very creative persons (VCP); mildly creative persons (MCP); slightly creative persons (SCP). VCPs have a significantly lower level of depression and have a better QoL compared to SCPs. MCPs have a level of depression between the other groups and a similar level of QoL than VCPs. These results suggest that creativity could have a noticeable influence on how patients experience their cancer. Further studies on this phenomenon will be necessary for creativity to be taken into account for psychological follow-up in oncology.
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EV0208

Temporal tumor as a cause of bipolar-like disorder?

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Introduction The relationship between brain tumours, temporal epilepsy and psychiatric symptoms are historically known.
Objectives To report a case of mania in a patient with previous diagnosis of bipolar disorder, temporal tumour and temporal epilepsy.
Methods Clinical records. Research on PubMed, using "lateral temporal epilepsy" or "brain tumour" and "mania".
Results A 52 years old man was conducted to the emergency department by the police. He was found with psychomotor agitation at the Sanctuary of Fátima. He was apparently hyperthimic with flight of ideas. He had a history of epilepsy and temporal tumour and two previous manic episodes. It was assumed as a maniac episode.
During inpatient evaluation, patient had memory for the occurrence. He described a sudden onset on the day before, after drinking wine. He described delirant atmosphere, persecutory and mystic delusional beliefs "this is the third secret of Fátima being revealed", followed by ecstasy and psychomotor agitation. Remission was obtained in one week on psychotropics. MRI documented the lesion. Electroencephalography performed one month later revealed "slow waves."
Conclusions Organic causes should be excluded before consider a psychiatric disorder. The hypothesis of epilepsy-related psychosis or mania and other effects of a temporal tumour should be considered in etiology. However, co morbidity with bipolar disorder cannot be excluded.
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Misophonia and affective disorders: The relationship and clinical perspective

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Misophonia is characterized by aversive reactivity to repetitive and pattern based auditory stimuli [1]. Misophonic sufferers demonstrate autonomic nervous system arousal, accompanied by heightened emotional distress. Sufferers describe extreme irritation, anger, and aggressive urge with physiological reactions including hypertonia, diaphoresis and tachycardia [2]. Some studies have found comorbidity with psychiatric disorders. However, most of these studies used small samples and few experimental methodologies [3]. This study identifies the possible relationship between misophonia and affective disorders, and any difference between the severity of misophonia in male and female patients. Fifty misophonic patients (female = 25, mean age = 46.28) were evaluated with Amsterdam Misophonia Scale (A-MISO-S) for the diagnosis of misophonia and with the M.I.N.I International Neuropsychiatric Interview for the diagnosis of affective disorders. Among $n = 50$ misophonic patients, we found major depression (MDD) = 11, melancholic depression = 5, dysthymia = 11, suicidality = 10, manic = 3, panic disorder = 8, agoraphobia = , social phobia = , obsessive compulsive disorder (OCD) = 14, post-traumatic stress disorder (PTSD) = 15. Misophonia was associated with MDD ($U = 76$, $P = .001$), suicidality ($U = 67$, $P = .001$), OCD ($U = 115$, $P = .002$) and PTSD ($U = 142.5$, $P = .008$). There was an indication of a significant difference between men and women in severity of misophonia ($U = 160.5$, $P = .002$). The presence of these varying affective disorders suggests that the sufferers are at high risk for affective disorders. Investigation of the co-morbidity will assist researchers to better understand the nature of the symptoms and how they may be interacting.
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Therapeutic patient education: A solution to the treatment of obesity and metabolic syndrome in psychiatry

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Introduction/objectives Obesity and overweight are major public health issues. Obesity is a risk factor associated with many non-communicable diseases such as diabetes, certain types of cancers, musculoskeletal disorders and cardiovascular, dermatological or gastroenterological diseases. Patients with severe psychiatric disorders have a higher risk of developing overweight or obesity than the general population. The risk of obesity in schizophrenics patients can be multiplied by a factor ranging from 2.8 to 3.5. Patients suffering from mood disorder have sightly lower risk of obesity, however we still consider a factor ranging from 1.2 to 1.5. This significant weight gain can be partly explained by medication.
Methods The hospital centre Le Vinatier, in France, has developed a therapeutic patient education program in helping patients to self-manage their preventable disease. In order to tackle the multifaceted nature of obesity, the program used the expertise of many different professionals: general practitioners, dieticians, dentists, physical adapted education teachers, pharmacists, nurses and so on. This programme is provided for patients suffering from obesity or an overweight complicated by diabetes, or/and metabolic syndrome, and/or history of cardiovascular diseases or/and a failure of a dietary monitoring. The program includes individual care and collective workshops in nutrition, oral heath, body image, adapted physical education, and roundtable.