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https://doi.org/10.1080/24750573.2019.1608065

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11th International Congress on Psychopharmacology & 7th International Symposium on Child and Adolescent Psychopharmacology

[Abstract:0004] [Psychopharmacology]

Olanzapine induced diabetic ketoacidosis

Ender Atabay[a] and Ayşe Rodopman Arman[b]

[a]Mersin City Research and Training Hospital; [b]Marmara University School of Medicine

ABSTRACT

Atypical antipsychotics (SGA) are used as first choice but this group of drugs may cause relatively more metabolic problems. Diabetic ketoacidosis (DCA) known as an acute, life-threatening complication of diabetes, can be triggered by use of SGA. In this presentation, we present a 17-year-old male patient who had DCA that thought to be triggered by olanzapine treatment.

Case presentation: E. has been followed up and treated for about 6 years in child and adolescent psychiatry outpatient clinic. He had no history of smoking, alcohol or substance abuse in any period of his life. There was no history of psychiatric disease in the family. His aunt has a history of type 2 diabetes. The first time he consulted us was about 2 years ago with the complaint of irritability, harm to his family and sleep problems. In this interview, we learned that she had been treated with risperidone 2 mg/day but had no benefit. Mental status examination revealed any hypomanic, manic, psychotic symptoms and signs. Aripiprazole 5 mg/day treatment was arranged and he benefited from drug. Patient was admitted again after 2.5 months and family had complaints of "inability to sleep, fears, biting himself, talking to himself". Avolition, dirtiness obsessions and cleaning compulsions, visual, auditory and auditory hallucinations were determined in the examination. Patient was referred to child neurology and psychiatric hospitalization was recommended. However family did not want hospitalization and no pathology was found in her neurological examination. Patient was planned to have olanzapine 5 mg, 2 times a day. Approximately 1.5 months later, the patient re-admitted to us, he was so irritable, anxious, unsleeping and suggested to continuation of olanzapine in morning 5 mg and evening 10 mg. In third week of treatment, patient was admitted to the emergency room with nausea, vomiting, abdominal pain and blurred consciousness. In the evaluation; blood glucose 434 mg/dl, urine glucose 3+, protein 2+, ketone 3+, pH 6.0; The blood gas pH was found to be 7.146 and it was accepted to the pediatric intensive care unit with diagnosis of diabetic ketoacidosis. Olanzapine treatment was discontinued and he was discharged with insulin therapy. The patient is still followed up with aripiprazole 15 mg/day treatment. How SGA lead to hyperglycemia remains unclear. Due to the weight gain effects of olanzapine, increasing peripheral and hepatic insulin resistance and stimulating X receptor are most known factors contributing to this effect. This mechanism does not seem possible to explain the rapid onset of diabetes. Some clinical trials with olanzapine have shown biphasic changes in insulin secretion in patients. Olanzapine acts on direct beta cells in the early period of treatment and that insulin secretion decreases significantly may accompany this metabolic condition. As in our patient, it is stated that this possibility increases in case of genetic predisposition. Particular attention should be paid to use of olanzapine, which may cause metabolic side effects more frequently in young patients with familial predisposition.

KEYWORDS
Adolescent; diabetic ketoacidosis; olanzapine

[Abstract:0012] [Psychopharmacology]

Hyponatremia during treatment with the clozapine and amisulpride combination: a suspected association and improvement with dose reduction

Mehmet Hamdi Örüm and Behice Han Almış

Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey

ABSTRACT

Clozapine is the only antipsychotic efficacy in treatment-resistant schizophrenia, but in such cases it has limited effectiveness. To improve efficacy, clinicians commonly augment clozapine with another antipsychotic. Clozapine has serious side effects due to its more

KEYWORDS
Clozapine; amisulpride; hyponatremia; combination drug therapy; drug side effect

receptor profile. The second antipsychotic to be added to clozapine should be less likely to cause these side effects. Amisulpride may be a suitable medication for clozapine-augmentation therapy. However, side effects may occur due to this combination.
Case presentation: Here, we report in 31-year-old male patient diagnosed with schizophrenia who presented with hyponatremia following the addition of amisulpride to clozapine and its improvement with dose reduction for the first time. In cases of adverse events that is non-fatal or that can be controlled by supportive treatments, dose reduction may be useful without discontinuing the drug. So, we would not like to lose the combination of clozapine and amisulpride in the management of treatment-resistant schizophrenia. Management of drug-induced syndrome of inappropriate secretion of antidiuretic hormone primarily demands the discontinuation of the suspected agent in daily routine of some physicians. In cases of adverse events that are non-fatal or that can be controlled by supportive treatments, a dose reduction may be useful without discontinuing the drug. Further systemic research should be conducted with respect to clozapine and amisulpride combination-associated hyponatremia and its improvement with dose reduction to provide a greater understanding of both its prevalence and etiology.

[Abstract:0016] [Tic disorders]

Improvement of Tourette syndrome symptoms with penicillin prophylaxis in two children presenting with severe functional disorder

Serhat Kala[a], Mahmut Zabit Kara[b] and Mehmet Hamdi Örüm[c]

[a]Private Psychiatry Clinic, Mersin, Turkey; [b]Child and Adolescent Psychiatry, Antalya Research and Training Hospital, Antalya, Turkey; [c]Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey

ABSTRACT
Although Tourette's Syndrome (TS) was previously considered a rare disease, it is reported that it affects approximately 1% of school age children in the 6–7 age group. Tics are defined in a wide range as involuntary, sudden, rapid, repetitive or sequential, non-rhythmic movements, gesture or sound extraction. Obsessive-compulsive Disorder (OCD), Attention-deficit/hyperactivity disorder (ADHD), and other behavioral disorders (e.g. Impulse Control Disorder) often present as part of the clinical presentation with tics in Tourette syndrome. The acronym PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections) describes a subgroup of children with TS and/or OCD that experience symptom exacerbations following streptococcal infections. We hypothesized that the prevention of streptococcal infections among children in the PANDAS subgroup would decrease neuropsychiatric symptom exacerbations.
Case presentation: Case 1: A 8 year-old, male patient. Hyperactivity, speech in the classroom, impulsivity, motor tics are the symptoms of the admission. He was diagnosed with TS for three years and treated with sodium valproate, risperidone, clonidine, atomoxetine, methylphenidate, previously. There was no a clinical remission with the treatment risperidone 0.75 mg/day and methylphenidate (Medikinet retard) 10 mg/day. ASO, CRP and Anti-DNase values were high. Penicillin prophylaxis was initiated. After 15 days, both tics and ADHD symptoms significantly improved.

Case 2: A 8 year-old male patient. Motor and vocal tics are the symptoms of the admission. He was diagnosed with TS, ADHD, learning disorder and treated with risperidone, clonidine, and methylphenidate. Despite this treatment, there was no a remission in the symptoms. After the initiation of aripiprazole, tics were significantly decreased. However, tics increased again in March-April. Aripiprazole dose was increased to 10 mg daily but no change. Risperidone and atomoxetine were added and no change was observed. ASO, CRP and Anti-DNase values were high. Penicillin prophylaxis was initiated. Clinical and laboratory improvement was seen after the fourth injection. Penicillin prophylaxis was found to be effective in decreasing streptococcal infections and neuropsychiatric symptom exacerbations among children in the PANDAS subgroup. TS, OCD, ADHD and other neuropsychiatric and neurodevelopmental diseases have a possible relationship between infections. It is recommended to look for markers such as ASO, CRP, and Anti-DNase in patients who have no response to treatment, clinical fluctuation and seasonal changes and penicillin prophylaxis should be initiated when necessary.

KEYWORDS
ADHD; OCD; PANDAS; tic; Tourette syndrome

[Abstract:0017] [Psychosomatic medicine – liaison psychiatry]

Hypoesthesia in the fingers innervated by the median nerve after surgery for axillary and palmar hyperhidrosis: a case of perspiration presenting with psychiatric symptoms

Emre Gedik[a] and Mehmet Hamdi Örüm[b]

[a]Department of Neurology, Kirklareli State Hospital, Kirklareli, Turkey; [b]Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey

ABSTRACT

Hyperhidrosis occurs as a result of increased sympathetic activity and reduces the quality of life leading to psychological and social problems. In some cases, sweat flowing drop by drop and psychological stress increases the amount of perspiration. As a medical treatment, psychotherapy, iontophoresis, systemic and topical anticholinergic therapy, topical therapy with aluminum chloride or biofeedback can be used. In this case report, we discussed a patient with perspiration who was admitted to the psychiatry outpatient clinic because of stress-induced sweating which was operated due to organic reasons, and his subsequent follow-up.

Case presentation: We report a 23-year-old man who developed tingling and numbness in the palmar side of the first three fingers of the left hand after thoracoscopic sympathectomy for hyperhidrosis. Electromyography study revealed a denervation in the left brachial plexus but this was not significant. It is thought that this complication is related operation position, hyperabducted arm. We examined the patient in every 15 days. The patient said that the severity of tingling and numbness decreased in the days 20–25. At the end of the 45 days, for the first time, loss of sensation reduced, and at the beginning of the three months, the patient did not differentiate loss of sensation. In this case report, the follow-up period of the sweating patient associated with stress was discussed. The patient was referred to surgery because of organic reasons. There was a postoperative complication. After this complication, we followed the patient and the complication process as neurology and psychiatry. The complication can be prevented by avoiding stretch and compression. Postoperative nerve injury has a good prognosis.

KEYWORDS

Hyperhidrosis; hypoesthesia; perspiration; endoscopic thoracic bilateral sympathectomy

[Abstract:0019] [Psychopharmacology]

Fluoxetine-induced petechial rash: a case report

Mehmet Hamdi Örüm[a], Mahmut Zabit Kara[b], Oğuzhan Bekir Eğilmez[a], Vildan Avcu[c] and Gamze Örüm[d]

[a]Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey; [b]Child and Adolescent Psychiatry, Antalya Research and Training Hospital, Antalya, Turkey; [c]Adiyaman University School of Medicine, Adiyaman, Turkey; [d]Faculty of Nursing, Inonu University, Malatya, Turkey

ABSTRACT

Fluoxetine is a nontricyclic serotonin (5-hydroxytryptamine) reuptake inhibitor commonly used in the treatment of major depressive disorder and anxiety disorder. It also blocks 5-hydroxytryptamine re-uptake in platelets and potentially leads to platelet dysfunction. This may be seen in the clinic as petechiae, purpura, and ecchymosis. In this case report, we present a 14-year-old male patient with the use of fluoxetine and the occurrence of petechial rash and the disappearance of symptoms with drug withdrawal.

Case presentation: A 14-year-old male patient was admitted to our psychiatry outpatient clinic and was diagnosed with generalized anxiety disorder according to DSM-5 criteria. Fluoxetine was started at 20 mg/day. There was a partial regression in her complaints at the sixth week of follow-up and the treatment was continued in the same dose. In the third month, a significant improvement was reported in psychiatric complaints. However, a dermatological problem appeared: Petechial rashes in a spot style of 10–15 cm in the area of the sternum. In the first month of the treatment there was little time and gradually increased. Clinical and laboratory tests were normal. Dermatology referral documented drug use may cause this adverse reaction. The drug was discontinued and began to decline within three weeks. At the end of the lower week, it had completely disappeared. Sertraline was started at 50 mg/day and there was a partial improvement of psychiatric symptoms at the sixth week of treatment and no similar side effects were observed. Several hypotheses have been proposed and studied to explain the mechanisms of selective serotonin reuptake inhibitors (SSRIs) leading to bleeding disorders. The platelets have a carrier similar to the serotonin reuptake carrier present at the presynaptic nerve endings. SSRIs decrease or consume serotonin reserves of platelets by inhibiting the serotonin reuptake transporter in platelets in a similar way to the effect on

KEYWORDS

Antidepressant; fluoxetine; generalized anxiety disorder; petechial rash

presynaptic nerve endings. Since the presence of serotonin is necessary for the aggregation and hemostasis of platelets, the efficiency of aggregation and hemostasis caused by platelet-mediated reduction in the depletion or depletion of serotonin is also reduced.

Especially in patients with platelet dysfunction and thrombocytopenia, it is recommended to be careful in the use of fluoxetine and other SSRIs.

[Abstract:0020] [Psychopharmacology]

Compulsive water drinking resulting in hyponatremia: a pimozide case

Mehmet Hamdi Örüm and Oğuzhan Bekir Eğilmez

Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey

ABSTRACT

Pimozide is an antipsychotic derivative used in the treatment of schizophrenia patients. It causes side effects such as tremor, rigidity, dystonia, akathisia, extrapyramidal symptoms, headache, galactorrhea, and gynecomastia. Edema, itching, skin rashes are rare side effects. Another rare side effect is psychogenic polydipsia and subsequent hyponatremia. In this case report, we discussed the polydipsia-hyponatremia syndrome due to pimozide which is not preferred due to cardiac side effects in the treatment of schizophrenia.

Case presentation: A 71-year-old male patient was followed up for more than 50 years with the diagnosis of schizophrenia. In the past, the drugs he used were haloperidol, chlorpromazine, quetiapine, risperidone, olanzapine, amisulpride, escitalopram, biperidene, alprazolam. He was admitted to the emergency room with vomiting, abdominal pain, dizziness, self-talk, and agitation. Laboratory findings were as following: serum sodium (Na) level 117 mEq/L, serum chlorine (Cl) level 92 mEq/L, serum potassium (K) level 4.0 mEq/L, urinary osmolarity 1300 mosmol/kg, urine sodium level 130 mEq/ L. It was determined that 8 mg/day pimozide was used before the application. Drug-induced inappropriate anti-diuretic syndrome was thought to develop. No medication was used, supportive treatment was given, and clinical symptoms improved after the third day. Serum Na 136 mEq/ L was determined in his laboratory. Clozapine was started at 12.5 mg/day. Slowly titrated 200 mg/day dose was reached. White blood cell and electrolytes were in normal limits before discharge. There are cases associated with the use of pimozide in the literature. The first study was the study of Koide, in which three cases were discussed. Later, Nishimura et al., Leclerq et al. made notifications by. There are not many studies about pimozide which is not used frequently because of its side effects. In our study, hyponatremia due to the use of pimozide, which was obtained by its own means. Possible mechanisms that may cause this include: action on the pituitary gland with increased synthesis and/or secretion of antidiuretic hormone (ADH), action on the kidney, either by direct action or by potentiating the activity of ADH at this level, central action on osmoreceptors with modifications of the threshold of activity leading to a secretion of ADH for an abnormally low level of blood osmolality. This case illustrates the risk of water intoxication in neuroleptic-treated patients with non-psychiatric care and emphasizes the interest of regular ionic control in such patients.

KEYWORDS

Hyponatremia; pimozide; inappropriate antidiuretic syndrome; schizophrenia

[Abstract:0027] [Psychopharmacology]

Facial edema due to low dose of vortioxetine: a case report

Gizem Kara

Department of Psychiatry, Dr. Ersin Arslan Research and Training Hospital, Gaziantep, Turkey

ABSTRACT

Vortioxetine is the one of the novel antidepressants, widely used as the first line of treatment major depressive disorder (MDD). Vortioxetine has been approved by the US Food and Drug Administration (FDA) in 2013 and also can be described as a multimodal serotonin modulator. Vortioxetine appears well-tolerated, and has advantages with very limited effects on weight gain and sexual functioning. Common adverse drug reactions include nausea, diarrhea, dry mouth, headaches, and sleep disturbances. In literature, cutaneous adverse drug reactions reported in only 1–3% of patients under vortioxetine treatment, but in terms of edema, only two cases have been reported in which 10 mg/day vortioxetine was used in these cases. In this case report, we present a patient who developed facial edema due to following low dose of vortioxetine use in (MDD).

Case presentation: A 34-year-old woman, married, living with her husband and one child, presented with depressive symptoms. She treated with sertraline 200 mg/day for three

KEYWORDS

Facial edema; antidepressants; vortioxetine

months. But her complaints were still presented, especially concentration problems led to many failures at work and she almost got fired. Hamilton Depression Rating Scale score was 16. She diagnosed with MDD and vortioxetine 5 mg/day was started and at the second week of her treatment, she had complaints of edema, feeling stiffness and swelling, difficult to sleep, and excessive itching on her cheek. Edema was isolated in her face. No significant laboratory findings including hemogram pathologies have been found. The patient was not taking any other medications, nor any foods which may cause any allergic reactions. Patient was referred to a dermatologist; the formal diagnosis was made as drug-induced dermatological edema. Vortioxetine was discontinued immediately and her treatment replaced with 150 mg/day of venlafaxine. After two days, patient's facial edema resolved. The patient had a score of 5 on the Naranjo's Adverse Drug Reaction Probability Scale which indicated a probable relationship between the dermatologic adverse effect and vortioxetine use. Vortioxetine related dermatological adverse effects can be attributed to a variety of non–immune-mediated mechanism, there is a higher likelihood of predictability and dose dependency, but this mechanism not clear. Recently, two cases were reported with edema and serious dermatological adverse effects associated with vortioxetine. These are such as severe pruritus or excessive itching, edema, petechiae, and ecchymoses in the legs in two MDD patients under 10 mg/day vortioxetine treatment. These side effects disappeared vortioxetine was discontinued in both patients. In another case report, acneiform eruptions were documented in a female patient using 10 mg/day dose of vortioxetine. Withdrawal of the medication, topical antibiotic treatment resulted in a decrease of lesions on the face of the patient. To the best of our knowledge, this is the first illustration of a patient who developed facial edema due to following low dose of vortioxetine use in MDD. This dermatological sign and other related symptoms disappeared following discontinuation of vortioxetine. This case report shows that, when vortioxetine use in depressed patients, in clinical routine practice, even if low dose of use, clinicians should be aware of adverse dermatological reactions such as facial edema, which may limit adherence and result in increased morbidity and decreased quality of life.

[Abstract:0038] [Addictions]

A case of psychosis with catatonic properties in a patient with anabolic steroid and HcG abuse

Mehmet Ünler, İrem Ekmekçi Ertek, Behçet Coşar and Zehra Arıkan

Department of Psychiatry, Gazi University School of Medicine, Ankara, Turkey

ABSTRACT

Anabolic steroids are common in athletes interested in bodybuilding and weight lifting. These people use HcG to reduce endocrinological side effects such as testicular atrophy within cycles of steroid use. We present a psychotic case with catatonic features in a patient using hcG after anabolic steroid use.

Case presentation: 17-year-old high school student, single male patient was brought to our outpatient clinic by his family for the last 20 days with complaints of introversion, denial of eating, denial of speech, slowing of movements, and insignificant behaviors. His history included insomnia, crying attacks, and guilt statements. It was learned that oral anabolic steroid abuse started about 4 months ago and continued for 2 months. In the last 3 weeks before his illness, his family reported that he had a previous IM hcG 5000 IU abuse weekly. It has been learned that the patient has been dealing with bodybuilding for 2 years and sometimes steroid abuse has been observed in the past and his brother has been followed up with bipolar disorder. In the mental examination, he was conscious, and his orientation was complete, his mutism was present. He had advanced psychomotor retardation and blocks of thought. Apathic facial expression was seen. The patient was hospitalized in our clinic and routine blood tests, cranial MRI, EEG and urine screening were performed. There were no pathological findings except neutrophilia. In the foreground, the patient was given lorazepam 1 mg orally with catatonia diagnosis. Because of the benefit of the patient with increasing speech, the lorazepam dose was increased to 1 mg three times a day. In the follow-up, olanzapine 5 mg once a day was added to the treatment for referential delusions and the dosing increased up to 15 mg/day. Haloperidol 1 mg once a day was added for residual psychotic symptoms of the patient when described sedation. The patient was discharged with partial remission with lorazepam 3 mg/day, olanzapine 15 mg/day and haloperidol 1 mg/day treatment. Although the patient had intermittent steroid use in the past, the recent emergence of psychotic and catatonic symptoms suggested that hcG may be effective in the forefront. Nevertheless, the effect of steroid use and familial burden could not be excluded. In the literature, a case of first-episode mania which developed after the use of hcG without prescription for weight loss was reported. HcG needs to be addressed in terms of triggering psychotic symptoms, in this topic advanced evidence is needed.

KEYWORDS

Anabolic steroids; bodybuilding; catatonia; HCG

[Abstract:0042] [Psychopharmacology]

Facial edema develops with mirtazapine: a case report

Sema Baykara, Sevler Yıldız, Sevda Korkmaz and Murad Atmaca

Department of Psychiatry, Fırat University School of Medicine, Elazig, Turkey

ABSTRACT

Mirtazapine is a tetracyclic antidepressant that increases serotonergic and noradrenergic activity. It has potent antagonistic activity to presynaptic alpha-2 adrenergic receptors and to serotonin 5-HT2 and 5-HT3 receptors. It blocks histamine-1 receptors, and it does not have anticholinergic effects. Side effects like sedation, fatigue, hypotension, constipation, dry mouth, impaired liver function, granulocytopenia have been reported due to mirtazapine. Edema is a rare side effect of mirtazapine. We presented a case of facial edema due to mirtazapine use which is rarely reported in the literature and aimed to drive the clinicians'attention to this side effect of mirtazapine.

Case presentation: The patient is a 51-year-old housewife. Six years ago, she had complaints of unhappiness, anhedonia, introversion, decreased appetite, and insomnia. She had used sertraline, paroxetine, imipramine, quetiapine with the diagnosis of major depressive disorder. The patient was admitted to our inpatient clinic with complaints of unhappiness, introversion, insomnia, and reduced self-care lasting for two months. Depressive mood, blocks in thought flow, psychomotor retardation and mutism were observed. The Brief Psychiatric Rating Scale and Hamilton Depression Rating Scale were administered, and she was diagnosed with recurrent depressive disorder according to the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5). No pathological findings were observed in the laboratory tests (hemogram, ALT, AST, urea, creatinine, Na, K, Ca, T3, T4, TSH) and ECG. The patient was started on daily haloperidol/biperiden 2 × 1 intramuscular (IM), venlafaxine 75 mg, mirtazapine 30 mg and alprazolam 1 mg treatment. Haloperidol-biperiden treatment was stopped one week later with a partial recovery of the patient's severe depressive mood, termination of negative affective discharge and compliance with treatment. On the seventh day of the treatment, edema occurred on her face. The patient's laboratory tests were done again. Dermatological examination and laboratory tests were evaluated together, organic causes to lead edema were excluded. It was suggested that psychiatric medications could lead edema. Mirtazapine treatment was discontinued and trazodone 50 mg/day was started. The edema on the patient's face resolved and disappeared the following days. Edema is a rare side effect and its pathophysiological mechanism is not clear due to use of mirtazapine. It can increase cyclic adenosine monophosphate (cAMP) by 5-HT2 receptor blockade, resulting in vasodilatation in vascular smooth muscles and edema (3). Facial edema due to mirtazapine use has been reported and it has been reported that the edema has resolved after discontinuation. In addition, 15 mg/day mirtazapine was started in a patient who did not benefit from moclobemide, fluoxetine and zolpidem treatment. After increasing the dose to 45 mg/day, edema on the face and limbs was seen and the edema was completely resolved by removing mirtazapine from the treatment. Mirtazapine is used to benefit from its sedative and antidepressant effects. Studies to explain the mechanism of edema side effects associated with drug use will be useful in elucidating this issue. It is important for clinicians to consider this side effect in patients using mirtazapine.

KEYWORDS

Facial edema; mirtazapine; antidepressant

[Abstract:0049] [Psychopharmacology]

Clozapine-induced myocarditis: a case report

Ahmet Özaslan and Burhanettin Kaya

Department of Child and Adolescent Psychiatry, Yıldırım Beyazıt Univesity Yenimahalle Research and Training Hospital, Ankara, Turkey

ABSTRACT

Around one third of schizophrenia patients are claimed to be resistant to antipsychotic treatment and are then commonly treated with clozapine. The use of clozapine is restricted due to its risk of inducing agranulocytosis, a rare but serious condition characterized by an acute drop in neutrophil count. Clozapine has several other common serious side-effects including weight-gain, which commonly leads to metabolic syndrome and less common side-effects include, seizures and myocarditis among other. Myocarditis is an uncommon, potentially life-threatening-disease that presents with a wide range of symptoms.

Case presentation: 28-year-old single male, with the history of 11 years of paranoid schizophrenia. He was treated with suitable dose-time with quetiapine, risperidone, amisulpiride, zuklopentixol, flupentixol, aripiprazole before and his complaints of suspiciousness, hearing voices, paranoid delusions towards his family members were still going

KEYWORDS

Schizophrenia; clozapine; myocarditis

on. He was diagnosed with treatment-resistant schizophrenia and decided to initiate clozapine. Prior to the clozapine initiation, the performed laboratory screening was in normal range. Clozapine was initiated with 25 mg/day dose and increased 25 mg/day. At the day of 19th and 325 mg/day clozapine dose, the patient complained of chest pain, flu-like symptoms, fatigue, loss of appetite. He had fever at 38.2C, tachycardia (110pulse/min) and tachypnea (respiratory rate:22). His blood pressure was normal (110/70 mm/hg). There was no pathological physical examination. At first, liver and kidney functions and electrocardiogram were normal. Cardiac enzymes white blood cell count, troponin levels, erythrocyte sedimentation rate, and C-reactive protein levels were elevated to 247, 21(RR:0-), 12.4, 4.5 ng/ml, 70 mm per hour, and 118 mg/dl, respectively. The patient was referred to cardiology and infection departments. Echocardiogram(ECHO) was showed decompensated hearth failure with myocarditis. The consultant cardiologist diagnosed myocarditis secondary to clozapine as no other confounding comorbidity was identified. The patient observed to the monitor under clinical conditions. Clozapine was ceased. The cardiac enzymes decreased to the normal level after six days of clinical observation. Infectious factor is ruled out. His treatment was reorganized as 20 mg/day olanzapine and discharged from hospital. Myocarditis is a rare but fatal situation due to the clozapine usage, which usually develops within the first month, especially in the first four weeks of commencement. Complaints like fever, tachycardia, chest pain, flu-like symptoms, fatigue are non-pathognomonic. Our case has fever, chest pain and cardiac enzyme changes. Due to the persistence of symptoms and an increase over time, we asked for suspicion of possible infectious or cardiological status and related investigations and consultations. The presence of heart failure in ECHO, accompanying ECG and enzyme changes supported myocarditis. The absence of an infectious agents of the patient and the regression of the symptoms within a short time after discontinuation of the drug distinguished us from the possible infectious causes of myocarditis. Once clozapine-related myocarditis has been diagnosed, it is mandatory to immediately stop clozapine treatment. All patients with a suspected myocarditis, even if asymptomatic, must undergo to a comprehensive laboratory and cardiological evaluation. When a myocarditis is diagnosed a supportive care must be initiated which degree should be dependent on clinical severity of myocarditis.

[Abstract:0050] [Schizophrenia and other psychotic disorders]

Repetitive psychotic episodes induced by rabies vaccine: a case report

Bahar Şen[a] and Tunç Alkın[b]

[a]Department of Child and Adolescent Psychiatry, Dokuz Eylul University, Izmir, Turkey; [b]Department of Psychiatry, Dokuz Eylul University, Izmir, Turkey

ABSTRACT

Psychosis is a condition of the brain broadly defined as a loss of contact with reality. Rabies is a dermatological disease caused by rabies virus transmitted through a bite from an infected mammal. We present a case of a patient who developed psychotic symptoms afar exposure rabies prophylactic vaccination.

Case presentation:. Thirty-six years old, married, female patient had auditory and visual hallucinations and religious delusions started within 2 days after rabies vaccination. Nearly 2 years ago, shortly after being vaccinated against rabies following a cat scratch, she had a psychotic episode and hospitalized for treatment. antipsychotic agents were used in different times and combinations. Her recent psychotic symptoms were improved with a short-term olanzapine treatment. This case demonstrates a challenge in a psychiatric emergency setting: The patient is considered to being suffered psychotic episodes related to rabies vaccine. To date, there is no specific treatment defined for post-vaccine psychosis. Most cases are treated symptomatically.

KEYWORDS

Antipsychotic; psychosis; rabies; vaccine

[Abstract:0070] [Psychopharmacology]

An atypical finding at the onset of manic episode: stuttering

Uğur Takım, Celaleddin Kartal and Mine Şahingöz

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Early recognition, diagnosis, and prevention in bipolar disorder (BD) is critical to prevent further progression. Several studies reported that BD patients may have non-specific symptoms such as mood fluctuation, irritability, sleep disturbance, increased anxiety and changes in energy level

KEYWORDS

Stuttering; bipolar disorder; manic episode; atypical finding

prior to a first or relapsing manic episode. There is insufficient information about the presence and timing of specific symptoms prior to a mania. In this case presentation, we purposed to present a patient with BD who reported stuttering before the onset of manic episodes.
Case presentation: A 22-years-old male patient was admitted to the hospital with the complaint of stuttering since last week. Neurologic examination was normal. He had a previous diagnosis of BD. He has been in remission for the past eight months without medication. Stuttering has regressed spontaneously in 4–5 days. A week later, his sleep diminished and he became more talkative, distractible and irritable. Therefore, he was diagnosed with a manic episode. He was hospitalized and started on valproic acid 1000 mg/day, olanzapine 10 mg/day and lorazepam 5 mg/day. He had a history of four previous mood episodes; one depression and three mania. He didn't use his medication after remission. According to his medical records, just before his previous manic episodes, he also had spoken with stammer. Shortly after the manic symptoms had resolved in 4–6 days, stuttering appeared in the patient. Etiology of stuttering is hypothesized to be incomplete lateralization of abnormal cerebral dominance, genetic factors, and overactive presynaptic dopamine systems in regions of the brain that modulate verbalization. In several researches, stuttering is associated with anxiety and depression. While some researchers asserted that anxiety is the main reason of stuttering, other researchers suggested anxiety as a factor that triggers the stuttering, provokes the maintenance of the stuttering and affects the intensity of it. We have presented a case of BD, who had stuttering before the onset of a manic episode. To the best of our knowledge, no other study is found which shows the relation among bipolar disorder, initial stage of manic attack and stuttering.

[Abstract:0080] [Psychopharmacology]

Strategies in treatment-resistant schizophrenia intolerant to clozapine: a case series

Sarah Marilyn Amin[a], Chua Sze Hung[a], Lew Sheau Voon[b], Nurul Nadiah Muhamad[a] and Jessica Kaur Moti[a]

[a]Hospital Mesra Bukit Padang, Ministry of Health, Malaysia; [b]Hospital Queen Elizabeth, Ministry of Health, Malaysia

ABSTRACT
Schizophrenia is a chronic debilitating mental illness running a relapsing-remitting course. Complicating the clinical picture and outcome, up to a third of the cases are treatment resistant. While clozapine is the only effective treatment, up to 70% of treated individuals are clozapine resistant and 17% are forced to discontinue treatment due to various side effects. The non-tolerant group represents an age old therapeutic challenge. Unfortunately, treatment beyond clozapine including various augmentation and combinations strategies lack good evidences.
Case presentation: We present three adult patient with the diagnosis of treatment resistant schizophrenia who discontinued clozapine due to various adverse effects. These cases are from both inpatient and outpatient services of a tertiary psychiatric center. They represent uniquely challenging clinical presentations and pathway to stabilization using three different combinations of non-clozapine atypical antipsychotics and maintenance electroconvulsive therapy (ECT). Strategies employed beyond clozapine are most of the time backed by limited evidences and guided by clinical experiences. Clinicians are forced to dig deep into their psychopharmacology knowledge. In psychiatric practice there is no "one size fits all" treatment, prescribing in this group of clozapine non tolerant treatment resistant clients is an art. Treatment has to be psychopharmacological sensible, taking into account safety, efficacy and shared decisions in a situation where high cumulative dose are frequently unavoidable. Understanding of receptor profiles and properties of different antipsychotics allows for presumably safer and complementing combinations. Non pharmacologic strategy such as incorporating ECT has some evidences to support and is widely utilized by our center. The advances in psychopharmacology, discovery of various atypical antipsychotics and understanding beyond traditional "dopamine hypotheses" allow clinician to attempt more heroic but sensible approach to bring about stabilization, better quality of life and eventually recovery. This case series might help to inform clinicians of other effective and tolerable strategies while we wait for further progress in the field of psychopharmacology.

KEYWORDS
Clozapine; treatment resistant schizophrenia; electroconvulsive therapy; combination antipsychotics; psychopharmacology; side effects

[Abstract:0085] [Schizophrenia and other psychotic disorders]

Somatic type delusional disorder: a case report

Ezgi Selçuk and Demet Sağlam Aykut

Department of Psychiatry, Karadeniz Technical University School of Medicine, Trabzon, Turkey

ABSTRACT

Delusional disorder is usually a persistent disorder with associated delusions or hallucinations. When the main domains of the delusional system have hypochondriac or somatic features, somatic subtype of delusional disorder comes to mind. In the somatic subtype of the delusional disorder, the person has a constant and unshakable belief that has a physical disease. As a result of the nature of the symptoms, these disorders are not seen much in psychiatric practice. Therefore, there are various difficulties in diagnosis and treatment. Here, we present a patient who presented to the psychiatric clinic with somatic complaints, the somatic subtype of the delusional disorder was considered, accordingly.

Case presentation: Our patient is a 22-year-old female, single, university student. She was referred to our outpatient clinic with the complaint of inability to feel the eyelids and the feeling of permanent stinging and dryness for the last year. The patient had complaints of introversion, unhappiness, lack of enjoyment of life, guilt, and recurrent death in the last year. Her complaints had begun 1 year ago after having allergies. She complained that the eyelids had hardening and could not feel the eyelids. She thought that her eyes would be blind, she would never get better, she would die blindly because she was a sinner. The patient was sure that her eyes would be blind and did not consider the situation excessive or absurd. The physician changes his complaints very often, all the doctors go by saying that the dryness of the eye is not an important case, although the patient was not convinced. The patient who thought that the doctors did not understand her illness, had attempted suicide 1 week before her admission to our outpatient clinic. When she consulted us, she had delusions of hopelessness, depression and introversion, unhappiness, inability to enjoy life, recurrent death thoughts, delusions of guilt and sinfulness. The patient was admitted to the psychiatry clinic with these complaints. The Beck Depression Inventory and Beck Anxiety Inventory scores were 33 and 28, respectively. 20 mg/day fluoxetine and 5 mg/day olanzapine treatment were started. One week later, fluoxetine treatment was increased to 40 mg and olanzapine treatment was increased to 10 mg per day. Approximately 4 weeks later, the patient's symptoms and level of functioning were increased. Her delusional thoughts were lost that she was a sinner and that she would die blindly. There was a partial reduction in the thought that there was burning and dryness in her eyes. The feeling of guilt has disappeared. As a result, the patient's communication with other patients increased. Beck Depression Scale: 11 and Beck Anxiety Scale: 9 were found on the 40th day of hospitalization. Although somatic complaints are commonly used in patients, somatic subtypes of delusional disorder may be overlooked. It is important that the clinical picture of schizophrenia is differentiated from the diagnosis of schizophrenia with a lack of prodromal period, good functioning and complete recovery with treatment. Especially in patients with somatic complaints, delusional disorder should be considered in differential diagnosis.

KEYWORDS

Delusional disorder; somatic subtype; somatic symptoms; differential diagnosis

[Abstract:0087] [Schizophrenia and other psychotic disorders]

Polydipsia and hyponatremia in a schizoaffective disorder: a case report

Dudu Demiröz, İbrahim Taş, Seher Serez Öztürk, Şenay Yıldız Bozdoğan, Sehure Azra Yaşar and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Compulsive water drinking or psychogenic polydipsia (PPD) is a psychiatric condition characterized by drinking water more than normal, which is continuous or habit-free without feeling thirsty. PPD is identified with some psychiatric disorders, especially schizophrenia. In addition, it can be seen in bipolar disorder, psychotic depression, personality disorders, alcohol and drug addiction, organic mental disorders and antipsychotic use. In this report, a case with polydipsia and hyponatremia in schizoaffective disorder will be discussed.

Case presentation: A 56-year-old woman staying in a nursing home. The patient was followed up with schizoaffective disorder for 10 years and was brought to our clinic by the nursing staff with complaints of irritability, increased mobility, drinking too much water, headache and insomnia. The patient was followed up with schizoaffective disorder and his last medication was risperidone 50 mg/14 days and sodium valproate 1250 mg/day. Plasma sodium value of the patient was 109 mEq/L and urine density was 1.005 mEq/lt. Other tests were found to be normal. The patient was carried to the emergency room. The patient was admitted to our clinic, after sodium value was corrected. We found that osmolality was low in urine osmolality test used to differentiate between SIADH and psychogenic polydipsia and we interpreted this result in favor of psychogenic polydipsia. Control urine density was 1.025 and blood sodium value was 135 mEq/lt. the patient was irritated, in full conscience, in complete orientation, having scattered attention with impairment in judgment and reality testing. The patient had

KEYWORDS

Psychogenic polydipsia; hyponatremia; fluid restriction

insomnia and he felt his abdomen full of water. Daily controlled fluid restriction was performed. Hyponatremia was not observed in the follow-up. Current hyponatremia status is evaluated depending on polydipsia, so that quetiapine and chlorpromazine 100 mg/day were added to the treatment of the patient. The quetiapine dose was increased to 400 mg/day. During his follow-ups, drinking behavior regressed. The patient was discharged after the improvement of his complaints. In most cases, fluid restriction is sufficient in the treatment of water intoxication. But, in severe cases, hypertonic saline solutions are recommended. Clonidine and enalapril are reported to have positive effects on serum sodium and urine output. In the literature, cases of polydipsia treated with quetiapine and risperidone have been reported. In our patient, hypertonic saline solution was used in the acute period. Effective fluid restriction has been made. In our patient, there was no abnormality in laboratory values after fluid restriction and it was interpreted in favor of psychogenic polydipsia. Quetiapine added to the current treatment may have contributed to correcting hyponatremia. Polydipsia and polyuria may occur in psychiatric disorders. This causes hyponatremic encephalopathy, which is sometimes associated with morbidity and mortality. Therefore, it is important to follow the patients' water intake.

[Abstract:0099] [ADHD]

Severe hyperthermia after administration of methylphenidate in a 7-year-old boy

Ömer Yolcu, Özge Gizli Çoban, Özüm Yolcu and Aslı Sürer Adanır

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Methylphenidate is used for management of attention-deficit/hyperactivity disorder (ADHD) in children. It is generally well tolerated and safe, but rarely associated with severe adverse effects such as physical retardation or sudden death. Less is known about its potential for inducing hyperthermia. There are only 4 reported cases of severe hyperthermia probably induced by methylphenidate in the literature. Although the underlying mechanism of methylphenidate producing this adverse effect remains largely uncertain, methylphenidate is structurally and pharmacologically close to amphetamine like substances, abuse of which can induce severe hyperthermia. Here, we report a 7-year-old boy with autism spectrum disorder (ASD) and ADHD, who developed severe hyperthermia after the introduction of methylphenidate, showed recovery after the cessation of the drug, and developed fever again with the re-prescription of it.

Case presentation: A 7 -year-old boy with ASD and ADHD presented to our outpatient unit. His parents reported that he was on long-acting methylphenidate 10 mg treatment (Medikinet retard®) for 2 months, and his behavioral symptoms were ameliorated with it, but he had wavy fever since then. The body temperature increased during the day, and decreased at night. Examinations and questioning of the parents ruled out infections, inflammatory diseases, familial Mediterranean fever, or other medications except methylphenidate. Upon questioning and medical reports, it was learned that he presented to the emergency unit with severe fever 2 years ago, while he had been taking short-acting methylphenidate 2×5 mg (Ritalin®) for 10 days. As his all examinations, laboratory tests and screenings were normal, he was discharged with anti-inflammatory drugs prescription. But his parents couldn't have reduced fever at home for fallowing 10 days. He presented to emergency unit again and methylphenidate had been stopped to exclude the drug fever. Fever in this pattern did not recur then. The fever was attributed to methylphenidate once more and it was stopped. Fever remitted quickly then. He is on atomoxetine and risperidone treatment now, without any complaint of fever. There are only 4 cases about severe hyperthermia associated with methylphenidate in the literature. Most of the cases are about children with brain injury and/or developmental mental disorders. First case was a 1-year-old girl with hypoxic-ischemic encephalopathy. Methylphenidate was administered for its antihypnotic action, outside the usual indications, as her circadian rhythm was irregular. The second case was a 10-year-old boy with autism who had developed neuroleptic malignant syndrome after haloperidol injection. Receiving a single dose of methylphenidate (5 mg), he subsequently developed fever. The third one is a 9-year-old boy with moderate intellectual disability. However, in the last case reported by Talbot and Ahuja about a 15-year-old girl, developed a kind of acute drug reaction including hyperthermia with 10 mg methylphenidate, no specific risk factors were mentioned. Although this adverse event is very rare, prescription of methylphenidate should be monitored in subjects especially with recent adverse reaction to antipsychotics, brain injuries and developmental disorders. Further work is required to clarify the mechanism of this adverse effect.

KEYWORDS

Methylphenidate; hyperthermia; attention-deficit/ hyperactivity disorder

[Abstract:0101] [Psychosomatic medicine – liaison psychiatry]

Thalamic cystic lesion with somatic delusions: a case report

Tansu Eda Topaloğlu[a], Yaşan Bilge Şair[a], Ahmet Şair[b] and Levent Sevinçok[a]

[a]Department of Psychiatry, Adnan Menderes University School of Medicine, Aydin, Turkey; [b]Department of Neurology, Adnan Menderes University School of Medicine, Aydin, Turkey

ABSTRACT

Thalamus has a crucial role in processing all the motor and sensory information and transfers them to the cortical, subcortical and cerebellar structures. Thalamic nuclei are also responsible for the development and maintenance of body image, for controlling attention, sleep-wake cycle and monitoring and modulating the neurochemicals in the brain. Thalamic lesions can cause several psychiatric symptoms such as thalamic tumors and infarction.

Case presentation: Here we present a case having resistant somatic delusions which might be related to a left-sided benign thalamic cyst. A fifty-two years old, man was admitted to psychiatry unit with the thoughts of an extra bone growing into the tibia of his right leg, abdominal distention due to an air leakage from a supposed hole in the intestines, feeling of air, water and feces moving across the right side of his body. His first complaints began one year ago with an abrupt fainting and loss of consciousness when has a worker abroad. Neurological, Orthopedics, gastroenterological, and neurosurgical examinations revealed no abnormalities and therefore the patient was referred to psychiatry department. At his first assessment he did not have insight. His functionality was decreased, and he was preoccupied with these somatic complaints. There was no cognitive impairment and any affective disturbances. In the cranial MRI, there was a cystic lesion in the posterior left thalamus including pulvinar and ventral posterolateral nuclei. Following psychiatric and neurological examination, the somatic delusions, and tactile hallucinations were thought to be related to this left-sided thalamic cystic lesion. Surgical intervention was not recommended. We started amisulpiride up to 800 mg/day, Since there was no improvement with a three months of amisulpride treatment, we switched to clozapine up to 100 mg/day, and zuclopenthixol, 3 mg/day. Autopsy findings of schizophrenic patients demonstrated a reduction in the volume of mediodorsal nucleus (MDN) in the thalamus. Thalamus was known to be one of the major areas in the physiopathology of schizophrenia. In addition, white-matter projections to the prefrontal cortex appeared to be different in schizophrenic patients. Concordant twin pairs displayed significantly reduced thalamic volume compared with control twins in MRI. Besides changes in the MDN of thalamus in schizophrenic patients, a number of studies reported volume and cell reduction in the pulvinar nucleus of thalamus which has connections with the temporal lobe which is important in visual and possibly auditory attention. Alterations in the MDN and pulvinar nuclei could affect the gating of sensory information, and thus the subjective experiences of the patient, in addition to information processing through thalamo-prefrontal circuits that constitute the belief evaluation system. Indeed, both altered sensory experience and aberrant belief evaluation are implicated in the two factor theory of delusions. We suggested that resistant somatic delusions and tactile hallucinations on the right side of the body developed in association with a cystic lesion which is located at the posterior part of the left thalamus. Because of the region that is located, the pulvinar nuclei is thought to be affected resulting in abnormal assessment of information.

KEYWORDS

Somatic delusions; thalamic cyst; pulvinar nuclei

[Abstract:0103] [Psychopharmacology]

Citalopram induced tardive dyskinesia improved after fluvoxamine treatment

Gamze Uvaçin, Elmas Beyazyüz and Yakup Albayrak

Department of Psychiatry, Tekirdağ Namik Kemal University School of Medicine, Tekirdağ, Turkey

ABSTRACT

Tardive dyskinesia (TD) is an extrapyramidal symptom characterized by involuntary, repetitive, purposeless movements that may affect various regions of the body. It commonly occurs as a side effect of long term use of typical antipsychotics. Besides typical antipsychotics, TD may also develop as a side effect of atypical antipsychotics, some antiemetics, antidepressants, and calcium channel blockers.

The pathophysiology of TD is not yet clear. There are various theories on this subject. These include: dopamine hypersensitivity due to long term postsynaptic dopamine receptor blockage, dysfunction of GABAergic neurons, imbalance between the dopaminergic and cholinergic systems, oxidative stress, altered synaptic plasticity, neurotoxicity, and defective neuroadaptive signaling. The most widely accepted of these theories is dopamine receptor

KEYWORDS

Citalopram; tardive dyskinesia; fluvoxamine; side effect; selective serotonin-reuptake inhibitors

blockage with dopamine antagonists, the most common cause being typical antipsychotics strongly binding to D2 receptors.
Case presentation: This is a case report of a 65-year-old male, who developed symptoms of TD following 8 months of treatment with citalopram 40 mg. A PubMed search revealed one previous case report of citalopram and TD. Citalopram treatment was discontinued. Treatment was continued with fluvoxamine, which differs in receptor profile from other SSRIs and has been reported to regress dyskinetic side effects in other cases. Upon discontinuation of citalopram and switch to fluvoxamine, the symptoms of TD disappeared rapidly. Fluvoxamine also shows agonistic effect towards sigma-1 receptors. In recent times, fluvoxamine has begun to draw more attention, and is especially thought to play a role in the pathophysiology of some psychiatric and neurodegenerative disorders concerning sigma-1 receptors found in the endoplasmic reticulum (ER). Sigma-1 receptors located on the ER are reported to have many functions such as regulation of ion channels such as Ca+2 and K+ channels, inhibition of Ca+2 flow with N-Methyl-D-aspartate (NMDA) receptors, and modulation of the secretion of neurotransmitters such as dopamine. It should also be noted that sigma-1 receptors play an important role in the neuronal plasticity processes. Induction of sigma-1 receptors with fluvoxamine may prevent neuronal death due to ER stress. Along with its serotonin reuptake pump effect, the SSRI fluvoxamine also shows agonistic effect towards sigma-1 receptors. In recent times, fluvoxamine has begun to draw more attention, and is especially thought to play a role in the pathophysiology of some psychiatric and neurodegenerative disorders concerning sigma-1 receptors found in the endoplasmic reticulum (ER). Sigma-1 receptors located on the ER are reported to have many functions such as regulation of ion channels, inhibition of Ca+2 flow with N-Methyl-D-aspartate(NMDA) receptors, and modulation of the secretion of neurotransmitters such as dopamine. It should also be noted that sigma-1 receptors play an important role in the neuronal plasticity processes. Induction of sigma-1 receptors with fluvoxamine may prevent neuronal death due to ER stress. Our patient, whose akathisia and TD were thought to be associated with citalopram, significantly improved with fluvoxamine treatment. These findings, which are consistent with the literature, indicate that more studies should be conducted on the role of sigma receptors in the pathophysiology and treatment of TD and other EPS.

