

sounds augmented but no mass or peritoneal irritation appeared. Blood test results were normal. Abdominal X-Ray showed gastric dilatation with small bowel faeces sign, which suggested diagnosis of gastric bezoar.

The treatment was the dissolution of the bezoar by Coca-Cola, solving the symptoms completely.

The patient refused having eaten hair or any other kind of object or indigestible material but admitted to be following a strict vegan diet. Finally, after an endoscopy was done, the patient was diagnosed of phytobezoar.

Conclusions: Based on literature, bezoars are rare in AN, being phytobezoars the most common between the types of bezoars. Nevertheless, there are some risk factors, such as delayed gastric emptying, dehydration or, in the case of phytobezoar, ingestion of food containing high amount of cellulose, hemi-cellulose, lignin, and tannins (celery, pumpkin, grape skins, prunes, raisins and, in particular, persimmons). Some of the symptoms caused by phytobezoar can be similar to those of the AN (abdominal pain, intestinal obstruction, poor appetite, vomiting, malnutrition, weight loss). Therefore, gastric bezoar could be an underdiagnosed or even undiagnosed disease in this group of patients. Taking this into account could reduce time until diagnosis and treatment, decreasing the risks associated.

Disclosure of Interest: None Declared

EPV0472

Superior mesenteric artery syndrome: when vomiting are not voluntary

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Introduction: Superior mesenteric artery syndrome is a gastro-vascular disorder in which the third and final portion of the duodenum is compressed between the abdominal aorta and the overlying superior mesenteric artery. This rare, potentially life-threatening syndrome is typically caused by an angle of 6°–25° between the abdominal aorta and the superior mesenteric artery, in comparison to the normal range of 38°–56°, due to a lack of retroperitoneal and visceral fat (mesenteric fat). In addition, the aortomesenteric distance is 2–8 millimeters, as opposed to the typical 10–20. However, a narrow superior mesenteric artery angle alone is not enough to make a diagnosis with no symptoms.

Symptoms are fullness and epigastric tightness after meals, nausea and vomiting (often bilious) and pain in the middle of the abdomen that improves with the prone or knees flexed to the chest. The diagnosis is supported by imaging tests (esophagogastroduodenal transit or CT) showing dilation and stasis proximal to AMS in the third duodenal portion.

Relief from vomiting with feeding through a enteral probe placed beyond the obstruction to the proximal jejunum supports diagnosis.

Precipitating factors should be corrected first, whenever possible. Acute symptoms can be resolved with gastric decompression and intravenous fluids. Therefore, surgical correction should only be done in well-studied patients with chronic recurrent episodes of AMS syndrome. The most recommended surgical technique is a laparoscopic proximal duodenojejunostomy

Objectives: To describe a case of superior mesenteric artery syndrome and review in literature the organic complications and associated psychopathology of this disorder

Methods: Clinical case report and brief review of literature

Results: 17-year-old woman with a diagnosis of anorexia nervosa. Admitted for behavioral disorder, repeated self-harm and low mood. Presents a BMI of 16.6. Irregular rules. Progressive diet is started to which nutritional supplements are added with good initial tolerance. It presents a loss of 2kg and begins with nausea, vomiting and postprandial epigastralgia. Oral panendoscopy and abdominal ultrasound are performed showing possible mesenteric aortic clamp so naso-jejunal probe and exclusive enteral feeding is prescribed. She received enteral jejunal nutrition progressively with feedback syndrome prophylaxis that included parenteral vitamin B1. After a few days, oral supplementation began. He remained hemodynamically stable, with no signs of heart failure. It gained 3kg of weight up to 43.2kg, starting before discharge from the hospital successfully oral tolerance.

Conclusions: Superior mesenteric artery syndrome is a serious complication in anorexia nervosa with a low incidence and an estimated mortality of 33%. A multidisciplinary approach that addresses both the medical and psychological needs of these patients throughout their hospital stay is necessary.

Disclosure of Interest: None Declared

EPV0473

Relationship between orthorexia nervosa and self-esteem in Tunisian medical students

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Introduction: The effect of self-esteem in eating disorders has been investigated in several studies, but it's still not extensively investigated in orthorexia nervosa.

Objectives: To study the prevalence and factors associated with orthorexic eating behaviors in medical students and it's relation with self-esteem.

Methods: A cross-sectional study was conducted through an online survey among medical students of the faculty of medicine of Sfax (Tunisia). Participants completed an anonymous self-administered questionnaire. We collected their sociodemographic and clinical data. Orthorexia nervosa (ON) was assessed using the self-reported scale, ORTO-15. We used the Rosenberg's self-esteem scale to assess self-esteem.

