Keywords "Schizophrenia" ;"Psychosis" ;"Late onset schizophrenia"
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further reading
Colijn MA et al. Psychosis in later life: a review and update. Harv Rev Psychiatry 2015;23(5):354-67.
Reinhard MM. Late-life psychosis: diagnosis and treatment. Curr Psychiatry Rep 2015;17(2):1.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1963

EV979

Major depressive disorder with psychotic symptoms in elderly. A case report

J.M. Hernández Sánchez[1,*], M.C. Cancino Botello[2], M.F. Molina Lopez[2], M.Á. Canseco Navarro[2], S. Arnés González[3], M. Muñoz Carril[3], J.A. Monzó[4]
[1] *Valencia, Spain*
[2] *Hospital General de Valencia, Psychiatry, Valencia, Spain*
[3] *Hospital General de Valencia, Emergency Medicine, Valencia, Spain*
[4] *Hospital General de Valencia, Internal Medicine, Valencia, Spain*
[*] *Corresponding author.*

Introduction The proportion of elderly people and affective syndromes are more and more common in developed countries. Elderly people have physiological conditions that may limit our intervention.
Objectives To present a case of a major depressive disorder with psychotic symptoms in a 72-year-old woman.
Methods Medline search and review of the clinical history and the related literature.
Results We present the case of a 72-year-old woman with psychiatric history of a major depressive disorder 14 years ago with ad integrum restitution after pharmacological treatment. In 2015, our patient was admitted to the psychiatry ward due to major depressive symptomatology (apathy, anhedonia, global insomnia, weight loss) that associated mood-congruent delusions (nihilistic, ruin, guilt, catastrophic) with deregulated behaviour. The patient was resistant to combined pharmacological treatment with aripiprazole, desvenlafaxine, mirtazapine and lorazepam, therefore, we decided to administer ECT, with successful results after 5 sessions. Brain tomography, blood and urine tests were normal. Clinical signs of dementia were not present.
Conclusions Inpatients with deregulated behaviour; it is important to rule out organic causes, especially in elderly, in whom dementia, brain tumors or metabolic disturbances may simulate psychiatric syndromes.
Keywords "Major depressive disorder" ;"Psychosis" ;"Late onset psychosis"
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further readings
Colijn MA et al. Psychosis in later life: a review and update. Harv Rev Psychiatry 2015;23(5):354-67.
Reinhard MM. Late-life psychosis: diagnosis and treatment. Curr Psychiatry Rep 2015;17(2):1.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1964

EV981

Obsessive versus delusional jealousy: Destruction in a form of creation – A review

R. Almeida Leite[*], E. Conde, T. Queirós Santos, M. Almeida, T. Azevedo Santos, A. Mesquita Figueiredo
Baixo Vouga Hospital Centre, Psychiatry and Mental Health Department, Aveiro, Portugal
[*] *Corresponding author.*

Introduction Jealousy is a complex emotional state and some degree is considered normal in mature love, but when does it become destructive in a relationship? There's a thin line between what is normal and what is pathologic. Pathological jealousy differs from normal by its intensity and irrationality. Obsessive and delusional jealousies are different types of pathological jealousy, difficult to distinguish, which is important, since they have different treatment. Despite the differences, both result in significant distress and carry the risk of homicide/suicide, so it's a matter deserving the psychiatrists' attention.
Objective Explore the psychopathological differences between obsessive and delusional jealousy and list the characteristics and difficulties in the approach to pathological jealousy.
Methods The results were obtained searching literature included on the PubMed and Google Scholar platforms.
Results Delusional jealousy is characterized by strong and false beliefs that the partner is unfaithful. Individuals with obsessive jealousy suffer from unpleasant and irrational jealous ruminations that the partner could be unfaithful, accompanied by compulsive checking of partners' behavior. This jealousy resembles obsessive-compulsive phenomenology and should be treated with SSRIs and cognitive-behavioral therapy. Delusional jealousy is a psychotic disorder and should be treated with antipsychotics.
Conclusion The common issue in pathological jealousy is the problem of adherence to treatment and bad prognosis. In order to achieve better treatment outcomes, we should follow-up the patient regularly. One key factor is to explore the psychopathology and motivate the sufferer for the proper pharmacological and psychotherapeutic interventions, trying to reduce the suffering caused by ideas of unfaithfulness.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1966

EV982

Differential diagnosis between schizophrenia and in major depression: The importance of abnormal bodily phenomena

M. Mancini[1,*], G. Stanghellini[2]
[1] *University "G. D'Annunzio", Department of Psychological – Humanistic and Territorial Sciences, Chieti, Italy*
[2] *University "G. d' Annunzio", Department of Psychological – Humanistic and Territorial Sciences, Chieti, Italy*
[*] *Corresponding author.*

Introduction Anomalies of bodily experience have for long been described as relevant features of schizophrenia and major depression, yet such experiences are usually neglected in clinical examination. Bodily experience is the implicit background of our experiences against which we develop a coherent sense of self as a unified, bounded entity, naturally immersed in a social world of meaningful others. Such tacit experiential background is often perturbed in schizophrenia and major depression. Empirical research shows that patients with schizophrenia and major depression frequently present many different kinds of anomalies of bodily experience in the course of their illness.
Objective To characterize the abnormal bodily phenomena in both schizophrenia and major depression.
Aim To improve differential diagnosis based on the identification of typical features of abnormal bodily experiences in persons affected by schizophrenia and major depression and to provide supplementary diagnostic criteria.
Method Analysis of empirical and theoretical research published in the last 25 years.

