

in neurotransmitter balance, oxidative stress, mitochondrial dysfunction and individual susceptibility to idiosyncratic reactions. Early diagnosis is challenging, necessitating a high clinical suspicion, neuroimaging and exclusion of other etiologies. Management strategies involve discontinuation of lithium, even when serum lithium levels are within the therapeutic range, supportive care, and, in severe cases, hemodialysis to reduce lithium levels rapidly.

**Conclusions:** Clinicians should maintain a high index of suspicion of lithium-induced encephalopathy, especially in patients presenting with neurological symptoms while on lithium treatment. Early recognition and intervention are essential for minimizing morbidity and preventing potentially irreversible neurological damage. Further research is needed to better understand the precise mechanisms underlying it, risk factors and to refine treatment strategies.

**Disclosure of Interest:** None Declared

## EPV0110

### Multifactorial etiology of manic episodes. About a case

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**Introduction:** Manic episodes have a multifactorial etiology, with frequent association with genetic factors, comorbidities such as systemic diseases or secondary to infectious diseases, and environmental exposure factors. The prevalence of bipolar disorder is markedly higher in patients with autoimmune disease. The risk of developing bipolar disorder in some studies has been seen to be higher among patients with rheumatoid arthritis, therefore chronic inflammation would be a potential mechanism and could be a modifiable risk factor for bipolar disorder. Growing evidence indicates that Sars-CoV-2 may also trigger the acute onset of mood disorders or psychotic symptoms.

**Objectives:** We present the case of a patient who presents symptoms compatible with an acute manic episode after an outbreak of rheumatoid arthritis and comorbid COVID infection.

**Methods:** 52-year-old patient. She went to the hospital emergency room presenting affective symptoms compatible with a manic episode and psychomotor agitation. Personal medical history: rheumatoid arthritis, antiphospholipid syndrome. Psychiatric personal history: Depressive disorder under follow-up by a private psychiatrist under treatment with antidepressants. During the interview, the patient presented accelerated speech, with great emotional incontinence. Saltigrade thought and tachypsychia. She verbalizes delusional ideas of megalomaniacal and mystical and religious characteristics. She verbalizes that she is the reincarnation of the holy spirit, that God has taken her body and speaks through her. In the emergency room, a Sars-CoV-2 infection that the patient was unaware of was diagnosed. She is admitted to the hospital in the mental health unit, in the first interviews the patient maintains speech with delusional ideas "I notice the stigmata of Christ on my body".

**Results:** The patient recovers after treatment for the COVID infection, remaining asymptomatic. It was decided to start lithium to stabilize mood and the patient presented good tolerance and treatment with antipsychotics. The patient presented a favorable response, remitting the psychotic symptoms of which she was critical and stabilizing the affective symptoms. The patient is diagnosed with Severe Manic Episode with Psychotic Symptoms, as the main diagnosis and we could conclude the diagnosis of Bipolar Disorder since she has presented 2 depressive episodes in the past that have required treatment and follow-up by psychiatry.

**Conclusions:** Manic episodes have a multifactorial etiology and require an individualized approach, and comorbid medical conditions must always be assessed in order to establish a therapeutic plan with patients.

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## EPV0111

### Carbamazepine-induced toxidermia: Case report and a literature review

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**Introduction:** Carbamazepine is effectively used in treatment of bipolar disorder for its thymoregulatory virtues, but it can induce numerous side effects, including skin eruptions that can be severe sometimes.

**Objectives:** To study the relationship between toxidermia and treatment with carbamazepine.

**Methods:** We report the case of a patient who developed a toxidermia following the intake of carbamazepine.

**Results:** Mr. AD, 19 years old, with medical history of diabetes, has been diagnosed with bipolar disorder since the age of 17. He was initially treated with risperidone with an irregular follow-up.

He was hospitalized in our department for a manic episode with psychotic features with agitation and refusal of treatment.

The patient was put on injectable treatment 15 mg/day of Haloperidol and 20 mg/day of diazepam.

After 5 days in hospital, we switched to the oral route, gradually increasing haloperidol doses to 30mg, reducing diazepam doses and introducing carbamazepine for thymoregulatory purposes.

Carbamazepine was progressively increased up to a dose of 800mg per day.

Fourteen days after the introduction of carbamazepine, the patient presented a generalized rash requiring the discontinuation of this medication. He was treated with an anti-histamine and local corticosteroids, on the advice of dermatologists.

In the days following discontinuation of carbamazepine, skin lesions regress and then disappear.

