EPV0111

Diagnostic difficulties in bipolar disorder type II

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Introduction: Bipolar disorder is one of the top 10 medical causes of disability according to the WHO and despite this, its diagnosis can be delayed up to 10 years after the appearance of the first symptoms of the disease. A major reason for the difficult diagnosis is the challenge of differentiating bipolar disorder type II from unipolar depression and borderline personality disorder, especially in those patients with no clear history of hypomania.
Objectives: To present a case report of a bipolar disorder undiagnosed for years to remark the importance of recognizing premorbid symptoms of the disease in order to implement an early intervention that potentially improves the prognosis of patients.
Methods: We compiled the patient's complete medical history and we carried out a non-systematic review of literature containing the key-words "bipolar disorder type II" and "diagnosis".
Results: We present the case of a 48-year-old woman going through a depressive episode, multiple suicide attempts and more than 10 admissions in the Acute Inpatient Psychiatric Unit. For 3 years, the evolution was torpid with a significant multidomain cognitive impairment in a previously functional patient. Different antidepressant treatments were tested, however they were not tolerated due to adverse effects such as anxiety, insomnia and nervousness. After considering multiple differential diagnoses, bipolar disorder type II was finally diagnosed. A hypomanic episode that took place after 3 sessions of electroconvulsive therapy during an admission for depression, allowed to guide the diagnosis and after the introduction of Lithium and Quetiapine as treatment, the patient experienced a complete remission of the symptoms.
Conclusions:

1. It is important to consider the differential diagnosis of bipolar disorder type II due to its impact on the patient´s life.
2. An early diagnosis improves the course and prognosis of the disease.
3. Patients resistant or intolerant to antidepressant treatment could have undiagnosed bipolar disorder.

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EPV0112

Syndrome of Irreversible Lithium-Effectuated NeuroToxicity: SILENT, but not innocent

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Introduction: Lithium is one of the main drugs used in Bipolar Affective Disorder. However, it has a narrow therapeutic window, which requires close monitoring and progressive dose adjustment, according to serum levels, clinical response and the appearance of side effects. The term 'SILENT' explains descriptively persistent neurological sequelae related to lithium salt intoxication when symptoms persist for more than 2 months after stopping treatment. SILENT Syndrome is more common in females, at ages ranging from 21 to 77 years and is characterized mainly by avermian-type cerebellar disorder, persistent extrapyramidal syndrome, brainstem dysfunction and dementia of varying severity. It can also result in apraxia of the body, changes in the coordination and balance, dysarthria, as well as intentional and kinetic cerebellar tremor, involuntary movements of orofacial dyskinesias or resting tremor.
Objectives: The authors intend to review the relevant and current literature in order to extend the knowledge about this condition and find the best conducts for clinical practice.
Methods: Non-systematic literature review.
Results: Complications from the use of lithium known in the medical literature include mainly nephrotoxicity, endocrine alterations and neurotoxicity.
The neurotoxic effects of lithium usually occur at high serum concentrations. However, they can also occur with lithium in the therapeutic range, and memory, attention and ataxia impairment may be some of the permanent sequelae.
The etiopathogenesis is unclear, but demyelination has been detected in multiple brain regions, mainly in the cerebellum. The mechanism of lithium-induced cerebellar injury is believed to be mediated by the entry of calcium into the cells of this organ.
The main factors that predispose to greater side effects and risk of toxicity are patients with decreased renal function, advanced age, use of diuretics, dementia, pregnancy, low sodium intake and physical illness with vomiting and/or diarrhea.
Conclusions: Lithium is a drug used mostly in affective disorders and given the narrow therapeutic window, it requires close monitoring in order to avoid side effects that can be permanent. In this way, it is important to review the factors that increase the lithium toxicity and make recommendations about it.