[Abstract:0106] [Schizophrenia and related disorders]

Urinary retention associated with aripiprazole in a 15-year-old boy

Hüseyin Kara[a] and Aslı Sürer Adanır[b]

[a]Department of Psychiatry, Akdeniz University, Antalya, Turkey; [b]Department of Child and Adolescent Psychiatry, Akdeniz University, Antalya, Turkey

ABSTRACT

Urinary retention and voiding dysfunction are rare side effects of second-generation antipsychotics (SGA). Urinary retention is the peripheral anticholinergic side effect of aripiprazole. In an open-labeled aripiprazole study, dysuria was reported in 13 of 300 patients. However, there are a few case reports of urinary retention and voiding difficulty associated with aripiprazole treatment. Urinary retention was reported in one case after aripiprazole initiation and in 4 cases, after the addition of aripiprazole to serotonin reuptake inhibitors. Here we report a 15-year-old boy with psychotic symptoms who manifested urinary retention with aripiprazole. To our knowledge, to date, this is the second case of urinary retention with only-aripiprazole, and the youngest case.
Case presentation: A 15-year-old male patient presented to our outpatient unit with irritability, paranoid delusions, poor content of speech, a decrease in energy and interest, sleep disturbances and not attending school. Aripiprazole 5 mg/day was initiated with the diagnosis of psychotic disorder. After 2 weeks, his symptoms were partially ameliorated, but he reported difficulty in urination. Urine analysis, urine culture and urinary system USG were performed and reported as normal. Aripiprazole dose was divided in half and given twice a day. In his next control visit, he stated no difficulty in urinating, so aripiprazole was increased to 10 mg/day and then 20 mg/day. With 20 mg, his paranoid delusions remitted totally, without any urinary complaints. Acute urinary retention may be of obstructive, infectious, inflammatory, pharmacological or neurological origin. In our patient, these causes were excluded. In addition, there was a temporal associativity between the symptom and the initiation of aripiprazole. Aripiprazole has a lower incidence of side effects than other SGAs. It has a partial agonist effect on D2 and 5-HT1A receptors and has an antagonist effect on 5-HT2A receptors. It also has a low affinity to the adrenergic α1 receptor, histamine H1 receptor, and the muscarinic receptor. 5-HT1A receptors play a role in controlling bladder contractions. The adrenergic α1 receptor promotes the contraction of the neck of the bladder, urethra and prostate to enhance bladder outlet resistance. Therefore, the effects of aripiprazole on these receptors may cause urinary retention. This case highlights the highly disabling urinary side effect of second-generation antipsychotics, in this case Aripiprazole.

KEYWORDS

Anticholinergic; aripiprazole; urinary retention; psychotic disorder

Clinicians who treat acute urinary retention should keep in mind the antipsychotics as a cause. Although it is generally recommended to consider discontinuing the medication, as in our case, urinary retention may be improved by dividing the daily dose in half and giving 2 twice a day. Also, not observing the retention after increasing aripiprazole to 20 mg suggests that tolerance may develop to this side effect over time. Therefore, it may be an alternative solution to divide the dose and increase it slowly, especially in patients with significant benefit. Further studies are required to elucidate the exact pathophysiology involved and medications that could be beneficial in treating this side effect.

[Abstract:0117] [Sleep disorders]

Sleep terror associated with the daytime use of risperidone

Hilal Yazıcı Kopuz, Özge Gizli Çoban, Arif Önder and Aslı Sürer Adanır

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Sleep terror is defined as sudden onset of anxiety during sleep, screaming, repetitive movements in the arms and legs, tachycardia, sweating and mydriasis. The symptoms often subside with age, and therefore, no treatment is required for most children. In some cases, medical treatments may cause parasomnia. In the preschool age, hyperactivity and aggression are most of the reasons to refer to child and adolescent psychiatry out-patient clinic. When behavioral therapies applying with families do not work, medical treatments may be needed. One of the first-line treatment option in the preschool age group is risperidone therapy. Here, we report of a patient who developed sleep terror after risperidone treatment.

Case presentation: A four-year-old boy was referred our outpatient clinic because of hitting his friends, not obey the rules in the school and excessive activity. His parents reported that he was also very active at home. The number of words he could say is limited to 4–5 words. He was found to have retarded development at all the stages according to the AGTE test. Auditory tests were in normal range. He was diagnosed as mild delay in cognitive development and attention-deficit/ hyperactivity disorder. Risperidone 0.25 mg/day in the morning was initiated for aggression. According to his parents, after risperidone treatment, he started to scream, cry and flutter himself 2 h later after falling asleep every night. They expressed that it took almost 10 min. When his parents tried to speak with him, he did not respond. Risperidone treatment was discontinued and the family was informed about sleep terror. Sleep terror did not recur after drug release. Numerous drugs used in the treatment of psychiatric disorders affect the sleep pattern of children. It is known that psychiatric drugs can cause insomnia, excessive drowsiness, nightmares and parasomnia [1]. It is known that antipsychotic drugs facilitate sleep transition through dopamine, serotonin, alpha-adrenergic, histamine and cholinergic receptor blockade and increase the amount of sleep. On the other hand, psychostimulants used in the treatment of ADHD delay falling asleep by increasing noradrenaline and dopamine at synaptic junction. The development of sleep terror with low-dose risperidone is extremely rare in the literature. One of the case in the literature, a 35-year-old female patient with Tourette syndrome was reported to develop sleep terror after 4 mg/day risperidone of evening dose. In another case, a 37-year-old male patient with a diagnosis of schizophrenia was reported sleep terror at 8th day after taking 6 mg/day risperidone evening dose. In both of the cases, after dividing the daily risperidone dosage into two doses, the symptoms did notrecur.[2] To our knowledge, this is the first reported case of developing sleep terror after risperidone daytime use in a child. Future studies are definitely needed to observe this side effects of risperidone.

KEYWORDS

Child; risperidone; sleep terror

[Abstract:0107] [Obsessive-compulsive disorders]

Body dysmorphic disorder with absent insight or a psychosis?

Ali Baran Tanrikulu, Hatice Yardım Özayhan, İbrahim Taş, Berrin Ünal, Osman Ak and Tüba Şerife Elmas

Beyhekim Psychiatry Clinic, Health Sciences University Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Body dysmorphic disorder (BDD) is a body-image disorder that characterized by persistent preoccupations with an imagined or slight flaw in one's appearance. Clinical phenomenology of body dysmorphic disorder was defined by Morselli in 1886, he named this clinical phenomenology as "dysmorphophobia".“Beauty hypochondriasis” was defined by Ladee and

KEYWORDS

Self mutilative behavior; body dysmorphic disorder; dimensional approach

this definition include specialties that are very close to current definition of BDD. In DSM-IV, psychotic and non-psychotic variants of BDD was classified separately: delusional disorder and somatoform disorder. In DSM-5, BDD was classified in "obsessive-compulsive and related disorder" and specifier that characterized by a spectrum of insight was added.
Case presentation: The patient is 33 years old, unmarried, living his the core family. He was brought to the hospital after self mutilative behaviors related to his obsessive preoccupation with his facial appearance and shape of shadow. He presented with delusional intensity beliefs that shape of his shadow was seemed disproportional to him. He tried to make proportional to shape of his shadow by using pliers and picking at his face skin. He had preoccupied with his shadow intensely in last 3 months. His first signs of perceived facial disfigurement especially about his hair and eyebrow begun 8 years ago. He had a hair transplant 5 years ago. He spent 4–6 h per day for looking his face in mirror. He perceived his hair and eyebrow asymmetric, his face ugly and disproportional. His complaints deteriorated after his mother was disabled by CVD 1.5 years ago. His occupational, social functions was very weak. The initial dose of fluoxetine was 20 mg/day. The dose of fluoxetine was then increased to 60 mg/day and olanzapine was added and increased to 10 mg/day. After 6 weeks of inpatient treatment his self mutilative behavior decreased and he understood that shape of his shadow may mislead him about his appearance but he was not stable. In our case, we discussed a BDD patient with absent insight. In pharmacotherapy, relatively higher SRI doses appear to often be needed, and SRI should be taken for at least 12 weeks before determining whether it is efficacious. Delusional BDD appears to respond to SRI monotherapy and additive antipsychotic medications are not effective. Delusional BDD is not a typical psychotic disorder from a treatment perspective. But, we added antipsychotic medication for his self-mutilative behavior.
Dimensional view of delusional thoughts in BDD may be more accurate than categorical view. In DSM-5, separate categorization of psychotic and non-psychotic types of BDD was abandoned. Beside that from treatment perspective higher dose SRI without additive antipsychotic medication is effective for treatment of BDD. İn case of self mutilative behavior antipsychotic medications can be effective in BDD.

[Abstract:0108] [Psychopharmacology]

Auditory hallucinations associated with bupropion use: a case report

Sevda Bağ, Suat Yalçın, Pelin Özkara Menekşeoğlu and Gülşen Teksin Ünal

Department of Neurology, Bakirkoy Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Istanbul, Turkey

ABSTRACT
Bupropion is an antidepressant that acts as a norepinephrine and dopamine reuptake inhibitor and has a favorable side-effect profile. The side effects from bupropion are many; however, cases of psychoses are rare. The dopamine enhancing effect of bupropion has been implicated for inducing perceptual changes and psychosis. We report a case of adult female diagnosed as nicotine abuse that developed bupropion induced hallucinations.
Case presentation: 40 years old female patient. She uses one packed of cigarettes a day for 10 years. the smoking cessation outpatient clinic with the intention of quitting smoking and bupropion started 300 mg/day. At the 15th days an audio-visual hallucinations have begun. The feeling of not being able to sleep with this reason and intense distress has begun. The patient who did not have any previous psychiatric treatment story came back to the cigarette outpatient clinic and presented to our outpatient clinic by requesting psychiatric consultation. He was cooperated an at psychiatric examination there were intense auditory hallucinations in the content of thought. The quality of life has fallen considerably. Bupropion of the patient was stopped and risperidone 2 mg/day was started. After one week hallucinations was stopped and It was thought that auditory hallucinations were related to the bupropion. Our case highlights that bupropion may induce psychosis in individuals who do not have any identified risk factors till now. Therefore, the clinicians should be vigilant about any psychotic symptoms during initiation or dose hike of bupropion in the patients. If any patient develops psychotic symptoms at this stages which could not be explained by the clinical status, the first response should be to stop bupropion.

KEYWORDS
Bupropion; hallucinations; psychosis; nicotine abuse

[Abstract:0124] [Mood disorders]

Post-stroke mania in an elderly patient: a case report

Oktay Kocabaş

Turhal State Hospital, Tokat, Turkey

ABSTRACT

Krauthammer and Klerman described the concept of secondary mania in 1978. Secondary mania may occur following several metabolic, neurological and/or toxic disorders. Elderly adults are at risk for secondary mania because of increased medical comorbidities and neurological changes. Secondary mania can be a rare consequence of cerebrovascular events. In this report, we presented a case with post-stroke mania in an elderly patient.

Case presentation: A 83-year-old, right-handed male patient presented to our outpatient clinic due to reduced need of sleep, increased sexual desire, became talkative, elevated energy, agitation and disinhibition. He also reported some jealousy delusions for his wife. There was no previous history of manic or depressive symptoms. He had past medical history of hypertension and stroke. Manic symptoms emerged 2 years later from cerebrovascular event. There was no significant family history of psychiatric disorders. His serum chemistry, hematology profile, thyroid function tests, urinalysis, and chest X-ray were unremarkable. Magnetic resonance imaging showed chronic infarct regions in right occipital lobe. The total score of Young Mania Rating Scale was 30. The patient started pharmacological therapy with olanzapine 5 mg/day and increased to 10 mg/day that resulted in remission of the symptoms after four weeks. The total score of Young Mania Rating Scale was decreased to 4. Depression is the most common mood disorder after cerebrovascular events at a rate of 50%. However, post-stroke manic episodes are rarely seen. Research shows that manic symptoms may occur immediately after cerebrovascular events and may occur in any period of the first two years. In our case, manic symptoms appeared at the end of two years in accordance with the literature. Previous studies have shown that a close relationship between damaged anatomical regions and neuropsychiatric clinical conditions after cerebrovascular events. Manic symptoms after cerebrovascular events are mostly associated with right hemisphere lesions. However, there are fewer cases of mania in left hemisphere lesions. Our case is a mania which is caused by lesion in the right hemispheric area which is frequently discussed in previous case reports. In conclusion, post-stroke mania causes should be kept in mind in elderly patients with manic symptoms and therefore, patient's medical history, examination and laboratory results should be assessed detailed.

KEYWORDS

Mania; stroke; cerebrovascular events

[Abstract:0125] [Psychopharmacology]

Combination of venlafaxine and agomelatine in the treatment of melancholic depression: a case report

Burak Okumuş[a], Çiçek Hocaoğlu[a] and Ali Mert Beşenek[b]

[a]Department of Psychiatry, Recep Tayyip Erdogan University, Rize, Turkey; [b]Department of Child and Adolescent Psychiatry, Recep Tayyip Erdogan University, Rize, Turkey

ABSTRACT

Broad heterogenity of clinical depression accelerated the studies trying to define sub-types of depression. According to previous studies; melancholic depression is a type of depression which has biological etiology, is un-effected by environmental circumstances, responds to somatic treatments rather than psychotherapy, is more prevalent in individuals without personality pathology and has specific vegetative symptoms (worsening in the mornings, waking up early [two hours earlier than routine waking up hour], significant psychomotor retardation and agitation, losing appetite, weight loss, excessive or inappropriate guilt).Because of having different psychopathology, biology and treatment responses; some authors have proposed different approaches to melancholic depression (1). In this study we aimed to present a 38 years-old female patient with major depressive disorder (MDD) (showing melancholic traits) in the light of the literature knowledge.

Case presentation: The patient is 38 years old, female and married, referred with symptoms of unwillingness, anhedonia, low appetite, and losing 11 kilograms in 1,5–2 months. In the psychiatric examination, she expressed that her symptoms started after giving birth 15 years ago and were similar to current ones. She stated Venlafaxine dosage has been increased and decreased periodically over the 13 years. Her illness periods especially were starting with difficulty in falling asleep, waking up early and difficulty in swallowing. With MDD (with melancholic features) diagnosis according to DSM-5, she received treatment of Venlafaxine 225 mg, Mirtazapine 15 mg for 4 weeks; but because of no response, her Mirtazapine was discontinued and she was started on Agomelatine 25 mg. Significant symptom decrease was observed with this treatment. Compared to non-melancholic depression, melancholia rarely responds to placebos, psychotherapies or social interventions. It is consistent with the literature our case showed melancholic features and had different responses to standard treatment. In addition sleep and circadian rhythm disturbances are often seen in MDD. Hypothalamus, which includes suprachiasmatic nucleus, also regulates eating behavior, sleep and affect. In postpartum depression; circadian irregularity of melatonin, seasonal affective

KEYWORDS

Agomelatine; depression; melancholia; venlafaxine

changes have been reported in different stages of reproductive cycle. In clinical trials; agomelatin added to serotonin and serotonin-noradrenaline re-uptake inhibitors is found effective especially in patients with low response to 4 weeks treatment. Patients followed with 24 months agomelatin treatment that has MDD with melancholic features have reported stable antidepressant effect, good tolerability and no absence syndrome after discontinuation. Our patient's post-partum onset, symptomatology (sleep, eating behaviors and affective changes) and good response to agomelatin addition to Venlafaxine treatment of 4 weeks are congruent with literature. Given the existence of chronobiological disturbances in melancholic depression and evidence regarding their treatment in improving depression, a chronobiological approach, including timely use of light and melatonin agonists, could complement the treatment of MDD. Bearing in mind the recent information; it can be said that melancholic depression is a different sub-type of depression regarding both clinical and biological aspects. However it is clear that new studies which focus on biological signs and effective treatments are needed.

[Abstract:0128] [Psychopharmacology]

Oral megadose aripiprazole ingestion for suicide attempt in a 16-year-old girl

Mihriban Ünay, Aslı Sürer Adanır, Arif Önder, Esin Özatalay and Özge Gizli Çoban

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Aripiprazole is a second-generation antipsychotic drug (1). It acts as a partial agonist at the dopamine D2 and serotonin 5-HT1A receptors and as an antagonist at serotonin 5-HT2A receptors. In children, it is commonly used for treatment of conditions such as bipolar disorder, schizophrenia, depression, and autism spectrum disorder (ASD) (2). Despite the fact that aripiprazole is one of the most prescribed antipsychotic drugs, there is only limited literature on aripiprazole overdose, especially in children. It is generally well tolerated in comparison with other second-generation antipsychotics, and it seems to have fewer harmful effects in overdose (3). Sedation and tachycardia were the most prevalent symptoms (4). Here, we report a pediatric patient with ASD who developed acute dystonia following aripiprazole overdose.

Case presentation: A 16-year-old girl presented to emergency service of our hospital because of suicide attempt with 105 mg aripiprazole. She had been diagnosed as having unipolar depression 8 months ago and had been on medication of fluoxetine since then, and aripiprazole was added in her last control visit. That day she argued with her parents and impulsively tried to commit suicide with 21 of 5 mg (totally 105 mg) aripiprazole tablets. One and a half hours after ingestion, her family recognized the situation and brought her immediately to emergency service, where she underwent active charcoal and gastric lavage. The child's mental status was clear on examination, only sedation and tachycardia were observed; her neurological examination, blood pressure, respiration rate and all laboratory analyses were between normal levels. No additional therapy was needed and she was discharged after 24 h' observation.

Despite the fact that aripiprazole is one of the most prescribed antipsychotic drugs, there is only limited literature on aripiprazole overdose, especially in children. There are only 2 cases, one of them was a 14-year-old boy with ASD who developed acute dystonia following aripiprazole overdose (5); and the second was a two-year-old patient with persisting lethargy and intention tremor after reported ingestion of 10 mg of aripiprazole (6). Ingestion of aripiprazole in overdose was generally well tolerated and caused no short-term fatalities. In a study based on 239 cases of aripiprazole exposure, no severe cardiotoxicity was seen in the single-drug exposure group and none of the reported cases were lethal (4). The most prevalent symptom is light somnolence, probably because of the antagonistic effect of aripiprazole on the histamine H1 receptor and the second-most prevalent clinical sign was tachycardia, as it was in our case.

In conclusion, aripiprazole is generally well tolerated in comparison with other second-generation antipsychotics, and overdose of aripiprazole has few and mild symptoms predominantly related to the sedative properties. However, further studies are needed for the safety of the drug at overdoses, especially in children.

KEYWORDS

Adolescence; antipsychotic drug; aripiprazole; suicide attempt

[Abstract:0133] [Psychopharmacology]

Raynaud's phenomenon related with atomoxetine treatment in a child with autism and attention-deficit/ hyperactivity disorder

Ali Karayağmurlu, Zeynep Nur Gülle and Murat Coşkun

Department of Child and Adolescent Psychiatry, Istanbul University, Istanbul, Turkey

ABSTRACT

Raynaud's Phenomenon (RP) is an episodic vasospasm of small arteries and arterioles, involving usually the digital arteries in fingers and toes. It is characterized by pallor, cyanosis and rubor, often accompanied by pain. RF may be an important condition as may lead to gangrene and loss of function. Atomoxetine (ATX) is a non-stimulant medication used to treat symptoms of Attention-deficit/ hyperactivity disorder (ADHD). Here, we aimed to report a case of RP due to Atomoxetine monotherapy.

Case presentation: This case report describes a patient with ASD in whom Raynaud's Phenomenon developed with Atomoxetine two days after increasing dosage and disappeared Raynaud's Phenomenon on the same day after discontinuation of the drug therapy. The patient is a 7 years- old boy diagnosed with autism spectrum disorder (ASD) at age 4 presented with his mother due to behavioral problems including hyperactivity, impulsivity and aggressive behaviors towards his peers. Patient's history, teacher's report and psychiatric examination revealed that he has significant ADHD symptoms. His current psychiatric examination confirmed diagnosis of ASD and ADHD. Upon diagnosis of ADHD he was started atomoxetine (ATX) 10 mg/day at morning which was increased to 18 mg/day after one week. In the next visit, two weeks later, no significant side effects reported and dosage was increased to 28 mg/day. Two days later starting ATX 28 mg/day the mother reported, on a phone call, that he had pallor and cooling on his fingers of both hands and circumoral cyanosis that emerged one hour later with the first dose of ATX 28 mg/day and lasted for two days. He was consulted to pediatric rheumatology with the suspicion of RP. The results of the laboratory investigations revealed that Antinuclear antibodies (ANA) was negative, erythrocyte sedimentation rate: 8 mm/hr, Anti-complement C3 antibody: 139 mg/dl (90–200) and Anti-complement C4 antibody: 17 mg/dl (20–40). No underlying pathology was found in the patient and secondary RP was diagnosed by the department of pediatric rheumatology. Discontinuation of ATX treatment was recommended. The symptoms totally disappeared two hours later the discontinuation. Although RP is considered a rare adverse effect clinicians should be careful about developing this condition during ATX treatment as it may lead treatment non-compliance and physical health risks particularly in subjects with limited verbal and/or mental capacity.

KEYWORDS

Adverse effect; Raynaud's phenomenon; atomoxetine; autism

[Abstract:0135] [Other]

Psychotic symptoms associated with montelukast in a 21-month-old girl

Gülseren Taşkıran[a], Aslı Sürer Adanır[b] and Perihan Turhan Gürbüz[b]

[a]Department of Child and Adolescent Psychiatry, Antalya Research and Training Hospital, Antalya, Turkey; [b]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Montelukast is a cysteinyl leukotriene- receptor antagonist that provides clinical benefit in the treatment of asthma and allergic rhinitis both in adults and children (as young as 6 months of age). Oral montelukast is generally well tolerated, but infants and young children seem to be prone to sleep disturbances, whereas older children and adolescents present depressive and anxiety symptoms and psychotic reactions. Here we report a 21-month-old girl manifested psychotic symptoms with montelukast, and showed recovery after the cessation of drug.

Case presentation: A 21-month-old girl was referred to our outpatient unit with agitation and fear symptoms and sleep disturbance. She began to fear from almost everything 1 month ago, be irritable and anxious, did not want to sleep; and her parents had severe difficulty in calming her down and make her sleep. For the last 2 days, she began to look at the walls with fear, as if she was seeing something scary, and cry. She also seemed to hostile to her baby doll. Family did not mention any physical or emotional trauma or any changes in the lifestyle. Her laboratory tests, neurological examination, cranial MRI and EEG were normal. It was learned that she had been diagnosed as asthma and bronchiolitis and been on montelukast 4 mg/day treatment for 2 months. Her clinical situation was evaluated as a psychotic process, with hallucinations, hostility and aggression. As montelukast had been known to cause hallucinations psychotic reactions, it was stopped and her symptoms ameliorated in a month without any psychiatric medication. In 2008, the FDA issued a warning about an increased risk of neuropsychiatric events associated with the use of leukotriene receptor antagonists, after reviewing all the information from the clinical trials and some post-marketing cases and issued an update in the "precautions" section of the prescribing information to include neuropsychiatric events reported in patients using these product. Since then, a strong association was shown between the use of montelukast and reports of psychiatric symptoms, especially in those aged 2–11 years. Sleep terror and nightmares were the most frequently reported psychiatric ADRs, especially in preschool children, but in the literature, there is only one case of hallucinations associated with montelukast; a case of a 13-year-old patient who

KEYWORDS

Aggression; hallucinations; montelukast; toddler

had visual hallucinations with montelukast, which disappeared within 48 h after the cessation of drug. Our case is the second in this point of view, and the youngest one. We did not reintroduce the drug for verification of the diagnosis because of the severe pattern of side effects and patient's age, but we believe in a strong association as her age was too young even for very early-onset schizophrenia, there was no family history about it, and a complete recovery was observed after the cessation of the drug. Although montelukast is considered as a safe drug in general, psychiatric adverse reactions should not be dismissed, especially in preschool children with change in temperament and agitation.

[Abstract:0136] [Addictions]

Oxybutynin addiction of 3 cases

Özge Gizli Çoban[a], Özge Demircan Tulacı[b] and Aslı Sürer Adanır[c]

[a]Department of Child And Adolescent Psychiatry, Uşak University School of Medicine, Uşak, Turkey; [b]Child and Adolescent Psychiatry Clinic, Balıkesir State Hospital, Balıkesir, Turkey; [c]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Oxybutynin is widely used for the treatment of overactive bladder. It has anticholinergic, antispasmodic and muscle relevant effects. Other anticholinergics such as biperiden mostly are used for prophylaxis and relieve extrapyramidal symptoms caused by antipsychotics. Biperiden and other anticholinergic agents are potential drugs of abuse. It may be because they induce euphoria and increase sociability and energy through an increase of dopaminergic activity. We present 3 cases with oxybutynin abuse.

Case presentation: Case 1: A 15-year-old girl presented to our outpatient clinic. She told that she had begun to use oxybutynin which was prescribed for enuresis for her brother. She started to take 25–30 mg/day oxybutynin last year and she gradually increased the dose 50–60 mg/day to get higher. While taking oxybutynin, she reported that she had experience visual and sensory hallucinations. Her parents told that she usually skipped the school, never obeyed the rules, argued with her teachers. She was diagnosed as "Conduct Disorder" and aripiprazole 5 mg was prescribed. In the follow up her symptoms improved and she reported that she hadn't been taking oxybutynin for the last 2 months.

Case 2: A 15-year-old girl, at the same class with "case 1" presented to our outpatient clinic. She told that she heard from her friend that oxybutynin made people more sociable. She described herself as shy that she could not make friendship easily. When she took oxybutynin she felt more comfortable and her social interactions increased. She was diagnosed as "Social Anxiety Disorder" and fluoxetine 20 mg was prescribed. In the follow up, she became more social in her friendships.

Case 3: A 17-year-old boy was consulted by pediatrician. He told that he had been used oxybutynin with his friend to get higher for six months. Initially, he took 50 mg/day oxybutynin and he increased the dose 75–100 mg/day to get higher. He experienced visual and sensory hallucinations when he took the drug. He said that 3 days ago he had taken 100 mg/day oxybutynin with his friend and took 100 mg more and lost his consciousness then. He clarified that he had taken more to get higher, not as an suicide attempt. After all, his parents presented him to emergency unit and he was treated in intensive care unit. He told that he was afraid and would never use oxybutynin again. In the follow up, motivational interventions were administered to him. Oxybutynin has anticholinergic properties, which is used for overactive bladder. Oxybutynin passes the blood-brain barrier and psychological and personality changes may be seen. Anticholinergic drugs seem to induce rapid tolerance to the euphoria effects that promotes the abuse and dependence mechanisms. We also describe here 3 cases of oxybutynin abuse. Anticholinergics may be abused to elevate the mood and get high. The possible mechanism that the blockade of the cholinergic receptors enhances striatal dopamine release. The resulting dopaminergic hyperactivity could be responsible for the euphoria and elevated mood. Clinicians are mostly aware of the misuse of biperiden. In conclusion, clinicians also should be aware of the misuse potential of oxybutynin.

KEYWORDS

Abuse; adolescent; children; oxybutynin

[Abstract:0138] [PTSD]

Eye movement desensitization and reprocessing (EMDR) treatment for a patient diagnosed with post-traumatic stress disorder after sexual abuse

Hüsna Kaan, Ali Karayağmurlu and Nusret Soylu

Department of Child and Adolescent Psychiatry, Istanbul University, Istanbul, Turkey

ABSTRACT

Eye movements and desensitization and reprocessing (EMDR) is an effective treatment method used in posttraumatic stress disorder that combines well-known elements of the different approaches such as psychodynamic, cognitive, behavioral and client-centered approach. Posttraumatic stress disorder (PTSD) can be seen with neurodevelopmental disorders such as Attention-deficit/ hyperactivity disorder (ADHD) and Intellectual Disability and may be difficult to treat in the presence of comorbidity. We aimed to report a case of treatment with EMDR in a 16-year-old patient with the diagnosis of ADHD and Borderline Mental Capacity (BMC).

Case presentation: A 16 year-old male patient living with his family was referred to our outpatient's clinic with the complaints of restlessness, quick temper, sudden awakening from sleep, remembering events again, nightmares and not enjoying life. According to the information received from the patient, he had been sexually abused by his two friends six years ago and five years later his complaints were started and were increased in the last six months. He was diagnosed with PTSD according to the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5). According to his medical history, the child was followed-up with the diagnosis of ADHD and BMC in our clinic between 2012 and 2018. Drug therapy with fluoxetine 20 mg/day was initiated and EMDR treatment was suggested. One EMDR session was administered and PTSD symptoms regressed after the treatment. Keeping in mind that EMDR is an applicable and effective treatment option for PTSD symptoms in patients with ADHD and BMC comorbidity might aid clinicians for treatment and follow-up.

KEYWORDS

EMDR; adolescent; posttraumatic stress disorder; ADHD

[Abstract:0139] [Autism spectrum disorders]

Clozapine induced enuresis nocturna in a child with autism spectrum disorder

Özgün Türe Tekin, Mustafa Dinçer, Mustafa Şahin, Yasemin Taş Torun, Şahin Bodur, Hesna Gül, Dursun Karaman, İbrahim Durukan and Mehmet Ayhan Cöngöloğlu

Child and Adolescent Psychiatry Department, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey

ABSTRACT

Autism spectrum disorders (ASD) are neurodevelopmental disorders including core symptoms with repetitive, stereotyped behavior, and social communication disabilities. Many patients with ASD have irritability and disruptive behaviors like aggressiveness, temper tantrums, or self-injury interfere with their socializations, their learning abilities, adaptive functioning and lead to distress in affected individuals and their caregivers. Clozapine's anti-aggressive effect was most commonly explored in patients with schizophrenia, with less evidence available for other psychiatric disorders, including autistic spectrum disorders, posttraumatic stress disorder and mood disorders. Clozapine as a treatment option in children with ASD with such difficult to treat events. Nocturnal enuresis is reported in 0.23–30% of patients taking clozapine. Still, it is most probably under-reported and underdiagnosed as patients are embarrassed and ashamed of admitting to having it and physicians avoid asking about it. In this case report, we describe clozapine-treated adolescent with ASD and show enuresis nocturna which occurs after the clozapine's dose increased 200 mg/day and remission in 3 weeks.

Case presentation: 12 year old child with typical autism who developed severe disruptive behaviors, violence and aggression while taking olanzapine 30 mg/day, risperidone 2 mg/day and aripiprazole 10 mg/day. All antipsychotic treatment of the patient was stopped by reducing. Clozapine was started. Hypersalivation that began in the first week of treatment continued during the treatment period. At the 13th week of clozapine treatment, the patient developed enuresis nocturna after the dose increased from 150 mg/day to 200 mg/day due to disruptive behaviors, violence, and aggression. 3 weeks without doing anything in clinical follow-up enuresis nocturna entered into remission. Severe disruptive behaviors, violence and aggression of patient decreased with clozapine 250 mg/day.

The serotonergic system may have a role in the biology of impulsivity and aggression therefore clozapine's effectiveness in aggressive behaviors is taken into account to be linked to its complex receptor binding affinities for D2, D4, and, particularly, 5-HT2A receptors. Clozapine is the drug the most reported antipsychotic in urinary incontinence and there has been estimation about the relevance of its cholinergic mechanisms, including agonist activity at muscarinic M4 receptors. Several mechanisms have been suggested to cause nocturnal enuresis among patients taking clozapine medications. Particularly, it has been suggested that the potent anticholinergic action of clozapine may lead to urinary retention and following overflow incontinence. Sometimes, it may be a result of clozapine's seizure threshold-lowering property, which causes seizures during sleep. Clozapine may induce diabetes mellitus and secondary polyuria that occurs during the night. Diabetes insipidus has also been related to clozapine treatment in several cases. In literature, similar to our patient, most of incontinence cases occurred in the first 3 months of clozapine treatment and resolved spontaneously. If clozapine-related

KEYWORDS

Enuresis; clozapine; autism; side effects; disruptive behavior

incontinence is stage specific and self-limited, such conservative measures or insomuch that passive approach of "wait-and-see" may sufficient. In persistent clozapine-induced enuresis, drugs such as desmopressin, oxybutynin and trihexiphenidyl have been suggested.

[Abstract:0147] [Psychopharmacology]

Epistaxis triggered with risperidone use

Selçuk Dalyan, Özge Gizli Çoban, Arif Önder and Aslı Sürer Adanır

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Risperidone is one of the most commonly used atypical antipsychotics. There is also a 5HT2A receptor blockage effect in addition to strong D2 receptor antagonism. The most commonly used treatments for Attention-deficit/ hyperactivity disorder (ADHD) are methylphenidate and atomoxetine, which have been approved for use by the FDA over the age of 6 years. Besides that it is reported that use of additional risperidone treatment reduced aggressive and disruptive behaviors. In this article, epistaxis with risperidone will be discussed in a patient with ADHD.

Case Presentation: A 9-year-old boy was admitted to our outpatient clinic with hitting his friends, difficulties with focusing and sitting, taking risks, playing with fire, harming animals and sleep problems. His parents reported that he was referred to the out-patient clinic with the same complaints 2 years ago. It was reported that short and long-release methylphenidate was used but the medications were discontinued because of unresponsiveness to treatment. In our clinical examination, it was observed that he had excessive motor activity, he tampered with the items in the room and his attention span was short. He answered questions very short and quick. When he was asked to read, he read very fast and he skipped words and lines. As a result of clinical evaluation and administered scales, ADHD was diagnosed and long acting methylphenidate treatment was started with 10 mg/day. Methylphenidate dose increased to 40 mg/day at subsequent controls. After improving symptoms with 40 mg methylphenidate treatment, one month later the efficacy of the drug decreased and behavior problems increased. It was considered as treatment-resistant ADHD so that 25 mg/day atomoxetine and 0.5 mg/day risperidone was added. Epistaxis was described for 4 days after the first day of risperidone and atomoxetine use. Blood tests (hemogram, liver function tests, prothrombin time, activated prothrombin time), blood pressure and heart rate measurements were found to be normal. Risperidone treatment was discontinued and treatment was continued with atomoxetine 25 mg/day and long-acting methylphenidate 40 mg/day. Epistaxis did not recur again with this treatment. One week later, quetiapine 25 mg was added for sleep problems. One month later, the patient under treatment of methylphenidate 40 mg, atomoxetine 25 mg and quetiapine 25 mg presented reduction of inattention, excessive mobility and disruptive behaviors. The patient is being followed regularly in our outpatient clinic. Thrombocytopenia is a rare side effect of atypical antipsychotics, which has also been reported during risperidone use. However, in our case, platelet counts are within normal limits. Studies have shown that 5HT-2A antagonism has vasodilatation effects and it blocks platelet aggregation. Risperidone has a potent 5HT2A antagonist effect. Therefore, in our case, it is thought that epistaxis caused by risperidone's vasodilatation effect. The fact that epistaxis does not recur with the discontinuation of risperidone supports this idea. Clinicians should be aware of this side effect of risperidone in terms of early diagnosis and intervention.

Clinicians should be aware of this side effect of risperidone in terms of early diagnosis and intervention.

KEYWORDS

Risperidone; epistaxis; ADHD

[Abstract:0148] [Psychopharmacology]

Emergence of tics during escitalopram treatment in an adolescent boy

Gökçe Sultan Uncu and Ali Karayağmurlu

Department of Child and Adolescent Psychiatry, Istanbul University School of Medicine, Istanbul, Turkey

ABSTRACT

Escitalopram(ESC) is a highly selective serotonin reuptake inhibitor that is used in the treatment of anxiety disorders. ESC is well tolerated and safe but its use has been rarely implicated in the etiology of movement disorders, including motor tics. We aimed to report a patient who developed simple motor tics in a dose dependent manner during ESC monotherapy.

KEYWORDS

Tic; escitalopram; adverse effect

Case presentation: A 12 year old boy presented with persistent and excessive worry and is subsequently diagnosed with generalized anxiety disorder in accordance to DSM-5 criteria. ESC was initiated at 10 mg/day and increased to 20 mg/day due to partial response. After a two month remission, involuntary eye twitching movements emerged. ESC was discontinued which led to resolution of motor tics. Due to relapse of GAD, patient was started on sertraline 50 mg/day without tic recurrence. Our case scored 8 (probable) on Naranjo Adverse Drug Reaction Probability Scale. To our knowledge motor tics due to ESC use are rare, with only a few cases reported in the literature. It would be useful that clinicians should be aware about developing this condition during ESC treatment.

[Abstract:0150] [Other]

Tinnitus probably associated with atomoxetine in a 15-year-old boy

Zehra Ece Soğucak[a], Aslı Sürer Adanır[b] and Özge Gizli Çoban[b]

[a]Health Sciences University, Tepecik Research and Training Hospital, Izmir, Turkey; [b]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Attention deficit-hyperactivity disorder (ADHD) is defined by a persistent pattern of inattentive or hyperactive-impulsive symptoms that cause significant impairment in social, academic, or occupational functioning. Evidence shows that pharmacologic treatments improve functional outcomes in children with ADHD. Stimulants and atomoxetine are the mostly used agents for ADHD in children.

Tinnitus is defined as a perception of a sound without an external acoustic source. People with tinnitus often describe it as a perception of ringing, whistling or buzzing in one or both ears. It can be persistent, intermittent, or throbbing, depending on the cause. Here we report a 15-year-old boy who had tinnitus with atomoxetine and showed recovery with long-acting methylphenidate (Medikinet retard®), without any adverse effect.

Case presentation: A 15-year-old boy was presented to our outpatient unit with complaints of attention deficit and aggression. It was learned that he had been diagnosed as dyslexia, oppositional defiant disorder, and ADHD and had been on atomoxetine 60 mg and aripiprazole 30 mg treatment, but he stopped atomoxetine because of tinnitus. His complaint disappeared after the cessation of drug. His otorhinolaryngology examination and audiological tests were reported as normal. He and his family did not mention any physical or auditory trauma, and other illness or changes in the lifestyle. After his psychiatric examination, long-acting methylphenidate 20 mg (Medikinet retard®), was prescribed, and aripiprazole was decreased to 20 mg/day. In his next visit, he reported partial response to methylphenidate 20 mg without any adverse effect. It was increased to 30 and then 40 mg, until complete response was gained. He is on methylphenidate 40 mg and aripiprazole 20 mg without any complaints. Atomoxetine is a non-stimulatory agent used in the treatment of ADHD. Atomoxetine has been shown to be superior to placebo in many studies conducted with children and adolescents. The most common side effects reported in children and adolescents are abdominal pain, loss of appetite, vomiting, drowsiness, irritability, malaise, dizziness and dyspepsia. To our knowledge, to date, there is not any case of tinnitus reported with atomoxetine. Unfortunately, we could not reintroduce the drug for verification of the diagnosis because he and his family did not give consent for it, but we believe in an association as his otorhinolaryngological and audiological examinations are normal and a complete recovery of tinnitus was observed after the cessation of the drug. Although atomoxetine is considered as a safe drug in general, it should be noted that this side effect may also be present in clinical practice.

KEYWORDS

Atomoxetine; tinnitus; ADHD

[Abstract:0152] [Schizophrenia and other psychotic disorders]

A case of schizophrenia with recurrent hyponatremia attacks and hypercortisolemia

Özgen Demireğen Özçelik, Hüseyin Kara and Başak Özge

Department of Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Schizophrenia is a public health problem that starts in youth, whose course of departure and termination varies from patient to patient and leads to a great extent of disability. Many factors have been predicted to be effective in the development of schizophrenia in an individual. One of these factors is thought to be the hypothalamic-pituitary hormonal axis. In

KEYWORDS

Hyponatremia; hypercortisolemia; antipsychotic treatment; pituitary-hypogonadal axis

particular, it is suggested that hormones involved in metabolic regulation are one of the factors that trigger schizophrenia. In a 2007 study, cortisol-dehydroepiandrosterone (DHEAS) levels in schizophrenia and bipolar patients were significantly higher than in the normal population. A case with schizophrenia and cortisol elevation was reported to have improved schizophrenia symptoms after adrenalectomy. In contrast to these data, in recent studies, findings suggesting that unhealthy nutrition is affected by stress in early psychoses, but the data do not support this effect mediated by hypercortisolism. In this case, we aimed to discuss a patient who had a history of hospitalization due to hyponatremia whose symptoms could not be suppressed with antipsychotic treatments but a high cortisol level was also detected.

Case presentation: A 44-year-old female patient was followed up with a diagnosis of schizophrenia for 20 years. She is also diagnosed with diabetes and hypothyroidism. The patient's complaints started in a commanding manner, as if he had heard a sound in his ears, a snake in his nose, and a feeling of electricity circulating in his body. The voices she heard tell her to drink a lot of water and eat less. When the patient's previous treatment scores were evaluated, nephrology hospitalization was found in 2015 with the diagnosis of inappropriate antidiuretic hormone release. At that time of hospitalization, the sodium value was found to be 111 ng/dl. At that time, the patient was treated with fluid restriction and cessation of treatment (quetiapine). In 2018, the patient was taken to the emergency room due to a feeling of worsening and fainting, and a decrease in sodium was observed in his blood test (sodium value: 110) because of the hyponatremia. The patient who had drug incompatibility for the last 2 months had an increase in paranoid thoughts in his auditory and visual hallucinations 2 weeks before his admission.

Cortisol levels were measured as 36ug/dL (normal range: 4.3–22.436 ug/dL).The patient who had hyperpigmentation on his face and TSH was found to be low, was consulted with endocrinology for multiple endocrinopathies. 1 mg dexamethasone suppression test was performed for differential diagnosis. As a result of 1 mg DST test, the diagnosis of Cushing was excluded. The patient had psychogenic polydipsia which was thought to be related to auditory hallucinations. It was observed that the sodium value was below the limit value (Na: 134; K: 4,81; Cl: 109).The cortisol value of the patient was 1.398 g/dL (normal range 4.3–22.436 ug/dL). Hyponatremia is a common condition in patients with antipsychotic use. The addition of cortisol levels to the hyponatremia clinic in this patient is a reminder of the importance of endocrine pathologies in patients with schizophrenia who have antipsychotics.

[Abstract:0158] [Autism spectrum disorders]

Coffin-Siris syndrome and autism: a rare combination

Nur Seda Gülcü and Ali Karayağmurlu

Department of Child and Adolescent Psychiatry, Istanbul University School of Medicine, Istanbul, Turkey

ABSTRACT

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that stars early in life, can last lifelong and characterized by persistent deficits in social communication and social interaction and restricted, repetitive patterns of behavior, interests, and activities. Several factors play role in the etiology of autism. One of the most important factors is genetic factors. Coffin-Siris syndrome is a genetic syndrome characterized by mental retardation, rough facial appearance, hirsutism/ hypertrichosis or sparse hairy skin, aplasia or hypoplasia of distal phalanx, 5th finger nail anomalies. In addition, congenital anomalies, heart, genitourinary, gastrointestinal and craniofacial anomalies, ophthalmological problems and hearing abnormalities may be accompanied by feeding difficulties. Here, we aimed to report a case with diagnosis of ASD and Coffin-Siris syndrome with ARID1B mutation.

Case presentation: A.K. is a 2-year-old, 10-month-old male child. Due to lack of speech, the patient was consulted with child and adolescent psychiatry by genetic department. According to the anamnesis obtained from the caregivers, he had not played with peers, had not responded back when his name was called and had not showed something for interest. There had not been connection with facial expression, eye contact and affective sharing. He was diagnosed to have autism according to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). According to his medical history, it was learned that he was diagnosed as Coffin-Siris syndrome by genetic department and a mutation was revealed in ARID1B gene. In this paper, a rare combination of ASD and Coffin-Siris syndrome is presented. As a result, clinicians will be able to keep in mind the association of genetic syndromes in patients with ASD.

KEYWORDS

Coffin-Siris syndrome; autism; genetic

[Abstract:0159] [Schizophrenia and other psychotic disorders]

Obsessive-compulsive disorder in schizoaffective disorder

Ayşe Çakır, Demet Sağlam Aykut and Evrim Özkorumak Karagüzel

Department of Psychiatry, Karadeniz Technical University School of Medicine, Trabzon, Turkey

ABSTRACT

Schizoaffective disorder is the intersection set of schizophrenia and Bipolar Disorder (BD). Obsessive-compulsive disorder (OCD) symptoms can be seen in patients with schizoaffective disorder. When there are symptoms of OCD accompanying schizoaffective disorder; there may be various difficulties in the treatment process due to reasons such as the treatment of a disease triggering the symptoms of the other disease. Therefore it may be need to try different treatment methods. In this case report; it is aimed to draw careful to handle of obsessive symptoms of a patient with schizoaffective disorder who presented to the psychiatry clinic with obsessive symptoms, and the management of these symptoms.