Results: Ninety five medical students completed the survey. The mean age was 25.8±3.4 years and the sex ratio (F/M) was 3.75. The average body mass index was 23.64±3.53 kg/m².

Fifty-eight percent of the students (58%) reported that they were dissatisfied with their eating habits, and 27.4% tried to control their weight. Several methods of weight control were used, the most frequent (65.4%) were diet and physical exercise, none resorted to laxatives and 8.4% consulted a nutritionist.

Self-esteem was very low in 27.1% and low in 34.7% of the students. Overall, the prevalence of orthorexia among our participants was 52.6%. The mean score of the ORTO-15 was 39.19 ± 4.48 .

Orthorexia was significantly correlated with the use of weight control measures ($p=0.035$) and physical activity ($p=0.042$).

Students with low self-esteem had higher tendency for orthorexia but with no significant correlation.

Conclusions: Our study supports a non-negligible frequency of orthorexic behaviors in medical students but future studies are needed to assess the direct effect of self-esteem on orthorexia.

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EPV0474

A review of mechanistic and clinical evidence for the use of probiotics and prebiotics in anorexia nervosa

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Introduction: Evidence is growing for the bio-immuno-metabolic model of pathogenesis in anorexia nervosa (AN), an eating disorder with a chronic and relapsing nature. The role of the gut microbiome in this process is also receiving intense research interest. The gut microbiome and the use of probiotics and prebiotics have been extensively studied in gastrointestinal (GI) disorders such as inflammatory bowel disease (IBD) and functional GI disorders (FGIDs). Exploring links between AN and these GI disorders may open new avenues of treatment such as the use of probiotics and prebiotics in AN.

Objectives: This review explores: i) GI presentation in AN and its relationship with the gut microbiome ii) factors influencing the gut microbiome presentation in AN including dietary patterns iii) whether the gut microbiome may be involved in the pathogenesis and maintenance of AN iv) gut microbiome presentation in GI disorders and commonalities with AN v) evidence for the potential use of probiotics and prebiotics as adjunct treatment in AN.

Methods: GI symptomatology and gut microbiome presentation in AN were examined through literature searches. Gut microbiome changes related to common dietary patterns in AN were explored. Microbiome changes that may influence development or maintenance of AN were considered. Microbiome alterations seen in relevant GI disorders were explored and commonalities considered between these and alterations in the microbiome in AN. Literature searches were performed for the use of probiotics and prebiotics in AN and relevant GI disorders.

Results: GI symptoms occur commonly in AN with evidence suggesting some symptoms continuing beyond weight restoration. Significant disruption of the gut microbiome has been associated with AN with some changes related to typical dietary patterns seen during AN development. Additionally, similarities exist between microbiome alterations in AN and those seen in IBD and FGIDs indicating factors apart from the diet, such as a pro-inflammatory milieu, in play. These changes may not only influence GI presentation in AN but may also have a role in maintenance of the disorder. Some evidence suggests that the pre-morbid gut microbiome may influence risk for AN development. Preliminary evidence of the use of probiotics in AN indicates a positive influence on immune modulation although no evidence exists as yet of their influence on AN symptomatology. There has been extensive research into the use of probiotics and prebiotics in IBD and FGIDs with some evidence for reduction in disease parameters and symptomatology with the use of multi-strain probiotics.

Conclusions: Some theoretical, mechanistic and clinical evidence exists for the use of probiotics in ameliorating GI symptoms in AN. However, further research is needed into the context of the gut microbiome changes in AN, the specifics of efficacy and the effects that probiotics and prebiotics may have in AN.

Disclosure of Interest: None Declared

EPV0475

Binge Eating, Anxiety, Depression, and personality disorder in a Clinical sample of obese Adult in Egypt

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Introduction: Obesity is a major public health problem and some developed countries have declared it 'the modern day epidemic'. One of the major eating disorders that leads to obesity is BED, which involves consuming large quantities of high carbohydrate food. Studying the factors that cause and contribute to BED can help tackle this major health hazard and alleviate a huge burden on the nationalized health service.

Objectives: To determine the frequency of Binge Eating Disorder (BED) among obese adults, and to study its relationship to depression, anxiety, life stressors, personality and self esteem.

Methods: The sample was a randomised sample of clinically obese individuals, body mass index (BMI) of 30 and above. The sample was collected from two sites; Nutrition Clinic in Student's Hospital, Cairo University and a Private Nutrition Centre. 250 cases were recruited over one year. All patients were subjected to a clinical interview derived from Kasr El Aini sheet, and measurement of Waist- Hip Ratio. Assessment of depression and anxiety was through Beck Depression Inventory, Hamilton Depression Rating Scale and Taylor Manifest Anxiety Scale (TMAS). Other tools used were the Eysenck's Personality Inventory, Eating Disorder Inventory -2.