Disclosure of Interest: None Declared

EPV0113

PEAKS AND VALLEYS: BIPOLAR DISORDER, RAPID CYCLERS AND ENERGY DRINKS CONSUMPTION

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Introduction: Bipolar Disorder (BD) is considered a serious mental disorder characterized by a changing mood that fluctuates between two completely opposite poles. It causes pathological and recurrent mood swings, alternating periods of exaltation and grandiosity with periods of depression. We talk about rapid cyclers when four or more manic, hypomanic or depressive episodes have occurred

within a twelve-month period. Mood swings can appear rapidly. Approximately half of the people with bipolar disorder may develop rapid cycling at some point.
Objectives: Presentation of a clinical case about a patient with Bipolar Disorder with rapid cycling and poor response to treatment.
Methods: Review of the scientific literature based on a clinical case.
Results: 33-year-old male, single, living with his mother, under follow-up by mental health team since 2012. First debut of manic episode in 2010. The patient has filed multiple decompensations related to consumption of toxics (alcohol and cannabis). Currently unemployed. He attended to the emergency service in June 2022 accompanied by his mother, who reported that he was restless. The patient refers that he has interrupted the treatment during the vacations, having sleep rhythm disorder with abuse of caffeine drinks. Currently the patient does not recognize any consumption.The patient reports that during the village festivals he felt very energetic, occasionally consuming drinks rich in taurine and sugars, even having conflicts with people of the village. Finally, the patient was stabilized with Lithium 400 mg and Olanzapine. In September, the patient returned to the emergency service on the recommendation of his referral psychiatrist due to therapeutic failure. The only relevant finding we observed in the analytical determinations were low lithium levels (0.4 mEq/L). The transgression of sleep rhythms and the abuse of psychoactive substances required the admission of the patient to optimize the treatment (Clozapine, Lithium, Valproic Acid). At discharge, he is euthymic, has not presented behavioral alterations and is resting well. Finally, it was decided that the patient should go to the Convalescent Center to continue treatment and achieve psychopathological stability.
Conclusions: Bipolar disorder is an important mental illness, having an incidence of 1.2%, being responsible for 20% of all mood disorders. Therefore, it is important to perform an adequate and individualized follow-up of each patient. Treatment with mood stabilizers tries to improve and prevent manic and depressive episodes, improving chronicity and trying to make the long-term evolution as good as possible, being important psychoeducation and psychotherapy.

Disclosure of Interest: None Declared

EPV0114

Cyclothymia, bipolar disorder and multiple sclerosis: A case report

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Introduction: We present the case of a 49-year-old woman who was diagnosed with multiple sclerosis at the age of 19 and suffers from an affective disorder that has been evolving for years. This condition, for which she has been followed by psychiatry and psychology for more than ten years, consists of alternating periods of hypomania lasting weeks and phases in which frank depressive symptomatology predominates, with no phases of euthymia in between and with a predominance of severe deterioration of her functionality at both poles.
Objectives: (1) We will review the term cyclothymia and explore the concept of "cyclothymic temperament" advocated by some authors, in order to be able to understand the dimension of the present case and reformulate its approach.
(2) The relationship between multiple sclerosis and bipolar spectrum disorders will be covered, reviewing the current knowledge in this regard and relating it to the patient's symptomatology.
Methods: A review of the patient's clinical history will be carried out, taking into account her life history, the complementary tests performed as well as the multiple therapeutic approaches tried over the last few years.
Likewise, a bibliographic review of the available scientific literature will be carried out in relation to the diagnosis of cyclothymia or bipolar disorder type II, the controversial term "cyclothymic temperament", and the relationship that these diagnoses have with the diagnosis of Multiple Sclerosis.
Results: (1) Our patient could fit into what many authors define as a cyclothymic temperament, fulfilling, in certain episodes, the criteria that the manuals propose for bipolar disorder type II.
(2) 2.1 The prevalence of bipolar affective disorder in MS is approximately twice as high as in the general population (rates of 0.3-2.4%). **2.2** Patients with MS have higher scores in cyclothymic and hyperthymic temperament than the control group. **2.3** Certain drugs generally used in BD also seem to have a beneficial effect on MS.
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