Case presentation: 43-year-old,high school graduate, unemployed, single, male, patient was reported. The patient got in touch with our outpatient clinic because of complaints that had persisted for 1 month such as depressed mood, decreased desire and interest, anhedonia, anxiety, insomnia, aggression obsessions and sexual obsessions and their associated avoidance behaviors, hypochondriac obsessions, suspicion obsessions and control compulsions, and stacking obsessions. With certain intervals in the disease periods of the patient who has been followed for 25 years with the diagnosis of schizoaffective, some manic symptoms such as insomnia, increase in energy, increase in the amount of speech, acceleration of thoughts, increase in purpose-oriented activities, increase in self-confidence are observed. In the intermittent of disease periods of no mood symptoms, the symptoms of auditory hallucinations, delusions of persecution and reference, avolition and anhedonia are also observed. The treatment of the patient has been regulated as olanzapine 10 mg/day, lithium 1200 mg/day, haloperidol 20 mg/day, quetiapine 100 mg /day, zuclopenthixol 200 mg/14 day 3 months ago. The patient was admitted to our clinic with increased symptoms of depression and exacerbation in the complaints of obsessions and compulsions especially in the last 1 month. Treatment of the patient who was hospitalized was regulated as zuclopenthixol 200 mg/14 day, quetiapine 300 mg/day and lithium 900 mg/day. When the patient was hospitalized, Montgomery-Asberg Depression Rating Scale (MADRS), Young Mania Rating Scale (YMRS), Yale Brown Obsessive-compulsive Scale (YBOCS) were evaluated as respectively 20, 3, 25 points. After 4 weeks of clinical follow-up, the patient's obsessive and compulsive symptoms improved more than 50% and his depressive symptoms decreased. The scales of patient was evaluated as MADRS: 8, YMRS: 2, YBOCS: 9 points. OCD can be seen in patients with schizoaffective disorder. However, studies conducted so far; although the association of schizophrenia and OCD or the association of BAB and OCD was examined in detail, there is not much information about the association of schizoaffective disorder and OCD. Antipsychotic treatment for psychotic symptoms during schizoaffective disorder may exacerbate symptoms of OCD, as well as antidepressant medications for OCD symptoms may exacerbate manic symptoms. In this context, there are various difficulties in the treatment and management of the coexistence of these two diseases.

KEYWORDS

Schizoaffective disorder; obsessive-compulsive disorder; antipsychotic treatment; antidepressant treatment

[Abstract:0161] [Psychopharmacology]

Successful treatment of obsessive-compulsive disorder with aripiprazole in preschool children: case series

Ali Karayağmurlu and Murat Coşkun

Department of Child and Adolescent Psychiatry, Istanbul University School of Medicine, Istanbul, Turkey

ABSTRACT

The aim of this study was to investigate the efficacy and safety of aripiprazole monotherapy in the treatment of obsessive-compulsive disorder (OCD) accompanied with attention-deficit/hyperactivity disorder (ADHD) with or without oppositional defiant disorder (ODD) in preschool children.

Case presentation: Six preschool boys (age range 4–7 years; mean 5.3 ± 1.0 years) with severe, distressing symptoms of OCD and behavioral problems were treated with an initial 0.5–1 mg/day of aripiprazole. Baseline and end-point symptom severity was assessed using the Clinical Global Impressions-Severity (CGI-S) scale and Children's Yale-Brown Obsessive-compulsive Scale-compulsion subscale (CY-BOCS-c). The data for this study were collected by reviewing medical records of the subjects.

Baseline and end-point CGI-S scores for OCD were 6–7 (6.83 ± 0.4) and 2–4 (3 ± 0.89) respectively. Baseline and end-point C-YBOCS-c scores were 17–19 (17.83 ± 0.75) and 6–11 (8

KEYWORDS

Aripiprazole; OCD; preschool

± 2.28) respectively. The Wilcoxon nonparametric paired t-test revealed significant differences between baseline and end-point CGI-S ($Z = -2.232$; $p = 0.026$) and C-YBOC-c scores ($Z = -2.214$; $p = 0.027$). Baseline and end-point CGI-S scores for ADHD in all subjects were 5–6 (5.5 ± 0.54) and 2–4 (3.66 ± 0.81) respectively ($Z = -2.232$; $p = 0.026$). Baseline and end point CGI-S scores for ODD in 5 subjects were 5–6 (5.6 ± 0.54) and 3–4 (3.2 ± 0.83) respectively ($Z = -2.121$; $p = 0.034$). The range of aripiprazole dosage was 0.5–4 mg/day (mean 1.66 ± 0.6). Duration of treatment ranged 10–18 weeks with a mean treatment duration of 13.3 ± 3.0 weeks. Most frequent treatment related side effects were sedation in four and weight gain (3–5 kilograms) in three subjects. No one of the subjects discontinued medication due to side effects. Aripiprazole monotherapy may be an effective and safe treatment option for OCD in preschool children particularly with behavioral problems.

[Abstract:0166] [Psychopharmacology]

Aripiprazole-induced tremor: a case report

Mehmet Ali Çiçek, Celaleddin Kartal and Serap Sarı

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Tremor, which is a rhythmic oscillation of a body part, is among the most common involuntary movements. Drug-induced tremor is an important differential diagnosis for tremor syndromes. Drug-induced tremor is often seen as a complication of antipsychotic therapy, but it is also known to occur due to medications such as antidepressants, sympathomimetics, antiarrhythmics, antiepileptics, and other drugs. In this presentation, we aimed to present a case which tremor developed after the use of aripiprazole.

Case presentation: The patient is a 47-year-old female, married, primary school graduate and unemployed. She presented to our clinic with complaints of tremor on her both hands for 3 months. Her neurological examination was normal except for a large amplitude tremor in both hands. She had no history of head trauma or other intracranial pathology. There was no history of familial psychiatric disease. Cranial magnetic resonance imaging (MRI) examination revealed no pathological findings. By the medical history of the patient, her first complaints started about 10 years ago which auditory hallucinations, persecutory delusions, psychomotor agitation, and she has been followed with the diagnosis of schizophrenia for 10 years. She was hospitalized to another psychiatric clinic 3 years ago. She has regularly used her medication for the last 3 years and she has been on remission. She has used aripiprazole 15 mg/day for the last 4 months, and clonazepam 1 mg/day and propranolol 60 mg/day for the last one week. It was thought that tremor has been presented in the patient for 3 months due to aripiprazole use. Aripiprazole was reduced to 5 mg/day and Quetiapine XR 400 mg/day was added. Propranolol 60 mg/day, clonazepam 1 mg/day were continued. As a result of this treatment change, the patient's tremor completely improved and her psychotic symptoms did not exacerbate. Aripiprazole is a second-generation antipsychotic. Unlike other currently available first and second-generation antipsychotics, the antipsychotic efficacy of aripiprazole is mainly attributed to a combination of partial agonist effects at human dopamine D2 and serotonin 5-HT1A receptors, and antagonist effects at serotonin 5-HT2A receptors. Extrapyramidal motor symptoms are major adverse effects of antipsychotic drugs mediated by blockade of dopamine D2 receptors (D2R) signaling in the nigrostriatal dopamine system. Because of aripiprazole partial agonist activity at D2R, it is believed that aripiprazole would be less susceptible than typical antipsychotics to induce extrapyramidal adverse effects. However, a few case reports and case series have been suggested that aripiprazole induced movement disorders may arise. A study of 231 patients with compared aripiprazole and quetiapine, the tremor was reported to be one of the most common side effects in addition to sedation and akathisia. Less tremor was detected in the quetiapine group (79%) compared with aripiprazole group (91%). In the treatment of antipsychotics induced extrapyramidal side effects, it is recommended to reduce the dose of the responsible antipsychotic or replace it with a less potent antipsychotic. If reduction of the antipsychotic dosage or a switch to a less potent antipsychotic is not practical or effective, an anticholinergic, beta-blocker or benzodiazepine may be added.

KEYWORDS

Drug-induced tremor; aripiprazole; quetiapine; extrapyramidal motor symptoms

[Abstract:0167] [Psychopharmacology]

Risperidone-valproate and quetiapine-lithium combination in the treatment of obsessive–compulsive disorder comorbid with bipolar disorder

Yavuz Selim Oğur and Ali Savaş Çilli

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Obsessive-compulsive disorder (OCD) in bipolar disorder(BD) is one of the most common comorbidities. Clinicians have difficulty in making treatment decisions when confronting comorbid OCD and BD. Because treatment of OCD may increase mood instability so psychotherapeutic treatments for OCD may not be appropriate in acute manic or depressive state of BD. There are no best option evidence-based treatment for OCD in manic, depressed or remitted phases of BD exists. Here, we reported a case of OCD comorbid with BD (BD-OCD) treated his manic episode successfully with risperidone-valproate and quetiapine-lithium combination treatment.

Case presentation: A 39-year-old male inpatient admitted with bipolar manic episode. Psychiatric examination include logorrhea, mood elevation, psychomotor agitation and obsessive–compulsive symptoms (cleaning, washing of his hands and environment). He had bipolar disorder for 18 years with previous positive response to combined treatment of lithium, valproate, risperidone and quetiapine. During inpatient care, despite the warnings, he insisted to clean his room several times and also other patients' room. He thought that his room and environment is very dirty and he must clean it. We surveyed blood lithium and valproate levels. Lithium level was 0.72 mmol/L and valproate level was 57.02 µg/mL. Lithium 900 mg/day, valproate 1000 mg/day, risperidone 2 mg/day and quetiapine 300 mg/day was prescribed for manic episode. Patient did not response the treatment during 4 days. We increased risperidone dose to 6 mg/day and quetiapine to 900 mg/day. After two weeks, lithium level was 1.05 mmol/ L and valproate was 89.94 µg/mL. The patient's manic symptoms were healed in 3 weeks. OCD symptoms were decreased but did not totally healed. BP-OCD patients frequently have sexual, religious, symmetry obsessions and repeating, counting, ordering/arranging compulsions when compared to non-bipolar OCD patients. Obsessions related to contamination and compulsions of washing and cleaning were very rare reported in BP-OCD patients. In our case, whether to consider obsessions and compulsions as a part of BP or a separate diagnosis is a problem. Classic European psychopathology suggests that anxiety symptoms, including OCD symptoms, are not diagnosed as a different disease when they co-occur with mood disorders. Previous studies show that BP-OCD patients are at a higher risk of provoking to mania induced by anti-obsessional medications such as SSRI's. Atypical antipsychotics (such as clozapine and olanzapine) can also worsen OCD symptoms. Risperidone was mentioned as an effective treatment in a recent meta-analysis of double-blind, placebo-controlled trials of atypical antipsychotic augmentation in treatment-refractory OCD. In a case of OCD with comorbid BD in manic phase, both OCD and manic symptoms responded to quetiapine 600 mg/day when given with lithium 600 mg/day. The prevalence rate of OCD with comorbid BD is not rare (ranging from 10 to 20%). It is important to find correct treatment for these patients. We presented a case that risperidone-valproate and quetiapine-lithium combination was useful for his BPD symptoms without worsening OCD symptoms.

KEYWORDS

Bipolar; obsessive-compulsive; comorbid; combination treatment

[Abstract:0176] [Psychosomatic medicine – liaison psychiatry]

Pain disorder presenting with resistant pelvic pain: a case report

Mehmet Gürkan Gürok, Aslı Kazğan, Sevler Yıldız and Murad Atmaca

Department of Psychiatry, Fırat University School of Medicine, Elazig, Turkey

ABSTRACT

In women, chronic pelvic pain is defined as the pain which is felt in pelvis, lasts for at least 6 months and not related with menstruation or sexual intercourse. The pain unknown origin under the light of gynecologic examination and laboratory examinations is defined as "chronic pelvic pain" and it may be idiopathic. Idiopathic chronic pelvic pain is classified under the heading of somatoform disorders. In pain disorder, the patient complaints about pain in one or more body locations which cannot be explained with a somatic disorder. Chronic pelvic pain is seen more among women with somatoform disorders. In this report, we have presented a female patient who was hospitalized and who complained of severe and resistant genital pain which is not encountered frequently.

Case presentation: The 35-year-old, married female patient who was graduate of high school was admitted to Gynecology, Urology, Internal Medicine, Algology Departments due to pain at vaginal region which has started 1.5 years ago. She has stated that the pain was compressive, almost every day, lasted minimum 30 min, deteriorated together with sense of anxiety and the pain was felt only in vaginal region. The patient was referred to Psychiatry Clinic as the tests did not reveal any organic disorders. She was detected to have a resistant genital pain, depressive mood, anhedonia, suicidal ideation and she was hospitalized at Psychiatry Clinic. In her medical history, she was learned to have a suicide attempt due to intra-familial stressors one year ago. Emotional and physical neglect were evident in her childhood. Her general examination and

KEYWORDS

Cognitive behavioral therapy; pain disorder; resistant pelvis pain; somatization

routine tests were normal. She was diagnosed with Pain Disorder and Major Depressive Disorder. She was started clomipramine 25, sulpiride 50, diazepam 2.5 mg/day and cognitive behavioral therapy, doses were gradually increased. On day 32 of therapy, behavioral scale scores of pain scale decreased to 4 from 9, HAM-D scale score decreased 28–12, BDI score decreased 30–11, frequency of pain episodes decreased to 2. She has benefited from therapy and discharged with clomipramine 175 mg, sulpiride 100 mg, diazepam 2.5 mg. Somatoform disorders are the disorders in which somatic complaints suggestive for a general medical condition are present however they cannot be explained. Pain disorder which is the subtype of this classification may coexist with mood disorders like depressive disorder, particularly in chronic pain. Somatization is the defense tools which hinder the unaccepted impulses and desires to come to conscious level according to psychoanalytic theory. Pain is converted to bodily pain as a symbol of unconscious conflicts. These patients cannot find a way to express their emotions through words, their response to stress and emotional stimuli is usually bodily rather than being emotional or cognitive. Our clinical evaluation and the scales support this knowledge. We consider that applying pharmacotherapy, cognitive and behavioral techniques would be useful in patients with resistant somatic complaints. In addition, it may be valuable to inquire the stress factors which could be associated with the symptoms and inquire the symbolic meanings of the symptoms.

[Abstract:0185] [Other]

Treatment using ECT on adolescent patient suffered from psychotic depression: a case report

Öznur Adıgüzel[a] and Nuray Atasoy[b]

[a]Department of Child and Adolescent Psychiatry, Ordu University School of Medicine, Ordu, Turkey; [b]Department of Psychiatry, School of Medicine, Bülent Ecevit University, Zonguldak, Turkey

ABSTRACT

Electroconvulsive therapy (ECT) is considered as an effective treatment alternative both in adolescent patients and in adult patients suffered from axis I psychiatric disorders and severe mood disorders when drug therapy fails. ECT is crosses on your mind when two or more pharmacotherapy trials are not responded or the severity of symptoms makes you not to wait for responding to pharmacological treatment. The adverse effects of ECT consist of short-term memory loss, late-period seizures and the risks associated with general anesthesia. Other minor side effects include headache, nausea, vomiting, muscle aches, confusion and agitation. These effects are similar to adults in adolescents. Although our knowledge about the use of ECT in adolescents has increased recently, studies on this subject still seemed to be insufficient. In this case, a 15-year-old adolescent patient with psychotic depression who did not respond to the treatment satisfactorily would be recommended by ECT. She was suffered from unwillingness to enjoy life, aversion, hopelessness, suicidal thoughts, self-worthless and guilty feelings, occasional sweating, tearing, palpitation, difficulty in breathing, the voices say that kill yourself. In our case, ECT was well tolerated without any other complication except for headache and short-term amnesia. The Hamilton depression scale (HDS) was administered to the patient and there was a significant decrease in the scale score after ECT. HDRS dropped to 6 from 22. Here, we aimed to increase the awareness of treatment, in which ECT may be a potential treatment option in children and adolescents, especially in patients with resistant to psychotic symptoms. **Case presentation:** The patient was treated with MECTA Spectrum 5000Q by obtaining consent from their parents for ECT. (MECTA Corp., Lake Oswego, Ore). Intravenous rocuronium bromide was administered for muscle relaxation. Bitemporal electrode placement method was chosen. Seizure activity was monitored clinically and by bifrontal electroencephalography. A total of 8 sessions of ECT were performed in which ECT increased by 20% to last for at least 20 s and it was administered one time per week. Despite of a positive response to treatment, the patient follow-ups and the evaluation of long-term remission with ECT would shed light on more detailed information about the use of ECT in adolescents. In adolescents, ECT may be a good option in patients who are not responding to pharmacotherapy or are expected to improve rapidly as in adults. As ECT is being used with severe psychiatric disorders, our experience may be increased about side effects and complications. At that time, it will be on consensus with treatment using ECT in children and adolescent. Treatment with ECT in adolescent's patients will provide more enlightening information about treatment management. ECT may be a potential treatment option in children and adolescents, especially in patients with resistant to psychotic symptoms. Increasing the experience, future studies and reports of child and adolescents will help psychiatrists in this area to reach a consensus on treatment.

KEYWORDS

Adolescent; electroconvulsive therapy; psychotic depression; resistance to treatment

[Abstract:0186] [Obsessive-compulsive disorders]

Arachnoid cyst and schizo-obsessive disorder: a case report

Fatih Özdemir and Çiçek Hocaoğlu

Department of Psychiatry, Recep Tayyip Erdogan University School of Medicine, Rize, Turkey

ABSTRACT

Psychiatric symptoms can be caused by lesions in certain areas of the brain, as reported frequently in the literature. Arachnoid cysts are benign space-occupying lesions originating from the arachnoid membrane. Most of them are congenital and are diagnosed randomly in childhood. The signs and symptoms of arachnoid cysts vary according to their size and location. The most common clinical conditions are seizures, headaches, focal neurological findings. Psychiatric symptoms associated with arachnoid cysts include reduced affect display, delusions of persecution, auditory hallucinations, obsessive-compulsive behavior, behavioral disturbance, personality changes, depression and anxiety. According to the recent studies, comorbidity of schizophrenia and obsessive-compulsive disorder was higher than predicted. When DSM-IV was published in 1994, it allowed for dual diagnosis of schizophrenia and obsessive-compulsive disorder, and the same year the term schizo-obsessive was introduced by Hwang et al. This hypothetical concept was supported by the recognition of obsessive-compulsive disorder (OCD) as a separate diagnostic class by subtracting the OCD from anxiety disorders. Accordingly, the definition of schizo-obsessive disorder, which includes patients with significant obsessive-compulsive symptoms in addition to positive, negative and cognitive symptoms of schizophrenia, has been suggested by Poyurovsky et al.

Case presentation: In this case, 43 years old female patient, who recently brought by relatives to our psychiatry clinic with agitation, insomnia, auditory and tactile hallucinations. During the clinical meetings with patient, arachnoid cyst in cranial imaging was determined, suspicion obsessions and control compulsions were realized. This case has been prepared as a good example of that importance of neuroimaging in the psychiatric disorders with atypical onset.

KEYWORDS

Arachnoid cyst; schizo-obsessive disorder; diagnosis; treatment

[Abstract:0187] [Schizophrenia and other psychotic disorders]

A case of DiGeorge syndrome with atypical psychosis

Pelin Özkara Menekşeoğlu, Özge Şahmelikoğlu Onur, Büşra Güney and Suat Yalçın

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

ABSTRACT

DiGeorge syndrome, is relevant with small interstitial deletions of chromosome 22q11 in 80% to 85% of individuals. It has been seen approximately prevalence of 1 in 4000 births. The tissues and organ systems which are embryologically derived from neural crest cells are affected in Di George syndrome. Disturbed neural crest cell migration may play a great role in the pathogenesis of the cardiac, facial, and psychiatric phenotypes in individuals with DiGeorge syndrome. We report a case of DiGeorge Syndrome presenting with atypical psychosis.

Case presentation: A 23 year-old female patient was admitted to psychiatry clinic due to complaints of decreased need of sleep, visual and auditory hallucinations, agitation, talking for herself for 5 years. In personal background she had the history of Fallot Tetralogy. Her parents were relatives. In psychiatric examination, restrictive affect, irritable mood, visual and auditory hallucinations, persecution delusions, decreased amount of speech were noted. In physical examination scar on mid-chest, dysmorphic face were noted. As a consequence of genetic consultation deletion of chromosome 22q11 noted. The patient met DSM-5 criteria for atypical psychosis and started haloperidol 10 mg/day, biperiden 5 mg/day injection and quetiapine 100 mg/day treatment. Within one week her symptoms gradually improved and started risperidone 4 mg/day as oral treatment. The patient discharged with 25 mg/ 2weeks risperidone-long term injection, biperiden 2 mg/day and quetiapine 100 mg/day treatment. Genetic analysis of a patient with the history of blood-relationship between parents should be evaluated very carefully as in this case. To identify DiGeorge Syndrome as a differential diagnosis in psychotic disorders increased awareness is essential.

KEYWORDS

DiGeorge syndrome; atypical psychosis

[Abstract:0188] [Mood disorders]

A case of bipolar disorder with hereditary ataxia

Pelin Özkara Menekşeoğlu, Özge Şahmelikoğlu Onur, Büşra Güney and Suat Yalçın

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

ABSTRACT

The role of cerebellum in mood regulation suggests that it may be important in the etiology of Bipolar Disorder. In the literature, there are limited numbers of cases of Affective Disorder resulting from cerebellum injuries. A case of Bipolar Disorder accompanying hereditary ataxia will be presented.

Case presentation: A 53-years old female patient who admitted with complaints of increased amount of speech, decreased need of sleep, hyperactivity and restlessness, increased religious habits, aggressiveness, irritability and refusal of the treatment for a week was hospitalized. In her psychiatric examination loud, rapid and increased amount of speech, flight of thoughts, irritable affect, persecutory delusion and auditory hallucinations were detected. In her neuropsychiatric examination Vital signs and detailed physical examination ataxia of gait, dysarthria, impaired orientation (time, place and person) were detected. MRI and Diffusion MRI scan showed no acute pathologies, but there were atrophy in both frontal and parietal regions, cerebellum. As a result of neurology consultation she was diagnosed Hereditary Ataxia. According to DSM-5 she was diagnosed as Bipolar and Related Disorder Due to Another Medical Condition. The treatment was started as haloperidol 20 mg/day, biperiden 10 mg/day, quetiapine 100 mg/day due to risk of refusal of treatment and changed to olanzapine 5 mg/d and increased up to 20 mg/day slowly due to aggression of ataxia and dysarthria. The patient started to take valproic acid + sodium valproate 500 mg/day as a mood stabilizer and then 7 days later the patient's blood valproic acid level was 91.8 mcg/ L. The patient was discharged with a remission at the 27th day of the admission with improvements of the symptoms. Increased awareness might be essential to identify the pathologies of cerebellum as a differential diagnosis in Bipolar Disorder clinic presentation.

KEYWORDS

Hereditary ataxia; bipolar disorder; cerebellum

[Abstract:0189] [Schizophrenia and other psychotic disorders]

Does Pisa syndrome develop with atypical antipsychotic use? Paliperidone as a probable trigger

Özlem Akçay Ciner[a], Vesile Uyanık[b], Esra Yazıcı[a], Mahmut Ciner[c] and Atila Erol[a]

[a]Sakarya University School of Medicine Department of Psychiatry, Sakarya, Turkey; [b]Sakarya University Research and Training Hospital Department of Psychiatry, Sakarya, Turkey; [c]Sakarya University School of Medicine Department of Radiology, Sakarya, Turkey

ABSTRACT

Pisa syndrome (PS) is a rare truncal dystonia with tilting similar to the Pisa tower, which was defined by Ekbom et al. in 1972. This syndrome was initially defined as a secondary dystonia or Pleurothotonus in the use of antipsychotics. It has also been reported in patients at later times with Alzheimer's, Lewy Body Dementia, Parkinsonism, Huntington's Disease, and Subacute Sclerosing Panencephalitis.

PS can develop with dopaminergic drugs, classic and atypical antipsychotics (APs), antidepressants and antiemetics. In this case report we present a patient with Pisa syndrome with paliperidone.

Case presentation: Our patient is a45-year-old married man who had a routine psychiatric follow-up due to schizophrenia, admitted to our outpatient clinic after several physician visits because of postural disorder in his body. The patient was diagnosed with schizophrenia when he was 27 years old. From the beginning of the disease, insight was poor and there were problems in drug compliance. The patient had 6 hospitalizations in total and his functionality had gradually decreased over time. Treatment history revealed that the patient was treated with olanzapine in the early stages of the disease, but the patient's compliance was poor. The patient started to use risperidone long-acting injection (LAI) 50 mg about 7–8 years ago, but after having difficulty in injection every 15 days, the treatment was changed to paliperidone LAI 100 mg/ monthly 4–5 years ago. It was learned that the patient had no previous history of postural disorder and trauma, and the patient's tendency to lean in his body began 3 years ago and increased over time. During the physical examination, the patient was seen to have an automatically lateral tilt. Increased tonus in cervical and thoracolumbar region muscle groups, right lateral flexion and right posterior axial rotation were observed. Radiological images were examined for cobb angle (used in the diagnosis of scoliosis and > 10 in favor of scoliosis) and 16 degrees in cervical region and 17 degrees in thoracolumbar region were measured. It was differentiated from congenital scoliosis and other secondary scoliosis reasons in the differential diagnosis with no history before and radiological imaging revealed no degeneration in the vertebrae. The patient was thought to have Pisa syndrome and paliperidone treatment was replaced by clozapine treatment. It was thought that the patient was compatible with PS as a result postural disorder was developed after AP use and there was no previously known postural disorder and trauma history, and no other pathology was detected in the examinations performed for the differential diagnosis.

KEYWORDS

Atypical antipsychotic; Pisa syndrome; paliperidone; schizophrenia

In the treatment of Pisa syndrome, reducing or cessation of the causing medication or switching to an atypical AP is recommended. Previously rare PS cases was reported with risperidone and paliperidone. Our case seems to be related with paliperidone too, so highlights the need to be cautious dystonic side effects of antipsychotics even they are atypical. PS should be kept in mind that tardive dystonia may develop after AP use even the AP is atypical and multidisciplinary approach should be considered when the patient is noticed.

[Abstract:0192] [Addiction psychiatry]

Eye movement desensitization and reprocessing therapy in a patient with alcohol use disorder and posttraumatic stress disorder

Ebru Mercandagi, Ahmet Bulent Yazici and Esra Yazici

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Post-traumatic stress disorder (PTSD) is a disorder characterized by involuntary, distressing and repetitive memories of the traumatic event and various symptoms associated with it. Eye movement desensitization and reprocessing (EMDR) therapy is an effective treatment for PTSD. In this case report, the application of EMDR therapy in a patient, with flashback episodes manifested by the somatic symptoms of the traumatic experience, who has been treated for alcohol use disorder will be discussed.

Case presentation: A 50-year-old male patient was admitted to our clinic with symptoms of alcohol use disorder(AUD). For the last 10 years, the patient received about 16 standard drinks per day. In psychiatric examination; he had depressed mood and tremors. In 2001, the patient had had a work accident by a high-voltage line and had required intensive medical treatment. In addition to the classical symptoms of PTSD, his body had begun to shake, aimless running and tingling sensation in the body. The patient had many traumatic experiences before and after this event. His complaints increased after an in-car traffic accident that resulted in the death of his child and started to drink alcohol every day. In order to overcome body tremors and to be able to work, he started to use alcohol continuously and increase his amount. After the accident, he used various antidepressant medications for the acute stress disorder and later diagnosis of anxiety disorder. In addition, he tried to be treated for addiction but no significant improvement was observed in his complaints after the treatments. He was accepted in the trauma-focused therapy program in addition to standard AUD treatment after being admitted to our Alcohol and Substance Addiction Treatment Center. In the clinical interviews, it was learned that the patient experienced a re-experience flashback of electric shocks during the current shaking and running-tingling attacks. A total of 5 sessions of 30-minute trauma-focused standard EMDR were performed. EMDR sessions were performed by decreasing the duration and amount of sessions as the patient could not comply with standard EMDR therapy. As a result of pharmacotherapy and EMDR treatments, current tremors and running-tingling attacks completely regressed. The patient's Hamilton anxiety scale (78.5%), depression scale (70%) and BPRS scores (93%) improved after the treatment. Up to 40–50% of patients with AUD have comorbid PTSD. As it is common for addictive patients to focus on alcohol use in order to overcome the traumatic experiences (self-treatment), trauma focused therapies can effectively reduce addiction symptoms in this patient group. In this study, it can be predicted that trauma oriented approaches will affect the prognosis positively in the addicted patients. In our case, the patient with PTSD symptoms had a significant decrease in his symptoms with EMDR treatment. The number of studies examining the effect of trauma-oriented treatment approaches such as EMDR in patients with AUD is very small, these methods should be used more frequently and further investigation should be made on the EMDR effect. EMDR can be effective treatment choice for patient with PTSD and comorbid AUD.

KEYWORDS

Eye movement desensitization and reprocessing; EMDR; Post-traumatic stress disorder; PTSD; Alcohol Use Disorder; AUD

[Abstract:0193] [Anxiety disorders]

A rare-known topic "chocking phobia": a case report

Aslı Enzel Koç[a], Gamze Vesile Çolak[b] and Çiçek Hocaoğlu[a]

[a]Department of Psychiatry, Recep Tayyip Erdogan University School of Medicine, Rize, Turkey; [b]Department of Psychology, Faculty of Humanities and Social Sciences, Yildirim Beyazit University, Ankara, Turkey

ABSTRACT

Choking phobia is an uncommon condition characterized by a conditioned intense fear of choking or suffocating when swallowing food, drinks or pills. Choking phobia is more common in female than in male. To understand the psycho-pathology of choking phobia, it is also important that it be classified into 2 types. The post-traumatic type is acute onset and the core of symptoms is phobia. The gain-illness type also has some trigger, but the core of symptoms is conversion. The presence of environmental stressors and life events may be linked to the onset of the phobia or worsening its intensity. Some patients with choking phobia are misdiagnosed as anorexia nervosa (AN). Patients with AN avoid eating because they fear becoming fat, not because they fear choking on food. Panic-disorder patients occasionally report episodes of choking. Panic disorder experience sensations of choking in the absence of food, pills, or fluids. There is no current evidence-based treatment for choking phobia. Because of their effects on reducing anxiety, the use of antidepressants has been suggested in the treatment of choking phobia. Cognitive behavioral treatment (CBT) can be combined with an SSRIs in standard doses and also initially in association with benzodiazepines if anxiety is present.

Case presentation: A 39-year-old female, married, with 3 children, housewife, self-referred for treatment, with DSM-5 major depressive disorder, a 5-month history of choking phobia. Although she had concerns about swallowing food since last year, she did not develop a full-blown choking phobia until after she choked on a piece of bread when the patient was eating alone at home. The patient described having a persistent fear of choking and dying while eating. She described she chewed for a long time. She ate biscuits that she had soaked in tea. She preferred to eat with others who might help her if she started to choke. She attributed her condition, in part, psychosocial stressors. In this case, the symptom produced the effect that her husband visited her frequently. She had also consulted an Otolaryngologists that showed no relevant alterations. On the mental examination, the patient was mildly anxious and depressed. Fluoxetine 20 mg/day and risperidone 1 mg/day was initiated. In addition, the patient started taking CBT. She had reduced the number of chews per bite. The case we reported responded to behavioral treatment and fluoxetine combined with risperidone. Further research about choking phobia is needed.

KEYWORDS

Choking phobia; diagnosis; treatment

[Abstract:0197] [Mood disorders]

Lithium exposure in the first trimester pregnancy: a case report

Beyazit Garip, Enes Sari and Cemil Celik

Gulhane Research and Training Hospital

ABSTRACT

Ebstein anomaly (EA) is a congenital defect of the tricuspid valve (TV) and the right ventricle (RV) associated with abnormal displaced of septal and posterior valve leaflets. Lithium exposure during the pregnancy results in cardiac malformations which have been well documented in the literature. On the other hand, there has been still ongoing debates on lithium exposure in first trimester pregnancy whether it increases the likelihood of developing EA or not. In this case report, the patient diagnosed with Bipolar Disorder who was exposure lithium in first trimester followed up at the end of the pregnancy to understand the possible effect of lithium on newborn.

Case presentation: A 37 years-old G0P0, pregnant patient was admitted to the hospital with mildly depressive symptoms and suicidal thought during the third trimester of pregnancy. The patient has been followed up with Bipolar Disorder for 17 years. During the treatment period, different medications have been given to the patient in terms of her clinical state. Those are lithuril, fluoxetine, quetiapine, risperidone and valproic acid which did not work for this patient due to lack of her compliance and social support. She experienced multiple manic and predominantly depressive episodes between 2008 and 2014 and she got pregnant because of unprotected sex during the manic attacks in 2018. The patient was 5 weeks pregnant when she was aware of pregnancy which she was still smoking cigarette, drinking alcohol, taking lithium 600 mg/day and quetiapine 200 mg/day at that time. After the pregnancy confirmation, she stopped taking lithium and quetiapine and gave up drinking and smoking. During the second trimester, she had triple test screen which came normal and no cardiac malformation reported. The patient was fallowed up at the inpatient unit until the end of the delivery that we have mostly administered supportive and cognitive therapy to protect the fetus from harmful effects of lithium or other psychotropic meds. After the delivery, no cardiac malformations were reported even first five weeks lithium exposure and alcohol nor smoking habit. This case mostly emphasized lithium exposure in first trimester which may not result in cardiac malformation all the time. On the other hand, we should consider the possible side effects of the mood stabilizers to prevent the further

KEYWORDS

Ebstein anomaly; lithium; pregnancy; first pregnancy

unexpected malformation. On the other hand, cardiac malformation of lithium is dose dependent which increases the risk of malformation with higher dose (900 mg/day). Dose-dependent teratogenicity of lithium was previously reported in rodent models although it has not been well studied in humans. Lithium exposure during early pregnancy is still controversial issue which needs to be studied in a large group of patients to addressed how long and how much lithium might is associated with EA anomaly.

[Abstract:0202] [Psychopharmacology]

Valproate-induced hyperammonemic encephalopathy aggravated by benzodiazepine: evaluation of the 3 cases and managment

Beyazıt Garip, Begüm Oğur and Cemil Çelik

Department of Psychiatry, Health Science University Gulhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

In rare case, valproate known to be inducing the development of the hyper-ammonaemia which results in loss of conscious due to stupor or lethargy.

Case presentation: The first case is a 27 years-old female who has been followed up with the diagnoses of schizophrenia and mental retardation. The current treatment of the patient is aripiprazole 400 mg/month depot and olanzapine 20 mg/day. Over the past 3 months, her medication compliance deteriorated and presented with disorganize behaviors and hostile thoughts that made her hospitalized. Due to acute exacerbation of the patient, she started to get lorazepam 5 mg/day in addition to valproic acid (VPA) 1000 mg/day. During the clinical follow up, the patient started getting sedative and lethargic. Even though plasma VPA level was in normal range (10 0 µgr/ mL), her conscious progressively became lethargic, not responding verbal and physical stimulation. Her blood ammoniac level was 414 mg/dl. After benzodiazepine discontinuation and bolus hydration, her last ammoniac level decreased to 98.4 mg/dl which is within the normal range. The second case is a 39 years-old female followed up with schizophrenia presented with agitate and disorganize behaviors. She was admitted to the hospital due to his agitation which might have been harmful both patient and community. Medication compliance of the patient was poor because of her lack of social support and poor insight. Her medications were rearranged after the admission, those were paliperidone palmitate 150 mg/month, olanzapine 10 mg/day, valproate 1000 mg/day, and lorazepam 2 mg/day to make her agitation relieved. During her clinical follow up, mental state of the patient was getting deteriorated even though olanzapine and lorazepam discontinuation. We checked the blood valproate and ammoniac levels. Valproate blood level 139 µg/mL and ammoniac level was 87 mg/dl but she was still lethargic. We decided to transfer the patient to intensive care unit to monitor her metabolic parameter. After he did have bolus hydration and close monitoring, she was discharged with good health condition. The third case is a 21 years-old female diagnosed with bipolar disorder admitted to the hospital due to manic episode. Even though she has been on multiple mood stabilizer (lithium 900 mg/day, valproate 1500 mg/day), she experienced manic episodes multiple times. Lorazepam 5 mg/day was added for his agitation after she was admitted to the hospital. We did measure her blood valproate level (79 µg/mL) at the beginning. While she was in the hospital, her fever increased, her infection markers and blood ammoniac level (165 mg/dl) got higher. We decided to cut down on her medications and started antibiotic for unknown fever. During the clinical follow up, we sent the blood culture which showed gram positive basil and then all the infection markers and ammoniac levels came back to normal. In the present case series, patients who were on valproate medications showed some metabolic abnormalities such as increased blood ammoniac levels, fever and cognitive alterations. We did understand from these patients that, lorazepam augmentation treatment to valproate might be triggering factors at both mental state alterations and ammoniac elevation. In these clinical settings, lorazepam co-administration with valproic acid should be taken into consideration to prevent further metabolic and cognitive abnormalities.

KEYWORDS

Valproic acid; hyperammonemia; benzodiazepine

[Abstract:0203] [Autism spectrum disorder]

A rare pica behavior in a male adolescent with autism spectrum disorder and moderate intellectual disability: coprophagia

Buket Kılıç and Ebru Çengel Kültür

Department of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey

ABSTRACT

Coprophagia is behavior that a person eats own feces. It is considered as a variant of Pica. In this case report, we present coprophagia behavior in a male adolescent with autism spectrum disorder, moderate intellectual disability and attention-deficit/ hyperactivity disorder.

Case presentation: Our case is a 16-year-old male adolescent patient who was followed up and treated in our clinic with the diagnosis of autism spectrum disorder, moderate intellectual disability and attention-deficit/ hyperactivity disorder. He is a 9th grade student in a public school serving only for children with autism. The patient was admitted to our outpatient clinic due to coprophagia behavior. This behavior has been repeated 3 times in 1 month and associated with scatolia (smearing of feces). The same behavior was observed several times last year. Treatment was started with the diagnosis of vitamin D deficiency. According to the blood iron parameters and CBC values, iron deficiency anemia was not considered, dietary recommendations were given. Zinc level was normal. The patient was given behavioral recommendations that could be administered in the same and consistent manner at home and at school. At his next 2 weeks control appointment, there was no coprophagia or scatolia. Improvement in his behavior continued at his following controls. Although coprophagy has a rare pica behavior, its prevalence increases when accompanied by some psychiatric symptoms such as autism, intellectual disability, organic brain injury, schizophrenia, depression and anxiety. The etiology of coprophagia is not well known. Concurrently taking detailed psychiatric history is valuable in terms of treatment approaches. Treatment of coprophagia must be patient-specific. Behavioral intervention techniques suitable for the patient should be administered in cooperation with family and school.

KEYWORDS

Autism; behavioral therapy; coprophagia; pharmacological therapy; pica

[Abstract:0209] [Psychopharmacology]

A case of neurogenic bladder development in a patient with olanzapine use

Özgen Özçelik and Hüseyin Kara

Department of Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Antipsychotic use brings many side effects. Atypical antipsychotics are known to have anticholinergic side effects, including urinary retention. Although the incidence of anticholinergic side effects due to olanzapine is not small, there are three case studies in the literature. One of these cases was followed up with depression with psychotic symptoms. It was reported that there was urinary retention with olanzapine and duloxetine. In 2008, urinary retention was reported in two geriatric patients using olanzapine. In this patient, a case of urinary retention following olanzapine use is reported.

Case presentation: We report a 36 years-old female patient who is married and has two children. The patient jumped from the third floor one week before the hospital admission. The patient's hip was found to be broken. The patient came with a wheelchair. During the patient's examination, she said that she jumped because she was afraid that her husband would kill her. she said that she always heard voices saying about what she had to do. These voices have been on for the last month before she had jumped from. She had thought that the devil was in his greater son and she'd be infected by wireless internet. the patient started to have religious tendencies 2 weeks ago. we thought that she had an acute psychotic symptoms and her treatment had prescribed. the patient was started with olanzapine 10 mg 2×1 and lorazepam 25 mg 2×1 dose. She had only olanzapine and Ativan treatment during a 2-month period.

Two months later while her examination, we learned that the patient presented to the urology outpatient clinic because of complaints of inability to urinate. Uroflowmetry was performed to the patient. The patient was diagnosed with a neurogenic bladder. However, the urologist did not understand what was the cause. When the patient came to the control of the psychiatric outpatient clinic, it was thought that the cause of urinary retention could be caused by medical treatment. The patient's neurogenic bladder diagnosis was thought to be due to olanzapine. It was planned to start aripiprazole by crossing from olanzapine treatment. It was observed that the patient's complaints decreased after drug change. Neurogenic bladder diagnosis can be seen due to various etiologic factors. These complaints are often overlooked, often because they are not likely to be expressed or presumed to be side effects of the drug. Because of the anticholinergic side effects caused by the use of antipsychotics, patients are often the victim of this condition. In this case, we also observed that olanzapine can rarely cause neurogenic bladder. Attention should be paid to the physician's knowledge about this subject and to take a detailed anamnesis during the mental state examination of the patient.

KEYWORDS

Neurogenic bladder; antipsychotic treatment; schizophrenia; urinary retention

[Abstract:0212] [Addictions]

A case of internet gaming disorder presenting with encopresis

Serhat Şahin[a], Yunus Yürür[a] and Caner Mutlu[b]

[a]9th Psychiatry Department, Bakirkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey; [b]Children and Adolescent Psychiatry Department, Bakirkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey

ABSTRACT

Excessive use of online computer games which leads to functional impairment and distress has recently been included as Internet Gaming Disorder (IGD) in Section III of the DSM-5. With the increasing infiltration of the Internet into daily life, psychopathological symptoms of Internet addiction have also been observed in recent years. To date, several co-occurring psychiatric entities with IGD have been reported in the literature. In this presentation we aimed to contribute to the literature by demonstrating and discussing a case that has internet gaming disorder presenting with fecal incontinence.

Case presentation: The patient was 13 years old and his mother sought therapy for him at the child and adolescent outpatient clinic. She claimed that her son had been spending 8–10 h per day in online video game which name is "Fortnite" in multiplayer mode for 2 years. His intense preoccupation with online games resulted in poor academic performance and also barely eating or sleeping while playing the game. Also revealed that a new-onset fecal incontinence associated with problematic computer use for 6 months in a frequency every two days without a previous history of incontinence He describes the situation as follows he has not gone to the toilet not to fail in the game. Meanwhile, household conflicts increased because of the boy's excessive spent time in video games and he has become very irritable when his game playing was interrupted by his parents or sister. After fecal incontinence he has thrown his dirty underwear in the trash secretly, after a while his mother realized after detecting the reduction in the number of his underwear. On psychiatric examination, his mood and affect was mild depressive, amount of speech and speed was slightly low, his attention and concentration was slightly decreased too, his physical and neurological examinations were unremarkable, laboratory results were normal. As a result of administered scale, high scores have been detected in Game Addiction Scale For Adolescents (especially in criteria about withdrawal and mood modification),Parental Attitude Research Instrument (in the criteria of overprotection, marital conflict, rejection of homemaking role in order with scores 53, 21, 34) and Turgay's ADHD scale. Treatment has been planned with cognitive behavioral therapy including parents also and starting with appropriate dose of methylphenidate. Research on problematic internet use has demonstrated an association between negative parent-child interactions as in our case and increased risk of disordered use of gaming and the internet. It is emphasized that online gaming addiction should be differentiated from internet addiction because players do not report the experience of being on the internet when they are playing. In addition, its psychological, social, and health consequences require further study. Extreme suppression or neglect by the mother may bring the same result like in encopresis. Hence; use of psychodynamic approaches may benefit both in understanding and treating the disorder in addition to family therapy, cognitive behavioral therapy and use of bupropion which all have been proposed as potential treatment measures. Consequently, there is both an empirical and clinical need to evaluate specialized treatments among adolescents with IGD.

KEYWORDS

Encopresis; Internet Gaming Disorder; Psychodynamic; Co-occurring

[Abstract:0214] [Other]

Factitious disorder: Munchausen syndrome

Sevda Bağ, Suat Yalçın, Pelin Özkara and Gülşen Teksin Ünal

Clinic of Psychiatry, Bakırköy Prof. Dr. Mazhar Osman Psychiatric Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Factitious disorder imposed on self, formerly Munchausen syndrome, is a type of mental illness in which a person repeatedly acts as if he or she has a physical or mental disorder when, in truth, he or she has caused the symptoms. Munchausen syndrome is a mental illness associated with severe emotional difficulties. Munchausen syndrome, named for Baron von Munchausen, an 18thcentury German officer who was known for embellishing the stories of his life and experiences, is the most severe type of factitious disorder. Munchausen Syndrome (MS) was first used by Asher in 1951 to describe a group of patients who wandered into a hospital, invented histories of illnesses, and were willing to undergo unnecessary surgical intervention. In this case, our aim is to recognize and emphasize that the patient who was admitted to the hospital with a complaint of hematuria and was admitted to hospital was actually MS.

KEYWORDS

Factitious disorder; Munchausen; hematuria

Case presentation: A 32-year-old female patient with four children was admitted to the internal medicine service because of hematuria. During his examinations, he had previously been referred to other hospitals with these complaints and it was found that he did not have any other blood diseases. When his sister was spoken in detail, it was learned that he was bleeding from his urine and presented to a number of emergency rooms. In the psychiatric examination of the patient no psychotic symptoms were found, but his mental capacity was found to be at the border. After she lost his father in the past, nobody was interested in her and therefore he started to apply to the emergency. The MMPI was requested and the patient was called for outpatient follow-up and the process is ongoing. Since the differential diagnosis is a difficult disease and has no definite treatment, MS is important to have early recognition by psychiatric and non-psychiatric physicians. Good clinical follow-up and observation of cases of artificial disorder can be prevented.

[Abstract:0218] [Psychopharmacology]

Coping with paliperidone-induced hyperprolactinemia in schizophrenia: a case report

İmge Coşkun Pektaş and Ümmühan Ceviz Özkal

Department of Psychiatry, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey

ABSTRACT

Hyperprolactinemia occurs in 70% of the patients using antipsychotics. The latest reports use an upper limit of 18 ng/mL for men and 24 ng/mL for non-pregnant women. Meanwhile, drug-induced hyperprolactinemia typically ranges from 25 to 100 ng/mL. Hyperprolactinemia can cause amenorrhea and dysmenorrhea, galactorrhea, breast engorgement/gynecomastia, impaired sexual function, infertility; and osteoporosis and pituitary tumor in patients with chronic hyperprolactinemia. Some atypical antipsychotics with high affinity for the dopamine D2 receptor, significantly increase serum prolactin levels. Several cases of hyperprolactinemia have been reported with paliperidone use. Addition of aripiprazole or switching to aripiprazole was found to reduce serum prolactin levels by regulating the dopamine D2 receptor. To our knowledge, this is one of the cases in which prolactin level is so high with paliperidone treatment. Also, this case report points out that hyperprolactinemia in schizophrenia may be treated efficiently by changing antipsychotic.

