decompensation for the past 14 years, successfully managed with lithium at a current dose of 600 mg per day. However, on this occasion, the patient sought hospitalization due to recent behavioural disturbances, including restlessness, disinhibition, abrupt changes in behaviour, pressured speech, sleep problems, agitation, and aggression. The patient also reported an increased sense of polyuria and polydipsia. Evaluation in the emergency department revealed elevated lithium levels of 1.47 mmol/L and hypokalemia, that justified lithium withdrawal. After lithium levels decreased, an estimated glomerular filtration rate remained low. She was diagnosed with lithium nephropathy, an adverse effect of long-term lithium therapy. Treatment with lithium changed to sodium valproate. Treatment with asenapine started and sustained for two months. Over the following two years, the patient experienced four additional hospital admissions in Psychiatry due to manic episodes.
Conclusions: Long-term lithium therapy can lead to lithium nephropathy with symptoms such as polyuria, polydipsia, and acute kidney failure. Consistent monitoring of patients receiving lithium is crucial to detect potential adverse effects.This case highlights the challenges in managing bipolar patients, as discontinuing lithium exacerbated symptoms despite switching to sodium valproate for nephropathy prevention. Long-term lithium treatment, while effective for bipolar disorder, poses significant renal risks. We emphasize continuous renal function monitoring and assessing the risk-benefit of lithium treatment while actively researching lithium nephropathy and its impact on glomerular function.

Disclosure of Interest: None Declared

EPV0103

Childhood trauma in bipolar disorder: experience of Arrazi hospital

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Introduction: Bipolar disorder is a chronic, recurrent, and disabling condition that typically begins in late adolescence or early adulthood. It is characterized by alternating phases of depression, mania, or hypomania. Childhood traumas are more frequently found in adults with bipolar disorder, suggesting their contribution to its development. They are also associated with more severe and complex clinical forms and a less favorable prognosis.
Objectives: Our objective is to assess the prevalence of childhood trauma rates in adults with bipolar disorder and to study the impact of childhood traumas on the clinical course of bipolar disorder, in comparison with a group of patients with bipolar disorder who did not experience trauma during their childhood.
Methods: This is a descriptive cross-sectional study using a questionnaire comprising sociodemographic criteria and the Childhood Trauma Questionnaire Short Form (CTQ-SF) to evaluate the connection between physical and psychological traumas during childhood and bipolar disorder. The study also examines the types of these traumas and their impact on the course of bipolar disorder in these categories.
Results: Data were collected from 54 patients with bipolar disorder at Ar-Razi Psychiatric University Hospital. Among this sample, 60% were female and 40% were male. The age of the participants in our study ranged from 18 to 54 years. According to the Childhood Trauma Scale, approximately one-third of patients with bipolar disorder had experienced childhood trauma. Moreover, most participants who had survived childhood trauma experienced more relapses than patients who had not experienced traumatic incidents during their childhood.
Conclusions: Childhood traumas and bipolar disorder appear to have a significant causal association, both in the development of the disease and its course. The results of our study support evidence published in articles to better clarify the nature of this association. However, our study has several limitations, including a limited sample size and difficulties in long-term follow-up during the disease. Therefore, further studies exploring this subject are desirable for better management of this condition.

Disclosure of Interest: None Declared

EPV0105

Difficulties in assessing the medical fitness of workers with mood disorders : A study of 101 cases

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Introduction: Assessing the medical fitness of workers with mood disorders remains a topical issue, because of its organizational, socioeconomic and professional impact.
Objectives: To assess the medical and occupational characteristics of workers with mood disorders.
To evaluate the impact of these psychiatric disorders on the medical decision of fitness for work.
Methods: Descriptive and retrospective study, over six years (January 1, 2018 to August 30, 2023) including all medical records of workers with mood disorders (bipolar disorder, anxiety disorder, and depression), referred to the occupational department of the Charles-Nicolle Hospital in Tunis for a medical fitness for work.
Results: The study included 101 patients, mostly female (sex ratio = 0.4), with a mean age of 43.3 ± 9.2 years. The most represented sector of activity was health care. The participants were mainly nurses (25%), followed by technicians (22%) and workers (21%). The mean job seniority was 16.5 ± 9.3 years. A pathological history was found in 74.3% of cases, of which 47.5% were psychiatric disorders. Mood disorders identified in our population were: bipolar disorder (53.5%), anxiety disorder (43.5%), and depression (3%). After medical examination and the decision of treating physician, 39% of the patients (N=39) were declared fit for work, and 31.4% (N=32) were fit with ergonomic adjustments. These accomodations consisted mainly of night shift exemptions in 75% of cases. Temporary unfitness was declared in 24 patients (23.6%).

