drugs of choice, this situation oblige forcing us to seek alternatives in the data sheet.
Objectives: To describe the complicated evolution of a case of acute mania difficult to threat with stabilizer drugs and antipsychotics of choice. We discuss the psychopharmacological approach.
Methods: Case summary. We have conduced a systematic review of the descriptions published to date, regarding this case.We presented a case, in a 48-year-old female, admitted to our hospital due to psychopathological descompensation of bipolar affective disorder, where we observed manic and psychotic symtoms.
Results: In the first instance, we started treatment with Lithium and Olanzapine, in increasing doses, along with benzodiazepine support.
During more than four months of follow-up , multiple drugs have been tested sequentially: olanzapine, aripiprazole and quetiapine. We observed a good response but low tolerance issue to secondary effects consisting of severe akathisia, in progressive stiffness (spasticity) and hands tremor, it was very disabling problem for patient, even though the use of biperiden.
This situation forced us to search another option of treatment, different from non-pharmacological therapies (ECT). After checking the literature and publications about it, we decided to start treatment with Caripracine 3mg/24h, for which the therapeutic indication is the treatment of manic with mixed symtoms.
Conclusions: We propose, through a clinical case, the use of cariprazine as a first choice in the acute decompensation of bipolar affective disorder, without symptoms of mixed mania.
During the treatment, the patient presente multiple difficulties and finally, a good response is was obtained with the use of Cariprazine, althought this patient continued showing slight akathisia well tolerated, she was able to leave after four months of hospitalization in the acude mental health unit.

Disclosure of Interest: None Declared

EPV0129

Cut From the Same Cloth: Bipolar disorder and Frontotemporal Dementia – Apropos a Clinical Case

S. Jesus*, A. R. Costa, M. Almeida and P. Garrido

Departamento de Psiquiatria e Saúde Mental, Centro Hospitalar do Baixo Vouga, Aveiro, Portugal
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1484

Introduction: Mood disorders have been reported in the literature as a risk factor for developing cognitive deficits. Bipolar disorder (BD) and Frontotemporal Dementia (FTD) share many common features, often presenting as a differential diagnostic challenge to the clinician. The clinical features of mania, such as euphoria, hyper-sexuality and difficulties in impulse control can mimic the impaired judgment and loss of inhibition seen in FTD. Depressive features such as anhedonia and social isolation can mimic apathy associated with FTD. Of the various subtypes, the behavioural-variant of FTD (bvFTD) is most similar to a manic episode.
Objectives: The authors aim to explore the relationship between BD and FTD, and the implications in differential diagnosis, treatment and prognosis with recourse to a clinical case example.
Methods: A non-systematized review of pertinent literature on the topic with focus on that which is most relevant to the theme was included. The authors present a clinical case of 55 year-old female with history of BD who was hospitalized in the context of a depressive episode with suicidal ideation and disorganized behaviour.
Results: It is not uncommon for patients with bvFTD to be initially diagnosed with BD, whereas on the other hand, patients presenting in late with an inaugural manic episode are considered to have dementia. The literature also reports that patients with BD appear to be at increased risk of a later FTD diagnosis, further contributing the diagnostic difficulties. Core symptoms that present in mood disorders, also make-up the clinical picture of FTD, and vice versa. Correct diagnosis is imperative as early-intervention may have significant impact on prognosis of the clinical pictures. The patient underwent complementary diagnostic imaging testing with magnetic resonance imaging, which documented atrophy in the frontotemporal regions which were not detected on previous exams, thus strongly suggesting a FTD diagnosis in a patient with history of BD.
Conclusions: The literature establishes, especially through various case reports, an apparent clinical overlap between FTD and mood disorders. A multifaceted connection between BD and FTD appears to exist, with clinical and genetic similarities having been described, although further studies are merited demonstrating this relationship. The clinical case highlights the challenges in FTD diagnosis in a patient with prior history of a mood disorder, especially BD, as well as demonstrating the difficult task in establishing a differential diagnosis between the two conditions when the mood disorder presents late in life. The clinician is alerted to the mimicry between the two conditions, taking into account the possibility of a FTD diagnosis in patients with history of BD presenting with unexpected cognitive and behavioural decline.

Disclosure of Interest: None Declared

EPV0130

Bipolar disorder type II - will the new classification help in setting an adequate diagnosis

S. Vuk Pisk[1,2]*, E. Ivezic[1,2], L. Senjug Mance[1], K. Matic[1], D. Svetinovic[1], V. Grosic[1,2] and I. Filipcic[1,2,3]

[1]Psychiatric Clinic Sveti Ivan, Zagreb; [2]Faculty of Dental Medicine and Health, Josip Juraj Strossmayer University of Osijek, Osijek and [3]School of Medicine, University of Zagreb, Zagreb, Croatia
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1485

Introduction: Bipolar affective disorder type II is often misunderstood, neglected and rarely receives the attention it deserves and often remains undiagnosed. Despite its neglect and insufficient diagnosis, it is an important diagnostic entity because it causes significant suffering and functional impairment, a chronic course of the disease and a high suicide rate. Cognitive impairments and multiple comorbidities that significantly affect the course and outcome of the disease are common.
Objectives: The purpose of this research was to determine the extent of the deficiency in diagnosing bipolar affective disorder type II in daily clinical work.