Case presentation: A 73-year-female with Alport syndrome was admitted to our Psychiatry Clinic at Marmara University with nihilistic and persecutory delusions. The patient had been treated for schizophrenia since 1985. She was followed up with paliperidone long-acting injection (PLAI) 100 mg once monthly during the maintenance treatment. Although the patient does appear to benefit from this treatment, serum prolactin level was 354 ng/mL. The patient was referred to endocrinologist and nephrologist. We thought that hyperprolactinemia could had been happened due to paliperidone treatment and the clearance of paliperidone was affected by renal impairment. By the way, we switched from paliperidone palmitate to oral aripiprazole. Aripiprazole 10 mg/day is fairly well tolerated. There was a dramatic change in serum prolactin level. The patient on aripiprazole had a lower serum prolactin level (40 ng/mL). The findings on physical examination were normal. On mental status examination, the patient's behavior was appropriate. Affect was blunt, and there was mild psychomotor retardation. Her speech was slow in rhythm but normal in quantity and volume. She was oriented to person, place and time. Attention and concentration were poor. There was response latency. Memory was intact, and there were no perceptual distortions. In our case, renal failure may have contributed to a significantly higher level of serum prolactin. Although serum creatinine level did not change in the last visits, it was observed that the addition of aripiprazole and subsequent discontinuation of paliperidone decreased the prolactin level from 354 ng/ml to 40 ng/ml. However, no significant differences were observed on PANSS total, Abnormal Involuntary Movement Scale (AIMS), Barnes Akathisia Scale (BAS). Hyperprolactinemia occurs with D2 antagonism, which is the primary mechanism of antipsychotics. Paliperidone palmitate long-acting injection is used for acute treatment and maintenance treatment of schizophrenia. It is a central D2 and 5-HTA2 receptor antagonist. It is mainly excreted by the kidneys and is subjected to metabolism by the liver to a minor degree. We wanted to draw attention to hyperprolactinemia, a very common side effect of antipsychotics, especially in elderly and accompanying diseases should be followed more carefully. Replacement with aripiprazole can be more effective in reducing the level of prolactin.

KEYWORDS

Aripiprazole; Hyperprolactinemia; Paliperidone; Prolactin; Renal impairment; Schizophrenia

[Abstract:0225] [Autism]

Comorbidity of bipolar affective disorder in a child with autism spectrum disorder: a case report

Hüseyin Sarikaya, Hatice Altun and Muhammet Daş

Department of Child and Adolescent Psychiatry, Kahramanmaraş Sutcu Imam University School of Medicine, Kahramanmaraş, Turkey

ABSTRACT

Comorbidity is a rule for ASD and the rates for at least one comorbid disorder vary between 63.3% and 96.4%. Although different studies reveal different rates, the three most common psychiatric comorbidities are Attention-deficit/ hyperactivity disorder (ADHD) (42–68%), mood disorders (37–77%), and anxiety disorders (56–65%). Other psychiatric disorders commonly observed in this group are sleep disorders, eating and nutrition disorders, tic disorders, sexual identity disorders, psychotic disorders and aggression. Here, the clinical features and treatment of a patient with ASD that is comorbid with bipolar disorder (BD) is presented.

Case presentation: An 11-year-old presented to outpatient clinic with less than 2–3 h of sleep, excessive mobility, increase in locomotion request, increased speech, irritability, increased sexual desire and distraction which last about ten days. According to the information obtained from the parents, it is learned that he has been diagnosed with ASD (atypical autism) since the age of 3, he has been receiving special education for 7 years, he had similar complaints 3 years ago for the first time, he experienced episodes of attacks at least once a year and each attack lasted for 10–15 days, the frequency of these complaints increased in the last 6 months, but the duration of the attacks did not change, the episodes were clearly defined by their teachers, he had received olanzapine, sodium valproate and risperidone medical treatments in the outbreak centers before, but he did not use long term and regular medication. There is nobody with BD in his family. In his mental health examination; it was observed that he was conscious, cooperative, had an increase in the amount of speech, frequent repetitions, flight of ideas, anger in an inappropriate manner and continued movement. In the psychiatric examination, ASD and BD diagnoses were determined according to DSM-5. He was started on clonazepam 1 mg/day and Risperdal 1 mg/day on medical therapy. Risperidone up to a dose of 2.5 mg/day was administered. During the follow-up of the patient, manifest decrease in symptoms such as inability to sleep, excessive movement, irritability, increased speech and increased sexual desire were observed. Correct identification of concomitant diseases in patients with ASD is difficult due to problems such as marked overlaps in the symptom presentation and shadowing diagnosis. In addition, the fact that people with ASD who have problems in processing and describing their emotions makes it more difficult to identify the differential diagnosis. In ASD, the clinical presentation of mania include increased speech and activity, distractibility, incompliance to therapy, cheerful appearance, hostile attitude, devastating behavior and aggressiveness, irritability, elevated mood, psychotic symptoms, grandiosity and sexual acts and speech. In our case, the majority of these symptoms were present and symptoms were improved with antipsychotic medication given for manic symptoms. Besides, It was also remarkable that the patient's symptoms started as early as 8 years. An increasing number of studies have argued that the behavior and symptoms considered to be additional or related features of ASD indicate the presence of comorbidities potentially seeking additional diagnosis. In patients with ASD, identifying comorbid conditions is important regarding both quality of life and compliance to education programs.

KEYWORDS

Comorbidity; bipolar disorder; autism spectrum disorder

[Abstract:0230] [Psychopharmacology]

A case report: aripiprazole-induced akathisia

Esra Merve Gökçe

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Akathisia is a movement disorder defined by the DSM-5 as restlessness, fidgeting of the legs, rocking, pacing, and the inability to sit or stand still (. It usually occurs during the first few weeks (and up to three months) of initiating or increasing an antipsychotic. While akathisia is more commonly associated with first generation antipsychotics, the side effect does occur in patients taking second generation antipsychotics (SGA), although usually at lower rates. In this presentation, we aimed to draw attention to our case who developed akathisia under aripiprazole medication.

Case presentation: A 50 years old female, married and secondary school graduated patient has admitted to our clinic with a history of anger, persecution, insomnia, reference delusions anxiety and loss of insight and reasoning. Questioning her medical history, we diagnosed the patient

KEYWORDS

Aripiprazole; akathisia; Barnes Akathisia Rating Scale; Naranjo Adverse Drug Reaction Probability Scale

delusional disorder and administered aripiprazole 5–10 mg/ per day. In the fifth day of her medication, patient complained from restlessness in her legs, uneasiness and leg pain. A neurological examination, laboratory tests and imaging methods did not reveal any abnormalities hence we concluded this as akathisia caused by aripiprazole treatment. The Naranjo's Adverse Drug Reaction Probability Scale score was 6 when Barnes Akathisia Rating Scale was 11. Aripiprazole treatment has stopped and propranolol 40 mg/day was administered to the patient. In the second day of this medication, all the symptoms related to akathisia have lost totally and yet Propranolol treatment has continued for 15 days on. Understanding of the pathophysiology of akathisia remains limited. Given the clinical profile of akathisia, it seems that a complex interplay of several neurotransmitter systems (for example, acetylcholine, norepinephrine, dopamine, serotonin, γ-aminobutyric acid (GABA), and neuropeptides) underlies its complex pathophysiology. Aripiprazole displays high affinity at dopamine D2 and D3 receptors, as well as 5-HT1A and 5-HT2A receptors. Additionally, it exhibits moderate affinity for 5-HT2C and 5-HT7, D4, adrenergic α1 receptors, and histamine H1 receptors. Akathisia secondary to conventional antipsychotic agents is frequently attributed to D2 receptor blockade in the mesocortical areas. It is likely that this mechanism may also cause akathisia secondary to treatment with aripiprazole. Akathisia remains a significant clinical problem in patients treated with psychotropic agents, particularly antipsychotic regimens. Despite the initial promise that SGAs would be devoid of akathisia effects, this has not been demonstrated in controlled trials. Prompt and accurate detection of akathisia continues to be a problem in most clinical settings with frequent dire consequences. In this case, we wanted to draw attention to the akathisia which has been caused by Aripiprazole treatment for 5 days.

[Abstract:0231] [Psychopharmacology]

Mirtazapine-associated prostatism: a case report

İbrahim Gündoğmuş, Sefa Öz, Mikail Burak Aydın, Azize Beril Taşcı, Ayşegül Taşdelen Kul and Özcan Uzun

Department of Psychiatry, Gülhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Mirtazapine is an antidepressant with noradrenergic and specific serotonergic mechanism of action, frequently used in the treatment of a number of psychiatric disorder such as anxiety disorder and major depressive disorder in clinical practice. Although it is known as a well-tolerated and safety drug, it may cause some side effects such as weight gain, sedation and hypotension. However, urinary side effects of mirtazapine are very rare. In the literature, a case report of Louis et al. reported that 77-year-old male patient with depression and Parkinson disease had mirtazapine-associated urinary retention. As far as we know, this is the only report. The prostatism, a medical condition affecting the quality of life, is observed in any way by an increase in the urinary tract pressure and the most common cause is benign hyperplasia. It is characterized by weak urine flow and difficulty in discharge, problems in urine projection, strain before urination, urine drop and feeling not bladder emptying. Herein, we present a case of prostatism following the use of mirtazapine.

Case presentation: A 37-year-old single male, employed as a teacher, presented to our psychiatry clinic complaining of lack of appetite, insomnia, unhappiness, and lack of energy. After detailed anamnesis and mental examination, the patient was diagnosed with major depressive disorder according to DSM-5 diagnostic criteria. Hamilton Depression Scale score was 52 and Hamilton Anxiety Scale score was 23. He was started on paroxetine 10 mg/day, which was titrated over 2 weeks up to 20 mg/day. Six weeks later, the patient's symptoms were partially regressed and the treatment of patient was planned with paroxetine 20 mg/day and mirtazapine 15 mg/day. Six weeks later, during the patient's check-up depressive complaints were reduced but; weak urine flow and difficulty in discharge, frequent urination, and urinary drip due to urological consultation was requested. There were no findings in the patient's urological examinations and investigations (blood, urinalysis, uroflometry, etc.). Afterwards, the patient was consulted to internal medicine and nephrology, but there was no evidence of etiology. Since the patient's complaints started after mirtazapine, it was planned to discontinue. The patient's prostatism symptoms regressed within two weeks. As his sleep deteriorated, he started mirtazapine 15 mg/day again as a self-medication. However, the patient's prostatism complaints started again and mirtazapine was stopped. The next treatment of the patient was planned as paroxetine 20 mg/day and trazodone 50 mg/day. The patient did not repeat his complaints at subsequent follow-up visits. To the best of our knowledge, there are no reports of prostatism associated with the use of mirtazapine in the literature. On the other hand, mirtazapine appears to be the most likely cause of prostatism due to recurrence of symptoms with the resumption of drug. In conclusion, prostatism seriously affects lifestyle and social relationships. Because there is no known risk factor for prostatism caused by mirtazapine, clinicians should be careful when prescribing antidepressants such as mirtazapine with noradrenergic effect. To clarify the mechanism of prostatism, studies on larger samples are needed.

KEYWORDS

Adverse effect; mirtazapine; prostatism; urinary

[Abstract:0233] [Mood disorders]

A case report of mania following traumatic brain injury successfully treated with olanzapine

Mehmet Arslan[a], Mustafa Çağrı Yıldız[b], Ali Metehan Çalışkan[b], Nafiye Yağlı[b], Sıla Çalışkan[c] and İbrahim Eren[b]

[a]Babaeski State Hospital, Kırklareli, Turkey; [b]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [c]Beyhekim State Hospital, Konya, Turkey

ABSTRACT

Traumatic brain injury (TBI) is a major health problem and a leading cause of morbidity and mortality. Neuropsychiatric disorders are common after TBI, ranging from subtle cognitive deficits to dementia, depression, post-traumatic stress disorder, mania, psychosis, agitation and aggression. We report a successful treatment of post TBI mania with olanzapine.

Case presentation: the patient is a 33-year-old married man without any previous neuropsychiatric disorder, was hit by a speeding vehicle while crossing a street in April 2017. He was diagnosed with intracerebral hemorrhage of right temporal lobe and subdural hematoma in left temporoparietal convexity. One month after discharge hospital, he was referred to our outpatient clinic with decreased need for sleep, grandiosity, elevated mood, increased energy, flight of ideas, paranoid and persecutory delusions. He was admitted for inpatient psychiatric hospitalization. His complete blood count, kidney function tests, liver function tests, thyroid function tests, protein, electrolytes, and sedimentation were within normal limits. The patient's Young Mania Rating Scale score was 36.Using DSM-5 criteria, he was diagnosed with bipolar disorder due to traumatic brain injury, with manic features. The patient was started on olanzapine 5 mg/day. Olanzapine was gradually titrated and reached 20 mg/day. His symptoms gradually reduced after one month of olanzapine treatment. Several case reports have associated head injury with the occurrence of psychoses. The most frequently reported association is with delusional or schizophrenia-like psychoses. However, several case reports also exist of affective disorders in relation to head injury. Mania develops in 1.9–9% of individuals after experiencing traumatic brain injury. Olanzapine is a second-generation antipsychotic medication effective for the treatment of acute bipolar mania and recommended for acute mania by various guidelines across the world. However, few pharmacologic (and no randomized) trials exist for the treatment of mania following TBI. Here, we present a case report of successful treatment of post TBI mania with olanzapine monotherapy. Randomized, double blind, placebo controlled trials to establish the most effective treatments for the variety of bipolar disorders associated with TBI are needed.

KEYWORDS

Mania; olanzapine; traumatic brain injury

[Abstract:0239] [Schizophrenia and other psychotic disorders]

Treatment of psychosis in Parkinson with aripiprazole: a case report

Selin Uysal Alkan, Evrim Özkorumak Karagüzel and Demet Sağlam Aykut

Department of Psychiatry, Karadeniz Technical University School of Medicine, Trabzon, Turkey

ABSTRACT

Hallucinations and psychosis are common in patients with Parkinson disease (PD). Treatment options include reducing medications used for the treatment of PD-related motor symptoms or introducing an atypical antipsychotic drug. There are a few open-label study and case reports having conflicting results concerning the effectiveness of aripiprazole in PD related psychosis. In this case report, we present a complete resolution of psychosis in PD by using aripiprazole.

Case presentation: A 40-year-old man with a diagnosis of PD admitted to the clinic with visual and auditory hallucinations, persecutory delusions and insomnia. On admission, he had no obvious cognitive deficits (Mini Mental State Examination score = 29/30). The results of laboratory tests and the findings of cranial magnetic resonance were normal. In his first evaluation, he had 40 points rating in the Scale for the Assessment of Positive Symptoms (PANS), 77 points in the Scale for the Assessment of Negative Symptoms (SANS). In his history of treatment he has been under pramipexole and rasagiline treatments for 4 years and quetiapine 900 mg\day has been added after hospitalization to psychiatry clinic. The patient's psychotic symptoms slowly regressed with the last treatment regime but after switching to levodopa/ carbidopa/ entacapone treatment regime by the neurology department, the psychotic symptoms had been aggravated. Then the olanzapine was started at 10 mg daily dose. But olanzapine resulted in worsening of motor symptoms. And after referring to our clinic lorazepam 0.5 mg and aripiprazole, 10 mg per day were started, without making changes in previous PD treatment (levodopa/ carbidopa/ entacapone). Aripiprazole dose was increased to 15 mg/day over 2 weeks. Then, his psychosis gradually

KEYWORDS

Parkinson disease; aripiprazole; psychosis

improved and he became more mobile then discharged. SAPS decreased to 9 points, and his final SANS rating was 40 points. He continues to do well on aripiprazole 4 months after discharge. Aripiprazole, an atypical antipsychotic, is usually well tolerated. Unlike the other antipsychotics, it has high affinity agonist properties for dopamine D2 and D3 receptors. It has also 5-HT1A partial agonist and 5-HT2A antagonist properties. it is believed to carry a relatively low risk of extrapyramidal adverse effects because of its high 5-HT2/D2 affinity ratio. Despite its promising receptor profile, there are cases in the literature that reported that aripiprazole has worsened motor symptoms and psychotic symptoms of PD. We deduced that aripiprazole was effective for reducing psychosis and well tolerated in a case with Parkinson disease despite the literature. Controlled studies are needed to clarify the potential therapeutical role of aripiprazole in PD patients and to achieve a better understanding of the conflicting results about this subject.

[Abstract:0240] [Mood disorders]

Cotard şyndrome associated with psychotic depression: a case report

Sevgi Güleç, Özlem Akçay Ciner, Atila Erol and Esra Yazıcı

Sakarya University School of Medicine Department of Psychiatry, Sakarya, Turkey

ABSTRACT

Cotard Syndrome is characterized by nihilistic delusions, delusions of immortality, derealization, depersonalization, hallucinations, negativism and suicidal ideation. It was shown to be associated with depression, schizophrenia, Capgras Syndrome, bipolar disorder and catatonia and in organic diseases. It is rarely reported an there is no consensus or standardized procedure for treatment.

In this case report, the diagnosis and treatment of Cotard Syndrome associated with psychotic depression will be discussed.

Case presentation: A 65 year old male patient with the complaints of "There was no world, I am not exist. I do not recognize the world, myself, and environment. My body does not belong to me, for example, I do not recognize my organs, or me. I feel I am dead." The patient's first psychiatric admission was 10 years ago was diagnosed with major depressive disorder and had suicidal ideas and an attempt and received sertraline 100 mg, risperidone 4 mg and quetiapine 300 mg treatment with gradual changes in dosages in year and had full remission. 2 month ago the depressive symptoms began and psychotic symptoms were added on after one month. At the psychiatric examination; his mood was depressive and anxious. He had anhedonia and his affect was congruent with his thought content. His attention and concentration were reduced, his thought flow and connotations were slowly. He had nihilistic and somatic delusions and depersonalization, derealization. No pathology was detected in neuroimaging and EEG tests. The patient was diagnosed with psychotic major depressive disorder and Cotard syndrome and sertraline 100 mg/day, risperidone 3 mg/day and quetiapine 100 mg/day were gradually started. Also lorazepam 2.5 mg/day was given in the first three days of treatment. The patient's symptoms were remitted with and externalized in 20 days. Patients with Cotard Syndrome were reported to have rates of depressive symptoms with 89%, anxiety with 65%, guilt feelings with 63%, hypochondriac delusions with 58%. The body's nihilistic delusions were 86%, while those related to the presence were 69%.In the presented case, there were anxiety, and nihilistic delusions related to both body and existence in accordance with the literature. Cotard syndrome is rare in literature. It is reported to be exist in 0.62% of patients with primary psychiatric disease. In Cotard Syndrome with affective symptoms, use of risperidone, clozapine and quetiapine and their combinations such as fluoxetine, venlafaxine were previously reported. Our case was successfully treated with risperidone and sertraline combination. Psychotic symptoms seen in Cotard Syndrome can also be seen in the natural course of schizophrenia and other psychotic disorders. This may cause depression patients to be skipped. For this reason, it is important to deepen the history with detailed anamnesis, to distinguish patients with symptoms consistent with the criteria of depression as in our case, and to perform appropriate treatment with proper diagnosis.

KEYWORDS

Cotard syndrome; depression; treatment; risperidone; sertraline

[Abstract:0244] [Disrupted behavior disorders]

Late-onset kleptomania: a case report

Pınar Sivrikaya and Çiçek Hocaoğlu

Department of Psychiatry, Recep Tayyip Erdogan University School of Medicine, Rize, Turkey

ABSTRACT

Kleptomania is a mental disorder that is defined as the inability to resist the impulses to steal objects that are not needed for personal use or monetary value. The prevalence of kleptomania is known as 0.6 percent. Current knowledge about kleptomania is generally derived from case reports and theoretical studies on etiology. With regard to comorbidity, kleptomania is related to the obsessive-compulsive disorder spectrum and to the broader spectrum of affective disorders. However, there is limited information about kleptomania. The causes of kleptomania, risk factor, the relationship between mental disorders and treatment are not fully known. Due to the embarrassment and forensic cases of these behaviors that people cannot prevent, the studies are insufficient.

Case presentation: Therefore, the etiology, prevalence and treatment of information is limited. It usually begins in the adolescent period, and the continues frequently in later ages clinically. The etiology is related to psychodynamic approaches. It may be associated with mood disorders, obsessive-compulsive disorder, substance abuse, and organic brain pathologies. In addition, it was reported to encountered in individuals with epileptic personality. There are cases in which selective serotonin reuptake inhibitors (SSRI), mood stabilizers, antipsychotics, opioid antagonists and antiepileptics have been used for treatment in the literature. Here, a late-onset kleptomania after the operation in a patient with epilepsy surgery following long-term antiepileptic use due to temporal lobe-induced epilepsy was presented. A 40- year-old man who had complaints of kleptomania is presented in the light of the literature knowledge. Taking notice of items about diagnosing and treating in this kind of patients are discussed in this case report.

KEYWORDS

Kleptomania; late onset; treatment

[Abstract:0245] [Sleep disorders]

The efficacy of ramelteon in the treatment of insomnia emerging with nightmares in a patient with post-traumatic stress disorder diagnosis: a case report

Elif Subaşı and Bülent Devrim Akçay

Department of Psychiatry, Gülhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Sleep disorders accompanied by recurrent nightmares are a common complaint among patients with post-traumatic stress disorder (PTSD). Sleep-related findings in post-traumatic stress disorder are included in the diagnostic criteria of re-experienced of traumatic events and increased arousal. Increased arousal findings are manifested by difficulty in initiating and sustaining sleep. Nightmares are also frequently reported by patients. They are in the form of repetition of traumatic events and carry the characteristics of threatening events. Nightmares in the form of increased distressing dreams are characteristic for sleep patterns in post-traumatic stress disorder. Nightmares that occur after trauma may persist for many years and impair daytime functioning. Indeed, sleep disturbances and nightmares that occur immediately after the trauma predict the development of PTSD. Nightmares with repetitive characteristics have been reported more frequently in veterans who are involved in armed conflict than in other trauma victims.

Case presentation: A 32-year-old male patient was had undergone many surgical operations after his armed conflict and traumatic event and admitted to psychiatry with the symptoms of PTSD that started during the physical therapy and rehabilitation period and with recurrent nightmares and insomnia related to traumatic event. The patient was diagnosed with PTSD related to gunfight and was treated with various antidepressants such as SSRI and SNRI group; second generation antipsychotics such as quetiapine, olanzapine; antidepressants with sedative effect such as mirtazapine and trazodone were non-effective therefore benzodiazepine was started to use. Benzodiazepine dose was gradually decreased due to the addiction and abuse potential and ramelteon, a melatonin receptor agonist, was started at 8 mg/day. After the initiation of ramelteon, the need for benzodiazepine decreased and the use of benzodiazepine was terminated. One month after the initiation of Ramelteon therapy, nightmares were decreased and subjective sleep quality increased significantly. PTSD is an etiologically unknown disease with a complex symptom pattern. Nightmares are very common and difficult to treat PTSD. In addition to psychopharmacological treatments for nightmares, it has been shown that repetitive active cognitive-behavioral therapies, involving psychoeducation and sleep hygiene teaching, on veterans do not cause a change in the frequency of nightmares or sleep quality at the desired level. Many drugs have been used in different groups such as serotonin reuptake inhibitors, typical antipsychotics, atypical antipsychotics, tricyclic antidepressants, alpha-1 adrenergic receptor antagonists, imidazopyridines non-benzodiazepine, benzodiazepines,

KEYWORDS

Post-traumatic stress disorder; nightmares; armed conflict; gunfight; ramelteon

hypnotics, non-selective beta-blockers, nipolytic acid derivatives, anxiolytics, anticonvulsants, monoamine oxidase inhibitors, glucocorticoids for the treatment of sleep disorders and nightmares associated with PTSD. In 2005, the only melatonin receptor agonist approved by the FDA was ramelteon, selective MT1 and MT2 receptor agonist. It is indicated in insomnia with difficulty in initiating sleep. It increases the total sleep time and sleep efficiency by decreasing sleep latency through MT1 and MT2 receptors seen in suprachiasmatic nucleus cells. The drug acts within a short time as one hour and has a short duration of action. Otherwise, there is no potential for addictive effect or abuse. In general, 8 mg/day dose is used in chronic insomnia cases with sleep initiation problems. This case showed that ramelteon could be used effectively in the period of planned discontinuation of benzodiazepines used in the treatment of insomnia and nightmares in PTSD cases.

[Abstract:0246] [Psychopharmacology]

A case of tardive dyskinesia induced by olanzapine use

Hüseyin Kara and Özgen Demireğen Özçelik

Department of Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Tardive dyskinesia (TD) is an irreversible, long-term adverse effect of treatment with first generation antipsychotic drugs. Longitudinal studies have associated first generation antipsychotics with a TD incidence of 5% in adults and 25–30% in patients of advanced age. The introduction of atypical antipsychotics has been associated with side effects of the extrapyramidal system (EPS) such as dystonia, parkinsonism, akathisia, TD and other side effects, while not as severe as those of typical antipsychotics. This case presentation will discuss a case of tardive dyskinesia induced by the atypical antipsychotic olanzapine.

Case presentation: The patient is a 64-year-old, retired and married man with three children. The patient, who was brought to our outpatient clinic by his family, reported starting 20 mg/day olanzapine a year ago due to a bipolar disorder diagnosis and not presenting for follow-up since then. His major complaint was involuntary movements around the mouth and the tongue that appeared six months ago. He reported using lithium a year ago but quitting it on his own. His psychiatric history involved a depressive attack five years ago and hospitalization at our service two years ago due to a manic episode. He experienced a cerebrovascular event four years ago. Examination determined tongue fasciculation, repetitive orofacial movements. Associations were normal, with no hallucinations or delusions and a euthymic mood. Olanzapine was stopped with a preliminary diagnosis of tardive dyskinesia, 100 mg/day quetiapine and 600 mg/day lithuril therapy was initiated. The patient showed bilateral rigidity in the follow-up examination two weeks later. Quetiapine was stopped due to suspicion of EPS-related side effects induced by quetiapine use, 12.5 mg/day clozapine was started with a plan to gradually increase the dose. In the follow-up examinations, the lip-smacking complaint of the patient was found to have ameliorated and tongue fasciculations had resolved. As blood levels of lithium were found to be low, lithuril dose was adjusted to 900 mg/day. The patient, who continued the 200 mg/day clozapine and 900 mg/day therapy and follow-ups for 4 months, presented a marked decrease in orofacial movements. Atypical antipsychotics have a more selective effect on dopamine receptors, unbind more quickly from these receptors, do not increase dopaminergic activity in the nigrostriatal pathway, and reverse dopamine blockage through 5-HT2A antagonism in this pathway at levels that decrease EPS symptoms, which explain the reduction in EPS side effects. Studies have shown that TD induced by long-term use of an atypical antipsychotic can recover after switching to another antipsychotic. On the other hand, the improvement in the involuntary movements experienced by our case may be connected to stopping olanzapine after reducing its dosage, variability in the course of TD, or spontaneous regression. Adverse effects of antipsychotic treatment in older patients is a separate issue and more care must be taken with regard to adverse effects such as anticholinergic reactions, parkinsonism, orthostatic hypotension, cardiac arrhythmia, decrease in bone mineral density, cognitive slowing, and late dyskinesia.

KEYWORDS

Olanzapine; tardive dyskinesia; atypical antipsychotic

[Abstract:0248] [Schizophrenia and other psychotic disorders]

A case of delusional parasitosis that responded to aripiprazole treatment]

Hüseyin Kara and Özgen Demireğen Özçelik

Department of Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Delusional parasitosis is a rare delusional disorder involving misbelief that the patient is infected by parasites, worms, insects, and bacteria, despite the absence of any medical evidence. Patients present to the dermatology, internal diseases, or infectious diseases outpatient clinics rather than psychiatrists because these cases believe that their complaints originate from a physical disease, which psychiatric treatment cannot resolve. This paper will discuss a delusional parasitosis case that benefited from aripiprazole.

Case presentation: 56-year-old, married, female patient. Presented with complaint of facial wounds that persisted for 10 years, stating they are infested with things resembling chicken-feathers. Collected contents within a paper tissue in her hand. Presented to dermatology at an external center, underwent biopsy, referred to psychiatry. Patient was started 100 mg/day sertraline. Reported not benefiting from the medication as well as from fluoxetine, risperidone, hydroxyzine HCL, and diazepam, which she had used before. Thought content was marked by activities pertaining to the disease. Stated that the rashes itched constantly, wounds formed as a result and they bled. Following the interview, sertraline was increased to 150 and 5 mg/day aripiprazole was added with a preliminary diagnosis of delusional parasitosis. Blood tests presented normal hemogram, biochemistry, vitamin B12 and folate results. In the follow-up one month later, aripiprazole was increased to 15 mg/day as the complaints had ameliorated. Complaints showed complete regression in the subsequent follow-up. Patient reported no longer scratching her face, few remaining lesions were spotted on her face. Patients report having parasites under the skin that move, crawl, bite, pierce. It is more prevalent across female, middle-aged patients. Skin lesions are typically localized in regions that hands can reach easily. Patients collect samples in boxes, bottles, plastic bags. This phenomenon, known as the "matchbox symptom," was determined in 26% of patients that presented to health professionals. Our case collected dead cells from the wounds on her face, which she described as chick feathers, and presented it as evidence. While the most recommended treatment for DP used to be antipsychotic pimozide, its use has decreased significantly as the disease is more prevalent across older patients who are more vulnerable to cardiotoxic and extrapyramidal side effects induced by pimozide. Currently, there is a general tendency to use atypical antipsychotics in this patient group as well. Aripiprazole has a pharmacological profile distinct from other atypical antipsychotics. It is a well-tolerated drug. It was reported to decrease depressive and anxiety symptoms in delusional parasitosis due to the 5HT1A partial agonist effect. Recommended dose range is 15–30 mg/day. We added aripiprazole to the sertraline therapy, which was administered to our patient as she had not benefited from multiple medications, and found that her complaints fully resolved. As the diagnosis, approach, and treatment is difficult in DP cases, the priority is to establish a reliable therapeutic relationship between with the patient. Patients adjust more easily to the treatment process once this therapeutic relationship is established.

KEYWORDS

Aripiprazole; atypical antipsychotics; delusional parasitosis; matchbox phenomenon

[Abstract:0249] [Demential syndromes]

Effect of hypothyroidism treatment on dementia

Meral Güneş Özdoğan[a], Esat Fahri Aydın[b] and Zeliha Yarar[c]

[a]Erbaa State Hospital, Psychiatry Clinic, Tokat, Turkey; [b]Atatürk University School of Medicine Department of Psychiatry, Erzurum, Turkey; [c]Erbaa State Hospital, Internal Medicine Clinic, Tokat, Turkey

ABSTRACT

Major Neurocognitive Disorder (MNcD) patients must demonstrate impairments in one or more of the cognitive domains(attention, executive function, learning and memory, language, perceptual motor ability, social cognition). Besides this these impairments represent a decline from previous level of functioning and these impairments interfere in independence in daily living activities. There are many different etiologies for MNcD and here we are presenting a case with MNcD due to another medical condition.

Case presentation: A 53 years old, retired, outpatient admitted to psychiatry outpatient clinic with complaints of memory impairment and increased day-time sleepiness. Since last year she needed help for her self-care, put flour into meals instead of salt, put food into wardrobe, spent her days without changing her clothes, could not find addresses properly, she usually lost her way and had difficulty in naming objects. Also she frequently asked the same questions in the psychiatric interview. Standardized Mini Mental Test (SMMT) score was 13 points (13/30). It was told that 15 years ago she was diagnosed with hypothyroidism and since then she did not used her medications. Thyroid Stimulating Hormone (TSH) value was 75 mIU/L. Brain MRI of the patient reported as "enlargement of ventricles and age-related cortical atrophy". Any other abnormality was not detected in routine tests and in physical examination and at the end of internal medicine consultation, hypothyroidism diagnosis was ensured. Any other psychiatric

KEYWORDS

Levothyroxine; hypothyroidism; neurocognitive impairment

disorder was not diagnosed, too. MNcD due to hypothyroidism was the possible diagnosis and 100 mcg of levothyroxine treatment was administered for hypothyroidism and vortioxetine 5 mg/day treatment was added. At the fourth week of treatment, TSH value of the patient was in normal range and symptoms of patients were mostly improved. At the sixth week of treatment SMMT score was 23/30. Also patient had used vortioxetine only two weeks and then she discontinued this medication. Vortioxetine was not prescribed again. Patient's symptoms mostly disappeared and her functional impairment decreased much after levothyroxine treatment. It has been shown that thyroid hormones are closely related to brain atrophy and cognitive functions as a result of its relationship with acetylcholine activity, cholinergic functions neurotropic factors such as nerve growth factor. In differential diagnosis of MNcD hypothyroidism should be kept in mind.

[Abstract:0250] [Psychopharmacology]

Chlorpromazine-induced urinary incontinence

Yusuf Ezel Yıldırım, Kübra Ilicepınar, Sinem Özdemir, Tonguç Demir Berkol and Pınar Çetinay Aydın

Department of Psychiatry, Bakırkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey

ABSTRACT

The dopamine receptor antagonists (DRAs) represent the first group of effective agents to prove highly effective for schizophrenia and nearly all disorders that result in psychotic symptoms. These drugs also referred to as first-generation antipsychotics (FGAs). The first of these drugs, the phenothiazine chlorpromazine (Thorazine) was introduce in the early 1950s. One of the most common side effects of chlorpromazine is moderate-severe anticholinergic effects. Anticholinergic actions may cause sedation, blurred vision, constipation, dry mouth and urinary retent45ion. Although urinary retention is commonly seen in relation to its anticholinergic effect, it has been reported in the past that chlorpromazine may rarely cause stress incontinence.

Case presentation: Our patient, a 61-year-old man, was treated in psychiatric ward with the diagnosis of schizoaffective disorder. During the follow-up, he was treated with risperidone 3 mg 2 × 1, quetiapine 100 mg 3 × 1, biperiden 2 mg 2 × 1 and he described a sleep problem. Then, chlorpromazine 100 mg 1 × 1 was added to his treatment. After the change of treatment, the patient started to complain about urinary incontinence. Urology consultation was requested and urinary ultrasound was performed, however no pathology was detected. After determining that there was no pathology in terms of urology, the treatment of the patient was reviewed. It was realized that the complaint of urinary incontinence started after the addition of chlorpromazine to the treatment, and then chlorpromazine was discontinued. Urinary incontinence improved after cessation of chlorpromazine. The fact that our patient complaint of severe urinary incontinence was not associated with an organic pathology related to the urinary tract led us to re-consider the side effects of the medication. The patient's urinary incontinence was evaluated as mixed type (combination of stress and urge incontinence) and drug-induced type. The clinical appearance of our patient can be explained by the combination of urinary retention side effects of chlorpromazine and the insufficiency of bladder functions due to the his increased age. Improvement of complaints after cessation of the drug indicates that urinary incontinence is related to the drug. The FGAs have gradually been replaced by the second-generation antipsychotics, however the FGAs still remain the most commonly prescribed antipsychotics in many parts of the world. Although there is an awareness about anticholinergic activity of this group of drugs, it has been shown that urinary incontinence may also be seen as an unexpected side effect.

KEYWORDS

Chlorpromazine; urinary incontinence; anticholinergic effects

[Abstract:0253] [Obsessive-compulsive disorders]

A rare syndrome, Potocki-Lupski syndrome with obsessive-compulsive disorder: a case report

Hande Yıldırım and Gülser Karakoç

Department of Psychiatry, Ege University School of Medicine, Izmir, Turkey

ABSTRACT

Potocki-Lupski Syndrome (PTLS), arising as a result of a duplication of 17p11.2, is characterized by cognitive, behavioral, and medical manifestations. Cognitively; global developmental delay, intellectual disability; behaviorally inattention, hyperactivity, anxiety may be seen. Some

KEYWORDS

Genetic; obsessive-compulsive disorder; Potocki-Lupski syndrome

individuals meet criteria for autism spectrum disorder. Medically, hypotonia, oropharyngeal dysphagia leading to failure to thrive, congenital heart disease, hypoglycemia because of growth hormone deficiency and mildly dysmorphic facial features are observed. Medical manifestations lead to identification of this syndrome in infancy; but those with only behavioral and cognitive manifestations may be identified in later childhood. While PTLS is associated with autistic spectrum disorders, inattention, hyperactivity, moderate intellectual disability and significant behavioral disturbances; obsessive-compulsive disorder (OCD) has not been reported with PTLS before. We present the case of 20-year-old woman with PTLS who complained of obsessions.

Case presentation: A 20 year-old woman with PTLS, was admitted to our outpatient clinic because of counting her clothes, photos in her mobile phone and urine drops, also excessive hand washing. She said she had thought her hands smell bad and washed her hands many times of day. She counted her clothes and her photos in her mobile phone to check number of them. Because of counting urine drop, she spent many of time in bath. In her psychiatric interview we learned that her motor and language development was late, sitting independently at 10 months, walking at 18 months, first word appeared at 12 months and talking with short sentences at 5 years of age; she had been diagnosed with PTLS two years ago while exploring her joint pain. She consulted a psychiatrist because of her obsessions last year. She has received sertraline 50 mg/day for a year and risperidone 1 mg/day for six months but this treatment did not reduce her obsessions. In psychiatric examination dysphoric mood, increased irritability, obsessions about contamination, worries about lack of her clothes, extreme concerns about number of photos, urine drop and extreme hand washing and counting compulsions, decreased social interactions and borderline intellectual functions were found. We presented here a case of PTLS who had symptoms of OCD. Although intellectual disability, inattention, hyperactivity, anxiety, autism spectrum disorder can be seen very often in PTLS; OCD has not been reported yet. It is increasingly clear that multiple variants in many different genes can influence risk for OCD. A couple of copy number variation studies in OCD examined specific chromosomal regions. Some of them found associations between deletions or duplications in special region and OCD. This case will be helpful to determine candidate region to understand of the pathobiology of OCD.

[Abstract:0260] [Psychosomatic medicine - liaison psychiatry]

Feeling like a man in an ambiguous body: a case report

Gülser Karakoç[a], Hande Yıldırım[a], Özen Sertöz[b] and Hayriye Elbi[b]

[a]Department of Psychiatry, Ege University School of Medicine, Izmir, Turkey; [b]Department of Psychiatry Consultation and Liaison Psychiatry, Ege University School of Medicine, Izmir, Turkey

ABSTRACT

During the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. Disorders, alternatively termed Differences of Sex Development (DSD) refer to a range of congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical. Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she identify. The aim of this case report is to exclude biological factors in patients presenting with gender dysphoria and to maintain long-term follow-up of ambiguous genitalia patients with a multidisciplinary team.

Case presentation: A 18-year-old phenotype female case presented to our outpatient clinic because of not feeling like a woman, wanted to change her gynecology and gender. In the history, the case was brought to the pediatric clinic at 2 months old because of the external genitalia was uncertain. Chromosome analysis revealed: 45 XO, 46 XY mosaicism. The case was evaluated as intersex; bilateral gonadectomy and vaginoplasty were performed. The case stated that the interest of the girls began when she was 5–6 years old, always played with football, arms, cars with boys, not played with girls, wanted to wear men's clothes, at the age of 12 with hormone therapy (estrogen) began to see menstruation, left with the treatment of her own will. The case reported that she had been investigating gender reassignment surgeries for the last 2 years and had presented to our outpatient clinic to change her gender. No active psychopathology was detected, psychological tests were performed and the related departments were consulted. Psychiatric follow-up was started before hormone therapy was administered. The patient continues to follow policlinic on a regular basis. Incomplete gonadal dysgenesis, also known as partial or mixed gonadal dysgenesis, includes either paired dysgenetic testes or a dysgenetic testis coupled with a streak gonad or a functional testis. Most common with mosaic 45,X/46,XY karyotypes, in which an individual has cells of both genotypes, mixed gonadal dysgenesis phenotypes extend from normal male to Turner female. The diagnosis best fitting our patient was mixed gonadal dysgenesis with 45,X/46,XY mosaicism, brain masculinization, and phenotypic elements of Turner's syndrome, including short stature. Questions of gender identity and sexual orientation may

KEYWORDS

Ambiguous genitalia; 45,X/46,XY mosaicism; gender dysphoria

dominate a life. Understanding the constituents defining gender identity and sexual orientation is a work in progress, with intricacies and subtleties not yet fully appreciated. Initial evaluation of gender dysphoria should focus on organic rather than psychological explanations. Only after ruling out intersexed conditions should primary psychiatric diagnoses be entertained. As soon as DSD is suspected, multidisciplinary consultations and diagnostic procedures are set-up in order to make prognostic interpretations on physical health and long-term outcomes regarding psychosocial and gender wellbeing. Ambiguous genitalia, a team approach to the workup "to minimize medical, psychological, and social complications" is recommended, with representatives potentially from genetics, endocrinology, urology, gynecology, psychiatry, and social services. Sex differences in the brain help us to understand the nature of sex differences in behavior and neuropsychiatric disorders, which will hopefully help to bring about sex-specific treatments and prevention strategies.

[Abstract:0262] [Schizophrenia and related disorders]

A catatonic patient at 8 years old: a case report

Süleyman Kızıldağ, Tuğba Yüksel and Hasan Durak

Department of Child and Adolescent Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Catatonia is a rare but severe psychiatric syndrome. It may be associated with mood disorders, schizophrenia, autism, mental retardation and medical diseases. Our aim in presenting this case is to indicate that catatonia can be observed at an early age of 8 years and to discuss which diseases are most accompany with.

Case presentation: Case presentation: An 8-year-old male boy, presented to the outpatient clinic with his parents. According to the anamnesis, it was learned that he went to the third grade in elementary school, lived in the Ergani, Diyarbakır and was the youngest of three siblings. For ten days his gaze has stabilized, a decrease in the amount of speech, excessive fear, and keeping the hands in front of his body. He said super heroes in the computer game followed him. İt was told that 4 months ago, the patient was overly afraid, not wanting to talk to anyone, he was complaining that the super hero came out of the phone and followed him. These complaints began a week after the operation of the right ear tragus nevus. He was presented to the child psychiatry outpatient clinic, it was learned that the prescribed fluoxetine treatment was not used. The complaints that started 4 months ago disappeared for 2 months. In his mental state examination: It was observed that he was looking at a fixed point. He was conscious, and his orientation was complete. His mood was anxious, his affect was compatible. It was observed that the amount of speech decreased and the content was poor. Visual hallucinations in the form of superheroes were described. No delusions, suicidal thoughts were described. Stupor, waxy flexibility, rigidity, posturing (keeping hands in front of his body) were detected in the patient. The values in the hemogram and biochemistry tests were within the normal range. The neurodevelopmental stages are normal. One month after birth, he was followed up for hydrocephalus. MRI and EEG taken 2 months ago were reported as normal. Family history normal. The patient was diagnosed as brief psychotic disorder accompanied by catatonia according to DSM-5 criteria. Risperidone 0.5 mg/day and alprazolam 0.5 mg/day were started. After one week, catatonic symptoms regressed and anxiety disappeared. The patient was followed up for differential diagnosis and treatment. In adult patients, it is mostly seen in women and is associated with mood disorders. In children and adolescents, it is more common in boys and is associated with higher rates of schizophrenia. İt is observed as 7.6–38% in adults; 0.6–17.7% in children In the treatment of catatonia, high-dose benzodiazepines and or ECT are given. ECT should be preferred if benzodiazepines are contraindicated or life-threatening malignant catatonia is present. In the literature, it was observed that catatonia cases in the early period of 8 years were rare. The fact that our case was boy and accompanied by brief psychotic disorder was consistent with the literature. early diagnosis and treatment of catatonia is important because it can result in death.

KEYWORDS

Catatonia; schizophrenia; catatonia; mood disorders

[Abstract:0263] [Mood disorders]

Comorbidity of bipolar type II and ADHD in an adult

Nilifer Gürbüzer, Celaleddin Kartal and Esat Fahri Aydın

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Attention-deficit/ hyperactivity disorder (ADHD) and bipolar disorder (BD) occur in childhood and adolescence period and continue in adulthood. Both disorders generally cannot be diagnosed or misdiagnosed. This situation causes high morbidity and disability rates. Differential diagnosis includes patients' clinical features, comorbidity, psychiatric story of the family and respond to the treatment. ADHD and BD are mostly diagnosed together. So, in this presentation our aim is to discuss a case in which BD and ADHD are seen together.

Case presentation: Here we report a 46 year-old male patient, married, university graduate and teacher. He was admitted our clinic 13 years ago. His complaints were concentration impairment, impulsive behaviors, increased sexual drive, increase in speed and amount of speaking. It was thought BD manic/ hypomanic episode and he was prescribed lithium and quetiapine. Because of having insufficient insight about his own disease, he had depressive and hypomanic episodes at times. He has not received an effective treatment for 12 years. His performance and social relationships were deteriorated because of continued concentration problems, impulsivity and uneasiness. Increase in the speed and amount of speaking, increased sexual drive, decrease in the need for sleep and grandiosity were added to his existing complaints. He consulted with the same complaints a year ago and he was thought to have BD type2. He had psychoeducation. He was prescribed aripiprazole 5–10 mg/day, quetiapine 25 mg/day. He did not benefit from propranolol with improved akathisia and he was prescribed lithium 600–900 mg/day, aripiprazole was stopped. Almost all of the symptoms were treated except concentration problems, uneasiness and sleep disorders. It was thought that he had ADHD. According to the diagnosis criteria of DSM-5, he was diagnosed as ADHD and prescribed methylphenidate. It was observed that all of his complaints were treated except his sleep disorder. In studies, ADHD prevalence among teenagers changes between 1.7–16%, among adults it changes between 1–5%. BD has 2.1% prevalence rate in adults. The rate of ADHD comorbidity of young patients with BD is known as 48%. Except hyperactivity and distractibility, symptoms like expansive mood, grandiosity, hypersexuality and decrease in need for sleep are significantly more common in BD comparing with ADHD. Inefficient performances which result from attention deficit and forgetfulness are generally refer to ADHD. ADHD proceeds chronically and continuously. In our case, having hypomanic and depressive episodes instead of psychotic symptoms, their occurrence in young adulthood and patient's well-being at times have brought us to the diagnosis of BD type2. Despite of having treatment, continued complaints such as uneasiness, concentration problems, sleep disorders, troubled social relationships, being unsuccessful and the occurrence of these symptoms in the childhood indicated the diagnosis of comorbid ADHD. BD and ADHD are generally misdiagnosed and seen together too often. They have high prevalence. Patients with ADHD comorbidity are not taken in consideration most of the time. Comorbidity information and taking it in consideration provide effective treatment. We think that effective treatment will decrease morbidity-mortality and will contribute to increase the quality of patients' lives.