Job mutation was recommended for four patients. Early retirement due to invalidity was proposed for two patients.
Conclusions: The decision on the medical fitness of workers with psychiatric disorders remains a delicate issue that requires the attention of both legislators and occupational health practitioners.

Disclosure of Interest: None Declared

EPV0106

Proteomic analysis of blood serum in bipolar disorder

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Introduction: Bipolar disorder (BD) often has symptoms similar to other mental disorders (BD), and there are no paraclinical criteria for differential diagnosis. (Geoffroy *et al.* Bip Dis 2017; 5 7). Published work on MD proteomics is scarce and focused on schizophrenia. (Dmitrieva *et al.* PeerJ. 2022; 10 e13907). Therefore, it is important to study potential biomarkers of BD using easily accessible material—blood serum (Rhee *et al. Transl Psy* 2023; 13 44). Identification of proteins involved in the pathogenesis of BD will help in the study of the pathogenetic mechanisms of BD, the development of differential diagnostic methods and pathogenetically based drugs.
Objectives: Carrying out a comparative proteomic analysis of blood serum from patients with BD and healthy individuals to identify potential biomarkers
Methods: We analyzed the protein spectrum of the blood serum of 14 patients with BD who were admitted during a depressive episode at the age of 32 [21;52] years with a disease duration of 8[5;11] years. The control group consisted of 10 mentally and somatically healthy individuals corresponding to the gender and age of the BD group. Blood serum was purified from 14 major proteins using affinity chromatography and separated by electrophoresis using the Laemmli method. After trypsinolysis, proteins were identified using HPLC/mass spectrometry on an Orbitrap instrument. Mass spectrometric analysis was performed on the Advanced Mass Spectrometry Core Facility of Skolkovo Institute of Science and Technology. Protein identification was carried out using the UniProtKB database using the Mascot search engine. The results were tested for significance using the nonparametric Fisher exact test with Yates correction.
Results: In patients with BD, qualitative mass spectrometry revealed differential expression of 21 neurospecific proteins. Among them: Protein dispatched homolog 3, Ceroid-lipofuscinosis neuronal protein 6, SWI/SNF complex subunit SMARCC1, Neurogenic differentiation factor 4, Protein furry homolog-like, REST corepressor 1 – are involved in the proliferation, development and differentiation of neurons; Hemicentin-2, Dystrophin, Voltage-dependent L-type calcium channel subunit alpha-1D, Syntaxin-binding protein 5, Small conductance calcium-activated potassium channel protein 1– participate in synaptic transmission of ion transport and form receptors.
Conclusions: Studying the role of these proteins in BD and their quantitative content in a larger number of patients is promising. This will help in the development of new diagnostic criteria and targets for drug therapy for BD.
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EPV0107

Clinical Characteristics and Aggression in Unipolar and Bipolar Course of Affective Disorders

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Introduction: The diagnosis and treatment of depression are complex due to its diverse forms. Recent focus in clinical practice has been on identifying markers for mono- and bipolar depression, as early diagnosis significantly impacts treatment.
Objectives: To identify clinical characteristics of unipolar and bipolar depressive disorders and assess their correlation with aggression levels in patients.
Methods: We studied patients at the Mental Health Research Institute of Tomsk NRMC: ICD-10 codes: Bipolar Affective Disorder (BD) (n=28), Recurrent Depressive Disorder (RDD) (n=33). Patients with BD were older (49 (33; 52) years) than those RDD (40 (31; 51) years) (p=0.018). The current depressive episode duration was shorter for BD (3 (2; 7) months) compared to RDD (5 (2; 12) months) (p=0.018). Gender distribution was comparable (p=0.568). We measured clinical symptoms (depression, anxiety, anhedonia) using psychometric tools (HAM-D, HAM-A, SHAPS) at admission and after 3 weeks of therapy. Aggression was assessed with the Buss-Durkee Hostility Inventory (BDHI) at admission.
Results: Patients with RDD demonstrated a higher severity of depressive symptoms upon admission (Table 1).

Table 1. Clinical Characteristics of Unipolar and Bipolar Depression Course

Severity of Symptoms	Bipolar Depression	Unipolar Depression	p (U-test)
HAM-D on admission	19 (15.5; 24)	22 (18; 26)	**0.044**
HAM-D after 3 weeks	4 (2; 6)	4 (3; 7.75)	0.219
HAM-A on admission	16 (12; 25)	19.5 (13; 26.75)	0.098
HAM-A after 3 weeks	3 (2; 6.5)	4 (3; 7.75)	0.219
SHAPS on admission	5 (1.25; 9)	3 (0; 10)	0.7
SHAPS after 3 weeks	1 (0; 4)	1 (0; 3)	0.44

The severity of some aggressive patterns was higher in patients with bipolar disorder (Table 2).