

and characterizing it with hyperthermia, extrapyramidal symptoms, altered mental status, and autonomic dysfunction. Current knowledge unequivocally shows that NMS most often occurs with the use of first-generation antipsychotics, especially in parenteral form. After the appearance of this disorder, the usual practice is to transfer the patient to monotherapy with clozapine, excluding antipsychotics from the chemical group that led to NMS.

However, there are isolated reports of the occurrence of this syndrome in patients on concomitant therapy of clozapine with lithium salts.

**Objectives:** The main objective is to present possible case of NMS in patients with concomitant use of clozapine and lithium

**Methods:** Case report: M. K., born in 1984, graduated from high school, unmarried, without permanent employment. In 2003, after the parenteral application of Depo preparation, he developed NMS. He was hospitalized at the Institute of Psychiatry in Belgrade when he was diagnosed with psychosis of the schizophrenic cycle. After discharge from the hospital, stable clinical remission persists with maintenance therapy with clozapine. In July 2018, after a short stay abroad, he developed a pronounced behavioral disorganization and was forced to be admitted to our institution.

On admission and in the initial phase of hospital treatment, the clinical picture is dominated by intense psychomotor restlessness, acoustic hallucinatory experiences, dysphoric-euphoric mood, and uncontrolled verbal and physical aggression towards medical staff and other patients. He was treated with clozapine, which was gradually titrated up to 600 mg daily, with benzodiazepine support (lorazepam 10 mg p.d.) without significant improvement, medical sedation, and lithium salts were introduced into the therapeutic protocol.

**Results:** Immediately afterward, psychomotor inhibition occurs, accompanied by somnolence, mild hypotension, sinus tachycardia, and subfebrile temperatures, without signs of muscle stiffness. Lab. analysis of CpK 628, other findings within reference values. Excluded psychopharmaceuticals from the therapeutic protocol, introduced detox. procedures and III generation cephalosporins, after which the patient's condition stabilizes.

**Conclusions:** It is important to bare in mind the possibility of NMS in patients with concomitant use of clozapine and lithium

**Disclosure of Interest:** None Declared

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### Treatment of tardive dyskinesias with vitamin E: A case series

B. Senol\*, F. N. Akarca, R. N. Ekinici and E. Goka

Psychiatry, Ankara City Hospital, Ankara, Türkiye

\*Corresponding author.

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**Introduction:** Tardive dyskinesia is usually persistent, irreversible involuntary movement of the tongue, lips, face, trunk and extremities in patients taking long-term dopaminergic antagonist drugs. Although it is mostly associated with the use of neuroleptics, cases of tardive dyskinesia existed before the discovery of these agents. Patients with schizophrenia and other neuropsychiatric disorders are particularly at risk for tardive dyskinesia because they are

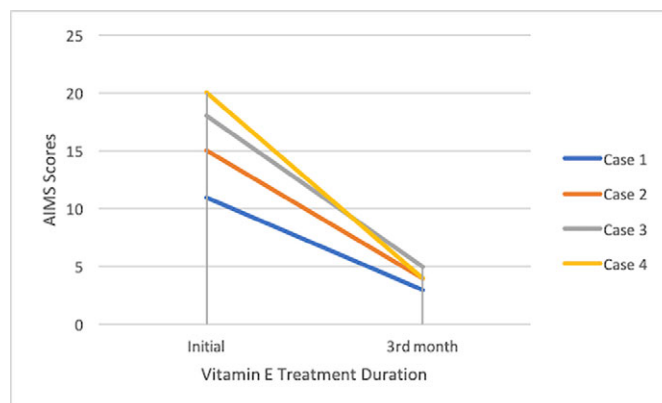
exposed to neuroleptics and anticholinergic agents for longer periods than healthy individuals. Free radicals are thought to be probably involved in the pathogenesis of tardive dyskinesia. Vitamin E is a fat-soluble antioxidant, and it is thought to be effective in the treatment of antipsychotic-associated tardive dyskinesia, as it has a cytotoxic free radical-binding effect.

**Objectives:** In this poster presentation, it was aimed to evaluate the clinical results of the treatment of tardive dyskinesia with high-dose vitamin E in four inpatients with serious mental illness and long-term antipsychotic use. In addition, the treatment of tardive dyskinesia will be discussed in the light of current literature data.

**Methods:** In the case report, there are three patients with schizophrenia and one with mild mental retardation. They were treated with 1600 IU of vitamin E per day. The patients continued their vitamin E treatment for 90 days. The severity of tardive dyskinesia of the patients was measured by Abnormal Involuntary Movement Scale (AIMS).

**Results:** At the end of the 90 day treatment, the AIMS measurements of the subjects decreased 72,7%, 73,3%, 72,2% and 80% respectively.

**Image:**



**Conclusions:** In our clinic, we observed that patients using long-term typical antipsychotics were prescribed antipsychotics in unindicated situations or in high doses, patients with high risk for tardive dyskinesia were not taken into consideration when planning treatment, and we encountered cases of tardive dyskinesia despite the widespread use of atypical antipsychotic drugs in hospitalized patients. The use of benzodiazepines is restricted especially in elderly individuals due to their side effects and the risk of addiction in long-term use. Although the clinical importance of vitamin E is unknown, it is preferred because it can be used with a low risk of side effects, considering that it can prolong bleeding time. Although the results of a review of tardive dyskinesia treatment do not suggest that vitamin E reliably improves tardive dyskinesia symptoms, our experience shows that patients benefit from vitamin E treatment. In this regard, there is a need for studies that will be conducted with a large sample and compare the effectiveness of vitamin E with the treatments known to be effective in tardive dyskinesia.

**Disclosure of Interest:** None Declared