KEYWORDS

Bipolar disorder; ADHD; comorbidity

[Abstract:0265] [Addictions]

Use of disulfiram in cocaine use disorder: a case report

Aslı Ceren Hınç and Hakan Coşkunol

Department of Psychiatry, Ege University School of Medicine, Izmir, Turkey

ABSTRACT

Disulfiram inhibits aldehyde dehydrogenase enzyme in alcohol metabolism, which causes toxic effects due to accumulated aldehyde when alcohol is consumed. Also, it inhibits the conversion of dopamine to noradrenaline by inhibiting the dopamine β hydroxylase enzyme and causes dopamine increase in the brain while decreasing noradrenaline in circulation. Some clinical trials have demonstrated success with the administration of disulfiram as an add-on therapy in patients with cocaine dependence. The aim of this case report is to discuss the efficiency of disulfiram treatment in a patient using cocaine.

Case presentation: A 20-year-old male patient was admitted to our clinic 3 years ago because of multiple substance use disorder. However, he did not use his drugs regularly. 2 months ago, 4 gr/day cocaine powder and 10 unit/ day alcohol use and high motivation for treatment were re-admitted to our clinic. In the psychiatric examination performed during admission, it was observed that substance and alcohol craving was prominent, his mood was depressive. Disulfiram 500 mg/day was added to the treatment of the patient who received fluoxetine 20 mg/day and haloperidol 2 mg/day for 2 weeks. At the end of 4 weeks, cocaine and alcohol craving symptoms regressed. To use of disulfiram reduced cocaine craving with alcohol and increased treatment compliance. The use of cocaine in powder form and heavy drinking are more common than crack form, so the effect of disulfiram is better for crack

KEYWORDS

Disulfiram; cocaine; alcohol

form cocaine users. The upcoming developments will be aimed at finding the superior effect of disulfiram when it is used in powder or crack cocaine, without considering alcohol usage. Disulfiram seems to exert a direct effect on cocaine use rather than through reducing concurrent alcohol use. Although there is not enough evidence for disulfiram in cocaine dependence, the results so far have been generally positive.

[Abstract:0268] [Schizophrenia and related disorders]

Body dysmorphic disorders and prodromal psychosis: a case report

Hasan Durak, Tuğba Yüksel and Süleyman Kızıldağ

Department of Child and Adolescent Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Body dysmorphic disorder; a psychiatric disorder in an obsessive-compulsive spectrum disorder with a mean age of 16–18 years old characterized by extreme intimidation of a person with a non-actual defect. In many psychiatric disorders, such as schizophrenia, there are extreme efforts related to the body. The case of prodromal psychosis presenting with the symptoms of body dysmorphic disorder is discussed with the literature.

Case presentation: The sick child was brought to the child psychiatry clinic by his family because of the idea that he was ugly. According to the received history; He is 16 years old and has 6 siblings, 10th grade, the success of the course is good, he thinks the face area is ugly, these ideas began two years ago in the process of preparing for the exam, complaints have increased over the last 5 months, therefore it couldn't not look at the mirrors and people's face, she didn't go to her friends, decreased self-care, outside the center, the child is referring to child psychiatry, sertraline 50 mg/day and Risperdal 1 mg/day started, medications used for 5 months, It was learned that there were no changes in complaints.

The patient's medical history was unremarkable. In his family history, it was learned that the patient had a psychotic disorder and received treatment. In the mental state examination, she was a patient at her age, showing her clothing to her sociocultural level. His consciousness was clear, his orientation was complete. forgiveness was inappropriate, mood depressed; mood was compatible. In the content of thought, his thoughts were delusional. It was found that his trial was impaired, he had no insight, and he had passive suicidal thoughts. The patient was treated with risperidone 2 mg/day, clomipramine 25 mg/day and lorazepam 1 mg/day with the diagnosis of dysmorphic disorder and prodromal psychosis. he was monitored and called for control, and the Control revealed a decline in the patient's complaints.

In this case, prodromal psychosis, which starts with physical symptoms, was considered. In children and adolescents, psychotic disorder is rare (0.1%) and our case is important to start with bodily symptoms.

Patients with body dysmorphic disorders have an overvalued view that their bodies appear to be defective. In the early stages of schizophrenia, some patients have somatic delusions related to the appearance of the body, and the disease may begin with symptoms of dysmorphic disorder in the body).

KEYWORDS

Body dysmorphic disorders; obsessive-compulsive spectrum disorder; schizophrenia

[Abstract:0274] [Psychopharmacology]

Nerve blockage in adolescents with chronic migraine: two case reports

Tuğba Uyar[a], Ömer Lütfi Gündoğdu[a], Ali Mert Beşenek[b], Murat Kaçar[b], Selim Polat[c] and Neslihan Deniz[d]

[a]Rize Recep Tayyip Erdoğan School of Medicine Department of Neurology, Rize, Turkey; [b]Rize Recep Tayyip Erdoğan School of Medicine Department of Child Psychiatry, Rize, Turkey; [c]Rize Recep Tayyip Erdoğan School of Medicine Department of Psychiatry, Rize, Turkey; [d]Rize Recep Tayyip Erdoğan School of Medicine, Rize, Turkey

ABSTRACT

Headache is a common complaint in adolescence and migraine headache is the most frequently seen childhood headache type. Chronic migraine prevalence is 5–7% in childhood and adolescence. Chronic migraine has serious negative effects on quality of life and causes set-backs in school functionality in this age group. Migraine headache prophylactic treatment has not yet been fully successful. The prophylactic treatments used in children and adolescents includes tricyclic antidepressants, serotonin reuptake inhibitors, antihistamines and beta-blockers and treatment response is found between 30–40%.

Case presentation: Two patients, who were referred to Neurology out-patient unit of Recep Tayyip Erdoğan University School of Medicine and who had no pathological findings in both neurological examinations and psychiatric interviews, received neuronal blockage treatment.

KEYWORDS

Chronic migraine; adolescent; nerve blockage; migraine treatment; migraine prophylaxis

This treatment included 1 cc of Prilocaine 1% injections bilaterally on supraorbital, greater occipital and lesser occipital nerves. No side effects were observed after administration in both of the patients. This treatment included 1 cc of Prilocaine 1% injections bilaterally on supraorbital, greater occipital and lesser occipital nerves, for four week once a day. Both patient's headache severity and frequency decreases after nerve blockage. No side effects were observed after administration in both of the patients. In the evaluation of chronic headaches in children and adolescents; psychiatric evaluation is as important as anamnesis, neurological examination in regard of treatment of possible etiologies. In the treatment of chronic migraine in children and adolescents, neuronal blockage is an alternative, safe and highly effective treatment method in pharmacological approach.

[Abstract:0275] [Psychopharmacology]

Bupropion-induced stroke and myocardial infarction in an elderly patient: a case report

Tuğba Uyar[a], Ömer Lütfi Gündoğdu[a], Ali Mert Beşenek[b], Selim Polat[c] and Canberk Karabudak[d]

[a]Rize Recep Tayyip Erdoğa School of Medicine Department of Neurology, Rize, Turkey; [b]Rize Recep Tayyip Erdoğan School of Medicine Department of Child Psychiatry, Rize, Turkey; [c]Rize Recep Tayyip Erdoğan School of Medicine Department of Psychiatry, Rize, Turkey; [d]Rize Recep Tayyip Erdoğan School of Medicine, Rize, Turkey

ABSTRACT

Bupropion is unique in that it affects dopamine and norepinephrine rather than serotonin. Carotid and cardio thromboembolism were found to be the major etiological factors for ischemic stroke. When we overview the literature, there are only a few case reports which pertain to this topic.

Case presentation: We present a patient who is a 76-year-old male with a major depressive episode who developed myocardial infarction and ischemic stroke associated with bupropion. Accounting for the temporal relation, prior reports of bupropion treatment–associated cardiovascular and cerebrovascular adverse drug reaction, and the pharmacologic action of noradrenalin on coagulation and the vascular system, the possible contribution of bupropion to simultaneous stroke and myocardial infarct in our patient was considered. Causality assessment may improve unbiased recognition, management, and voluntary reporting of infrequent adverse effects such as bupropion treatment–related cerebrovascular and cardiovascular accident.

KEYWORDS

Bupropion; elder drugs; drug induced stroke

[Abstract:0277] [Psychopharmacology]

Aripiprazole-induced azoospermia: a case report

Begüm Oğur and Beyazıt Garip

Department of Psychiatry, Health Science University Gulhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Clozapine is a potent antipsychotic which is widely used or treatment of schizophrenia. In order to prevent metabolic side effects of clozapine, low-dose aripiprazole augmentation is recommended. In addition to that, it is also effective on clozapine side effects such as prolactin elevation, amenorrhea and galactorrhea. The aim of this study is to present one of the side effects which is seen rarely in patient who is on aripiprazole treatment.

Case presentation: A 29 year-old male diagnosed with schizophrenia has been followed up for three years. Olanzapine (10 mg per day was discontinued due to metabolic side effects switched to aripiprazole which increased to 30 mg/day. The patient`s symptoms did not improve well enough with aripiprazole treatment and then it was decided to switch to clozapine. During the treatment period, all biochemical and parameters were in normal range. The patient clinical findings improved after clozapine initiation but it caused lots of metabolic side effects that need to be solved. Aripiprazole 5 mg/day augmentation was started to cut down on clozapine side effects. After aripiprazole augmentation, the patient complained about ejaculation problems which we thought it might be associated with aripiprazole initiation. After that, we decided to stop aripiprazole before sending him to the semen analysis to understand whether it was associated with aripiprazole or not. According to semen analysis after 2 months follow up without aripiprazole, azoospermia got solved and he had no ejaculation problem. According to literature, patient who may have low sperm counts after antipsychotic use should be well evaluated. Decreased number of sperm has

KEYWORDS

Aripiprazole; hypoprolactinemia; psychosis; prolactin

been reported previously in some cases but the exact mechanism is still remained unexplained. What we need to do as a future directions is to is to clarify this finding in a large group of patient might be more effective. Azoospermia seems to be underestimated side effects of aripiprazole. It has not been proven yet whether this side effect is temporary or not. In this case, it seems to be temporary situation but patient who are on higher dose of aripiprazole should also be well evaluated to understand whether this side effect is dose dependent or not.

[Abstract:0280] [Demential syndromes]

Dementia with Lewy bodies: a case report

Mustafa Çağri Yildiz[a], Şenay Yıldız Bozdoğan[a], Ali Metehan Çalışkan[a], Mehmet Arslan[c], Sıla Çalışkan[b] and İbrahim Eren[a]

[a]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Beyhekim State Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT

Dementia with Lewy bodies (DLB) has a prevalence of 4.2% of all dementia diagnosed in community-based studies and 7.5% in clinic-based studies. It is estimated that approximately 10–15% of dementia cases evidence Lewy body pathology at autopsy. Evidence suggests that Lewy body dementia might be underdiagnosed, often being mistaken for the more familiar Alzheimer disease. Clinically the distinction is important, as it can have profound implications for management and prognosis. An alternative diagnosis of Lewy body dementia can lead to a trial of treatment that can be associated with dramatic improvement in the patient's symptoms. In this case report, we aim to describe a patient with probable diagnosis of Lewy body dementia and treatment of disease.

Case presentation: The patient who was 62 years old, female, married and she was presenting behavioral changes, such as anxiety and aggressiveness, episodes of visual hallucinations (arguing with plants and objects), along with severe delusions, such as that family members were stealing her money or that her water and meal were poisoned. These episodes varied throughout the day. Her husband also reported fluctuation in cognition and behavior before her hospitalization. Laboratory tests were performed, including a complete blood count, thyroid hormone levels, liver and kidney function. All the results were within normal limits. A magnetic resonance imaging scan of the brain revealed a discrete cortical atrophy and a small punctuate irregular foci of decreased T1 and increased T2 signal scattered within the white matter without clinical relevance. It was prescribed rivastigmine patch 15 mg/day, with a posterior optimum response regarding cognitive functioning, behavior (discrete fluctuations) and neuropsychiatric symptoms, although delusions and hallucinations remained. She also has been severely sensible to antipsychotic drug when used to control intense delusions episodes and hallucinations so clozapine prescribed as 12.5 mg/day and clozapine doses increased to 25 mg/day. With this treatment her symptoms partially regressed and the patient was discharged from the hospital. Lewy body dementia showed progressive dementia severe enough to interfere with the ability to function at work or at usual activities and a decline from previous levels of functioning. When we considered the combination of history-taking knowledgeable informant (her husband) and the neuropsychological evaluation, we evidenced cognitive impairment with prominent deficits in attention, executive functions and visuoconstructive abilities. In addition, the patient showed a number of other core features that are essential for diagnosis of probable or possible of DLB, namely fluctuating cognition, recurrent visual hallucinations, and spontaneous motor features of parkinsonism. The patient whose diagnosis is Lewy body dementia has important psychiatric problems. Also Lewy body dementia treatment is very important to prevent the complications of the disease. Otherwise these patients must be examined by psychiatrist and neurologist during clinical follow-up and must be treated for psychiatric disease.

KEYWORDS

Lewy body dementia; cognitive impairment; clozapine

[Abstract:0281] [Psychopharmacology]

Lithium-induced acne vulgaris: a case report

Yasemin Gökçenoğlu[a], Ali Metehan Çalışkan[a], Mustafa Çağrı Yıldız[a], Sıla Çalışkan[b], Mehmet Arslan[c] and İbrahim Eren[a]

[a]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Beyhekim State Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT

Acne vulgaris is a chronic inflammatory skin disorder which has a high prevalence among adolescents and young adults and can be associated with emotional and psychological burden on patients. Several forms of emotional distress and psychological complications can occur with acne. Such complications may be worse than the physical impact of the skin condition. Current literature suggests that skin changes in acne are associated with changed body image, psychological distress, anxiety, social anxiety disorder, suicidal ideation and depression. Estimates of the incidence of lithium-related skin conditions range from 3% to 45%. In addition to acne, associated conditions include psoriasis, eczema, hair loss, hidradenitis suppurativa, nail dystrophy and mucosal lesions. Acneiform eruptions tend to occur within the first 6 months of therapy, and they may be linked to lithium's tendency to increase circulating neutrophil chemotaxis, stimulate lysosomal enzyme release, and induce follicular hyperkeratosis.

Case presentation: The patient who was 43 years old, male, married, had some complaint like anhedonia, loss of energy and interest in daily activities, feelings of hopelessness, sleep disturbances, decreased appetite and libido. These symptoms were increased almost 2 weeks and disturbed him so; he presented to psychiatric outpatient clinic. His psychiatric treatment includes lithium 1200 mg/day, olanzapine 20 mg/day, lamotrigine 100 mg/day. He presented with a severe eruption of cysts, papules, nodules and a few comedones on his face. He had no other lesions on his body. He had no history of acne or other dermatologic conditions. He had started taking lithium carbonate 4 months earlier for the treatment of bipolar disorder; we diagnosed lithium-related acne and recommended that lithium be replaced by an alternative drug(valproic acid). With this treatment his symptoms regressed and the patient was discharged from the hospital and at his 6-month follow-up visit, the acneiform eruption had improved, but not completely resolved. A variety of drugs may provoke acne with drug induced acne (DIA) often having some specific clinical and histopathologic features. DIA is characterized by a medical history for drug intake, sudden onset, and an unusual age of onset, with a monomorphous eruption of inflammatory papules or papulo-pustules. The diagnosis of DIA is made by a detailed history with a record of drug onset, dosage regimen and therapy duration, absence of additional triggering factors, clinical relationship between the introduction of the drug, and the onset of an acne-like eruption. In all cases, the withdrawal of the drug should be followed by improvement of the acne lesions. This case is atypical because of the presence of comedones and the facial distribution. Lithium-related acne may be resistant to conventional treatments, and a decrease or discontinuation of the medication can sometimes be beneficial.

KEYWORDS

Lithium; acne vulgaris; bipolar disorder

[Abstract:0282] [Psychopharmacology]

Panic disorder developed by varenicline use

Hüseyin Kara and Özgen Demireğen Özçelik

Akdeniz University School of Medicine Psychiatry Department

ABSTRACT

Varenicline was the partial agonist of α4β2 nicotinic receptors used in smoking cessation therapy and was introduced in 2006 after receiving approval from the US Food and Drug Administration (FDA). In the literature, there are depressive mood, sleep disorder, suicide, agitation, aggression, psychotic and manic attack episodes that developed after varenicline use. It was stated by the FDA in 2009 that varenicline may cause severe neuropsychiatric findings. Here, we present a panic attack which occurred after the use of varenicline in a 34 year-old male patient who has not had a panic attack for five years.

Case presentation: A 34-year-old male patient was treated with panic disorder five years ago. He hadn't had a panic attack for five years, but he had a panic attack on the 12th day of varenicline treatment, which was initiated to quit smoking. While waiting in the red light in the car, palpitation, sweating, shortness of breath, a feeling of tightness in the chest, the thought of having a heart attack and fear of death. These complaints were presented to the emergency department and the examinations were evaluated as normal. He had been taking an attack after having started using varenicline. The patient stated that she had had a panic attack at least three times a week for a month and was referred to our outpatient clinic by a cardiologist.

He said he had quit the sport and that he was away from the situations where he had to spend the effort because he was going to have an attack. Duloxetine (30 mg/day) was initiated with the diagnosis of Panic Disorder according to DSM-5 criteria. At the same time eight sessions of cognitive behavioral therapy were administered. At the end of two months, the patient's complaints were completely resolved. Psychiatric disorders associated with the use of varenicline are increasing or there may be flare-ups or worsening of existing

KEYWORDS

Varenicline; panic disorder; smoking cessation

psychiatric disorders. Therefore, the relationship between varenicline and psychiatric symptoms should be carefully considered. The FDA indicated that there may be a relationship between the use of varenicline and suicide. Between May 2006 and December 2008, 227 cases with varenicline have a tendency to commit suicide. 28 of these cases resulted in death. While 50% of these cases had a history of psychiatric disease, 25% did not have a history of psychiatric disease. The current psychiatric status, past psychiatric and family history of patients with cigarette addiction who are thought to be appropriate to use varenicline should be evaluated. It is necessary to evaluate the mental state examinations before and during the use of varenicline therapy. Patients and their families should be informed about possible psychiatric symptoms and drug side effects.

[Abstract:0283] [Psychopharmacology]

Methylphenidate induced acute orofacial dyskinesia: a case report

Mehmet Arslan[a], Sıla Çalışkan[b], Yasemin Gökçenoğlu[c], Mustafa Çağrı Yıldız[c], Ali Metehan Çalışkan[c] and İbrahim Eren[c]

[a]Babaeski State Hospital, Kırklareli, Turkey; [b]Beyhekim State Hospital, Konya, Turkey; [c]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Attention-deficit/ hyperactivity disorder (ADHD) is a common neurodevelopmental disorder in childhood. Methylphenidate is FDA-approved for the treatment of attention-deficit/ hyperactivity disorder (ADHD) in children and adults. The most common side effects include headache, irritability, tics, chorea, psychosis, and, more rarely, dyskinetic disorders.

Case presentation: A 14-year-old girl was referred to our outpatient clinic by her parents who complained of her excessive and inappropriate hyperactivity, inattentiveness, excessive talking, excitement, difficulty to remain focused on schoolwork and not obeying the class rules. She was diagnosed with ADHD according to Diagnostic and Statistical Manual of Mental Disorders, Fifth edition and was prescribed short-acting immediate-release methylphenidate at a dose of 10 mg/day. 2 days after initiation of treatment she developed involuntary rapid, to and fro movements of the lower jaw. No abnormal movements were noticeable in any other body parts. There was no history of any movement disorders in this patient. Routine laboratory assessments and magnetic resonance imaging were normal. She was diagnosed as having methylphenidate induced dyskinesia and started on intramuscular biperiden (0.4 mg/kg). Methylphenidate treatment was discontinued. Dyskinesia resolved immediately after administration of biperiden.

Methylphenidate is commonly used as an effective drug in the treatment of ADHD. The drug increases extracellular dopamine levels in the striatum, prefrontal cortex, olfactory tubercle, and nucleus accumbens via inhibiting dopamine reuptake. The mechanism of acute dyskinesia due to methylphenidate remains unknown. Drug-induced movement disorders are usually caused by antipsychotics and antiemetics. Antipsychotics are the most common cause of dyskinesia. A limited number of cases that developed orofacial dyskinesia after methylphenidate therapy are presented in the literature. In conclusion, this report suggests that clinicians should be aware of the possibility that methylphenidate can cause dyskinesia and therefore, side effects should be monitored. Further research is required to determine the frequency and clarify the mechanism of this adverse effect.

KEYWORDS

Methylphenidate; orofacial dyskinesia; attention-deficit/ hyperactivity disorder

[Abstract:0285] [Psychopharmacology]

Reversible normoprolactinemic galactorrhea in major depressive disorder with a stable dose of fluoxetine: a case report

Ayşegül Taşdelen Kul, İbrahim Gündoğmuş and Mikail Burak Aydın

Department of Psychiatry, Gülhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Fluoxetine, which is frequently used in clinical practice, is an antidepressant that is selective serotonin reuptake inhibitor (SSRI) group, used in the treatment of many psychiatric conditions such as depression and anxiety disorders. Although it is an effective and safety agent, it may cause side effects. Especially the fluoxetine-associated hormonal adverse effect is rarely reported. Thus, there are reports that fluoxetine is associated with hyperprolactinemia and galactorrhea in the literature. There are also reports of

KEYWORDS

Adverse effect; antidepressant; fluoxetine; normoprolactinemic; galactorrhea

antidepressant-associated hyperprolactinemic and normoprolactinemic galactorrhea of SSRIs such as escitalopram and sertraline. However, as far as we know, there is only one case of fluoxetine associated galactorrhea without hyperprolactinemia. In this report, we present a 31-year-old case of galactorrhea that started after fluoxetine use without prolactin elevation.
Case presentation: A 31-year-old single female working as a medical doctor presented to the psychiatric clinic with symptoms of unhappiness, pessimism and hopelessness. After the patient's psychiatric examination, she was diagnosed with major depressive disorder according to DSM-5 diagnostic criteria. Her Hamilton Depression Scale was 46. Fluoxetine 20 mg/day treatment was initiated. Partially improvement was initiated in the symptoms at a follow-up three week later but, she reported that milk had begun to be secreted from both breasts over the previous week to the extent that it marked her clothing. The patient described this condition for the first time. The patient was not taking any other medication and the menstrual cycle was regular. There was no story in her life that could cause this. Her blood tests were normal. In particular, her prolactin level was 26 (within normal range). She was consulted to obstetrics – gynecology and endocrinology clinics. However, there was no pathology that could explain the galactorrhea. The use of fluoxetine was discontinued and galactorrhea decreased in two weeks. The patient was started on duloxetine 60 mg/day but the patient was stopped because she could not tolerate it. At the patient's request, fluoxetine was started at 20 mg/day and repeated in galactorrhea for two weeks. But the drug continued with her own request. One year later, fluoxetine treatment was stopped after depressive complaints of the patient disappeared and galactorrhea decreased in three weeks. The patient relapsed again to the galactorrhea when she started her treatment with fluoxetine 20 mg/day 2 years later, but continued on self-medication. According to Naranjo Adverse Drug Reactions Probability Scale, we evaluated 9 points as a definite adverse effect. In the literature, cases of galactorrhea associated with fluoxetine-induced hyperprolactinemia have been reported. But hyperprolactinemia is not the only mechanism responsible for the development of fluoxetine-induced galactorrhea. In the present case, galactorrhea without hyperprolactinemia developed after the onset of fluoxetine. The temporal relationship between the use of fluoxetine and the onset of galactorrhea, and the solution after the discontinuation of treatment, indicate a causal link between the two conditions. Clinicians should keep in mind that fluoxetine can be seen as a possible cause for galactorrhea at normal prolactin levels. Future research should explore the mechanisms of fluoxetine-induced normoprolactinemic galactorrhea.

[Abstract:0286] [Psychopharmacology]

Oculogyric crisis with atypical antipsychotics: a case report

Sıla Çalışkan[a], Mehmet Arslan[c], Yasemin Gökçenoğlu[b], Mustafa Çağrı Yıldız[b], Ali Metehan Çalışkan[b] and İbrahim Eren[b]

[a]Beyhekim State Hospital, Konya, Turkey; [b]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT
Oculogyric crisis (OGC) is an acute dystonic reaction, commonly seen with the administration of typical antipsychotics, and rarely reported with atypical antipsychotics. In psychotic patients, there are cases of OCG accompanied by psychotic exacerbation during antipsychotic treatment. OGC is rarely reported with atypical antipsychotics such as olanzapine, quetiapine, aripiprazole and amisulpride. Here, we report presentation and management of oculogyric crisis caused by olanzapine.
Case presentation: A 33-year-old married female patient was brought by her relatives to the psychiatry clinic diagnosis with schizophrenia and mental retardation. She had some complaint like irritability, aggression, sleep disturbances, visual hallucinations. In patient history during 12 years, there are multiple hospital admissions, and her medication includes lots of drugs like risperidone, olanzapine, biperidene, clonazepam, mirtazapine, clozapine. Olanzapine 5 mg/day was ordered and titrated gradually to 20 mg/day. However, within one week of hiking the dose, she again started reporting repeated episodes of up-rolling of eyeballs with upward fixation, each episode lasted for 5–6 min, and generally this state was relieved spontaneously but sometimes need oral anticholinergic medication. When we got deeper questioning about patient's history disclosed that patient had a lot of oculogyric crises like this. After that we reduce and cease of oral olanzapine and shifted on clozapine. At present, she is free from OGC and maintaining well on 300 mg of clozapine daily for the past one year. Olanzapine in higher doses shows a higher D2 binding affinity which probably increases the risk of OGC. Sometimes, it is difficult to implicate any specific atypical antipsychotic for developing acute dystonic reaction as many patients have previous exposure of typical antipsychotics. Previous antipsychotic exposure might have priming effect on the striatum and underlying susceptibility with possible genetic predisposition. OGC generally responds to oral anticholinergics, but in troublesome cases, tapering or

KEYWORDS
Oculogyric crisis; atypical antipsychotics; olanzapine

discontinuation of antipsychotic with switching to other safer antipsychotic is recommended. Clozapine is a choice agent with minimal propensity for EPS. For timely diagnosis and appropriate management of OGC, physicians must be aware of the varied presentation of OGC as recurrent dystonic reactions have obvious implications to medication adherence.

[Abstract:0287] [Mood disorders]

Onset of mania after continuous positive airway pressure in bipolar disorder: a case report

Sıla Çalışkan[a], Mehmet Arslan[c], Mustafa Çağrı Yıldız[b], Yasemin Gökçenoğlu[b], Ali Metehan Çalışkan[b] and İbrahim Eren[b]

[a]Beyhekim State Hospital, Konya, Turkey; [b]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT

Obstructive sleep apnea (OSA) is a common disease which impacts quality of life, mood, cardiovascular morbidity, and mortality. Continuous positive airway pressure (CPAP) is the first-line treatment for patients with moderate to severe OSA. In this case report we present a patient with bipolar disorder with comorbid (OSA) who were treated with CPAP for their sleep apnea.

Case presentation: The patient is a 47-year-old married man diagnosed with bipolar disorder. His first mood episode occurred at the age of 24. He has been followed in our clinic for 6 years. His last manic episode was two years ago. He was taking lithium (900 mg/day), quetiapine (400 mg/day). His lithium level was 0.7 mEq/ L. His wife described the patient as usually tired, restless sleep and severe snoring. He presented to the sleep center. He was diagnosed as OSA. CPAP treatment were prescribed. One week after starting the CPAP treatment, the patient presented to the emergency department with manic symptoms including grandiosity, elevated mood, tangential thought process, increased energy, significantly decreased need for sleep, and delusional thoughts for a week period. Laboratory tests were performed, including a complete blood count, thyroid hormone levels, liver and kidney function. All the results were within normal limits. Due to manic symptoms, lithium was increased to 1200 mg/day and quetiapine was increased from 400 to 800 mg/day. After three weeks of increased medication, his mood stabilized. OSA affects 2–4% of the general population. It is well documented that CPAP use in OSA leads to improvement in sleep quality, daytime sleepiness, daily performance, psychosocial adjustment, and psychological symptoms, including improvement in mood. It is possible that various mechanisms may be involved in the precipitation of a manic episode with CPAP correction of underlying OSA in bipolar disorder. The prevalence of OSA in bipolar disorder is expected to be high because of high comorbid obesity. We report here a case of a manic episode in a 47-year-old man with OAS after starting CPAP treatment. Future studies are needed to explore further these anecdotal findings and to understand the underlying mechanisms.

KEYWORDS

Obstructive sleep apnea; mania; Continuous positive airway pressure

[Abstract:0288] [Psychopharmacology]

Paliperidone palmitate-induced tardive dystonia: a case report

Mehmet Arslan[a], Mustafa Çağrı Yıldız[b], Yasemin Gökçenoğlu[b], Ali Metehan Çalışkan[b], Sıla Çalışkan[c] and İbrahim Eren[b]

[a]Babaeski State Hospital, Kırklareli, Turkey; [b]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [c]Beyhekim State Hospital, Konya, Turkey

ABSTRACT

Long-acting injectable (LAI) antipsychotics are an effective option in schizophrenia that increase treatment adherence in potentially non-compliant patients. Paliperidon palmitate demonstrates its effects by antagonizing central dopamine type-2 (D2) and serotonin type-2 (5HT2A) receptors. It could be used in acute stage and maintenance treatment of schizophrenia, and schizoaffective and bipolar disorders. Tardive dyskinesia is a potentially treatment-resistant movement disorder that can be a problem after long-term antipsychotic use. The specific pathophysiologic processes underlying movement disorders remain incompletely understood. Dystonic reactions are variable in location and severity and are occasionally painful. We report a case of TD following the administration of antipsychotic, which was paliperidone palmitate.

KEYWORDS

Paliperidone palmitate; tardive dystonia; clozapine

Case presentation: A 35 year-old male patient was hospitalized to the department of psychiatry Konya Research and Training Hospital for increasingly aggressive and disruptive behavior, irritable mood and low medical adherence. He has been diagnosed as having schizophrenia disorder 12 years ago. In patient's history there are lots of stayed in hospital and lots of medicines like risperidone, olanzapine, biperidene. His psychiatric treatment changed and prescribed paliperidone palmitate IMLAI for his low medical adherence. After administration of paliperidone palmitate almost three weeks later he presented with involuntary orofacial movements. The score of the Abnormal Involuntary Movement Scale (AIMS) was 14. Because of this side effect we cease of paliperidone palmitate and she was shifted on clozapine 12.5 mg/d for the treatment of tardive dystonia and hiked up clozapine doses to 600 mg/d. With this treatment his symptoms partially regressed, his AIMS score had decreased to 6 and the patient was discharged from the hospital. At present, he is free from tardive dystonia and maintaining well on daily 600 mg of clozapine for the past six months. TD is generally considered the most severe extrapyramidal sequelae of antipsychotic treatments. Drug-induced tardive dystonia is difficult to treat and persist in many patients. Stopping the offending agent alone is shown to be insufficient to resolve TD. If continued antipsychotic therapy is necessary, clinicians should consider switching the antipsychotic medication to clozapine. This case serves as a clinical reminder that dyskinesia can occur with all antipsychotic medications.

[Abstract:0289] [Psychopharmacology]

Dystonia as an unexpected interaction of ciprofloxacin and clozapine: a case report

Mustafa Çağri Yildiz[a], Mehmet Arslan[c], Yasemin Gökçenoğlu[a], Ali Metehan Çalışkan[a], Sıla Çalışkan[b] and İbrahim Eren[a]

[a]Health Sciences University, Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Beyhekim State Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT

Clozapine remains the antipsychotic of choice for patients with treatment refractory schizophrenia and for schizophrenia patients with a history of suicidality, but it does require an attentive clinician to oversee treatment due to certain common side effects (e.g. constipation, sialorrhea, orthostasis, metabolic adverse effects, and sedation) and a small number of rare but serious issues (neutropenia, seizures, myocarditis, and cardiomyopathy). One contributing factor to tolerability issues is clozapine's narrow therapeutic index and its susceptibility to kinetic interactions with medications or environmental exposures such as smoking. To improve the likelihood of response and to avoid unnecessary toxicity, clozapine plasma level monitoring is commonly performed. Although ciprofloxacin is also a strong CYP 1A2 inhibitor and has been in routine use for over 25 years, there is a paucity of information about the potential seriousness of its interaction with clozapine. Presented here is a case report in which use of ciprofloxacin in a patient on stable clozapine doses was associated with dystonia.

Case presentation: The patient who was 55 years old, male, married, had complaints of excessive and rapid speech, irritability, aggression, sleep disturbances, increased appetite and libido. These symptoms were increased almost one month and disturbed him so he presented to psychiatric outpatient clinic. His psychiatric treatment includes valproic acid 1250 mg/day lithium 1200 mg/day biperidene 4 mg/day propranolol 60 mg/day and quetiapine 600 mg/day. He also presented with EPS symptoms. He was admitted for inpatient psychiatric hospitalization. Valproic acid, biperiden, propranolol, quetiapine was reduced and stopped. Clozapine 25 mg/day ordered and titrated up to 400 mg/day. When the patient used lithium 1200 mg/day and clozapine 400 mg/day, he had urinary tract infections. Because of this ciprofloxacin 1000 mg/day was ordered. 3 days later he presented with dystonia and because of drug interaction ciprofloxacin was stopped and dystonia healed. With this treatment his symptoms regressed and the patient was discharged from the hospital and disease in remission now. Ciprofloxacin is a fluoroquinolone antibiotic whose broad spectrum of activity was noted in the early 1980s. By 1987, kinetic interactions between ciprofloxacin and other medications, particularly theophylline, were well documented and presumed to be based on inhibition of metabolism by the responsible cytochrome P450 enzyme, later characterized in 1992 as CYP 1A2. The revised clozapine PI now contained specific language on dosage modifications when adding or removing strong 1A2 inhibitors.

Clinicians prescribing medications with narrow therapeutic indices must be mindful of potentially important kinetic interactions and have a reliable resource to identify kinetic data when adding agents to high-risk medications.

KEYWORDS

Ciprofloxacin; clozapine; dystonia

[Abstract:0290] [Mood disorders]

Steroid-induced mania in Behcet's disease: a case report

Mustafa Çağri Yildiz[a], Mehmet Arslan[c], Yasemin Gökçenoğlu[a], Sıla Çalışkan[b], Ali Metehan Çalışkan[a] and İbrahim Eren[a]

[a]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Beyhekim State Hospital, Konya, Turkey; [c]Babaeski State Hospital, Kırklareli, Turkey

ABSTRACT

Behcet's disease is recognized as a disease that cause inflammatory perivasculitis, inflammation of the tissue around a blood or lymph vessel. Corticosteroids are very commonly prescribed among both hospitalized and outpatient medical and surgical patients. While many of the common endocrinological and pathological side effects of corticosteroids are well understood, the incidence, presentation, and treatment of neuropsychiatric manifestations have not been commonly characterized and studied. Though most practitioners are familiar with the term "steroid-induced psychosis," the affective and behavioral symptoms related to corticosteroid use are varied and can be unpredictable. In many cases, the appropriate treatment and its duration can be elusive. In this report we presented case about mania caused by using high dose steroid.

Case presentation: The patient who is, 41 year-old male, was brought to hospital by his family with complaints of excessive and rapid speech, hyperactivity, decreased need for sleep, visual hallucinations, agitation, and irritability that had lasted for 10 days. It was learned that he had a history of Behcet's disease and had been treated with 1 mg/day of colchicine. Oral prednisolone (60 mg/day) was added to his treatment by a rheumatologist three weeks ago in order to treat edema on legs. It was learned that after 10 days of treatment, the prednisolone dose was reduced to 30 mg/day; and his complaints raised to the surface. The patient was prescribed 1250 mg/day of valproic acid, 10 mg/day of olanzapine. In addition to psychiatric treatment, colchicine and prednisolone treatment was continued. The patient was consulted to rheumatologist and prednisolone dose decreased to 4 mg/day. With this treatment his symptoms regressed and the patient was discharged from the hospital and is currently being cared for by her rheumatologist. Corticosteroids have been in use for over six decades to treat a wide variety of pathologies from asthma and allergies to autoimmune diseases and dermatologic conditions. Although the pathophysiological mechanism by which corticosteroids cause psychiatric side effects is unclear, it is considered that mechanism is related with cholinergic and dopaminergic stimulation. Corticosteroids change ion efflux and serotonin release by causing dysfunction of membrane Na-K pump. It is estimated that about 20% of patients who receive high dose corticosteroids, defined as greater than 40 mg of prednisone or its equivalent, will develop a psychiatric disorder like mania, psychosis, or depression severe enough that with condition will require pharmacotherapy. There may be useful symptom prevention strategies when giving patients steroids, though none would have directly administered to patient. Dosing plays a significant role in the development of neuropsychiatric symptoms, thus minimizing the dose is a primary preventive strategy with the goal of maintaining a 40 mg daily dose of prednisone or its equivalent.

KEYWORDS

Mania; steroid; Behcet's disease

[Abstract:0294] Other]

Spontaneous ejaculation induced with atomoxetine

Ferhat Yaylacı[a], Begüm Şahbudak[b] and Önder Küçük[c]

[a]Gaziosmanpasa University School of Medicine Hospital Child and Adolescent Psychiatry Department, Tokat, Turkey; [b]Atatürk Research and Training Hospital Child and Adolescent Psychiatry Department, Katip Çelebi University School of Medicine Medical School, Izmir, Turkey; [c]Tokat Mental Health Hospital Child and Adolescent Psychiatry Department, Tokat, Turkey

ABSTRACT

Atomoxetine is one of selective norepinephrine reuptake inhibitors and non-stimulant drug for treatment of ADHD. While it is well tolerated in child and adolescents, sexual side effects have been reported in adults. The known about side effects of atomoxetine is limited in adolescents. It has long been known that both disease and its treatment cause sexual dysfunction in patients. Brain structures specific to human sexual response(e.g. Hypothalamus, limbic system, cortex) are mediated by various neurotransmitters(dopamine, serotonin, acetylcholine, nitric oxide) and hormones(e.g. testosterone). Drugs associated these mediators and hormones may cause sexual dysfunction. We aimed to report a case 16 year- old with ADHD with the atomoxetine' s sexual side effect.

Case presentation: 16 year old boy was diagnosed as ADHD. Atomoxetine treatment was stated as 40 mg/day (0,5 mg/kg/day) and titrated up to 80 mg/day one week later. 1 month

KEYWORDS

Atomoxetine; sexual side effects; spontaneous ejaculation

later, it was described spontaneous ejaculation nearly every day that started on third day of atomoxetine treatment. That situation was not accompanied with sexual stimulation and erection. This clinical situation was correlated with atomoxetine treatment starting. Atomoxetine is a selective inhibitor of presynaptic norepinephrine carriers in the central nervous system. It also has low affinity for serotonin and dopamine transporters. In the literature, data on sexual side effects of atomoxetine are mostly seen in adults. In a randomized controlled trial, adult male patients treated with atomoxetine had relatively more sexual and genitourinary side effects compared with placebo while there were no sexual side effects(decreased libido, abnormal orgasm, premature ejaculation, sensation decreased orgasm) reported in male adolescents. Side effects of spontaneous ejaculation reported by atomoxetine; Naranjo's Adverse Drug Reaction Probability Scale was evaluated as 6 points. Ejaculation is a complex mechanism with a central and peripheral pathway in the Central Nervous System(CNS). In humans, the peripheral pathway is adrenergic and mainly facilitated by norepinephrine. Adrenergic activity may decrease ejaculatory latency and induce spontaneous ejaculation. This side effect reported by atomoxetine; it may be via the peripheral nervous system. There are generally adult patient case reports about spontaneous ejaculation in the literature. The known sexual side effects of atomoxetine in adolescents is so limited. This rare sexual side effect is unlikely to be considered. This side effect should be kept in mind in adolescents taking atomoxetine. It is considered to evaluate sexual side effects of stimulants and non-stimulants in randomized controlled studies.

[Abstract:0295] [Other]

Rapid elevated blood level of prolactin thought to be caused by receptor polymorphism in a female adolescent with low-level risperidone therapy

Neriman Klit[a] and Ferhat Yaylacı[b]

[a]Tokat Mental Health Hospital Child and Adolescent Psychiatry Department, Tokat, Turkey; [b]Gaziosmanpasa University School of Medicine Hospital Child and Adolescent Psychiatry Department, Tokat, Turkey

ABSTRACT

Most typical first-generation antipsychotics and some atypical second generation antipsychotics block DRD2 receptors and, consequently, increase circulating prolactin levels. Polymorphisms in the DRD2 gene can affect binding of antipsychotics to these receptors, thereby modifying prolactin release from the pituitary gland. This case report aimed to present a 16- year old adolescent girl diagnosed with depression that had seen acute elevation in prolactin blood level with low risperidone treatment.

Case presentation: Our case was 16 years old girl who had been decided to treat with fluoxetine and risperidone for her self-destructive behaviors and depressive symptoms in hospital because of her family bipolar history. Her blood prolactin level has elevated to 189.8 ng/mL from 22.45 ng/mL in a one day with 0.5 mg risperidone and has returned to 33.6 ng/mL in a one day after risperidone has quit and aripiprazole started. Considering this, it was thought that genetic DRD2 receptor polymorphisms might be present in our case so the treatment was continued with aripiprazole. While using antipsychotics, plasma prolactin levels have been reported to increase in a dose-dependent manner, but even low daily dosages of classical antipsychotics and some atypical antipsychotics can cause significant elevations. Besides the dose and duration of antipsychotic medication, prolactin levels may be influenced by the genetic differences that influence prolactin metabolism and D2 receptor density. Genetic variants of CYP2D6, the main enzyme involved in the metabolism of risperidone, have been studied to establish a link with the pharmacodynamic effects of antipsychotics. It is important that clinicians consider genetic susceptibility with prolactin elevation in patients even with low-dose antipsychotics.

KEYWORDS

Antipsychotic; polymorphisms; prolactin

[Abstract:0299] [Obsessive-compulsive disorders]

Combination of electroconvulsive therapy and benzodiazepines in an obsessive-compulsive disorder case presenting with catatonia and autistic-like features

Yağmur Karakuş[a], İrem Yıldız[b], Elif Anıl Yağcıoğlu[b] and Cengiz Kılıç[b]

[a]Department of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey; [b]Department of Adult Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey

ABSTRACT

Catatonia associated with obsessive-compulsive disorder (OCD) is an uncommon psychiatric condition and there are only a limited number of case reports in the literature. OCD is commonly considered to be heterogeneous condition. Co-occurring symptoms of subthreshold autism spectrum disorder (ASD) has been identified in a number of cases. OCD cases with such comorbidities can be severe and treatment-resistant.

Case presentation: A 21-year-old male patient with OCD with the symptoms of thoughts of doubt, mental rituals, checking compulsions, ritualistic behaviors, repetitive touching, looking and repeating phrases, was evaluated in our inpatient adult psychiatry ward. In addition to the OCD symptoms, he had serious difficulty in social relationships, deficits in social-emotional reciprocity, dependence on routine, stereotypical speech and insistence on sameness suggesting autistic-like features. However, autistic symptoms were not present during early childhood, as would be expected of typical autism, and became manifest when social demands exceeded his limited capacity in high school years. Although he received treatment for OCD for four years with several high-dose selective serotonin reuptake inhibitors (SSRIs) and antipsychotic augmentation, remission could not be achieved. Cognitive-behavioral therapy (CBT) could not be maintained due to his lack of insight. The severity of his symptoms escalated after his father's sudden death and he was in a catatonic state at his first hospitalization. Catatonia presented with posturing during sleep, staring, immobility, ambitendency, catalepsy, waxy flexibility, negativism, echolalia and echopraxia. The mental status examination did not reveal any psychotic or affective symptoms. In the beginning of the treatment, he was not capable of performing daily routines such as showering, dressing by himself, and following meal times. In addition, he had enuresis diurnal and nocturna. After an unsuccessful trial of oral administration of lorazepam 6 mg/day, electroconvulsive therapy (twice a week with flumazenil) and lorazepam 6 mg/day were concurrently initiated. After 12 ECT sessions, the symptoms of catatonia were ameliorated and daily functioning improved. Although SSRI treatment for OCD was continued, his obsessive and compulsive symptoms did not improve. Catatonia is rarely seen in OCD patients. A challenge for psychiatrists is to make differential diagnosis and find an effective treatment for this unusual clinical manifestation of OCD. There are a limited number of cases in the literature successfully treated with ECT and benzodiazepines. However, obsessive and compulsive symptoms sometimes persist, even though catatonia symptoms improve.

KEYWORDS

Catatonic State; obsessive-compulsive disorder; autistic features; electroconvulsive therapy

[Abstract:0301] [OCD]

A case of pediatric obsessive-compulsive disorder with spiritual thoughts and neurodevelopmental comorbidities

Ezgi Öztürk and Dilek Ünal

Department of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey

ABSTRACT

Obsessive-compulsive disorder (OCD) is a mental disorder in which people have unwanted and repeated thoughts or feelings and behaviors that they feel an urge to repeat. It has a bimodal age distribution, with a first peak at age 11 and a second in early adulthood. According to the epidemiological studies prevalence rate of pediatric OCD varies between 2% and 4%. Comorbidity is common in OCD affected children and adolescents. Prevalence rates as high as 51% in children and 36% in adolescents for attention deficit-hyperactivity disorder (ADHD) and 51% and 47% for oppositional defiant disorder (ODD) were reported in youth with OCD.

Case presentation: A 14-year-old female was referred for not being able to perform daily activities while seeing or thinking of certain people who she thought were messy or disagreeable and repeating activities until she could stop thinking of these people. Her symptoms started at the age of 11 and peaked after she started high school. She felt that when she touched or thought of these people their bad personality traits could be transferred to her so she had to touch or think of someone she trusted for relief. Due to her obsessive thoughts she wasn't able to take notes during classes, study, dress up or open doors at the first attempt. Her grades that were good before went down. Eventually she failed 9th grade. She was a restless baby who cried a lot. Since early childhood she easily lost her temper when her demands weren't met. She was a hyperactive, impatient and stubborn child who broke the rules. When she started school she talked a lot during classes and she couldn't focus on her homework. After puberty she began to have more arguments with her mother and sometimes pinched or hit her. The patient was diagnosed with OCD, ADHD and ODD. She was prescribed fluoxetine 20 mg/day. One month later OCD symptoms began to decrease, but fluoxetine was discontinued due to sedation. Her treatment was changed to sertraline 50 mg/day. Her initial obsessions and compulsions mostly disappeared with this treatment. However, in the following sessions she began to develop a contamination

KEYWORDS

OCD; ADHD; ODD; neurodevelopmental disorder; comorbidity

obsession and we learnt that her compliance to the medication was poor. Her sertraline dose was increased to 100 mg/day. After that the frequency of her cleaning compulsions significantly decreased. Comorbidity of ADHD in early-onset OCD was found to predict a higher severity of OCD and a higher grade of persistence of OCD. Disruptive behavior disorder comorbidity was also reported to be associated with augmented OCD severity and a worse response to selective serotonin reuptake inhibitors. In this case these neurodevelopmental disorders were thought to affect treatment adherence as well. Comorbidities of ADHD and ODD in children and adolescents with OCD is a challenging condition that has an impact on overall functioning and treatment course.