Biologically, we observed a rise in eosinophilic polynuclear cells to 580, followed by a gradual decrease after stopping the treatment.

A pharmacovigilance opinion was sought, concluding that carbamazepine was responsible for the toxidermia, given the delay in

onset and the favorable evolution after discontinuation of the incriminating treatment. Moreover, this undesirable effect is well described in the literature.

Hence the contraindication to further use of carbamazepine in Mr. AD.

In addition, the patient was put on sodium valproate with good tolerance.

**Conclusions:** Each prescribed drug must be considered as potentially capable of causing cutaneous reactions as an adverse effect. Both the prescriber and the patient must be made aware of this phenomenon. The attitude can be modulated on a case-by-case basis, after specialist advice, depending on the severity of the rash and the disease to be treated.

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## EPV0112

### Exploring maladaptive early schemas in adults with bipolar disorder

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**Introduction:** Bipolar disorder is a severe and chronic mental pathology, with an estimated prevalence of 1% in the general population. It is a complex pathology, encompassing a wide variety of severe and contradictory symptoms, with harmful repercussions on the patient's personal, emotional, social, professional and conjugal life, precipitating relapse. By improving our knowledge of bipolar disorder, we can support and accompany patients, helping them to understand their illness, to be able to manage it, to resolve the problems that may arise from it, and to prevent relapses and the occurrence of further episodes.

**Objectives:** The aim of our work is to explore maladaptive early patterns in people with bipolar disorder in the intercritical period in relation to their symptomatology and functional disability, given that consideration of maladaptive early patterns (IAPs) could lead to better identification, understanding and management of bipolar disorder.

**Methods:** We conducted a cross-sectional, descriptive and analytical study. The sample in our study consisted of 40 bipolar adults and 40 control adults, recruited from the various inpatient and outpatient departments of our hospital. They were all university graduates, aged between 20 and 60, followed for at least 06 months and stabilized on treatment. After collecting the various socio-demographic and clinical data, we used the Young schema questionnaire-short form (YSQ-S1).

**Results:** Our study sample seemed to be characterized by certain specificities: high "self-sacrifice", "high demands" and "exaggerated personal rights". Feelings of dependence and incompetence were also high among our patients, especially those with type I bipolar disorder, leading to a marked decline in self-esteem and autonomy.

**Conclusions:** The data we have retained from this work show us the importance of drug, psychotherapeutic and family management in

achieving thymic stability and psychological and relational well-being.

**Disclosure of Interest:** None Declared

## EPV0114

### Corticosteroid-induced mania, review and case report

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**Introduction:** Corticosteroid treatment has been associated with the appearance of psychiatric symptoms such as depression, mania or psychosis. It is believed that manic symptoms appear with lower doses than psychotic ones. Furthermore, manic symptoms are usually associated with brief treatments against depressive ones that often appear with chronic administration of corticosteroids. The symptoms can persist for to 2 months, with an average duration of 3 weeks. The prognosis is favorable with a complete remission of symptoms in more than 90% of patients. Treatment initially consists in reducing or removing corticosteroids. However, sometimes symptomatic treatment with antipsychotics or mood stabilizers is necessary.

**Objectives:** To review about corticosteroid-induced mania

**Methods:** We carry out a literature review about corticosteroid-induced mania, accompanied by a clinical description of one patient previously diagnosed of bipolar disorder who presents a manic episode after corticosteroids treatment.

**Results:** A 25-year-old male was admitted to the short-term hospitalization unit from the emergency department due to manic symptoms. He had a previous diagnosis of attention deficit hyperactivity disorder sin adolescence and also a diagnosis of bipolar disorder established 7 years ago. During the last year he had received treatment with asenapine 10 mg and lamotrigine 200 mg, with good response. Several weeks before his admission he received corticosteroid treatment during several days, due to an respiratory infection. In this context he appeared more nervous, dysphoric, hyperthymic, impulsive, with increased speech pressure, insomnia and tachypsychia. Despite the withdrawal of corticosteroid treatment, manic symptoms persisted. During admission, asenapine's dose was increased with a complete remission of the manic symptoms.

**Conclusions:** Corticosteroids are associated in a high percentage with the appearance of manic symptoms. The prognosis is usually favorable after the withdrawal of corticosteroid treatment. However, sometimes the symptoms do not disappear despite withdrawal - mainly due to individual vulnerability - or this one is not possible. In these cases, treatment with antipsychotics or mood stabilizers is indicated.

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