Methods: A total of 82 adult psychiatric inpatients diagnosed with affective disorders (depressive disorders and bipolar affective disorders) and borderline disorders participated in this study. They completed HCL-32, MDQ and PHQ-9 questionairres. The average age of the sample is 43.9 years. A total of 76.8% were women in the sample.
Results: 72.8% of respondents achieved a score above 14 on the HCL-32 questionnaire and thus met the criteria for possible hypomania. All three criteria for mania on the MDQ questionnaire were satisfied by 27.5% of respondents. 68% of respondents have moderate or severe symptoms of depression according to PHQ-9.
Conclusions: The results confirmed our assumption about the lack of recognition and diagnosis of bipolar affective disorder type II. Only 5 respondents (6.1%) were diagnosed with BAP II upon arrival. After the research, 73% of them met the criteria for diagnosing BAP II. As a correctly established diagnosis affects the selection of adequate therapy, we have tried to emphasize the importance of correct recognition of BAP II.

Disclosure of Interest: None Declared

EPV0132

Bipolar disorder and cannabis abuse. A clinical case report

S. Villa*, R. Obrador and J. M. Crespo

Psychiatry, Bellvitge Universitary Hospital, L'Hospitalet de Llobregat, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.1486

Introduction: Cannabis or marijuana is a common substance of abuse. Its active compounds are Delta-9-tetrahydrocannabinol (Δ9-THC or THC), cannabidiol or nabiximol. The last two ones might have a therapeutic effect in some mental disorders. THC is a toxic substance that has euphoric, sedative and antalgic effects. It is the third most consumed psychoactive substance in the world, with 10% of people consuming it with an abusive patron.
The comorbidity of Bipolar Disorder (BD) and the cannabis abuse takes place in a 20% of the patients in some series. This has been related with a worse prognostic for the BD, being especially related to apparition of more episodes of mania.
We did a review of both disorders due to a case of a patient we had admitted to the psychiatry department of the Bellvitge Universitary Hospital with a debut of hippomania and history of cannabis consumption.
Objectives: To expose a clinical case and to do a review of the literature related to BD and cannabis abuse.
Methods: It is a one patient report of a 35 year old male that was a habitual consumer of cannabis. He achieved a consume of 1g per day. He began consuming it on December 2020, until 4-5 days before the hospitalisation on March 2022. His hospital admittance was due to a debut with hippomania clinical features.
Review of various scientific articles related to both disorders.
Results: Our case clinical features were mainly an alteration in his conduct right after cannabis withdrawal. It consisted in mental hyper clarity, increased speed of his thought, insomnia, inadequacy, hyperactivity and increased energy; hipersexuality and wellness feeling.
His development was favourable with an olanzapine based treatment, later switched to aripiprazole. After the hospitalisation, his symptoms have been mainly related to the anxiety spectrum, due to a basal neurotic personality. He presented some depressive symptoms, but not with entity of decompensation. He hasn't consumed cannabis since the admittance.
It's been described that substance abuse is related to retardation on the diagnosis. Also, this comorbidity is related to a worse development in both disorders. In the case of BD, cannabis consumption has been related to more episodes of mania.
Lithium is the only treatment proved to improve both disorders at the same time.
Comorbidity for affective disorders with substance abuse has been described as a risk factor for suicide, overdose and homicide.
Conclusions: Cannabis seems directly related with the onset and the exacerbation of a BD. This relation seems bilateral, since an untreated mania might result in a cannabis abuse disorder. Worse prognosis for BD might be because comorbidity with cannabis abuse is related with worse adherence to treatment and more decompensations. Also, the abuse of substances can provoke retardation in the diagnosis. By now, lithium seems to be the only treatment with proved efficacy treating comorbidity of both disorders.

Disclosure of Interest: None Declared

EPV0133

The effect of pandemic as a trigger for first episode bipolar disorders

S. Cakir

Psychiatry, MoodART Clinic, Istanbul, Türkiye
doi: 10.1192/j.eurpsy.2023.1487

Introduction: The traumatic effects of COVID-19 pandemic is well studied in community and fragile groups. The association between COVID-19 infection and development of severe mood disorders have not well studied.
Objectives: Nonetheless the casual relation or stressor effects of Covid-19 pandemic on chronic psychiatric illness is not known yet. The present study is aimed to investigate the effects of pandemic as a triggering factor in first episode Bipolar disorder (BD) patients that onset after pandemic.
Methods: The study included a total sample of 55 patients diagnosed with first episode BD according to DSM-5 criteria.
The two groups of patients that illness onset was before (BP)and after pandemic (AP), were investigated and compared for psychopathology and life evet stressors. Impact of Event Scale-Revised (IES-R) for PTSD symptoms, Generalize Anxiety Disorder scale for anxiety symptoms, The Montgomery–Åsberg Depression Rating Scale (MADRS) to examine depressive symptoms; and Young Mania rating Scale (YMRS) for manic symptoms, Brief Psychiatric Rating Scale-18 (BPRS) was used for psychotic symptoms.
Results: The statistical analyses were performed using the Statistical Package for Social Science, version 26. Thirty-five patients that illness onset before pandemic and 20 patients that illness onset after pandemic were compared.