[Abstract:0302] [Psychopharmacology]

Improvement of paliperidone palmitate-induced hyperprolactinemia with the addition of aripiprazole: a case report

Ümran Eğilmez and Memduha Aydin

Department of Psychiatry, Selcuk University School of Medicine, Konya, Turkey

ABSTRACT

Antipsychotic drugs are indispensable agents in acute phase and maintenance therapy in schizophrenia. Side effects are seen due to antipsychotic drugs, which can often impair treatment compliance. Hyperprolactinemia is a frequent and serious side-effect of antipsychotic medication. Hyperprolactinemia may be asymptomatic, but may lead to gynecomastia, galactorrhea, amenorrhea, sexual dysfunction, hirsutism, infertility, decreased bone mineral density and an increased risk of breast cancer. Aripiprazole which is a partial dopamine D2 receptor agonist, can lower prolactin concentrations and potentially reduce prolactin-related effects when given with antipsychotics. We reported a patient who developed hyperprolactinemia while taking paliperidone palmitate long-acting antipsychotic treatment which improved on the introduction of aripiprazole.

Case presentation: A 43-year-old woman with schizophrenia was admitted to the inpatient clinic because of increased psychotic symptoms after discontinuation of treatment. The patient's PANSS score was 96, CGI score was 6 and Calgary depression score was 2 at the first evaluation. Long action injectable antipsychotic treatment was planned for the treatment of patient due to noncompliance. Oral paliperidone 3 mg/d was started and the dose was increased up to 9 mg/d. The prolactin level was found to be high (115,3 ug/L) in the 10th day of the treatment and, galactorrhea was detected. The level of macroprolactin in the patient was found to be 198 ug/L. No pathology was detected in the cranial MRI but microadenoma size was determined as 7×2.7 mm in pituitary MRI. The patient was consulted to the endocrinology and ophthalmology department. Visual field examination was normal. Endocrinology suggested changing the antipsychotic drug and initiating cabergoline treatment. The patient's prolactin level reached 202 ug/L after the first dose of paliperidone palmitate 1 monthly formulation (PP1M). The femoral head was osteopenic in the measurement of bone densitometry. Upon this aripiprazole 2,5 mg/d treatment was started. After 5 days, the level of prolactin was 103 ug/L and aripiprazole dose was increased to 5 mg/day. On the following 7th day, the level of prolactin was 64 ug/L. The patient was given the third dose of PP1M (150 mg/m). Prolactin level was 146 ug/L after 15 days and aripiprazole dose was increased up to 7.5 mg/day. PANSS score was 61, CGI score was 4, Barnes akathisia scale was 0, Simpson Angus scale was evaluated as 0 on the 55th day of hospitalization and she was discharged. After 15 days, the prolactin level of the patient was decreased to 54 ug/L, and no galactorrhea was observed. The level of prolactin increases faster due to the PP1M loading dose regimen. The addition of aripiprazole as a partial dopamine receptor agonist to PP1M therapy is generally well tolerated. It is suggested as a treatment option that can reduce hyperprolactinemia due to antipsychotic. This option gives patients the opportunity to continue with antipsychotic treatment. Further studies are needed to determine the true effect of this antipsychotic combination on prolactin levels.

KEYWORDS

Aripiprazole; hyperprolactinemia; paliperidone palmitate; schizophrenia

[Abstract:0304] [Eating disorders]

A different clinical presentation of anorexia nervosa: "food allergy"

Özlem Akçay Ciner, Atila Erol, Esra Yazıcı and Ahmet Bülent Yazıcı

Sakarya University School of Medicine Department of Psychiatry, Sakarya, Turkey

ABSTRACT

Anorexia nervosa (AN) is a severe food restriction, life-threatening psychiatric disorder with the high mortality. Patients are able to hide weight loss. This concealment behavior may also occur under different medical conditions.

In this case, an anorexia nervosa patient will be presented who says that she has "food allergy".

Case presentation: The patient is 36 years old, a housewife, married woman followed by dermatology for urticaria for 20 years. The patient was hospitalized with the diagnosis of angioedema after swelling in her tongue approximately 1 year ago. After this event she intensely concerned about swelling of the tongue again and going back to the hospital. Thus, she had difficulty moving away from home and being alone. The patient was in treatment by the allergy department because of angioedema, and the doctor informed that she could have allergy to spicy foods. After this information, the patient did not eat spicy food. However, over time, the patient stopped eating not only spicy food but also bitter and sour foods. She also started not eating pastries and desserts. She was worried they might put spices etc. in the food when she went to her friends thus she began to decrease the meeting with her friends. The patient, decreased from 58kg (BMI: 19,39) to 50kg (BMI: 16,72) in approximately 8 months after this eating behavior. When the patient's eating behavior was questioned, it was learned that she paid attention to the foods she ate throughout her life and he took care to eat protein and vitamin. It was learned that the weight of the patient was 70 kg during the pregnancy period but returned to 58 kg within one week. The patient was not doing sports, not experiencing vomiting and menstrual irregularity. The patient's first psychiatric admission was due to physical symptoms of anxiety. After psychiatric admission, psychotherapy and hydroxyzine were recommended. The patient did not complain about losing weight, although her relatives said that she seemed very weak and she did not feel any discomfort from her body's poor appearance. However, the last time she was referred to our outpatient clinic, the patient was diagnosed with AN, she and her relatives were informed. The patient received 1 kg through the control examination after three weeks with Mirtazapine 15 mg/day. In this case report we present a patient with AN restricting food intake with – camouflage of – "food allergy". As seen in this case, AN patients may have very different causes even medical reasons which was not understood by professionals for limiting food intake but the result is not changed. AN start with reasons such as "food allergy" and a "healthy diet-orthorexia nervosa (ON)". In the literature, the study showed that the rate of accompanying ON to eating disorders was 28%, and the rate of ON increased to 53% after treatment. AN is a psychiatric disorder that can have fatal consequences. Taking a detailed anamnesis from the patients is important in terms of revealing the weight loss of patients with various masks.

KEYWORDS

Anorexia nervosa; eating disorders; food allergy

[Abstract:0310] [Eating disorders]

Hyalophagia in a 3-year-old child: a case report

Gülnur Baş and Tuğba Yüksel

Department of Child and Adolescent Psychiatry, Dicle University School of Medicine, Diyarbakır, Turkey

ABSTRACT

Pica which is under the title of "Feeding and Eating Disorder" in DSM-5 is defined as the persistent eating of non-nutritive substances which are inappropriate for developmentally, culturally or socially for a period of at least 1 month (1). In this article, a 3-year-old case with hyalophagia (consumption of glass materials) is discussed with the literature.

Case presentation: A 3-year-old girl patient presented to our outpatient clinic with the complaint of having the habit of eating paper, eraser, pencil, plastic objects and glass with her mother. According to the anamnesis we received, we learned that her complaints were existed for 1.5 years and she had eaten 3 glasses in the last one month. She had also sleep and appetite problems, hyperactivity, irritability and no gastrointestinal problems. Her mother was 24 years old, housewife and uneducated, her father was 28 years old, worker and uneducated. She had no brother or sister. Her mother used medication at her pregnancy for the risk of abortion. She was born as 2300 grams by normal spontaneous vaginal way on time, her developmental steps were normal and she had been using carbamazepine for 5 months after febrile convulsion. There was no psychopathology in her family history. At mental status examination; she was a normal girl who was conscious, oriented and had normal communication and perception skills for her age. Ankara Development Screening Inventory was consistent with the age. Hydroxyzine 10 mg/day treatment was started, psychoeducation was given to the family, followed by recommendations. After 3 weeks, partial recovery was described. The follow-up of the patient whose hematologic

KEYWORDS

Pica; child; eating glass; hyalophagia

examinations are within normal limits is ongoing. Pica usually occurs between 18–24 months in normal development children. Male gender, small age, developmental retardation, autism spectrum disorder and schizophrenia are accepted as the risk factors (2). In addition, a close relationship between poverty, inadequate mother-child interaction, neglect and abuse and pica was shown (3). Although there are many studies showing the relationship between pica and iron and zinc deficiency in the literature, the laboratory parameters of our patient were within normal limits. Soil, stone, clay, paint, stucco, fabric, hair are frequently reported as non-food materials in small children with pica but there is no evidence of eating glass at very young age. In our case there was no developmental retardation but low sociocultural and socioeconomic levels support the literature.

When the literature is researched, it is observed that there are few studies about the etiology, epidemiology and treatment of the pica, more studies are needed on this subject.

[Abstract:0314] [Schizophrenia and other psychotic disorders]

Is it a novel indication for antipsychotic drugs, or a coincidence? A report of a psoriasis case

Mehmet Güneş, Ali Baytar, Mahmut Bulut and Mehmet Cemal Kaya

Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Schizophrenia is a polygenic, multifactorial disease in which neurobiological, environmental and genetic studies have shown that inflammatory pathways play a role in the pathogenesis. Psoriasis is a chronic inflammatory disease that involve mainly in the skin along with many organs. Some studies have found a possible link between psoriasis and psychosis. Our aim is to report the improvement of psoriasis symptoms in our patient who used long-acting depot antipsychotic (LAAP) for psychosis.

Case presentation: 43 years old male patient. He wasn't working. There was no use of alcohol. He had substance abuse in the past and was smoking 2 packs a day. His brother had a diagnosis of schizophrenia. The patient was consulted to us while he was being followed up in a dermatology clinic. It was learnt that since the age of 20 he had been on follow up in another psychiatry clinic with a diagnosis of schizophrenia. He had been diagnosed with psoriasis vulgaris for 10 years. The lesions were gradually spreading all over his body. However, he expressed that his delusions of skepticism and evil were intensified. It was learnt that the auditory hallucinations with reference delusions continued uninterruptedly for 2 years. He was prescribed quetiapine 200 mg/day but did not use his medication regularly through those years. His medications revised on follow up as he did not benefit from treatment regimens. He was started on risperidone 6 mg/day, haloperidol 20 mg/day and olanzapine 10 mg/day respectively. Either those treatment regimens did not improve the symptom or drug compliance couldn't be achieved. The patient was re-evaluated before discharge. Psychotic findings were found to be continued. The patient was hospitalized to psychiatry clinic. His biochemical parameters(liver, kidney and thyroid) were found to be within normal limits. Cranial MRI was inconclusive. Mental status examination revealed auditory hallucinations, reference-persecution delusions, and negative symptoms such as avolition and anhedonia. During psoriasis flare up episodes his psychotic symptoms aggravated. Since he got the diagnosis of psoriasis he was hospitalized to dermatology clinic because of exacerbations. Each time the psychotic symptoms were also worsened. It was learned that during these episodes he couldn't use his antipsychotic treatments on a regular basis. Paliperidon 3 mg/day oral treatment was initiated. Some improvement was noted without any significant side effect. Than paliperidone palmitate 100 mg/month injection therapy was initiated. The patient reported a significant decrease in his psychotic symptoms, furthermore, noted an improvement in his body lesions due to psoriasis. The prevalence of psychopathology in dermatologic patients is estimated to be 30–40%. A family history of autoimmune disease increases the risk of schizophrenia by 10%. A family history of schizophrenia increases the risk of autoimmune disease by 6%. In the literature, there have been no reports of improvement of psoriasis symptoms by controlling psychotic symptoms with LAAP. Due to the fact that antipsychotic treatments can be effective on many receptors, we wanted to discuss the use of antipsychotic treatments in the treatment of autoimmune diseases and the fact that similar etiological factors of schizophrenia and psoriasis can be treated with a single agent.

KEYWORDS

Schizophrenia; psoriasis; long acting antipsychotic

[Abstract:0316] [Schizophrenia and other psychotic disorders]

Acute psychotic episode after steroid withdrawal

Olcay Şenay[a], Ayşe Tuğçe Varlı[b] and Irmak Polat[a]

[a]Department of Psychiatry, Istanbul School of Medicine, Istanbul University, Istanbul, Turkey; [b]Department of Child and Adolescent Psychiatry, Istanbul School of Medicine, Istanbul University, Istanbul, Turkey

ABSTRACT

Alterations in steroid homeostasis is known to play a role in psychiatric syndromes. Despite the diverse literature on the psychopathology in Cushing's syndrome, Addison's disease and steroid-induced psychiatric symptoms, effect of steroid withdrawal is rarely discussed. Here we present a case of acute psychosis, which occurred after the withdrawal of steroid therapy.

Case presentation: 52-year-old woman was referred to our inpatient unit from another center with symptoms as feeling anxious, talking to herself, auditory and visual hallucinations and tendency to sleep. She claimed that she saw a person with large eyes and sparse teeth, telling her to kill her brothers and sisters with different colors of knives and this person cut the throat of imaginary women and forced the patient to drink their blood. We learned that these symptoms began abruptly about a month ago, without any known psychosocial stress factor. In the psychiatric history, she had been treated for anxiety disorder and depression for 7 years; her current medication was duloxetine 60 mg/day and clonazepam 1 mg/day. According to the information obtained from her doctor, no psychotic symptoms were observed during her follow-up. In the medical history, she had been diagnosed with sarcoidosis approximately 20 years ago and she was under methylprednisolone treatment 32 mg/day until past 3 months. Due to the remission state of the disease, steroid treatment was decided to end and her relatives state that the medication was ceased in 24 h.1 month after the steroid cessation, the psychotic symptoms appeared. Gradually shortness of breath and tendency to sleep was added and she was admitted to emergency room with deterioration of her general condition. She was diagnosed with adrenal insufficiency and started on hydrocortisone 30 mg/day. Pulmonology, cardiology and neurology had no further suggestions at that time. By the consultant psychiatrist, amisulpride 800 mg/day was added to her current medication. The patient was admitted to our inpatient unit for further evaluation. Endocrinology consultation suggested to lower hydrocortisone dosage to 15 mg/day then to switch to prednisolone 5 mg/day. Psychotic symptoms and anxious mood regressed gradually throughout hospitalization. By the time she stated neither auditory nor visual hallucinations and reached euthymic mood, we started to lower the dosage of medications. Amisulpride was decreased to 400 mg/day, duloxetine was decreased to 30 mg/day and she was discharged with this treatment. Psychiatry and endocrinology follow-ups are suggested. Both steroid administration and withdrawal may reveal psychiatric symptoms. In spite of the general knowledge about corticosteroids inducing psychotic disorders, psychosis after sudden withdrawal have been presented in limited number of case reports in the literature. Some researchers suggest that these symptoms may appear after discontinuation of medication, possibly as a consequence of a previous sensitization, however some associate this with adrenal insufficiency. In our case, we relate the acute onset of psychotic symptoms to the adrenal insufficiency due to abrupt cessation of steroid therapy. Adverse psychiatric symptoms can be prevented by gradual dose reduction of steroids. Psychiatrists should be aware of the possibility of withdrawal psychoses as a result of steroid therapy.

KEYWORDS

Steroid; steroid withdrawal; psychosis

[Abstract:0318] [Mood disorders]

Late-onset bipolar disorder manic episode: a case report

Süleyman Kızıldağ[a], Mehmet Güneş[b], Hasan Durak[a], Mehmet Cemal Kaya[b] and Mahmut Bulut[b]

[a]Department of Child and Adolescent Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey; [b]Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Bipolar disorder is a psychiatric disorder observed in late adolescence and early adulthood. 90% of the patients have an attack before the age of 50. The incidence of late onset bipolar disorder is low, the incidence in the United States is between 0.1% and 0.4%. Our case draw attention that the first manic episode can be seen even in the late period as 88 years old.

Case presentation: 88 years old female patient was brought to the outpatient clinic by her daughter. According to the anamnesis, The patient who presented to psychiatry for the first time, described the symptoms of increased irritability, increased and meaningless speech, increased psychomotor movements, decreased need for sleep, hypersexuality, disorganized

KEYWORDS

Bipolar disorder; geriatric mania; dementia; late-onset

speech. Patient's complaints initially started 3 years ago. At that time, there was irritability and decrease need for sleep. It was said that these complaints lasted up to 4–5 days in the spring and autumn months for last three years. Apart from these periods, it was learned that her cognitive functions returned to normal, functionality was normal.

In the examination of her mental state; it was observed that the patient could not sit in position during the interview. She was conscious, orientation was complete, her mood was hyperthymic, irritable; her affect was incompatible. It was determined that her judgement was disturbed, there was no insight, the amount of speech and the speed of speech increased and there were flight of ideas. Hemogram, biochemistry and hormone profile examinations were within normal range. In the neurology consultation, it was stated that there was no organic pathology, dementia was excluded. Cranial MRI was reported as normal. In the patient's medical and family history; there was no psychiatric or medical illness but her sister and sister's daughter were diagnosed with bipolar disorder and received treatment. After the anamnesis and mental state examination, according to DSM-5 diagnostic criteria, patient was diagnosed with bipolar disorder I (psychotic manic episode). The patient was prescribed risperidone 2 mg/day, sodium valproate 1000 mg/day and lorazepam 1 mg/day. After 2 weeks, it was observed that the patient had significant benefit from the treatment, the need for sleep, the amount of speech returned to normal and the disorganized speech disappeared. Late-onset mania is reported to be caused mostly by neurological, especially vascular pathologies. In our case, vascular pathologies were excluded by not showing any pathological findings in MR. The decrease in the need for sleep, and the symptoms of irritability which had started 3 years ago were episodic in the spring and autumn periods and compatible with hypomania. In the other periods, depressive symptoms were not described. The first manic episode was observed at the age of 88 years and the patient was diagnosed with very late-onset bipolar disorder I. When the literature was reviewed, it was observed that late-onset mania cases were rare. It is important that the first manic episode of our patient started at the age of 88 and that there was no neurological pathology.

[Abstract:0319] [Anxiety disorders]

Premenstrual conversion disorder: a case report

Betül Türkmen, Esra Yazıcı, Ahmet Bülent Yazıcı and Atila Erol

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Premenstrual dysphoric disorder is a common disease with the emotional, behavioral and physical symptoms as mood fluctuation, irritability, dysphoria, decreased concentration, insomnia and fatigue, breast tenderness, edema, headache weight gain and abdominal pain. There are case reports of premenstrual mania, hypomania and psychosis but no premenstrual conversion disorder has been reported. It has been well known premenstrual hormonal changes may be related with psychiatric symptoms but conversion disorder is probably rare.

In this case report, conversion disorder seen during premenstrual period is reported.

Case presentation: A 40-year-old single female patient was admitted to the psychiatry outpatient clinic with the symptoms of numbness and weakness in his hands and feet, inability to go to the toilet, vomiting, nausea, fatigue and inability to meet self-care needs. According to the psychiatric history, her complaints have started about 1 week prior the menstruation for 12 years and within 1–2 days after her menstrual bleeding. Mild depressive symptoms had been continuous between premenstrual periods. During this period, the patient did not have any psychotic symptoms. The patient's history revealed that she had been diagnosed with epilepsy after a 4-year-old tonic-clonic generalized seizure and started taking antiepileptic drugs after that period; He had been on duty for 15 years and had been using carbamazepine 1200 mg/day and valproate 1000 mg/day. After repetitive examinations and investigations, 2 years ago, organic reasons including epilepsy were completely excluded by MRI and EEG by neurology and her complaints were considered psychiatric, and escitalopram 10–20 mg 1 × 1 treatment was started. The patient's depressive symptoms were reduced after the escitalopram but premenstrual symptoms were continued. Prior to current admission she was in a "coma-like table" for 3 days with no talking, eating and taking self-care as toilet needs. At the psychiatric examination; the finding of la belle indifference strengthens the diagnosis of conversion disorder. Sertraline 50 mg was added to the treatment and the patient's symptoms reduced significantly. In our case, as a result of the psychiatric examination performed in our case, weakness in hands and feet, loss of strength, loss of walking, inability to speak and difficulty in swallowing, and DSM-5 conversion disorder meet mixed diagnostic criteria. Although the patient had symptoms which could be considered as catatonic stupor, catatonia was excluded due to the lack of symptoms such as additional negativism, echopraxia and grimacing to meet the diagnostic criteria of catatonia.

KEYWORDS

Premenstrual dysphoric disorder; conversion disorder; premenstrual hormones

The fact that the findings were started 1 week before the end of the month and the complete disappearance on the first day suggested that there is a premenstrual conversion disorder. Hormonal changes may have contribution in this condition but it is not enough to a complete explanation. The psychobiosocial etiology needs to be understood with further studies. Premenstrual syndrome affects the vast majority of women in the community. Conversion disorder may be one of presentations. Different clinical presentations and lack of standard treatment methods make it difficult to approach and treat diseases.

[Abstract:0321] [Mood disorders]

New-onset mania in the elderly: a case after bereavement

İmge Coşkun Pektaş and Ümmühan Ceviz Özkal

Department of Psychiatry, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey

ABSTRACT

Bipolar disorder (BD) constitutes approximately 20% of mood disorders in the elderly and 8% of new BD cases occur in geriatric patients. The incidence of new-onset BD decreases as age progresses, and the newly developing BD constitutes 6–8% of cases in people aged 60 and over. BD in later life is a complicated neuropsychiatric syndrome with diagnostic and therapeutic difficulties. Diagnosis of late-onset bipolar disorder requires rigorous evaluation for all potential secondary causes. Neurological deterioration seems to be predisposed to the development of late-onset bipolar disorder. The sudden loss of the loved one can initiate various psychiatric diseases in people without mental illness. While previous studies have suggested there is a link between sudden bereavement and onset of common psychiatric disorders, this case shows the association of acute bereavement and late-onset mania.

Case presentation: A 78-year-old female, lives with her family in Istanbul, was referred because of psychiatric symptoms started after the unexpected death of the husband. The patient who did not have a medical and psychiatric history presented with a reduced requirement of sleep, irritability, increased energy, increased goal-directed activity in the form of housework. In the examination of the mental state, there are findings of The preoccupation of his deceased husband in thought content, subjective experience of thoughts racing, distractibility, psychomotor agitation, abstraction was preserved, reasoning and insight were partial. Her speech was spontaneous and pressurized; her mood was dysphoric; and her affect was wide ranging, dramatic, and labile. The patient was referred to neurological consultation. Neurological examination was normal. Also, neuroimaging studies excluded neurological mania. Drug usage wasn't mentioned. She doesn't have a family history of affective illness. The Mini Mental Status Examinations revealed the scores of 25. Upon admission, we gradually increased the dose of olanzapine to 10 mg once daily. Mania, in this case, was attributed to the sudden loss of a loved one. Suddenly losing a loved one can increase the risk of mania. Most theories about mania see it as a defense against the underlying depression. The manic state may also result from a tyrannical superego, which produces intolerable self-criticism that is then replaced by euphoric self-satisfaction. Bertram Lewin regarded the manic patient's ego as being associated with pleasurable or feared impulses. Melanie Klein also accepted mania as a defense response to depression, using manic defenses such as omnipotence, where one developed delusions of grandeur. We present an interesting case of late-onset bipolar disorder after the devastating loss of a family member while evaluating secondary mania. Our case should alert clinicians to the possible onset of a wide range of psychiatric disorders, including disorders such as mania, after an unexpected death in otherwise healthy individuals. Our results show that the unexpected death of a loved one may be a significant risk factor for manic episode onset, especially among older adults, and even among those who have not had a history of mood, anxiety, or alcohol disorder before. Also, this case presentation demonstrates that the clinicians should have mania in mind amongst the possible grief reactions.

KEYWORDS

Bipolar disorder; funeral mania; late-onset mania; mania after bereavement

[Abstract:0324] [Psychopharmacology]

A psychotic type mania disorder accompanied by Huntington disease

Elif Merve Kurt, Ali Savaş Çilli and Atila Erol

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Huntington's Disease (HD) is a progressive, neurodegenerative, hereditary basal ganglia disease, usually accompanied by chorea-dominated movement disorders, cognitive dysfunction,

KEYWORDS

Huntington Disease; mania; psychotic; clozapine

psychiatric symptoms, and subcortical dementia. Our case is "a psychotic-type mania disorder" accompanied by HD.

Case presentation: A 28-year-old, high school graduate, single (divorced) woman, living with her child and family, who had been followed-up for 7 years with HD. She was hospitalized with complaints of insomnia, talking to herself, talking too fast and excessive, hyperactivity, and hearing voices for 2–3 months. She was trying to go out of home and become aggressive when blocked. She claimed herself spoken to God, angels and demons. She also believed that she is an angel, the devils are dealing with her, and she is married to the prophet, so she wants to be addressed as "Your Excellency". Her affect was labile and her mood was elevated and irritated. The speed and amount of speech was increased, the tone was natural. The flow of thought was accelerated. She had persecution, mystic and grandiose delusions and auditory hallucinations. She had impaired judgement and lack of insight, reduced attention and concentration, deteriorated abstract thought, increased psychomotor activity regardless of her choreiform movements. On physical examination, there were no features except choreiform movements. The patient had been hospitalized with irritability, unhappiness and self-injury and had been treated with escitalopram 10 mg/day and quetiapine 300 mg/day before. Aripiprazole and olanzapine had been added to the treatment in outpatient clinics, but there was no significant benefit. She was hospitalized with the initial diagnosis of "psychotic – type manic attack" and lorazepam 5 mg/day and haloperidol 3 × 1 mg/day treatment was started. The patient's irritability and hyperactivity decreased in 15 days and her sleep improved; her auditory hallucinations, mystic and grandiose delusions continued. Although haloperidol treatment decreases choreiform movements, haloperidol therapy is discontinued because it causes a decrease in voluntary motor movements (chewing and speaking); clozapine was started at 25 mg/day and increased to 50 mg/day. Lorazepam was decreased and stopped. Her manic and psychotic symptoms reduced in 1 month and she was discharged with clozapine 50 mg/day. She was stable with same treatment in next controls in two months. The prevalence of psychiatric disorders in HD is between 23–73%, mania and bipolar disorder is between 5–10%. Irritability, depressive mood, behavior disorders, impulsivity, apathy, sleep disorders, affective disorders, anxiety and psychotic symptoms may accompany to HD. It was reported that a HD patient with psychotic manic episode was treated with haloperidol 10 mg/day, divalproex 1500 mg/day and lorazepam 4 mg/day. Atypical antipsychotics are preferred more frequently in HD because they have less side effects than haloperidol. There are publications reporting the use of olanzapine, aripiprazole and clozapine. In a HD patient with hallucinations and paranoid delusions, clozapine was started at 25 mg/day and increased to 200 mg/day, and choreiform movements were also reported to be improved.

Psychiatric symptoms are frequently accompany to HD. In our case, a typical psychotic manic episode with HD was successfully treated with clozapine 50 mg/day.

[Abstract:0326] [Psychopharmacology]

Epistaxis with risperidone treatment in two pediatric patients

Haluk Ümit Yeşilkaya[a], Leyla Delikanli[b] and Gül Karaçetin[b]

[a]Psychiatry Department, Bakırkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey; [b]Department of Child and Adolescent Psychiatry, Bakırkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey

ABSTRACT

An atypical antipsychotic risperidone with high affinity for D2 and 5 HT2A receptors has been shown to be effective in the treatment of various psychiatric disorders, including disruptive behavior disorders in young populations. Although it is usually a well-tolerated drug, some side effects such as drowsiness, rhinitis, headache, weight gain, increased appetite and upper respiratory tract infection have been reported during risperidone treatment. Risperidone-associated epistaxis has been rarely reported in adults In this study, two patients with a diagnosis of major depressive disorder and diagnosed with autism will be presented with risperidone therapy and epistaxis cases.

Case presentation: 7-year-old child female with atypical autism was brought by her family to our outpatient clinic with complaints of being hyperactive and having deficient attention. in her history, she was first brought to the child and adolescent psychiatry unit 5 years ago and diagnosed with autism. When she started to school – at special subclass-her teacher referred her to psychiatry because of her difficulties for attention. She does not have any other medical disease nor abnormalities in her routine blood screening. She was diagnosed with ADHD, considering his irritability, she was started on 0,25 risperidone /day. One month later she was brought by the family to the emergency psychiatry unit because of nose bleeding. Her blood examination including was normal. Any other cause that may explain the bleeding could not been detected. Risperidone was planned to cease due to its possible causal

KEYWORDS

Epistaxis; risperidone; 5-HT2A receptor antagonism

association with nose bleeding as it was previously reported in the literature. Aripiprazole was initiated 2,5 mg per day and the bleeding did not appeared at his follow-ups. 15-year-old adolescent male was referred to our emergency psychiatry unit by another clinician following the medical care for a suicidal drug intake on previous day. In the psychiatric examination, he was labile but mostly had a depressive mood for a year. He had pessimistic thoughts and anhedonia. His energy was decreased. He stated that he felt desperate about the future and suddenly decided to take the drugs excessively and randomly that were prescribed by a psychiatrist 2 weeks ago to get rid of these thoughts. He had currently no suicidal thoughts or plan. He had no delusions nor hallucinations. Upon further questioning, he has no psychiatric family history nor mood episode. He was diagnosed with major depressive disorder and planned to start risperidone 0,5 mg/day and gradually increased to 1 mg per day plus sertraline 25 mg/day. When he took 1 mg risperidone he started to bleed his nose and was taken by his family to emergency. In his blood examination elevated creatine kinase, alanine transaminase and aspartate transaminase level was determined. it is planned to stop risperidone and sertraline and consulate him with pediatrician. His blood examination including was normal. He continued sertraline 25 and gradually increased to 50 mg/day. His nose bleeding did not repeated at his follows-ups.

Risperidone causes thrombocytopenia and 5-HT2A receptor antagonism. It is thought to cause bleeding by reducing platelet aggregation with 5HT2A receptor antagonism.

[Abstract:0329] [Psychopharmacology]

Atomoxetine-induced daytime urinary incontinence in a 9 year old case

Anıl Akar, Özge Gizli Çoban, Arif Önder and Aslı Sürer Adanır

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

The maturation of daytime control of bladder function is usually achieved between 2 and 3 years of age, whereas it is normally between 3 and 7 years for the night time control. According to the International Children's Continence Society (ICCS), daytime urinary incontinence (DUI) is involuntary loss of urine during the day. It is also defined in the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM V), as an involuntary voiding of urine during the day, with a severity of at least twice a week, in children >5 years of age, in the absence of congenital or acquired defects of the central nervous system. The prevalence of daytime incontinence ranges from 2% to 20%. In this case report, we discuss about a case with daytime urinary incontinence occurring after atomoxetine treatment, showed complete recovery after the cessation of the drug, and occurred again, with the re-initiation of it.

Case presentation: A 9-year-old girl was referred to our outpatient clinic with attention problems, excessive mobility and behavioral problems; and diagnosed as attention-deficit/hyperactivity disorder (ADHD). Atomoxetine 10 was initiated and increased to 18 mg/day. In the next visit, her parents reported that she had daytime urinary incontinence 1–2/day, with accompanying urgency and frequency. She was referred to pediatric nephrology and organic etiology was ruled out. Atomoxetine was discontinued and she was followed for a while without any medication. Symptoms of incontinence disappeared within the same day after the discontinuation of atomoxetine. In her next visit after 15 days, atomoxetine treatment initiated and the symptoms of incontinence occurred again. Whereupon, atomoxetine was discontinued and long acting methylphenidate 20 mg/day initiated. During the follow-up period, urinary incontinence did not recur. To our knowledge, it is the first case in the literature in which daytime incontinence was observed during atomoxetine use. Although atomoxetine is not classified in the stimulants group, it is a well-tolerated and effective drug for the treatment of ADHD. Atomoxetine is a potent presynaptic noradrenaline reuptake inhibitor. In ADHD and enuresis comorbidity, atomoxetine treatment has been shown to be effective on both ADHD and enuresis symptoms in patients. It is thought that its positive effect on enuresis is demonstrated by the noradrenergic agonist mechanism. In our case, it is not clear with which mechanism of action that atomoxetine treatment developed daytime incontinence. However, the decrease in the symptoms of incontinence with atomoxetine discontinuation and the relapse of the enuresis with the resumption of the atomoxetine treatment, suggest that the enuresis is caused by the atomoxetine treatment. Although the mechanism of action is not clear, clinicians should be aware with respect to this side effect.

KEYWORDS

Atomoxetine; child; daytime urinary incontinence

[Abstract:0330] [Schizophrenia and other psychotic disorders]

Epileptic seizures with psychosis: a case report

Mehmet Arslan[a], Nafiye Yağlı[b], Yasemin Gökçenoğlu[b], Saliha Çalışır[b], Sehure Azra Yaşar[b] and İbrahim Eren[b]

[a]Babaeski State Hospital, Kırklareli, Turkey; [b]Health Sciences University, Department Of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Epileptic psychoses are classified either based on the relationship between psychoses and seizures in terms of time or based on the duration of psychotic symptoms. Symptoms widely vary and may involve not only psychotic symptoms but also anxiety or mood disorders They are specifically separated into chronic psychoses or multiple types of acute episodic psychoses, which are further divided into postictal and interictal psychoses. Together, they comprise 95% of psychoses in patients with epilepsy (PWE).

Case presentation: 32-year-old farmer presented with abnormal behavior for 2 weeks, consisting primarily of auditory hallucinations and non-bizarre paranoid delusions. He reported hearing voices telling that his relatives were plotting against him and insisted that these people had attempted to harm him in various ways. In patient history his relatives revealed similar symptoms for the past few months including excessive suspiciousness and occasional references to unnamed persons advising her, with progressive worsening in the one month prior to presentation. He did not report any neurological symptoms and also he denied any history of substance abuse. His medical history included a diagnosis of generalized tonic–clonic epilepsy, for which he was receiving maintenance therapy with phenytoin 300 mg/day since the past 2 years. She had suffered one episode of generalized convulsion after defaulting on phenytoin 10 months earlier; thereafter she resumed phenytoin therapy and did not suffer any further convulsions. Olanzapine 2.5 mg/day was ordered for psychotic symptoms and the dose of olanzapine increased to 10 mg/day and with this treatment his symptoms regressed and the patient was discharged from the hospital and disease in remission now. The psychopharmacological effects of phenytoin encompasses a broad spectrum ranging from decreased cognition, sedation and psychomotor retardation to antidepressant and antimanic activity and mood stabilization. The wide and somewhat unpredictable range of these psychopharmacological actions has also hindered attempts to develop phenytoin into a psychotropic drug. Prolonged phenytoin overdose for instance has been associated with chronic encephalopathy with cerebellar degeneration, while acute toxicity can produce delirium and even seizures. Psychosis can develop in patients with epilepsy through a variety of mechanisms, including drug toxicity. Assaying of antiepileptic drug levels is confirmatory of toxicity, and should be performed in all epileptic patients presenting with psychosis. If seizures contribute to psychosis, psychosis must be treated by clinicians.

KEYWORDS

Epileptic seizures; phenytoin; psychosis

[Abstract:0331] [Psychopharmacology]

Drug interaction between risperidone and oseltamivir: a case report

Mert Beşenek

Department of Child and Adolescent Psychiatry, Recep Tayyip Erdogan University School of Medicine, Rize, Turkey

ABSTRACT

Atypical antipsychotics (AAP) are frequently used in treatment of aggressive/oppositional behaviors and Conduct Disorders (CD) seen in childhood and Risperidone is the most widely selected AAP in this matter. Risperidone has high affinity to 5-HT2A, 5-HT2C, D2, H2 receptors and because of high H2 affinity, it may cause moderate levels of sedation (rates are 29–89%) as side effect. Risperidone is mostly eliminated through kidneys; so medications which alter kidney excretion may interact with Risperidone. In this study we aimed to present a patient on Risperidone treatment who was referred to emergency unit with severe sedation.

Case presentation: Male patient who is 2 years 10 months old; was consulted for symptoms of sleepiness, sedation and stupor. It was hard to maintain a cooperation with the patient, his consciousness were blurred at the times he woke up but other than that he was in a constant state of sleepiness. These symptoms were present for 6 h. Patient has been using Risperidone treatment of 0,25 mg twice a day for 3 months and he has been using Oseltamivir 30 mg twice a day for 2 days. He has been diagnosed with Conduct Disorder 3 months ago, was started Risperidone medication and had never experienced any side effects before. On the second day of Oseltamivir treatment, after the morning dose of Risperidone he developed symptoms of sleepiness and sedation. Current clinical situation was accounted

KEYWORDS

Interaction; oseltamivir; risperidone

for drug interaction with Oseltamivir. His medications were discontinued, sufficient hydration was done and he was monitorized for. He gradually regained normal conscious state and was discharged. There are numerous case reports indicating that Oseltamivir may directly cause adverse neuropsychiatric adverse effects. It has been speculated that Oseltamivir is causing a hyper-dopaminergic state in especially prefrontal cortex thus resulting in various neuropsychiatric symptoms including hallucinations, delirious speech, frightening episodes, abrupt anger, abnormal overactivity, irritability and impulsivity. Risperidone alone may cause sedation but; it's treatment response and side effects are generally expected in the first 2 weeks of Risperidone administration. With the fact that literature findings of Oseltamivir's neuropsychiatric adverse effects consists of over-reactive clinical symptomatology; sedative/hypo-active symptoms of our patient cannot be accounted for Oseltamivir or Risperidone alone, but on an interaction between these two drugs. Pharmacological studies found that Oseltamivir does not alter cytochrome systems at significant level; but it may lower some drugs' renal excretion. Given the fact that elimination of Risperidone is mostly done by kidneys, possible drug interaction between these two medications should be noted. To our knowledge; this is the first case report that indicates a possible pharmacokinetic interaction between Oseltamivir and Risperidone. In the previous studies, drug interaction profile of Oseltamivir was found to be low but in line with the results of our case report while using it with AAP drugs, further caution is warranted. It can also be said that new studies which focus on pharmacokinetic drug interactions between antiviral agents and psychotropic medications are needed.

[Abstract:0337] [Personality disorders]

Dissociation in psychiatric (axis I) and personality (axis II) disorder: a case report

Cansun Şahin Çam, Cansu Budak and Ümmühan Özkal

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Dissociation affects consciousness, memory, and/or identity, thinking, emotions, sensorimotor functioning, and/or behavior. Primary clinical components of dissociative psychopathology amnesia, depersonalization, decreolization, identity confusion, and identity alteration. Dissociative Identity Disorder (DID), previously called multiple personality disorder, has been researched most extensively of all the dissociative disorders. The estimated DID prevalence around the globe is about 5% among the inpatient psychiatric population, 2–3% among outpatients, and 1% in the general population. There are several conditions found to be associated with this disorder, including depression, self-harm, post-traumatic stress disorder (PTSD), substance use disorder, borderline personality disorder or anxiety, and conversion or somatoform disorder.

Case presentation: 21 year old, female, university student. She had a history of auditory and visual hallucinations, depressive mood episodes, conflicts with family members for three years. She stated that she had been hearing one of her teacher's, her father's and some other peoples' voice inside her head and she communicated with them via thinking. She believed she managed this communication by means of telepathy. She also stated that she turns into the characters of the books she reads; acts, feels and looks like them since she was fourteen years old. She had unstable emotions and distorted self-images. She often behaved theatrically. She was changing her identifications and sense of self as her relationships changed. She uses particular primitive defense mechanisms and pathologic internalized object reactions (splitting and projective identification). Her neurological examination, blood tests, brain MRI and EEG findings were normal. Steinberg Identity Alteration Questionnaire (SIAQ), Childhood Trauma Questionnaire (CTQ), and self-report screening tool of the Borderline Personality Disorder section of the Structured Clinical Interview for DSM-IV (SCID-BPD) were administered. Dissociative Experiences Scale (DES) score was 36 and the results showed that she had many dissociative symptoms, like amnesia, decreolization, depersonalization. The Minnesota Multiphasic Personality Inventory (MMPI) profile revealed the traits of cluster B personality disorder. The differential diagnosis between a psychotic disorder, dissociative disorder and borderline personality disorder was necessary. More interviews with her showed that her teacher, her father, the book characters and some unknown people whose voices she heard were actually parts of her. She felt and acted like them in stressed situations. We established a diagnosis of dissociative disorder, most likely a subthreshold dissociative identity disorder. The patient also manifested "as if" personalities. "As if" personality is the expression of identification with the environment, a mimicry of a good adaptation to the world of reality despite the absence of investment of emotional energy in objects. The "as if" personality experiences dissociation as a defense mechanism. We decided that she would benefit from psychotherapeutic approach rather than medications. Dissociation is a complex and common construct in psychopathology. Symptoms of dissociation are present in a variety of mental disorders. The findings underline

KEYWORDS

Personality disorders; borderline personality disorder; dissociative disorders; dissociative identity disorder

the importance of careful psychopathological assessment of dissociative symptoms in the entire range of mental disorders.

[Abstract:0339] [Obsessive-compulsive disorders]

N-acetyl cysteine therapy in a patient with treatment-resistant OCD

Cansu Budak, İsmail Peker and Serhat Ergün

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Obsessive-compulsive disorder (OCD) is a good example of a neuropsychiatric disorder, mediated by pathology in specific neuronal circuits, and responsive to specific pharmacotherapeutic and psychotherapeutic interventions. Despite the adequate treatment trials, half of patients with OCD continue having residual or impairing symptoms. It is proposed that glutamate plays a significant role in pathophysiology of obsessive-compulsive disorder. Considering role of the glutamate system, novel therapeutic strategies including N-acetyl cysteine (NAC) are suggested in the literature. Here, we report a NAC trial as an augmentation therapy in a patient with treatment resistant OCD.

Case presentation: A 25-year-old male, physical education and sports teacher, unemployed, lives with his family. He was diagnosed with OCD three years ago. His pharmacological treatment history involved selective serotonin reuptake inhibitors (SSRIs; escitalopram, sertraline), serotonin and norepinephrine reuptake inhibitor (SNRI; venlafaxine), tricyclic antidepressant (TCA; clomipramine), benzodiazepines, antipsychotics (quetiapine, risperidone, olanzapine, haloperidol). When the patient presented to our outpatient clinic, Y-BOCS score was 28. He had suicidal thoughts so he was admitted to psychiatry inpatient clinic and cognitive behavioral therapy (CBT) was started. Pharmacological treatment of the patient was simplified as clonazepam 2 mg/day, clomipramine 300 mg/day, risperidone 2 mg/day. After 4 weeks, the suicidal thoughts regressed, his functionality increased and Y-BOCS score was 12. Weekly interviews was planned at the end of the hospitalization. After 3 months follow up period, his Y-BOCS score was 24. CBT was discontinued due to the fact that patient could not comply with CBT. NAC was initiated as an augmentation therapy. NAC dosage was gradually increased and we planned to resume the treatment at least 12 weeks. NAC dosage was 600 mg/day for the first week, 1200 mg/day for the second week, 2400 mg/day for the third and fourth weeks and 3000 mg/day for the other weeks. At the end of the 4th, 8th, and 12th weeks of NAC augmentation, the Y-BOCS score was 33, 36, and 38, respectively. Glutamate-modulating agents (GMAs) such as riluzole and memantine have been studied as an add-on therapy in the treatment of OCD; and promising results have been achieved. NAC is favorable among GMAs according to its benign side effect profile. NAC is a safe and readily available agent that has been found to modify the synaptic release of glutamate in subcortical brain regions via modulation of the cysteine-glutamate antiporter. Despite some studies showed that NAC is superior to placebo as an augmentation to pharmacological treatment of OCD; our case did not improve with 12 weeks of NAC augmentation to the treatment. The results of the studies about augmenting NAC in OCD contradictory. Consistent with our result, one study did not demonstrate a significant benefit of NAC in reducing OCD severity in treatment-resistant OCD adults. Despite our case did not improve with this novel treatment option, this result must be considered that it is just for one case. Future studies with more participants would record more accurate results about efficacy of NAC in treatment resistant OCD.

KEYWORDS

Obsessive-compulsive disorder; acetylcysteine; treatment

[Abstract:0340] [Psychopharmacology]

Orofacial dyskinesia and parkinsonism after long-term treatment with lithium: a case report

İmge Coşkun Pektaş, Ümmühan Ceviz Özkal and Cansun Şahin Çam

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Lithium is a neuroleptic drug used for both acute treatment and maintenance therapy in bipolar disorder (BD) and depression augmentation. Patients with bipolar disorder in long-term treatment with lithium are typically kept at serum lithium concentrations between 0.6 and 1.0 mEq/L, whereas in the long term administration 1.2 mmol/L or higher may be toxic. Tardive dyskinesia (TD) is an iatrogenic movement disorder which is one of the most

KEYWORDS

Bipolar disorder; extrapyramidal symptoms; lithium; orofacial dyskinesia; Parkinsonism; tardive dyskinesia

important side effects of long-term antipsychotic use. Although lithium is sometimes recommended as treatment for TD, studies have reported that the incidence of TD is not less visible, and that even tardive dyskinesia with lithium monotherapy has been reported. We aimed to present this case with tardive dyskinesia because of the long term treatment with lithium, which through our knowledge he had never used antipsychotics.

Case presentation: A 54-year-old man was diagnosed with BD at the age of 39. There was a 15-year history of BD, which had been stable over the past ten years with lithium 1200 mg/day. Recent medication adjustment was made, the dose of lithium was increased to 1500 mg/day. The patient also had a fine resting tremor in both hands that had not been well controlled for two years on propranolol 40 mg daily. On a mental status examination, the patient appeared euthymic, he had a normal range of affect. His thought processes were linear and logical. No suicidal or homicidal thoughts were existed and he did not report any delusions or hallucinations. The most remarkable feature on the neurological examination was the hypokinetic Parkinsonism signs, orofacial dyskinesia and tremor. Abnormal involuntary movements (dyskinesia) of tongue, jaw and lips; lingual movements (slow lateral and torsion movement of tongue) were clearly present within oral cavity. Jaw movements (lateral movement, chewing, biting, clenching) were clearly evident with small amplitude. Bucco-labial movements (puckering, pouting, smacking) were soft. The neurological evaluation revealed other involuntary movements such as swallowing and grimacing. Slowness of movement (bradykinesia) and muscle stiffness (rigidity) were minimal. Investigations for secondary extrapyramidal movement disorders like Wilson's disease, iron metabolism, thyroid and liver dysfunctions, dyslipidemia and mitochondrial disorders resulted in normal ranges. And the family history indicated any sign of an extrapyramidal disease. Serum lithium concentration was 1.34 mEq/liter. The serum levels of lithium were gradually decreased to 900 mg per day and this schedule of lithium administration resulted in a mean serum lithium level of 0.6 mEq/L. Drug-induced parkinsonism (DIP) was treated by lithium withdrawal and bornaprine (4 mg/day) adjustment. Choreiform and athetoid movements of the mouth, tongue and lips resolved following dose reduction. The patient slowly improved.