Result Ongoing bodily feelings of disintegration/violation and nothingness/mechanization (e.g. one's body experienced as a object-like mechanism) are the most typical experiences in people with schizophrenia whereas major depressives are not able to detach themselves from the experience of bodily failure or chrematization (from chrema = corpse, i.e., feeling like a corpse) and therefore, feel worthless, guilty, or decaying. They feel chrematized in their very self.
Conclusion These experiences might be considered as specific and they can contribute to differential diagnosis of somatic complaints in schizophrenia and in major depression.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1967

EV983

Psychosis in a blindness patient: A case report

M. Marinho*, C. Moreira, F. Catarina
Centro Hospitalar Psiquiátrico de Lisboa, Lisbon, Portugal
* *Corresponding author.*

Introduction Using a clinical case as illustration, the present work engages the different psychopathologic alterations that blindness patients could present.
Methods The presentation and discussion of a clinical case of psychosis in a blind patient are addressed. The scientific documentation used as support was obtained from PubMed/Medline search engines using as keywords blindness and psychosis.
Results A 43-years-old male patient, with a medical history of arterial hypertension, heroine dependence (presently with methadone schema) and bilateral blindness caused by a bilateral retinal detachment 20 years ago, was admitted in the psychiatric ward. The patient's historical record includes a previous personality with paranoid characteristics, as well as a hospitalization due to persecutory and auto-reference ideas and kinaesthetic hallucinations with 1 month of evolution, coincident with address changes. Lab tests revealed the following results: haemoglobin 13.8; Leucocytosis 13,400; CRP: 6.2; ALT > AST. Positive results were obtained in the drug tests for cannabinoids, as well as for the anti-HCV antibody (IgG). Finally, the patient was medicated with an antipsychotic and humour stabilizer, achieving a significant improvement after 10 days of hospitalization.
Conclusions Although studies reveal that mental and behavioural disorders, especially those with symptoms of psychosis and mental retardation, are common among people with congenital blindness, more knowledge of the prevalence and aetiology of mental and behavioural disorders among people suffering from blindness is needed.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1968

EV984

Cycloid psychosis: A case report

G. Martinez-Ales*, I. Louzao, A. Irimia, M.F. Bravo, J. Marin
Hospital Universitario La Paz, Psychiatry, Madrid, Spain
* *Corresponding author.*

Introduction Episodes of time-limited acute psychosis, with full recovery in between, are categorized as acute polymorphic psychotic or brief psychotic disorders. Leonhard described the three forms of cycloid psychosis (CP). Perry considers it a separate entity.
Case report We report the case of a 54-year-old male, with a 9-year history of brief psychotic disorders. He was admitted to an inpatient unit after a 4-day episode of persecutory delusion, leading to high emotional repercussions and isolation at home. Euthymia was present. Previous admissions, 9 and 5 years before, presented similar clinical pictures. Treatment with low dose paliperidone during 6-month periods had led to the complete resolution of the episodes (restitutio ad integrum: no psychotic manifestations and the ability to run his business). In this episode, 8 days after the reintroduction of 12 mg of paliperidone per day, cessation of the symptoms took place. Careful reconstruction of the clinical history showed no stressors or drug consumption. And immediately previous 5-day phase of insomnia, hyperactivity and expenditure was described by the patient's wife.
Discussion Three inpatient admissions, a careful clinical history and a thorough review of the evidence regarding Perris criteria led to a diagnosis of CP.
Conclusion CP, a classical nosological approach, is helpful in a clinical setting, as it might imply different prognosis and treatment. Recognition of CP, not included as an entity by the major diagnostic systems, requires a high index of suspicion.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1969

EV985

Cryptococcal meningitis in acute onset psychosis: A case-study

P. Michielsen[1,*], M. Arts[2]
[1] *Mental Health Western Northern Brabant, Halsteren, Netherlands*
[2] *University Medical Center Groningen, Old Age Psychiatry, Groningen, Netherlands*
* *Corresponding author.*

Introduction Cryptococcal meningitis is a frequently observed opportunistic infection in patients with late-stage HIV-infection, especially among people living in South-East Asia and Central Africa. The worldwide incidence is estimated at one million cases. The worldwide mortality of HIV-associated cryptococcal meningitis remains high (10–30%), due to the inadequacy of antifungal treatments and complications of increased intracranial pressure. Clinical symptoms of cryptococcal meningitis are fever, headache, vomiting, and altered mental status. Neck stiffness, papiledema, and focal neurological symptoms are sometimes present.
Objectives We describe the case of a patient who first developed a delirium, and a few months later an acute-onset psychosis, after a past cryptococcal infection.
Aims To report a case-study describing acute-onset psychosis as a neuropsychiatric consequence of HIV-infection.
Methods A case-study is presented and discussed, followed by a literature review.
Results A 49-year-old African-born male was admitted to hospital with an acute psychosis. He had been treated by an internist after being found to have HIV. As a result of non-compliance over a period of about four months, his cd4-count had dropped to 40. Six months earlier he had developed cryptococcal meningitis, which left him a number of neurological and psychiatric symptoms. During his stay in hospital, there had to be good collaboration with the specialist in internal medicine whose dual task was to manage the patient's dramatically low cd4-count as well as his psychosis.
Conclusion Cryptococcal meningitis is a risk factor for psychiatric disorders and mortality in HIV-infected persons.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.1970