duplicates. The frequencies of clinical features in 7 major symptom domains were tabulated, and temporal ranks were assigned to these features based on their order of first appearance relative to one another in each patient. Median ranks were used to sequence the clinical symptom domains.

Results: A total of 230 unique cases (185 female) met inclusion criteria, which included age 19 years or older. The most frequent features were seizures (60.4%), disorientation/confusion (42.6%), orofacial dyskinesias (39.1%), mutism or staring (37.4%), dyskinesias involving other body parts (36.1%), and memory disturbance (34.8%). Auditory hallucinations were common but often atypical for psychiatric disorders. Median temporal ranks for symptom domains indicated the following temporal sequence: behavioral/psychiatric, fever, seizures, catatonic features, cognitive dysfunction, motor dysfunction (including dyskinesias), and autonomic dysfunction.

Discussion: Anti-NMDAr encephalitis is uncommon, but every psychiatrist is likely to encounter these patients in clinical practice. Prompt and effective treatment is associated with much better outcomes, so early recognition is crucial. The best strategy for recognizing this disorder is to have a high index of suspicion when an individual develops new psychiatric symptoms in the context of a recent viral prodrome (malaise, headache, loss of appetite), when accompanied by seizures or unexplained fever, or when the quality of the psychiatric symptoms is unusual (e.g., non-verbal auditory hallucinations). Orofacial dyskinesias are distinctive for this disorder, but this feature often emerges relatively late, so relying on its presence to make a diagnosis may lead to unnecessary treatment delays.

F63. INHIBITED TEMPERAMENT IS A TRANSDIAGNOSTIC FACTOR ACROSS SCHIZOPHRENIA, PSYCHOTIC BIPOLAR DISORDER, AND MAJOR DEPRESSIVE DISORDER

Brandee Feola*,1, Kristan Armstrong1, Neil Woodward1, Stephan Heckers1, Jennifer Blackford1
1Vanderbilt University Medical Center

Background: Diagnostic categories are a fundamental piece of psychiatric disorders; however, a patient’s symptoms and behaviors seldom fit under...