Several types of neurological adverse events may occur with lithium treatment. A fine resting tremor is a common side effect of lithium. Also lithium conveys an intermediate risk to produce DIP. Based on this case with uncommon presentation, we emphasize the importance of neurological examination in patients receiving mood stabilizers. Our case report should alert clinicians to the possible neurological side effects of lithium, including extrapyramidal symptoms such as DIP and tardive dyskinesia.

[Abstract:0342] [Psychopharmacology]

Risperidone associated various bleedings in four pediatric cases

Deniz Namıduru and Cem Gökçen

Department of Child and Adolescent Psychiatry, Gaziantep University School of Medicine, Gaziantep, Turkey

ABSTRACT

Risperidone is a well-known molecule for treating irritability, temper tantrums in several pediatric cases diagnosed with autism spectrum disorder or disruptive behavior disorder and augmenting the medication of mood disorders. Effect of this atypical antipsychotic drug is mainly via D2 and 5HT2A receptor antagonisms. Despite its ameliorative aspect, serious side effects has been observed in pediatric populations during the administration. Here we discuss four different risperidone caused bleeding and its underlying plausible mechanisms.

Case presentation: Four patients have been referred to our outpatient clinic between 2017–2018. Risperidone dosage and titration was similar among the cases. Their ages, genders, diagnoses, and treatment modalities are indicated in Table 1. Physical examinations and investigations were normal during the course of risperidone treatment (complete blood count [CBC], prothrombin time[PT], activated partial thromboplastin time [aPTT]). 2 weeks after the cessation nearly all bleeding symptoms has been diminished. 5HT2A antagonism and thrombocytopenia could be the possible explanation of bleeding regarding these cases. None of the patients have blood dyscrasias or low platelet number at their medical records. 5-HT2A receptor antagonism effect could reduce platelet aggregation and vasoconstrictor release from platelets in microcirculation. The most rational commentary relating this adverse reaction is that its mentioned 5HT2A action. Despite this explanation, it is difficult to inform that risperidone definitely is the cause of the bleeding in these cases. Although, the chronological sequence and response to drug cessation in the absence of diagnosable medical causes are suggestive of possible causality. Further studies are warranted on this area. Since this rarely reported adverse event may display an important role in patients' compliance, clinicians' awareness about this seems necessary.

KEYWORDS

Adverse effect; bleeding; child; risperidone

Table 1. Sex/Age/Diagnosis/Treatment/Adverse Reaction Type.

Patient	Gender	Age	Diagnosis	Treatment	Adverse Reaction
Patient 1	Female	17 year old	Mild Intellectual Disability/ Conduct Disorder	Risperidone 0.5 mg/b.i.d.	gingival bleeding
Patient 2	Female	14 year old	Moderate Intellectual Disability/Conduct Disorder	Risperidone 0.5 mg/b.i.d.	increased menstrual bleeding
Patient 3	Male	9 year old	ADHD/ODD/Conduct Disorder	Risperidone 0.5 mg/b.i.d. + Metilphenidate E.R. 27 mg/q.d.	epistaxis
Patient 4	Male	12 year old	ADHD/ODD	Risperidone 0.5 mg/b.i.d. + Metilphenidate E.R. 18 mg/q.d.	epistaxis

ADHD: Attention-deficit/ hyperactivity disorder ODD: Oppositional defiant disorder

[Abstract:0345] [Psychopharmacology]

Exfoliative dermatitis with lithium use

Sema Baykara, Dilek Ulukan, Aslı Kazğan, Muhammed Fatih Tabara, Sevda Korkmaz and Murad Atmaca

Department of Psychiatry, Fırat University School of Medicine, Elazığ, Turkey

ABSTRACT

Lithium is one of the mood stabilizers used to prevent acute attacks and in maintenance therapy in Bipolar Disorder. effects due to neurological, endocrine and dermatological systems associated with lithium use can be seen, as it has a narrow therapeutic index. Dermatological side effects of lithium include acneiform rash, exfoliative dermatitis, maculopapular erythematous rash and psoriasis. Exfoliative dermatitis (erythroderma) of which about 90% of the body covered with erythema and squamous is a condition that can develop with drugs. We aimed to report a case of exfoliative dermatitis during lithium use.

Case presentation: 22 years old, single, male patient with bipolar disorder who had unhappiness, malaise, anorexia, introversion, insomnia for the last three weeks, was admitted to the psychiatric clinic. He has been diagnosed with bipolar disorder type I for 4 years, had two manic episodes, and previously used aripiprazole, olanzapine, carbamazepine, and quetiapine. Physical examination was normal. He had no known drug allergy. Being on depressive episode with Beck depression scale score 28, he was started on lithium 300 mg/day. On the second day of lithium treatment, the patient developed lesions characterized by itchy erythema and desquamations, which were common in both palms, forehead, back and chest. The patient whose blood and biochemical tests and other system examinations detected normal was diagnosed as exfoliative dermatitis according to the Dermatology consultation. All the medications, including lithium, were discontinued. After 1 week, lesions regressed. valproate 250 mg/day was started on the 7th day and gradually increased. On the 35th day of her hospitalization his symptoms decreased. Meanwhile his BDI score was 11, and he was discharged with Valproate 750 mg/day, aripiprazole 5 mg/day, sertraline 50 mg/day, mianserin 30 mg/day treatment and recommendations. Exfoliative dermatitis is a relatively rare inflammatory skin disease which is characterized by diffuse erythema and squamous tissue. It may occur with drug reactions. The result is good when the responsible drug is discontinued. Among all psychotropic drugs, critical dermatological side effects are more frequent with mood stabilizers especially with Carbamazepine and Lamotrigine. The prevalence of secondary skin reactions in patients during lithium treatment is lower than in other mood stabilizers. We present the case with exfoliative dermatitis due to lithium use to drive clinicians' attention that severe dermatological side effects including exfoliative dermatitis may be seen during lithium use.

KEYWORDS

Bipolar disorder; exfoliative dermatitis; lithium

[Abstract:0350] [Psychopharmacology]

Treatment of burning mouth syndrome with low-dose clozapine: a case report

Mehmet Gürkan Gürok[a], Alaaddin Hekim[a], Aslı Kazğan[a] and Neşe Göçer Gürok[b]

[a]Department of Psychiatry, Fırat University School of Medicine, Elazığ, Turkey; [b]Department of Dermatology, Fethi Sekin City Hospital, Elazığ, Turkey

ABSTRACT

Burning mouth syndrome (BMS) is a chronic disease in the tongue and other parts of the mouth although there are no local or systemic reasons like pain, burning, dry mouth, sensing a foreign object, and a sense of bitter metallic taste in the mouth. Its etiology is not clear yet, it is considered that many factors, which include systemic, local, psychogenic and idiopathic

KEYWORDS

Burning mouth syndrome; clozapine; treatment

reasons, play roles in its etiology. In this case report, a case that had burning mouth syndrome and depressive disorder that developed secondarily is presented.
Case presentation: A 67-year-old, married, primary school-graduate female patient in postmenopausal period had complaints of a metallic bitter taste in her mouth and a sense of burning that lasted during daytime 2 years ago. After the complaints in her mouth, she had other complaints like unhappiness, sense of distress, insomnia, bodily complaints, unwillingness, not enjoying life and crying. There were no findings in her physical examination; and there were no findings in her family history, either. Her routine blood and biochemistry tests, iron, zinc and B12 levels were normal. Consultation was carried out for the patient with the internal medicine, otolaryngology and dermatology departments. venlafaxine 150 mg/day, clonazepam 1.25 mg/day and clozapine 25 mg/day were initiated for the patient for depression and anxiety, and trazodone 50 mg/day for her sleep problems. In addition, Cognitive-behavioral techniques were administered to the patient for her depressive complaints. On the 16th day of the treatment, her depressive and intraoral complaints were significantly improved. The mouth burning of the patient decreased, and sense of taste improved. BMS is a condition that is detected with difficulty, and its etiology is not fully explained yet. It may affect the quality of life of patients negatively, and might go undetected because of psychological problems that develop secondarily. The treatment of BMS is not clear yet; and for now, it is understood that it is specific to the patient. The present case supports that the Cognitive Behavioral Therapy and antidepressant-antipsychotic treatment combination is effective in depressive patients who have burning mouth syndrome.

[Abstract:0358] [Psychopharmacology]

Spontaneous ejaculatıon associated with the use of sertraline: a case report

Özge Demircan Tulacı[a] and Özge Gizli Çoban[b]

[a]Department of Child and Adolescent Psychiatry, Ataturk City Hospital, Balıkesir, Turkey; [b]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT
Sertraline is a selective serotonin reuptake inhibitor exerting its effect by inhibiting serotonin transport. Sertraline is used to treat depression, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and premenstrual dysphoric disorder. Sexual dysfunction is among the side effects of antidepressants, which occur frequently, impair quality of life and influence the adherence of the patient to treatment adversely. Common side effects associated with antidepressant treatment are decrease or lack of libido, ejaculation problems, difficulty in arousal, decreased lubrication, delayed orgasm, anorgasmia and erectile function disorders. In the literature, spontaneous ejaculation cases associated with escitalopram, citalopram, duloxetine, venlafaxine, reboxetine, milnacipran and nefazodone have been reported. The aim of this report is to address a case of spontaneous ejaculation associated with the use of sertraline. To our knowledge, this is the first case reported in the literature of spontaneous ejaculation associated with the use of sertraline.
Case presentation: A 18-year-old patient referred to child and adolescent psychiatry outpatient clinic with complaints of hand washing, and tidying his belongings for about two hours every day over the last three months. He had no known medical illness. He was diagnosed as obsessive-compulsive disorder and sertraline was initiated at the dose of 50 mg/day. Two weeks later at control visit, he reported that he had ejaculations every day without sexual arousal and erection after the onset of sertraline treatment. The patient was consulted to urology department and no pathology was found in urological evaluation. It was thought that this may be due to sertraline so that it was replaced with fluoxetine 10 mg/day. The complaints of the patients improved completely after the switching of drug. Sexual side effects are common problems encountered during SSRI treatment. According to a survey on how clinicians deal with the side effects of SSRIs, 36% of psychiatrists prefer switching to another antidepressant to manage sexual dysfunction related to SSRIs. The effects of serotonergic drugs on sexual function may relate to drug dose, serotonin receptor subtypes affected and the relative effect on serotonergic versus other receptors. Ejaculation is mediated by a spinal control center which coordinates sympathetic and parasympathetic stimulation in order to induce the two phases of ejaculation: seminal emission and expulsion. Emission is described as secretion of seminal fluid and movement of seminal fluid to proximal urethra. Expulsion phase is under coordinated control of noradrenergic and somatic outputs. Central nervous system regions controlling ejaculation exert inhibitor or excitatory effect, using serotonergic and dopaminergic pathways. It is facilitated by dopaminergic transmission and inhibited by 5HT1A antagonists and 5HT2 agonists. Sertraline may have its effect on serotonergic receptor subtypes in these areas. Dopaminergic transmission may also play an important role in the pathogenesis of spontaneous ejaculation. Clinical studies are

KEYWORDS
SSRI; sexual side effects; spontaneous ejaculation

warranted to evaluate the incidence of sexual side effects caused by sertraline. However, sexual side-effects should be taken into consideration before prescribing a sertraline treatment, because sexual dysfunction may play an important role in non-compliance with treatment.

[Abstract:0365] [Eating disorders]

Pica in an adult patient

Nilifer Gürbüzer, Celaleddin Kartal and Hacer Akgül Ceyhun

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Pica is defined as the desire of eating substances at least during one month long that are not approved in the cultural aspect and not common in society without the feeling of disgust and being inappropriate to development level. According to the DSM-5 it is included under eating disorder. The precise cause of Pica has not known yet; but it is seen mostly due to psychosocial development disorder and sometimes it is seen as a result of lack of some food. Therefore, in this presentation our aim is to discuss a case in which our case diagnosed with pica.

Case presentation: A 19-year-old female patient, who is a university student has eaten unfamiliar substances (napkins) especially when her anxiety is high for about six years. When she has not eaten napkins she feels anxious. She feels happy after or while she is eating napkin. However she knows that this is absurd, she cannot avoid herself eating napkin. It is found out that she concealed her absurd behavior from her relatives and friends. The patient consulted our clinic two years ago. The patient was examined and asked for blood tests. Iron deficiency anemia was detected. Pica was thought to be and iron treatment was started. After the interview with the patient, it was determined that the patient had negative automatic thoughts and thought errors. He was taught to correct them by seeing the logic inaccuracies and to create alternative thoughts. Simultaneously cognitive behavioral therapy and iron treatment was conducted. At the third month of the treatment, the patient's eating disorder was cured. The main cause of Pica has not been clearly known; but, mostly it is observed due to psychosocial development disorder and sometimes it is seen as a result of lack of some nutritious food. It is reported when the lack of nutrition such as iron calcium B1-B6 vitamin, zinc, PICA can be observed but the reason cannot be clarified. For example, iron deficiency anemia is seen among individuals who eat soil. It is not clear whether the patient eats soil due to iron deficiency or iron deficiency is occurred because of soil eating. Also it is not clear that relation between the disorder of dopaminergic system. In literature, there are many cases that eat inedible substances. Pica is observed more common among pregnant, lactating women, babies, people who has organic brain disorder, psychosis and as cultural. Pica is a multifactorial clinical condition that is not yet fully known. It is known that Pica has a close relationship with iron deficiency. However, there was no clear evidence that Pica was etiology or outcome. In Pica, as a result of the recovery of iron deficiency, desire to eat substances completely ends or decreases. This shows that iron deficiency is a cause. However the absence of Pica in each case of iron deficiency shows that different factors are involved as in our case.

KEYWORDS

Eating disorders; iron deficiency; pica

[Abstract:0370] [Psychopharmacology]

Aripiprazole-induced hoarseness: a case report

Ümit Işik[a] and Perihan Çam Ray[b]

[a]Department of Child and Adolescent Psychiatry, Süleyman Demirel University School of Medicine, Isparta, Turkey; [b]Department of Child and Adolescent Psychiatry, Cukurova University School of Medicine, Adana, Turkey

ABSTRACT

The most common adverse effects of aripiprazole include fatigue, nausea, increased appetite, headache, sedation, and somnolence. To our knowledge, there is no case of aripiprazole-related hoarseness in the existing literature. In this report, we describe a patient with ADHD and ODD who developed hoarseness with the aripiprazole oral solution.

Case presentation: A 4 years and 7 months old boy who had no significant medical history, was referred to our outpatient clinic by his mother with the complaints of hyperactivity, being easily distracted, irritability, anger bursts, and aggressiveness toward his parents and his peers. His symptoms caused problems at kindergarten and at home. As a result of his psychiatric and psychometric examinations, the boy was diagnosed with ADHD and ODD. Aripiprazole oral solution 1 mg/day was prescribed for his disruptive behaviors and the dose was increased to 2 mg within five days. During the first week of initiation of aripiprazole oral

KEYWORDS

Aripiprazole; hoarseness; side effect

solution 2 mg/day, he developed hoarseness. After development of hoarseness, family terminated aripiprazole treatment without reference to clinic. His hoarseness resolved within three days after discontinuation of the medication. However, ten days later, family restarted aripiprazole 2 mg/day because of complaints of patient's. According to his mother's report, the hoarseness reappeared within two days and then family stopped the medicine and hoarseness disappeared again. When the patient was brought back to our clinic by his parents, there was no hoarseness. During the development of hoarseness, the patient was only using aripiprazole treatment, there was no additional drug use. During aripiprazole treatment, the patient had only complaints of hoarseness and cough. The patient had no additional complaints such as pain, difficulty in swallowing or burning sensation in her throat. Patient was consulted to pediatrics department for differential diagnosis and detecting possible effects of ariprazole treatment. After the pediatric examination, no disease was detected in the patient. His medical history, and routine biochemistry examinations were unremarkable. In the present report, we established the temporal relationship between aripiprazole treatment and hoarseness. We believe that, in this case, hoarseness was the direct effect of aripiprazole on the grounds that there was no history of such behavior before aripiprazole and development of hoarseness after challenge, dechallenge, and rechallenge with aripiprazole and complete resolution after its discontinuation is suggestive of a causal effect. The probability of adverse event have calculated with the Naranjo's Adverse Drug Reaction Probability Scale and our patient was getting 7 points which refers to probable adverse effect of a drug. According to an eHealthMe report compiled from the FDA reports, 69,325 patients taking aripiprazole had suffered adverse effects, of which 142 patients (0.2%) had hoarseness or changing voice. However, so far nobody has recorded a patient who has had hoarseness in the aripiprazole treatment. To our knowledge, in the literature, this report is the first to record the occurrence of hoarseness after the implementation of aripiprazole.

[Abstract:0372] [Psychopharmacology]

Asymmetric breast growth due to hyperprolactinemia that cause aesthetic problem ın a girl with congenital rubella syndrome and severe mental retardation

Ezgi Gezgin and Tülin Fidan

Department of Child and Adolescent Psychiatry, Eskisehir Osmangazi University School of Medicine, Eskişehir, Turkey

ABSTRACT

Congenital rubella syndrome(CRS) includes a triad of severe birth defects in the form of sensorineural deafness, ophthalmological abnormalities and congenital heart disease as a result of the mother's rubella infection during pregnancy. Psychiatric disorders are seen in up to half of all patients born with CRS. The rate of mental retardation among children with CRS is as high as 42.5% and 4.12–7.3% of CRS patients show signs of autism. We are presenting a girl diagnosed with CRS and severe mental retardation that has a asymmetric breast growth which cause aesthetic problem due to high prolactin level without galactorrhea.

Case presentation: A 14-year-old girl was admitted to our outpatient clinic by her parents with complaints of her restlessness and aggressive outbursts. The patient had CRS, severe intellectual disability and some atypical autistic symptoms. Risperidone was prescribed for behavioral problems 6 years ago. She had still been on risperidone treatment 1 mg/day, however she had not come to control for over 2 years. She started to menstruate at age 10 and her breast had been growing since then, and patient was unable to use bra. 1 month ago they went to the general surgery with complaints of having notable asymmetrical breast physically. Surgeon recommended breast reduction operation, but her family was reluctant due to behavioral and affective problems during recovery period. İn physical examination microcephaly, smaller left ear and eye and bigger right breast had been observed. She had not have ability to talk. Laboratory findings showed elevated prolactin levels (76 ng/mL). According to pediatric endocrinology consultation, hyperprolactinemia was thought to be due to the use of risperidone. Risperidone was gradually decreased than replaced by aripiprazole. 1 month later, prolactin level (11.4 ng/mL) and also breast size was reduced. Restlessness and aggressive outbursts were disappeared. Risperidone is one of most used antipsychotic agents in the treatment of aggression and irritability associated with ASD that increases prolactin levels. Hyperprolactinemia can cause amenorrhea or oligomenorrhea, breast enlargement, pain or galactorrhea. These symptoms are less researched in psychiatric patients. Existing data suggest that they are common but that clinicians underestimate their prevalence. In our case, use of risperidone, hyperprolactinemia and its associated symptoms were present. Since our case has lacked the ability of verbalize, she could not communicate her pain and due to the lack of galactorrhea, for her enlarged breasts, her family sought treatment through breast reduction surgery and had no idea that was related to risperidone. After the detection of hyperprolactinemia, her medication was changed, her symptoms was

KEYWORDS

Rubella syndrome; Congenital; risperidone; hyperprolactinemia; intellectual disability; autism spectrum disorder

resolved and surgery was no longer needed and burden on the family was reduced. Side effects of psychotropic drugs can be neglected in intellectually disabled children, thus interpretation of drug side effect is essential to prevent unnecessary surgical operations and antipsychotics use.

[Abstract:0374] [Psychopharmacology]

Severe urinary retention in a young female patient using duloxetine: a case report

Mikail Burak Aydın, İbrahim Gündoğmuş, Azize Beril Taşcı, İbrahim Boynueğri and Ayşegül Taşdelen Kul

Department of Psychiatry, Gülhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Urinary retention is defined that is sudden onset of inability to void or presence of important amount of postmicturitional residual urine. Mainly it is a problem of men, prevalence of urinary retention in females is extremely low. As in other voiding dysfunctions, the main purpose of diagnostic and evaluative workup is to find out underlying etiology. Although it is evaluated that it may be due to organic etiological reasons, it can be seen as a side effect of some drugs such as antidepressant and antipsychotics. Duloxetine that is a serotonin-noradrenaline reuptake inhibitor in addition to major depressive disorder treatment, is used effectively in the treatment of diabetic neuropathic pain and fibromyalgia. Although it is an effective and safe treatment option, it has side effects such as loss of appetite, sweating and palpitations. However, rare side effects of urinary system have been reported. In the literature, urinary side effects such as difficulty in urination and frequent urination are described. However, these side effects were generally seen in male patients. In the present report, a 32-year-old female patient with urinary retention with duloxetine use was presented. **Case presentation**: 32 years old woman, married, has two children, high school graduate, housewife. She presented to our outpatient clinic for reasons such as reluctance, unwillingness to work, forgetfulness and thoughtfulness. HAM-D score was 36 and HAM-A score was 26. The patient was diagnosed with major depressive disorder according to the DSM-5 criteria and was started as treatment of duloxetine 30 mg/day and after one week the dose was titrated up to 60 mg/day. At the first month of the follow-ups, HAM-D depression score decreased to 21 and HAM-A score decreased to 12. The patient had difficulty in urinating and expressed a very disturbing expression before this. So the patient's difficulty in urinating had progressed until the emergence of the emergency room service and intravesical catheterization. She had recurrence in her complaints after the procedure. However, the patient did not think in etiology because she started complaints two weeks after the use of duloxetine. The laboratory tests were normal and the patient was asked for urology and internal medicine consultation. There was no organic pathology that could explain the retention as a result of the consultation. Duloxetine was considered as the cause of urinary retention and the daily dose of duloxetine was decreased by 30 mg/day. There was a decrease in her complaints and duloxetine was discontinued. Sertraline 50 mg/day treatment was started. The patient's urinary complaints did not start and there was a decrease in depressive symptoms. Duloxetine, which is frequently used in clinical practice because of the low side effect profile, may rarely have urinary side effects. So, these side effects are generally seen as tolerable severity. However, the urinary symptoms of our patient were severe, and intravesical catheterization was administered. The most likely mechanism for this possible side effect is that duloxetine may have a noradrenergic effect on micturition. The fact that clinicians take into account urinary side effects while administering duloxetine to patients will improve the treatment compliance.

KEYWORDS

Urinary retention; duloxetine; adverse effects

[Abstract:0378] [Schizophrenia and related disorders]

A case of epileptic seizure induced by olanzapine in an adolescent patient with schizophrenia

Özlem Çiçek, Fatih Hilmi Çetin and Serhat Türkoğlu

Department of Child and Adolescent Psychiatry, Selcuk University School of Medicine, Konya, Turkey

ABSTRACT

Schizophrenia is a heterogeneous clinical picture in which disturbances in the field of emotion, thought and behavior lead to serious loss of function in the social and occupational areas. When this disorder starts before the age of 18, early-onset schizophrenia is defined as very early onset

KEYWORDS

Adolescent; epileptic seizure; olanzapine; schizophrenia

schizophrenia when it starts before the age of 13 years. In this presentation, we aimed to look into the relationship between antipsychotics and epileptic seizures in a patient who had no history of epilepsy and had a generalized tonic clonic seizure triggered by olanzapine use.

Case presentation: A 16 years old male patient presented with bizarre behaviors with complaints of incontinence, backwards walking, insomnia, decrease in self-care, and withdrawal and the patient's complaints started two years ago after the family stress factor. According to the information received from relatives; In addition to his disorganized behavior, he lived a period in which he talked to himself and hallucinated. Blood tests, brain MRI, and EEG results were within the normal range and there was no history of psychiatric disease in the family. In the mental state examination, a male patient with an age of general appearance and behavior, decreased self-care, euthymic mood, blunted affect, thought process slowed, thought content was poor and there were themes about his parents not understanding him. There was no psychopathology in perception. There is no insight. When Risperidone up to 2 mg/day dose, EPS side effects developed, after than aripiprazole dose had been increased up to 20 mg/day, but was stopped due to the development of akathisia. Treatment with risperidone and aripiprazole was gradually decreased and discontinued because of side effects, olanzapine treatment was started. The patient, who had partial benefit, developed generalized tonic clonic seizures 2 times about 5 min when the dose of olanzapine 20 mg/day was increased. Olanzapine treatment was gradually reduced and stopped. The patient was consulted again with neurology for organic etiology. According to the results of neurological examinations, a new treatment plan was planned. Almost all first- and second-generation antipsychotic drugs are reported to increase the risk of epileptic seizures. It has been shown that the risk of epileptic seizures is greater especially during clozapine treatment. In patients with clozapine use at 600 mg/day and over 5%, to 300–600 mg/day 3–4%, for those who use less than 300 mg/day and 1–2% for epileptic seizures. Another study found that EEG changes were common with olanzapine doses of >20 mg. People with a history of seizures are in the risk group; therefore, care should be taken when selecting antipsychotics and dosing titration. Although there was no previous history of seizures in the case presented above, a generalized seizure was observed after the dose above 20 mg, similar to the literature. Typical antipsychotics may be preferred in seizures triggered by atypical antipsychotic use and antiepileptic treatment can be started. These adverse effects should be considered and care should be taken in high doses.

[Abstract:0379] [Pschopharmacology]

Intramuscular haloperidol-induced oculogyric crisis

İrem İlter

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

Oculogyric crisis is an acute dystonic reaction of the ocular muscles associated with neuroleptic medication, particularly typical antipsychotics. Dystonic reactions have been reported in 10–60% of patients treated with neuroleptics, and are believed to occur more commonly in patients just starting or increasing the dose of the neuroleptic. One report suggested that 90% of dystonic reactions occur within 4 days of starting a neuroleptic and can last from seconds to hours. Risk factors for acute dystonic reactions include young age, male gender, use of high-potency antipsychotics, high dose, and parenteral administration.

Case presentation: A 56-year-old female patient, primary school graduate, not working, divorced was presented. The patient was brought to our clinic with complaints of psychomotor agitation, mystic preoccupation, crying, persecution and reference delusions. Prior to hospitalization, the patient was discontinued the paliperidone and was started on haloperidol 10 mg/day and increased to 20 mg/day. Haloperidol deconate 100 mg IM was administered to the patient whose agitation was continued and the dose of oral haloperidol was reduced to 15 and 10 mg/day. The patient was treated with haloperidol deconate 100 mg IM on the 15th day. After the injection, the patient's relatives said that he saw a different movement in the eyes of the patient, but no findings were found in our follow-up in the clinic. After the patient was discharged with the current treatment, the oral dose of haloperidol was reduced to 5 mg/day and the patient was started on biperidene 2 mg tablet. Dystonic reactions may also occur more frequently in the afternoon and in the evening. A study evaluating 200 patients receiving antipsychotics for the first time found that >80% of dystonic reactions occurred between 12.00 and 23.00 h. The mechanism by which antipsychotics induce acute dystonic reactions is believed to be due to dopamine blockade in the basal ganglia. Any medication that antagonizes nigrostriatal dopamine function has the potential to cause dystonic reactions. In addition, presynaptic dopamine depletors (e.g. reserpine) can cause acute dystonic reactions. Dopamine agonists or acetylcholine inhibitors show an antidystonic effect. The use of anticholinergic agents to safely reverse dystonic reactions indirectly supports this hypothesis. As shown in our case, the use of antipsychotics is an effective factor for oculogyric crisis, even if it does not carry risk factors.

KEYWORDS

Dystonia; oculogyric crisis; haloperidol

[Abstract:0382] [Other]

Gender dysphoria in a patient with gender development disorder: a case report

Ezgi Selçuk and Evrim Özkorumak Karagüzel

Department of Psychiatry, Karadeniz Technical University Medical School, Trabzon, Turkey

ABSTRACT

The abnormality of the development of the external and internal genital organs and the related circumstances which create problems in the identification of gender are described as gender development disorders. These individuals are born with the gender characteristics (chromosomes, genital organs and/or hormonal structure) which are not strictly in line with male or female categories or which are included in both categories. This presentation deals with the dilemma, in relation to gender identification, of a patient with gender development disorder.

Case presentation: The patient is a 18-year-old, intersex, single, university student was admitted alone about his/ her displeasure with his/her sexual orientation which is for males. The patient has been identified herself/himself with the females since his/her childhood. S/he is the youngest one of three and has two elder sisters. His/ her family was expecting to have a baby boy till his/her birth. Both the family and the doctor were astonished when s/he was born intersex. His/her father chose a male name for him/her. The patient had both male and female genital organs till s/he was 11 and later his/ her vagina was closed by itself. When s/he was a child, s/he was wearing the ornate and colorful hairgrips of his/her elder sisters and playing with their dolls. S/he wanted to act the mother when they were playing a house game. In the school age, s/he realized that s/he was interested in males. S/he has been troubled with the changes in his/her body such as the growth of beard and moustache hair since his/her adolescence and cannot accept these changes as they were unique to males. In his/her dreams and fantasies, s/he usually sees that s/he possesses a female body with breasts and vagina and s/he gets rid of the penis, then becomes so happy. The patient has a traditional family which forces him/her to be a male and dress like a man, if s/he does not, according to his/her, s/he will be ostracized. The patient was examined at the clinic and observed that s/he suffered from depressive emotionality, loneliness, and not being understood. S/he has been still under psychotherapy treatment. Prediction of psychosexual characteristics that each individual with gender development disorder will develop in adult life is difficult and contradictory. Although the patient was brought up entirely as a boy with socially male characteristics, she/he felt himself/herself as a woman and tried to keep it as a secret. This proves the significance of organic factors in sexual identity preference in spite of the environmental stimuli and effects. Since limited data is present about the management of gender dysphoria in a psychosexual disorders, this case may highlight the co-occurrence of gender development disorder; and gender dysphoria and provide an insight to this issue.

KEYWORDS

Gender dysphoria; gender development disorder; sexual identity

[Abstract:0383] [Psychopharmacology]

Increased intraocular pressure induced by long-acting injectable aripiprazole: a case report

Şermin Gök, Celaleddin Kartal and Serap Sarı

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

The intraocular pressure (IOP) above the reference range of 10–21 mm Hg is generally accepted as ocular hypertension (OHT).

Antipsychotic agents are less likely to induce angle-closure glaucoma (ACG) because of their weaker anticholinergic action as compared with tricyclic antidepressants. Perphenazine, trifluoperazine, and fluphenazine are known to cause OHT and ACG. In this case report, we aimed to discuss the case of glaucoma-diagnosed schizophrenia with increased IOP and glaucoma symptoms after long-acting injectable aripiprazole therapy.

Case presentation: A 23-year-old male, single, high school graduate, does not work, has been using brimonidine, latanoprost, timolol maleate + dorzolamide for the treatment of glaucoma since childhood. Patient's complaints started about 3 years ago in the form of insomnia, irritability, causeless crying and laughs, and introversion. Sertraline 50 mg/day and olanzapine 10 mg/day treatment was given for these complaints. However, he did not use regular medication. In addition to the psychosocial stress factors that developed approximately 6 months after these complaints, secondary auditory and visual hallucinations, persecution and reference delusions, psychomotor agitation were added.

He had been hospitalized to the psychiatry ward twice with these complaints. Aripiprazole oral 10–30 mg/day treatment was started on his last hospitalization. The patient who had

KEYWORDS

Aripiprazole; paliperidone; intraocular pressure; glaucoma

undergone aripiprazole long-acting injection treatment due to drug incompatibility was observed to have complaints of headache, pain around the eyes, blurred vision, after the depo injection. The patient was consulted to the ophthalmology clinic and an increase in the intraocular pressure was reported. Although the patient continued to treat glaucoma regularly, aripiprazole treatment was discontinued due to the fact that the increase in intraocular pressure might be related to the antipsychotic treatment. The treatment was arranged as oral paliperidone 6 mg/day and then paliperidone palmitate 100 mg/month. After 6 months follow-up, the patient's psychotic symptoms were almost complete and the intraocular pressure values measured by the ophthalmology clinic were within normal limits (right eye 18 mm Hg / left eye 16 mm Hg). When the literature on glaucoma induced by aripiprazole was scanned, a single case report was found.

Aripiprazole has a high affinity for dopamine and serotonin receptors. There is no marked affinity for cholinergic muscarinic receptors. This binding profile demonstrates the effect of aripiprazole on the angle, possibly mediated by serotonin receptors, unlike muscarinic receptors. Iris and ciliary body include 5-HT receptors and norepinephrine receptors that play a role in pupillary dilation. How the 5-HT receptor binding affects the anatomy or physiology of the iris / ciliary body complex is not yet known. It was thought that increased serotonin levels would loosen the iris sphincter, cause mydriasis and narrow-angle structure. Aripiprazole causes a supraciliary effusion by leading to a displacement of the lens iris diaphragm to the anterior side. This mechanism also results in increased intraocular pressure. To date, paliperidone-induced glaucoma has not been reported in the literature. In conclusion, although the relationship of glaucoma with some first-generation antipsychotic drugs is reported more clearly, it should be considered that this side effect may also develop with second-generation antipsychotics.

[Abstract:0384] [Psychopharmacology]

Methylphenidate-induced glaucoma in a 13-year-old case

Mehmet Emre Gül, Özge Gizli Çoban, Arif Önder and Aslı Sürer Adanır

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

ABSTRACT

Attention-deficit/ hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorder of childhood. Stimulant medications are the recommended first-line pharmacotherapy in the treatment for ADHD. Methylphenidate is one of the stimulant drug which used in the treatment of ADHD. Normal intraocular pressure ranges 10 mm Hg to 20 mm Hg. Although intraocular pressure may increase due to cortisone treatment, it is a rare side effect associated with methylphenidate treatment. Methylphenidate is a sympathomimetic amine and contraindicated in glaucoma because of the theoretical risk of increased IOP due to possible mydriasis. In this article, we present a patient who had developed increasing in intraocular pressure after the use of methylphenidate treatment due to hyperactivity and attention deficit.

Case presentation: A 13-year-old boy presented with his mother to our outpatient clinic, with the complaints of hyperactivity and academic failure. He was referred by his teacher due to wandering in classroom, not obey the rules, having trouble staying in his seat. It was observed that he constantly tampered with the items on the table, and had a short attention span. His mother reported that he had been hyperactive since pre-school period, he couldn't study alone and he was easily distracted while doing homework. In the next visit, the diagnosis of ADHD-Combined type was concluded as a result of the evaluation of the Teacher Information Form and The Turgay DSM-IV-Based Child and Adolescent Disruptive Behavioral Disorders Screening and Rating Scale. Since blood pressure and hemogram did not reveal any abnormality, the treatment was started with a single daily dose of methylphenidate (10 mg/day). Over the next visit, it was reported that the complaint of attention deficit and hyperactivity had been improved. After 1 week, during routine eye control, the ophthalmologist had stopped her methylphenidate treatment because of the high intraocular pressure (25 mmHg). The patient was followed-up without any medication and then the patient's intraocular pressure decreased to normal range (19 mmHg). It was concluded to follow up without any medication. After that, two subsequent intraocular pressure measurements revealed within normal limits. Although the use of methylphenidate is theoretically contraindicated in patients with glaucoma, the number of studies conducted on this subject is extremely limited. Although there are case reports of glaucoma due to methylphenidate treatment in the literature, similar results were not found in the studies. In a study, fifty-seven patients diagnosed of ADHD and administered with oral methylphenidate hydrochloride treatment for at least one year and sixty healthy control subjects had been evaluated and no glaucoma was detected in both groups. In a case report, there was no increase in intraocular pressure with methylphenidate treatment in a patient whose intraocular pressure was controlled with 0.5% betaxolol hydrochloride treatment.

KEYWORDS

Attention-deficit/ hyperactivity disorder; glaucoma; methylphenidate

Methylphenidate may cause an increase in intraocular pressure by decreasing the degree of trabecular outflow of the humorous aqueous stream, resulting in a glaucoma crisis. Clinicians should be aware of this side effect of methylphenidate. Nevertheless, especially in cases where intraocular pressure is well controlled, especially in wide-angle glaucoma, methylphenidate should not be excluded from treatment options.

[Abstract:0389] [Neuroscience: Neuroimaging- genetics- biomarkers]

Microduplication 22q11.2 in a child with autism spectrum disorder

Cemre Yaşöz, Özalp Ekinci, İbrahim Adak, Bilge Öztürk and Mohammad Al Bayati

Department of Child and Adolescent Psychiatry, Health Sciences University School of Medicine, Istanbul, Turkey

ABSTRACT

Microduplication of the 22q11.2 chromosomal region was first recognized in 1999. Since then, over 50 additional cases have been reported. Clinical features are highly variable including facial dysmorphism (79%), behavioral problems (77%), intellectual/learning disability (77%), muscular hypotonia, epilepsy, cardiovascular anomalies (15%) and hearing loss (20%). 22q11.2 microduplication is shown to be associated with a high rate of ASD and psychiatric screening is suggested for all the affected patients.

Hereby, we present the first case from Turkey; a 41 months old male with 22q11.2 microduplication who was diagnosed with autism spectrum disorder.

Case presentation: A 41-months old boy was admitted to our clinic with the complaints of failure of normal back-and-forth conversation, walking on toes, stereotyped motor movements, adverse response to specific sounds, anxiety, absence of interest in peers and lining up toys. He had inconsistent eye contact and had significant difficulties in pointing, responding to his name, and engaging in pretending games. He was the only child of 48-year old mother and 58-year old father. The parents were both healthy and the family history was negative for autism. The patient was born after a 38-week normal pregnancy by elective caesarean section without complications Early developmental milestones were within normal limits. The mother described him as a difficult baby, often crying, not easily comforted and with poor sleep. He walked at the age of 11 month and acquired approximately 50 words up to 3 years. He did not have any medical disease diagnosis and his neurologic evaluation including EEG and cranial magnetic resonance imaging was normal. Because of his dysmorphic facial characteristics he had gone under cytogenetic analysis at the age of 40 months that indicates a 22q11.2 microduplication. He is diagnosed with autism spectrum disorder according to DSM-5 criteria. His psychiatric evaluation and parent rated scales both revealed a comorbid ADHD-combined type diagnosis. He was referred to an autism education program and risperidone was prescribed for the treatment of stereotyped motor movements, bruxism, sleep problems and tantrums. 1 year later, his tantrums, bruxism, stereotyped motor movements and sleep problems improved significantly with risperidone 2 mg/day treatment. For the treatment of ADHD symptoms, atomoxetine was prescribed in the dose of 4 mg/day after the approval from pediatric cardiology. On his most recent examination at age 58 months, he was taking atomoxetine in the dose of 20 mg/day and his ADHD symptoms were reported to decrease markedly. Our case shows the clinical heterogeneity of the 22q11.2 microduplication and the wide genetic complexity of ASD. Genetic evaluation of ASD should include also 22q11.2 chromosomal region. Since 22q11.2 microduplication has a high rate of ASD, psychiatric screening should be done for all patients with 22q.2 microduplications.

KEYWORDS

22q11.2 duplication syndrome; autism spectrum disorder; developmental delay

[Abstract:0393] [Schizophrenia and other psychotic disorders]

Differential diagnosis of malignant catatonia with neuroleptic malignant syndrome and use of electroconvulsive therapy (ECT) in treatment: a case report

Esra Akay, Naile Özge Özyurt, Sinay Önen, Kamil Mert Angın and İbrahim Taymur

Department of Psychiatry, Health Sciences University Yuksek Ihtisas Research and Training Hospital, Bursa, Turkey

ABSTRACT

Catatonia is a neuropsychiatric syndrome most commonly characterized by mutism, stupor, refusal to eat or drink, posturing, and excitement or hypokinesis. Catatonia with escalating fever and autonomic instability is known as malignant catatonia. Malignant catatonia resembles neuroleptic malignant syndrome (NMS) in many ways. NMS is an idiosyncratic,

KEYWORDS

Electroconvulsive therapy; malignant catatonia; neuroleptic malignant syndrome

life-threatening complication of treatment with antipsychotic drugs that is characterized by fever, severe muscle rigidity, leukocytosis, raised creatinine phosphokinase and autonomic and mental status changes. The relationship between catatonia and NMS remains a moot point. There is considerable overlap in symptomatology between NMS and lethal catatonia.
Case presentation: A 28-year-old unmarried female patient admitted to emergency room with acute psychotic symptoms. In emergency room, patient was receiving intramuscular haloperidol 10 mg, biperiden 5 mg. And patient was called to psychiatry outpatient clinic. 2 days later the patient was hospitalized after complaints of contractions, dullness, slow to act. Patient was receiving oral olanzapine, lorazepam and intramuscular haloperidol, biperiden, chlorpromazine in hospital. The patient was discharged from the hospital by refusing treatment by her family due to the deterioration of her general condition. A few days later, the patient was admitted to the emergency department with high fever, impaired consciousness, contraction and muscle stiffness. The patient was hospitalized in the intensive care unit with a diagnosis of NMS and the laboratory values were CK:4820 U/ L, CRP:13,2 mg/ L, WBC:27.81. Dantrolene and diazepam treatment was started but there was no response to treatment. The patient was re-evaluated by the psychiatrist. Patient was thought to have malignant catatonia due to previous lethargy, slow movement and stereotyped movements. ECT started and 12 sessions completed. The patient was discharged after all the complaints improved. Lethal catatonia which is an acute clinical form of catatonia shows itself with high fever, rigidity and excessive motor activity or stupor. It may be showed aggression and suicide attempts. The hallucinations, delusions may be accompanied. Tachycardia, excessive sweating, dehydration, variable blood pressure, peripheral cyanosis, skin hematomas are seen. Extreme exhaustion, stupor and extremely elevated fever continues this hyperactive period. It responds to treatment. However, if it is untreated, coma, cardiovascular collapse and death can be seen. NMS is a life-threatening condition which is characterized by delirium, muscle stiffness, fever and irregularity of the autonomic nervous system. It requires accurate diagnosis and treatment without wasting time. These are clinically indistinguishable except history of antipsychotic drug use. In this case, the differential diagnosis is so difficult. Because of the indication of ECT treatment in both diagnoses, ECT treatment was administered rapidly. ECT often is ignored by physicians for first-line treatment. However, in cases similar to this case, ECT should be started as soon as possible. Malignant catatonia and NMS are clinically indistinguishable. In such cases, the physician should decide quickly. If it is necessary, ECT should be started immediately.

[Abstract:0402] [Schizophrenia and other psychotic disorders]

Peripheral edema due to clozapine treatment: a case report

Berrin Ünal, Bilge Çetin İlhan, Seda Kırcı Ercan, İklima Zeynep Bayraktar and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT
Second-generation antipsychotics (SGAs) are preferred for the treatment of schizophrenia due to their low tendency of inducing extrapyramidal symptoms (EPS) and tardive dyskinesia compared to typical antipsychotics. Clozapine is an SGA having potential side effects such as agranulocytosis, epileptic seizure, myocarditis, orthostatic hypotension, sedation, weight gain and sialorrhea. Peripheral edema on the other hand, is a rare side effect of SGAs. In this report, a case of peripheral edema due to clozapine is discussed.
Case presentation: A 22-year-old male patient with the diagnosis of schizophrenia had been admitted to the emergency department, with eating and drinking refusal, difficulty in walking and speaking, common tremor in the body. His treatment at the time was 1000 mg/ day valproate and 400 mg/day clozapine, which had been ceased by the doctor in emergency room for the possibility of complaints being a side effect of the drugs. The patient was admitted to our service because of the continuing complaints, which were first thought as EPS side effects. After consultation to neurology and internal medicine departments, condition of patient was learned to be not due to organic causes. During follow-up, we decided to start clozapine treatment again due to the exacerbation of psychosis and Parkinsonism symptoms. On the 6th day of treatment, when using 100 mg/ day clozapine, a moderate level of edema (++) on both hands, wrists, feet and distal parts of legs was observed. His blood parameters were within normal limits. He had no history of urticarial (hives), angioedema and allergy. The dose of clozapine was gradually decreased to 50 mg/day. On the 10th day of treatment, edema was still mildly (+) observable. After gradual discontinuation of Clozapine within one week, the edema was completely recovered. Although there are significant speculations about mechanisms of edema caused by antipsychotics, studies have shown a significant relationship between dopaminergic antagonism and idiopathic edema. Edema may be due to the antagonistic effect of clozapine on renal dopamine receptor type 4 (D4). Alpha-adrenergic receptor mediated peripheral vasodilatation has been especially emphasized as a potential mechanism for AAP-induced

KEYWORDS
Schizophrenia; atypical antipsychotics; side effect

edema. The incidents of edema caused by antipsychotics is indeed not rare, yet they are often reported by neither clinicians nor patients, mainly due to edema being temporary. As in our case, it was generally sufficient to reduce the dosage or switch to a different drug in the treatment of peripheral edema associated with AAP.

[Abstract:0406] [Mood disorders]

Concurrent thyrotoxicosis and psychotic episode: a case report

Berrin Ünal, Deniz Altunova, Seda Kırcı Ercan, Ebru Çiftçi, Osman Ak, İkbal İnanlı and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Thyroid dysfunction in psychiatric patients is higher than healthy population. Also, the prevalence of psychiatric disorder was found to be higher in patients with thyroid disease. Psychiatric conditions such as affective symptoms (depression, mania), anxiety, psychomotor agitation, emotional lability, distractibility, sleep problems, cognitive dysfunction and hostile attitude to the environment can be seen in patients with high thyroid hormones and not treated with antithyroid hormone therapy. In this case, we aim to discuss a 25-year-old female patient with psychotic episode in the postpartum period who had found out thyroid dysfunction and family history of bipolar disorder.

Case presentation: The patient was 25 years old, who had been married for 2 years and mother of a 9 months old baby. She had no previous psychiatric illness. She was admitted to our inpatient clinic with complaints of insomnia, irritability, loss of appetite, weight loss in the last 1 month, outbursting with inappropriate clothes, increased mobility, skepticism, and persecutory ideas. Two months after giving birth, she had complaints of unhappiness, pessimism, decreased functionality, but she get well without any treatment. Her psychiatric examination revealed irritable mood, auditory and visual hallucinations, flying idea, paranoid, referential and grandiose delusions. Physical examination; Body Temperature: 37.5, Pulse: 110, ECG: Tachycardia, and she had exophthalmos. We started the treatment with olanzapine 5 mg/day and titrated to 30 mg/day. In routine tests, sT3 = 17,6, sT4 = 4,32, TSH < 0,01. Thyroid USG and Scintigraphy were compatible with Graves' disease. Metimazol 15 mg/day was added to the treatment. Thyroid hormones returned to its normal limits about 10 days. She was discharged after 1 month of inpatient treatment. One month after discharge, her psychotic symptoms disappeared completely. The dose of olanzapine was decreased to 10 mg. The thyroid function tests were normal and the patient was followed up regularly by the Endocrinology Department. Thyrotoxicosis can lead to psychiatric symptoms with impaired consciousness, loss of orientation, delusion and hallucinations. Symptoms have regressed when the patient becomes euthyroid in hyperthyroid cases. One study reported that psychosis is a rare complication of hyperthyroidism, with 1% of cases reported, and most patients with psychotic symptoms are previously diagnosed with mania and/ or delirium. Hyperthyroidism cases are usually associated with psychotic attack in the literature. However, cases with manic attack after hyperthyroidism have also been reported. In our case, the presence of family history of bipolarity and the onset of postpartum period requires us to keep in mind the possibility of bipolar disorder.

KEYWORDS

Bipolar disorder; psychosis; thyroid dysfunction; Graves' disease; hyperthyroidism

[Abstract:0409] [Mood disorders]

The efficacy of clozapine in rapid cycling treatment-resistant bipolar disorder: a case report

Osman Ak, Sehure Azra Yaşar, Deniz Altunova, Ebru Çiftçi, Ali Baran Tanrıkulu, Yasin Yılmaz, İkbal İnanlı and İbrahim Eren

Health Sciences University Konya Research and Training Hospital, Yazır Psychiatry Clinic, Konya, Turkey

ABSTRACT

Clozapine, an atypical antipsychotic, is primarily used for the treatment of treatment-resistant schizophrenia, and may also have a role in other treatment-resistant psychotic conditions, such as schizoaffective disorder and psychotic mood disorders. Rapid cycling bipolar disorder (RCBD) is an independent predictor of inadequate treatment response in patients with BD and is associated with greater morbidity vs. non-rapid-cycling disease. We present the case of severe, treatment-resistant RCBD that responded to clozapine.

Case Presentation: 54 year old female, widow patient. She was being followed up for 30 years with a diagnosis of BD and she was hospitalized for 1 or 2 times with manic attacks every year.

KEYWORDS

Psychotic mood disorders; long-term treatment; treatment resistant

The patient did not use regular medication, and the period when she was in good health lasted about 6 months after being hospitalized. For the last 2 years, he has had more than four episodes per year. The patient hospitalized for treatment with complaints irritability, restlessness, decreased need for sleep, increased energy, increased psychomotor activity, much speech, spending a lot of money and grandiose delusions Because treatment compliance was poor, oral paliperidone was started with a long-acting treatment plan. Treatment with paliperidone did not respond to the maximum treatment dose and olanzapine treatment was started, titrated up to the maximum treatment dose. Quetiapine 900 mg/g was added to the treatment of the patient whose symptoms did not regress with olanzapine treatment and 9 sessions of ECT were administered. Treatment of the patient whose symptoms did not improve sufficiently was switched to clozapine, and the dose of clozapine was titrated to 400 mg/day. No side effects related to clozapine treatment were observed. The patient was discharged with clozapine 400 mg/day and quetiapine 600 mg/day. The patient was clinically stable after outpatient follow-up. RCBD is a complex, often severe and disabling psychiatric disorder and it often poses a therapeutic challenge. The many studies suggest that clozapine may be particularly effective in the treatment of medication-resistant unipolar depression and bipolar disorder. We believe that clozapine may be an effective therapeutical tool for the mid- and long-term treatment of treatment resistant rapid cycling bipolar disorder.

[Abstract:0416] [Sleep]disorders

Night terror triggered with montelukast: a case report

İsmail Demir[a] and Arzu Çalışkan Demir[b]

[a]Yeşilyurt State Hospital Otorhinolaryngology (ENT) Clinic, Malatya, Turkey; [b]Department of Child and Adolescent Psychiatry, Inonu University School of Medicine, Malatya, Turkey

ABSTRACT

Night terrors are common in pediatric populations with a prevalence of 14.7% in children 3–10 years of age. Sleep disturbances, including nightmares, related to leukotriene receptor antagonists have not been described in clinical trials. However, several cases of sleep abnormalities, including nightmares, have been reported in post-marketing experience in patients treated with montelukast.

Case presentation: A 5-year-old girl presented with snoring, nasal congestion and post-nasal drip to the otorhinolaryngology outpatient clinic. Montelukast treatment was started. The events began after initiation of montelukast. The patient presents for evaluation of nocturnal episodes consisting of abrupt awakening with screaming and confusion lasting ten minutes in duration. Montelukast was stopped and night terrors ceased. After two weeks, montelukast was reintroduced with recurrence of sleep terrors. Studies have shown a strong relationship between montelukast and nightmares. Insomnia and nocturnal awakenings have been reported with montelukast. We cannot suggest a mechanism for montelukast induced nightmares. To our knowledge, nightmares have not been reported with zafirlukast, another leukotriene receptor antagonist. However, higher susceptibility of children to this adverse effect should not be excluded. It is important to bear in mind that montelukast may be a cause of nightmares, particularly in children. Unexplained nightmares can lead to unjustified psychiatric consultation and possibly to additional treatments. Patients, doctors and their families should be fully informed about this risk.

KEYWORDS

Montelukast; nightmare; night terrors; leukotriene antagonist; sleep disorders; side effects

[Abstract:0423] [Other]

Thrombotic thrombocytopenic purpura with psychiatric symptoms: a case report

Kamil Mert Angın, Sinay Onen, Ibrahim Taymur, Ozge Fındıcaklı and Esra Akay

Department of Psychiatry, Bursa Yuksek Ihtisas Research and Training Hospital, Bursa, Turkey

ABSTRACT

Thrombotic thrombocytopenic purpura (TTP) is characterized by anemia, thrombocytopenia, neurological symptoms, renal failure, and fever. Neurological findings are such as headache, mentally and consciousness changes, seizures and focal neurological deficits. In our case, we discussed the patient who was diagnosed with TTP and admitted to the emergency department with an acute changes of behavior and personality.

KEYWORDS

Thrombotic thrombocytopenic purpura; changes behavior; agitation; neurological symptoms

Case presentation: A 40-year-old male patient was brought to the emergency department by his family with complaints of irritability and bizarre behavior that started 2 days before. The patient was consulted to our clinic because of agitation. His psychiatric examination showed that he was conscious and cooperative. His orientation was preserved, memory was intact. His affect was labile, mood was irritable. He had a negativist attitude, ambivalent thought content and agitation. Pathology of thought and perception was not consistent. There was no history of alcohol, smoking or psychoactive substance use and no previous diagnosis of systemic disease. Vital functions were as follows; Blood pressure:110/60, heart rate: 84/minute, body temperature: 37C. It was recommended that organic pathologies should be ruled out primarily because of the acute development of psychiatric symptoms and lack of previously known psychiatric disorders. Laboratorial exams: LDH:13410 U/L, Creatinine: 1.3 U/L, AST: 443 U/L, ALT: 450 U/L, Total Bilirubin: 4.11 mg/dL, Direct Bilirubin: 0.89 mg/dL, Glucose: 196 mg/dL, Leucocyte: 8400 U/L, HGB: 6.4 g/dl, Thrombocyte: 41000 mm^3. Purpuric rashes in the bilateral lower extremities where detected in the physical examination of the patient. Brain CT and MRI and neurological examination did not exposed any neuropathological finding. The patient with the findings of thrombocytopenia, anemia, purpuric rashes, high LDH levels was diagnosed as TTP hospitalized by hematology clinic. Haloperidol 1.5 mg/day was started for his agitation. During hospitalization, treatment of fresh frozen plasma, corticosteroid and plasmapheresis were administered for treatment of TTP. Psychiatric symptoms also improved along with clinical and laboratory findings after 5th day of hospitalization. TTP can easily be diagnosed in the existence of the of sudden onset thrombocytopenia, anemia, neurological findings with fever and impaired renal function. The earliest and most common findings are neurological abnormalities and bleeding. Mental state alteration in TTP is one of the most common neurological manifestations and may present in a wide spectrum from confusion and disorientation to coma. In our case, there was no change in mental status during and after admission. Neurological examination was within normal range and psychiatric symptoms such as ambivalent thoughts, negativist attitude, irritability and occasional psychomotor agitation were prominent. Roncero et.al (2000) reported a 25-year-old female patient who was admitted to the psychiatry clinic due to pseudo psychiatric symptoms which are manifested by non-specific and variable neurological symptoms and was diagnosed as TTP after detailed examination process. In literature there were no TTP cases which initially started with psychiatric symptoms exception of this case. Sudden onset, variable and unstable psychiatric symptoms may cause psychological interpretation of the disease. This may result in inaccurate or delayed diagnosis and inadequate treatment. This situation shows the importance of elimination of organic pathologies in psychiatric evaluation.

[Abstract:0426] [Psychopharmacology]

Rapid efficacy of mirtazapine in the treatment of hyperemesis gravidarum with esophagus perforation: a case report

Ayşegül Taşdelen Kul, İbrahim Gündoğmuş, Sefa Öz and Demir Faruk Dağ

Department of Psychiatry, Gülhane Research and Training Hospital, Ankara, Turkey

ABSTRACT

Hyperemesis gravidarum is a medical condition that can cause serious consequences for mother and fetus. It is estimated to occur in about 80% of pregnant women and is characterized by severe nausea and vomiting. So it may been caused that medical consequences such as hypoglycemia, hypopotassemia, even esophagus perforation or medical abortion. Nausea and vomiting during pregnancy is probably thought to be related to hormonal changes and it is necessary to exclude other organic causes of vomiting before diagnosis. Since the pathophysiology of nausea and vomiting in pregnancy is not clear, there is no scientific treatment for cause; treatments are usually intended to relieve symptoms. Application of anti-emetics with liquid-electrolyte and vitamin supplements is first choice. Mirtazapine, a noradrenergic and specific serotonergic agent, has anti-emetic effects due to the blockage of 5-HT3 receptors. Therefore, there are reports suggesting the use of mirtazapine in the treatment of hyperemesis gravidarum in the literature.

Here, we present the rapid efficacy of mirtazapine in a case of resistant hyperemesis gravidarum in a 34-year-old woman.

Case presentation: The patient was 28 years old, gravida 4 and parity 3. Married, a housewife, admitted to our hospital of gynecology and obstetrics clinic with the complaints of severe nausea and vomiting. On her examination is presented that esophagus perforation. She had no symptoms of depressive and anxiety. In the second week of pregnancy, the patient's complaints of nausea and vomiting started and she was diagnosed with hyperemesis gravidarum at sixth week. The treatment of ondansetron, methochloramide and prednisolone was not sufficient to relieve the symptoms and could not tolerate any food or

KEYWORDS

Rapid efficacy; mirtazapine; treatment; hyperemesis gravidarum; esophagus perforation

drink. By the 8th week, the patient had a weight loss of 8.5 kg compared to pre-pregnancy. In the patient's urine, normoglycemic ketone positivity was present. During pregnancy, the patient's social and familial stressors were formed and the complaints of hyperemesis gravidarum increased. Medical aborts was planned because of the worsening of the patient's and the baby's vitals. The patient was finally consulted to psychiatry. After a detailed history and psychological examination, the patient was not diagnosed psychopathologically according to the DSM-5 diagnostic criteria. The patient was recommended to use mirtazapine. The patient was able to tolerate food and drinking for the first time in a month after two hours after receiving the first mirtazapine 15 mg. Two weeks later, the patient's nausea and vomiting decreased significantly. Oral mirtazapine was continued 60 days and after ultrasound examination showed normal growth fetus. Mother's weight gain was normal. She gave birth with vaginal delivery at 38 weeks of gestation. After the birth, both the patient and the baby were good. It has been reported that severe hyperemesis gravidarum have been related with an increased risk of preterm delivery, miscarriage, low birth weight and perinatal mortality. In our case, severe hyperemesis gravidarum was associated with medical abortion. In addition, mirtazapine has been a very rapid effect in our patient unlike other cases. In conclusion, mirtazapine should be considered as a therapeutic alternative in the treatment of resistant hyperemesis gravidarum.

[Abstract:0431] [Mood disorders]

Ultra-rapid cycled early onset bipolar disorder treatment and management: a case report

Zehra Algan, Merve Sarraf and Özlem Özcan

Department of Child and Adolescent Psychiatry, Inönü University School of Medicine, Malatya, Turkey

ABSTRACT

Bipolar disorder (BD) is one of the most important mental disorders that characterized by severe and recurrent episodes of mood disorders, leading to significant disability. In this presentation, we aimed to share the diagnosis, treatment and monitoring processes of ultra-rapid cycled BD with no organic etiologies.

Case presentation: The 11-year-old girl patient firstly presented our clinic in October 2016 with complaints of frequently crying, tension, and abnormal behavior. In her history; the patient's complaints started 6 months before after being frightened by friends in the school's fire escape for the first time. During that period of 2 months, she had decreased sleeping need and increased mobility by 1 week of well-being and 1 week of abnormal mobility periods. In addition, it was determined that the family did not apply to the hospital because the attacks occasionally lasted for 3 days. Family noticed that, she had much more intense mobility, reduced the need for sleep and crying episodes than the previous attacks, and abnormal behaviors such as removing the clothes after the school began. It was learned that the patient was inward and unable to express herself well in premorbid. Her uncle and aunt had BD too in her family history. During the 2-year follow-up period, 3 manic 5 hypomanic attack episodes detected and she was treated in the inpatient service during her manic episodes. Rapid cycle is a rare case of BD with 4 or more attacks within 1 year. If these attacks last 48 h and not more than 1 week, it is named ultra-rapid cycle. Rapid cycle is a transient phenomenon in most bipolar cases and is usually associated with poor prognosis. Although the literature examining the pharmacological treatment of the rapid cycle is scarce, there is no clear consensus on that. The available evidence suggests that it is difficult to maintain the stability of the treatment because there is very fast transition between mania and depression, and an effective response cannot be obtained in the acute rapid cycle with atypical antipsychotics. Lithium and anticonvulsants show an equivalent but lower clinical response. Besides there was a higher rate of general functional deterioration in this patient than the patients without rapid cycling. Our case also had to discontinue the school for 1 year because of attacks. When BD begins in childhood or adolescence, it is usually characterized by continuous rapid cycle, mixed symptoms, and destructive behavior. Recent studies indicate that the age of onset of the disease is earlier in the fast-cycling group of patients. Additionally, in studies investigating family history in the rapid cycle, there is a higher prevalence of mood disorder in the first-degree relatives of patients with rapid-cycling disorder than those without In clinical management of BD, early recognition of the rapid cycle related features like early onset, female gender, family history, etc. are essential. Furthermore, we think that the detailed follow-up of these cases will contribute to the literature because of the poor power and prognosis of these cases.

KEYWORDS

Bipolar disorder; children; rapid cycling; treatment

[Abstract:0432] [Other]

Factitious disorder with psychotic symptoms: a case report

İlkin Karaarslan, Bilge Çetin İlhan, Yasemin Gökçenoğlu, Seda Kırcı Ercan and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Factitious disorder consists of a patient inducing symptoms or signs to assume the role of being sick and to receive care. There is no secondary gain, such as escaping responsibilities or receiving money, as is found with malingering. The onset of this disorder usually occurs in early adulthood. It can be manifested through both physical and psychological signs and symptoms. Psychiatric disorders are rarely simulated in factitious disorder cases, however could lead to problems in diagnosis, treatment and follow-up. In this case, we present a twenty-nine year-old man, who had symptoms for ten years and had been diagnosed with various illnesses including psychosis, bipolar disorder, depression, anxiety disorder and epilepsy.

Case presentation: A 29-year-old male patient grown up in orphanage, working as a clerk. The patient was admitted to inpatient clinic with complaints of fear, anhedonia, suicide thoughts, unwillingness, incompatibility with people around, insomnia and persecution delusions. The complaints of the patient had begun 10 years ago after the loss of his girlfriend, as unhappiness, malaise, and unwillingness. The patient had been hospitalized in many hospitals with different diagnoses along the past 10 years. After all sick leaves and medical reports of several days and months given to the patient by different doctors, it was understood that he had continued work for only 1 month in total. The patient told that contracture had developed in his right hand due to his suicide intervention, however after we contacted his family we learned that he had a congenital condition in his arm, which had been followed up in a physical rehabilitation clinic. He was normal in terms of his mental state examination, not having any hallucinations. He had no complaint of illness, during the times he was alone. He had three episodes of non-epileptic seizures during his clinical follow-ups, especially when he thought that he could not take enough attention from the healthcare workers. EEG was recorded for excluding the any possibility of epilepsy, which resulted to be non-epileptic after neurology consultation. The symptoms of patient recessed after ten days, and he was discharged after a two months follow-up. Factitious disorder is a condition in which the individual consciously induces or simulates physical and/or mental illness, yet being unconscious of her/his underlying motivation. They perceive hospital environment and the doctors as powerful sources of love (e.g. like a mother), fulfilling their need for dependency and approval. Therefore, the disease manifests itself as a means for receiving attention and love for the person. Despite the observed psychotic symptoms such as persecutory delusions, we thought in our case that these were due to him having a factitious disorder, such that he had been admitted to hospital many times yet having no secondary gain.

KEYWORDS

Munchausen syndrome; atypical psychosis; non-epileptic seizures; suicide attempt

[Abstract:0436] [Psychopharmacology]

Edema of hands and feet with atomoxetine in a girl with autism and attention-deficit/ hyperactivity disorder

Ibrahim Adak, Busra Ustundag, Maruf Aggul, Mohammad Al Bayati, Hüseyin Demir and Ozalp Ekinci

Department of Child and Adolescent Psychiatry, Erenkoy Research and Training Hospital for Psychiatry and Neurology, Health Sciences University, Istanbul, Turkey

ABSTRACT

Edema is defined as swelling caused by an excess of fluid in body tissues. This condition usually occurs in legs, ankles, hands or feet. Causes include diseases, allergies and medications. Considering medication related causes, atomoxetine treatment has never been reported to cause edema. Here, we present an 8 year old girl with diagnoses of autism and attention-deficit/ hyperactivity disorder (ADHD) who developed edema on her hands and feet after adding atomoxetine to aripiprazole treatment.

Case presentation: An 8 year old autistic girl using aripiprazole treatment at a dose of 2 mg/day for her irritability symptoms was admitted for attention deficit problems. She was given a diagnosis of ADHD. Upon history, it was revealed that aripiprazole treatment improved her irritability symptoms without any significant adverse effects. So we added 10 mg/day atomoxetine to aripiprazole treatment for her ADHD symptoms. After using 10 mg/day atomoxetine for a few days, her hands and feet were swollen. Upon this, the child's family presented to a pediatrician. As a result of detailed physical examination and laboratory work up, no organic pathology was detected to cause edema. It was thought that the cause of edema could be atomoxetine treatment and recommended to terminate the drug treatment.

KEYWORDS

Edema; atomoxetine; autism; ADHD

After discontinuation of atomoxetine, the edema of hands and feet disappeared. Atomoxetine has been one of the first line psychopharmacological treatment in children and adolescents with ADHD. Nausea, decreased appetite, weight loss and sleep disturbances are most frequently reported adverse effects during atomoxetine treatment. A literature review revealed no reports of atomoxetine related edema of hands and feet in children and adolescents with diagnoses of autism and ADHD. Therefore, to our knowledge, this is the first reported case of atomoxetine related edema of hands and feet in an autistic child. Emergence of edema with atomoxetine trial and disappearance with medication discontinuation may suggest a causal link between atomoxetine and edema in this case. However, despite this causal link, it is unclear through which pathophysiological mechanisms atomoxetine could cause this side effect. Possible mechanisms could be sodium overload, fluid replacement and hyperpermeability of blood vessels that could be induced by the drug treatment. Whatever the pathophysiological mechanism could be, the clinicians should be familiar about the possibility of edema of hands and feet in children treated with atomoxetine. In such cases, clinicians may order a pediatric consultation. Alternative medications for ADHD including different forms of methylphenidate may be considered in case of need.

[Abstract:0433] [Schizophrenia and other psychotic disorders]

A case of violence: the importance of treatment continuousness in schizophrenia

İlkin Karaarslan, Bilge Çetin İlhan, Seda Kırcı Ercan, İklima Zeynep Bayraktar and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Violent behavior in psychiatric cases in general population has increased. Among psychiatric disorders, schizophrenia has always a special role in violence attempts. Although the risk of homicidal behaviors are higher in the schizophrenic individuals compared to the overall population, little is known about the relevant conditions triggering this act of violence among criminals. The available results suggest that certain factors, including some socio-demographic characteristics, male gender, young age, alcoholism, substance abuse, incompliance with the treatment, antisocial personality disorder, paranoid subtype, history of suicidal ideation and attempts, history of frequent hospitalization increase the potential for occurrence for violence episodes. In this case, we present a schizophrenic patient killed his mother unexpectedly.

Case presentation: A 55 year-old male patient, single and had been living with his mother with Alzheimer's disease. The patient admitted to our inpatient clinic as a forensic case for killing his mother. The symptoms of the patient had begun with aggression, disorganized behaviors, grandiose and persecution delusions when he was 20 years old. He had been hospitalized with the diagnosis of schizophrenia for several times. His last hospitalization was in May 2018, after which was discharged with Paliperidone long acting injection (LAI) form 150 mg/month treatment with symptoms recessed. Over his outpatient follow-up by a different psychiatrist, paliperidone LAI had been reduced to 100 mg/month, after two injections of which, psychotic symptoms have begun within 2 months. Psychotic symptoms begun quickly afterwards, which resulted as him killing his mother over persecution delusions. The patient was admitted to our service again forensically this time. He had limited overall interaction, and did not tell anything about the incident. We continued his medication by increasing again, the dose of paliperidone LAI to 150 mg/month, which resulted in recession of his psychotic symptoms. The patient is still being treated in our inpatient clinic.

The tendency of violence occurs due to disorganized, agitated behavior, or due to the nature of delusions and hallucinations. In the literature, it is reported that psychotic patients' family members and people with whom they have close relationships generally have a higher risk for violent behavior. It is thought that this situation may be related to the fact that delusions and hallucinations are more closely related to patient's close environment, due to the decrease in social functionality during the course of the disease. Hence it may be possible to foresee potential violent acts that could have more serious consequences, such as murder. In our case, decrease in dosage of drug treatment may have caused the tendency to violence.

KEYWORDS

Psychosis; hallucinations; persecution delusions; LAI antipsychotics

[Abstract:0435] [Schizophrenia and other psychotic disorders]

Non-epileptic seizure in schizophrenia: a case report

İlkin Karaarslan, Bilge Çetin İlhan, Seda Kırcı Ercan and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Psychogenic non-epileptic seizures (PNES) resemble, or can be mistaken for, epileptic seizures but are not associated with the characteristic electrophysiological changes seen in the latter. The prevalence of psychogenic non-epileptic seizures in the general population has been estimated to be between 2 and 33 per 100000.Here we present a patient who has psychogenic non-epileptic seizures occurring in response to visual hallucinations.

Case presentation: A 39-year-old male patient was presented with complaints of irritability, insomnia, and auditory and visual hallucinations. The patient had been hospitalized with the diagnosis of schizophrenia in many hospitals with these complaints that had started about 20 years ago. He had low benefit from different anti-psychotic drugs. We started his treatment with paliperidone 6 mg/day, which was afterwards increased to 12 mg/day. Paliperidone long acting injection (LAI) form was continued due to patient's oral treatment inadherence. After the first 2 administered doses, the patient developed seizures. He was consulted to neurology department over the EEG recording acquired in our clinic, which resulted that the seizures did not have neurological origin. A few days after the last seizure, the patient explained that his seizures had begun after his auditory and visual hallucinations. Afterwards, there was no recurrence of seizures during follow-up. Treatment of the patient was continued with paliperidone LAI form 150 mg/month. His psychotic symptoms were recessed via this treatment, after which he was discharged from hospital. The definition of what constitutes a psychogenic non-epileptic seizure does not encompass its origin, i.e. the cause underpinning these events is not always understood. Many patients with non-epileptic seizures of psychogenic origin, experience significant morbidity, because of inappropriate treatment for epileptic seizures.PNES episodes could occur among patients who have a history of psychosis, such as schizophrenia. Hence, the important clinical message about our case was the occurrence of visual hallucinations, which have resulted in non-epileptic seizures and receded as a result of the treatment for psychosis.

KEYWORDS

Pseudo-seizures; hallucinations; psychosis

[Abstract:0437] [Schizophrenia and other psychotic disorders]

A manic episode induced by electroconvulsive therapy (ECT) in a patient with schizophrenia

Rabia Erdoğan, Çağlar Turan and Atila Erol

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Electroconvulsive therapy; It is an effective and safe method for the treatment of psychiatric disorders such as depression, catatonia and depressive, manic or psychotic conditions. Among the side effects of electroconvulsive therapy manic slip although rare has been reported. Most reported cases are depression or bipolar disorder. In our case, we present a schizophrenia patient who experienced manic slip after ECT.

Case presentation: Our patient was diagnosed with schizophrenia 18 years ago. He was hospitalized 6 times in psychiatry wards. His medication adherence was poor throughout the illness course. He was brought to our clinic with complaints of talking to himself and laughing, closing into, suspiciousness, thinking that he was a prophet and worsening in his personal hygiene. In the psychiatric examination of the patient; he was conscious and his orientation was completed. He had intermittent eye contact. Memory examination was normal. His mood was euthymic. Affect was dull, determined and consistent with thought content. Concentration decreased. He did not speak spontaneously and the amount of his speech decreased. The abstract thinking was preserved. His thought content was poor. He had persecution, reference and mystic delusions. Psychomotor behavior was slow. His judgment was broken, he had no insight. Physical examination of the patient was natural. According to the anamnesis information, resistant schizophrenia was accepted and clozapine 25 mg was started. Since electroconvulsive therapy has benefited before, the ECT was planned to provide rapid recovery. Necessary analyzes were performed. MRI and EEG were normal. The patient had bradycardia. Consulted with cardiology and anesthesia. Three sessions of ECT were performed. There was an increase in insomnia, mobility, joy, speech and religious discourse. The patient was re-evaluated. It met manic attack criteria according to DSM-5criteria. We decided to stop the ECT. Haloperidol 10 mg IM injection was added to the treatment twice a day because the patient was very active and aggressive. Clozapine was gradually increased to 700 mg/day. There were regressions in the patient's symptoms. He was discharged in a psychiatric clinic after a total of 52 days. Among the side effects of electroconvulsive therapy manic slip although rare has been reported. There are two options to discontinue ECT when mania attack develops or to continue treatment due to the antimanic properties of ECT. We terminated ECT in our patient and started antipsychotic treatment. We waited a while for mood stabilizer treatment. We did not require mood

KEYWORDS

Electroconvulsive therapy; mania; schizophrenia

stabilizing medication because the patient's manic symptoms improved. When using ECT in psychiatric disorders, especially on resistant cases, side effects should be considered seriously. It is important to recognize these side effects early and treat them effectively.

[Abstract:0438] [Schizophrenia and other psychotic disorders]

Acute psychotic disorder ın the course of neuro-Behcet

Rabia Erdoğan, Sevgi Güleç, Esra Yazıcı and Ahmet Bülent Yazıcı

Department of Psychiatry, Sakarya University School of Medicine Research and Training Hospital - Psychiatry Sakarya, Sakarya, Turkey

ABSTRACT

Behçet's disease is chronic disease accompanied by recurrent, inflammatory, recurrent oral aphthae, and systemic symptoms such as genital ulcer, eye and skin lesions, neurovascular findings and arthritis. Approximately 20% of the patients have central nervous system symptom and this is known as neuro-Behçet syndrome. It has been reported that depression, anxiety and general psychiatric symptoms accompanying this disease in BD are higher than the normal population. However, it is not known exactly what is the relationship between BD and psychiatric symptoms. Our case presented with acute psychotic disorder in the course of neuro-Behçet.

Case presentation: Here, we report a 38-year-old male patient who was admitted to the outpatient clinic with complaints of aggression, self-harm, the belief of being controlled with a chip placed in his brain, jealousy and aggression. He was diagnosed as Behçet's disease 12 years ago due to the symptoms of recurrent oral sores, joint pain, and blurred vision in both eyes. he had limbic encephalitis two years ago and diagnosed with Neurobehcet that time. He had various medications as cyclosporine, azathioprine and finally he was on Lacosamide 300 mg/day and mycophenolate 2000 mg/day. In the first day of hospitalization in the psychiatric examination: he had complete orientation and cooperation. There was cognitive decline in the terms of attention, instantaneous memory and concentration. He was in normal rates of IQ clinically. His speech was spontaneous and coherent. His mood was depressive and affect was not appropriate with the content of thought. He had suicidal thoughts and delusions of persecution, jealousy, reference, and control. His abstract thought was preserved. Perception included congruent hallucinations with his delusions, with no separate hallucinations. Judgment was weakened. Psychiatric scales were scored as Clinical Global İmpression (CGI): 5, Brief Psychiatric Rating Scale (BPRS): 28, Positive and Negative Syndrome Scale (PANSS): P: 18 N: 12 G: 33. There was no significant sign in physical examination and neurological examination. The hematologic and biochemical markers are in normal ranges in blood tests and no substance was determined in urine analysis. Also there was no pathologic sign in the cranial MRI and EEG. Olanzapine 10 mg/day was started but the aggression and excitation of the patient did not decrease so haloperidol was added to treatment for the first five days of hospitalization and shifted to olanzapine 20 mg gradually. On the 22nd day of treatment, his psychotic symptoms improved. The patient was discharged with the scores of CGI: 3, BPRS:8, PANSS: P: 9 N: 8 G: 17 with olanzapine 20 mg/day. In the literature, there are few cases of psychotic disorders in the course of neuro Behçet. This case is important due to the comorbidity with Neurobehcet and psychosis. The fast and nearly response to treatment and fast improvement of delusions with olanzapine is noteworthy. There is not enough data on the potential biological substrate of this mechanism and the management of cases.

Psychosis may be comorbid or a presentation form of Neurobehcet disease and further studies are needed whether psychiatric symptoms can be considered a clinical feature of BD and therapeutic approaches.

KEYWORDS

Neuro-Behcet; psychosis; olanzapine

[Abstract:0440] [Schizophrenia and other psychotic disorders]

A case with respiratory arrest under clozapine treatment

Rabia Erdoğan, Özlem Akçay Ciner, Çağlar Turan and Ali Savaş Çilli

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Clozapine is a highly effective antipsychotic, and is the only antipsychotic with an indication for suicidal behavior and treatment-resistant schizophrenia. However, it has many side effects like agranulocytosis, glucose intolerance, myocarditis and cardiomyopathy and constipation. Also, a small body of evidence demonstrates an increased risk of lower respiratory infections, including

KEYWORDS

Respiratory arrest; clozapine; pneumonia; schizophrenia

pneumonia, in individuals using atypical antipsychotics especially clozapine. We present a patient with schizophrenia who developed aspiration pneumonia during the hospitalization of clozapine treatment.
Case presentation: Our patient is a 62-year-old man with 47 years of psychiatric history of schizophrenia. His symptoms were previously well controlled with clozapine 300 mg/day and 100 mg/day chlorpromazine. He was hospitalized for his auditory hallucinations and grandiose and persecutory delusions after the patient leaves the medication on his own. Clozapine was prescribed again 25 mg/day and increased to 300 mg/day in 12 days and 50 mg/day of chlorpromazine added to the treatment. The patient also had voice change for a long time which was diagnosed as reflux laryngitis by otolaryngologist. Treatment for gastro-esophageal reflux was also initiated. Twelve days after clozapine initiation, clozapine-induced sialorrhea was occurred. He had mild sedation (difficulty to wake up in the morning) when clozapine reached to 300 mg/day. Early in the morning, he developed respiratory arrest. The patient was rapidly intubated and transferred to the intensive care unit. Chest computed tomography demonstrated multifocal infiltrates concerning for an infectious etiology and sputum culture were positive for gr (-) bacilli. WBC was 19,800 cells/mL. He was treated with piperacillin-tazobactam for presumed pneumonia. He gradually improved and was extubated on day 12. Olanzapine 10 mg/day was started on for the control of psychotic symptoms in intensive care unit. Urine and blood cultures were negative, and a chest radiograph showed no infiltrate anymore and he was transferred to the inpatient psychiatry service to continue to the treatment. Olanzapine was increased to 20 mg/day, psychotic symptoms were revealed and the patient was discharged with 20 mg of olanzapine treatment. After 2 weeks of the externalization he was stable with same treatment. Clozapine is the only antipsychotic approved for treatment-resistant psychotic disorders, and the use of clozapine is increasing as psychiatrists strive to treat patients with severely treatment-resistant disease. Monitoring for sedation, sialorrhea, and dysphagia during clozapine initiation is warranted, particularly in populations with increased risk of pneumonia including women, patients receiving high-dose therapy, and those with multiple medications or co-morbidities. Gastro-esophageal reflux should also be considered as an additional risk factor for aspiration. Psychiatric patients using clozapine and have gastro-esophageal reflux, and also have symptoms such as sedation, and hypersalivation should be closely monitored, aspiration pneumonia and respiratory arrest should be kept in mind.

[Abstract:0441] [Schizophrenia and other psychotic disorders]

Psychotic symptoms after a traffic accident, a case report

Tüba Şerife Elmas, Saliha Çalışır, Samet Paydaş, Mustafa Yasin Yılmaz, Zeynep Yücehan and İbrahim Eren

Deparment of Psychiatry, Health Sciences University Konya Research and Training Hospital, Konya, Turkey

ABSTRACT
Traumatic brain injury (TBI) is defined as one or more of the findings; loss of consciousness for a period of time physiologically as a result of trauma, loss of memory containing the events immediately before or after the accident, changes in the mental state at the time of the accident or focal neurological losses that may be temporary or permanent It is known that TBI is associated with mood, personality and behavioral changes. TBI is considered as a risk factor for psychiatric disorders. We will discuss a case of psychotic symptoms that develops 1 year after the car-in-the-side traffic accident and has no neurological findings.
Case Presentation: A 56-year-old- man was admitted to psychiatry inpatient clinic with complaining of skepticism, susceptibility, irritability, aggression, hearing noises, talking to oneself, talking about things that don't exist, thinking that his wife is cheating, insomnia, take of his clothes- undressing, he feels as rotten meat when he puts his hand on his head, trembling in his hands and feet, fear, anxiety since two months. After he got up from his night sleep and started slapping his wife, he was brought to the emergency by his relatives. There is no known psychiatric disease and drug use, about 1 year ago in the car-in-the-side accident was learned. There was no neurological findings only a temporary loss of consciousness because of just hitting his head and cranial MRI was normal. Psychiatric examination: male patient with bad self-care, showing age, eye contact insufficient, consciousness open, orientation full, amount of speech, speed and tone increased, mood anxiety, affect inappropriate – limited, attention distracted, memory normal, auditory and visual hallucinations, normal intelligence. Judgment, abstraction and reality assessment are impaired, association of ideas are messy, thought content has persecution, reference and jealousy delusions, no insight, psychomotor activity increased, sleep disturbed, impaired appetite. In diffuse axonal injury (DAI), there is a multiplication effect on the surfaces, which are relatively soft or covered (e.g. in-car spaces), with a long duration of acceleration. During head trauma, the rigid cavity containing CSF and parenchyma is shaken under the influence of linear and rotational forces. Brain shaking can be anteroposterior, coronal and axial, or a combination of these. As a result, the deeper brain regions cannot move at the same speed

KEYWORDS
Traumatic brain injury; psychosis; car-in-the-side traffic accident

or move in the opposite direction, while some areas of the brain that are fixed to the rigid structures of the brain and the vascular structures are shaken without sudden ruptures. These different accelerations also create a tension that leads to "rupture" of the neurons in the deep regions of the brain. Therefore, DAI is commonly seen in deeper regions such as basal ganglia, brain stem, corpus callosum. These may cause neuropsychiatric sequelae; generally cognitive deficits, especially information processing, attention, memory, cognitive flexibility and problem-solving disorders are observed. Significant impulsivity, affect imbalance and disinhibition are common due to damage in the frontal, temporal and limbic regions. It is very clear that everyone with TBI should be evaluated in terms of possible psychiatric disorders.

[Abstract:0442] [Schizophrenia and other psychotic disorders]

Delayed-onset psychotic symptoms after cavernoma hemorrhage: a case report

Tüba Şerife Elmas, Hatice Yardım Özayhan, Saliha Çalışır, Ali Baran Tanrıkulu, Zeynep Yücehan and İbrahim Eren

Deparment of Psychiatry, Health Sciences University Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Different types of psychiatric disorders such as anxiety disorders, behavior disorders, depression, mania and psychosis can be seen after cerebrovascular disease. The physical and psychiatric symptoms after cerebrovascular disease (CVD) are related with the areas of the brain. In the temporoparietal/ temporoparieto-occipital junction and especially in the right hemisphere lesions compared to the left, it is stated that there is a higher probability of development of secondary psychosis. There are also few case reports in the literature describing stroke-related psychotic symptoms. In most of them, psychosis appeared within the first week after the vascular event, and usually persisted for a short period of time (i.e. up to 4 months). As a different hypothesis, it is thought that the lesion site leads to a continuous electrical activity and this may be the organic substrate for psychosis even years later. In this study, our aim is to describe the case of a patient who developed psychosis, about 4 years after cranial cavernoma hemorrhage.

Case presentation: A 25-year-old- man was complaining of skepticism, susceptibility, irritability, aggression, hostile attitude to family, inappropriate laughing, auditory and visual hallucinations, increased sexual desire, insomnia since two months. His anger is too much, he cannot control himself. He hit the window, his third finger severing from the middle phalanx line. He's not convinced to go to the hospital. The patient was forced by police. He was hospitalized for follow-up and treatment. There is no known psychiatric disease and drug use. About 4 year ago a sudden fall in the bathroom, then arteriovenous malformation – cavernoma hemorrhage was detected. Cranial MRI revealed a right frontoparietal periventricular white matter hemorrhagic zone, infarct at the medial section of the left occipitoparietal region and at the level of the left temporal occipital region and left basal ganglia. In the mental status examination, the patient was showing age, with a good self-care, his eye contact was adequate and consciousness was open, he was cooperative and oriented. He had difficulty in speaking, his associations were derailed. Mood was irritable, affect was restricted and inappropriate, a lack of mental capacity was observed, memory was normal, attention was distracted with auditory and visual hallucinations. He had increased psychomotor activity, distorted sleep, and his thought content included persecution and reference delusions. Judgment, abstraction, and the ability to assess reality were impaired. Neurological examination: consciousness is open, motor aphasic, right hemiparesis, muscle strength right upper 3/5, right lower 4/5, deep tendon reflex increased on the right, right Babinski positive, eye movements four directions free, corneal reflex + / +, pupillary reflex + / +, gag reflex + / +, no autonomic dysfunction, right nasolabial groove erased. Atypical psychosis after stroke reported a right temporoparietal lesion in five patients with subcortical atrophy. Eight patients with right temporoparietal stroke or traumatic injury have been reported to be associated with psychosis and seizure in seven cases. As a result, the right hemisphere is more likely to develop psychotic symptoms in temporoparietooccipital lesions. However, psychosis may be seen in subcortical deep structures and other localizations.

KEYWORDS

Cavernoma hemorrhage; psychosis; delayed onset

[Abstract:0443] [OKB]

Obsessive-compulsive disorder or schizophrenia? A case report

Tüba Şerife Elmas, Saliha Çalışır, Bilge Çetin İlhan, İklima Zeynep Bayraktar, Zeynep Yücehan and İbrahim Eren

Deparment of Psychiatry, Health Sciences University Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Obsessive-compulsive disorder (OCD) is a psychiatric disorder which seen with recurrent obsessions and/or compulsions, chronic, demonstrate periodic course and affects social and daily functions of the individual considerably. Schizophrenia and OCD are defined as different disorders but clinical manifestations may overlap or change from one to the other. Psychotic symptoms in OCD are reported to be 10–17%. It is known that obsessions and compulsions in schizophrenia are usually absurd and stereotypical and that obsessive thoughts are self-consistent. In obsessive-compulsive disorder, obsessions are known to be foreign to the self and accompanied by significant anxiety as well as in our patients. In this case report, we discussed the clinical features of a patient with psychotic OCD who was confused with schizophrenia.

Case presentation: A 43-year-old, single, unemployed man was referred to our inpatient clinic by police. The patient constantly checks that his parents wash their hands after the toilet. He listens to the toilet door, tells them to wash the stool 4 times, and urine twice. If they don't, he's beating, screaming, turning the lights on and off. He's not letting his parents go to the toilet outside home. When they come from outside, he makes his parents make out to all their clothes. If they get up in the bathroom at night, they put a metal tray behind the door of his parents' bedroom to let him know when they leave the room. He stays awake at night. He locks in every place, doesn't let them in the kitchen. He doesn't eat unpackaged food and he wants to throw away. They couldn't get fresh bread from the oven. He prepares his own meals. He is checking everything, while his mother cooks. He has not bathed in almost 6 months. If his parents are not at home, he can go outside, eat outside. He has no friends. His complaints have increased for the last 5–6 years. He grasped his mother's throat, tried to kill her. He refused to go to hospital and to receive treatment. Psychiatric examination: male patient with bad self-care, showing age, eye contact enough. consciousness open, orientation full, speech normal, mood anxiety, affect inappropriate – limited, attention distracted, memory normal, no pathology of perception, normal intelligence. Judgment, abstraction and reality assessment are impaired, thought flow is slowed, association of ideas are messy, thought content has contamination obsessions, persecution, reference and grandiose delusions, no insight, increased sexual desire, psychomotor activity increased, sleep disturbed (YBOCS: 74, PANSS-P: 31, PANSS-N: 35, PANSS-G:59). Obsession may turn into delusion when resistance to disturbing thought is left and insight is lost, it is called "OCD" with psychotic features. In these patients, Schneiderian first degree findings such as hallucinations and delusions were not present, but insight and resistance to obsessions were eliminated and no sense of compulsion was experienced. This group had more varied and severe ruminations and ritual behaviors, social and work harmony was more impaired, the diseases were longer lasting and there was no remission, and they responded worse to psychotherapy and pharmacotherapy.

KEYWORDS

Obsessive-compulsive disorder; psychotic features; no insight

[Abstract:0444] [Other]

A case of adolescent factitious disorder presenting with dizziness

Ayşe Kanbur, Şafak Eray and Ayşe Pınar Vural

Department of Child and Adolescent Psychiatry, Uludag University School of Medicine, Bursa, Turkey

ABSTRACT

Factitious disorder (FD) is a mental disorder in which a person acts as if he/she has a physical or mental illness when, in fact, he/she has consciously created the symptoms. The patient benefits from FD as he/she attracts attention and support, and gets rid of individuals responsibilities. In this case, a case of an adolescent with FD, who has previously sought help of primary physicians and other medical specialists will be presented; and the psychological symptoms, diagnosis and differential diagnosis will be discussed on the basis of literature.

Case presentation: The patient is a 15-year-old, 9th grade, female student. She came to our outpatient clinic with the complaint of dizziness. We learned that; her dizziness suddenly started 4 months ago and in the first weeks she could only walk with support, but as the time passed, she was unable to walk or sit. In 4 months, she was examined by otorhinolaryngologists, pediatric neurologists, and ophthalmologists with the prediagnoses of epilepsy, vertigo, and intracranial mass. Cranial MRI, EEG, hearing tests, blood tests, and visual examinations were performed. Medical treatment for dizziness was initiated, but the treatment was not beneficial and all the test results were normal. No organic disease could be detected, so she was directed to us as a last resort. The patient was hospitalized with the prediagnosis of conversion disorder (CD). In her mental examination, she was found to be afraid of making eye contact. There were discrepancies in her complaints during the follow-up examinations. The patient said that she had difficulty lying in bed due to dizziness, but she could easily sleep, eat and watch TV. She could not walk alone and care for herself. She

KEYWORDS

Factitious disorder; dizziness; conversion disorder; vertigo; epilepsy; adolescent

said that her constant dizziness continued, however, her affect was euthymic. In further examinations, it was learned that her complaints had begun when she moved to a different city and started high school. Also, anxieties and depressive themes were found and sertraline treatment was started. After the interviews, observations, and detailed investigations, the preliminary diagnosis of CD was withdrawn, and the patient was re-diagnosed with FD. A treatment plan was made and the family was informed. Psychiatrist's suspicion of FD is the first and most important step for diagnosis. The diagnosis of FD can be confused with organic pathologies or CD and is difficult to diagnose. In our case; not being diagnosed with any organic disease despite repeated hospital admissions, patient's willingness to be hospitalized, the increase of symptoms during interviews, inconsistencies in complaints and responses to treatment, not having any financial gain and worsening of symptoms before discharge were the findings that supported the diagnosis of FD and discouraged the diagnosis of CD.

[Abstract:0447] [Autism spectrum disorders]

Methylphenidate-induced obsessive-compulsive symptoms in autism: a case report

İbrahim Taş, Bilge Çetin İlhan, Seda Kırcı Ercan and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Autism spectrum disorders (ASDs) are characterized by severe qualitative impairments in socialization, communication, restricted repetitive behavior, and interest-related activities. Many symptoms can be seen in ASDs, such as hyperactivity, irritability, tantrums, aggressive behavior, stereotypic behavior, obsessive-compulsive symptoms (OCS) and depression. Methylphenidate treatment can be used to control hyperactivity autism patients, with the most frequently reported side effects of nausea, decreased appetite, weight loss, and sleep disturbances. Besides from these common side effects, methylphenidate has also been reported to cause some unusual side effects such as hallucinations, hyper-sexuality or inappropriate sexual behavior, skin eruptions, manic/psychotic reactions, and OCSs.

Case presentation: The patient is a 23-year old male patient. The first complaints related to the patient had been during the early stages of development, starting at his age of 3.5 years as obsessions, whirling about, not responding when called, speaking with single word. He had been admitted to child psychiatry at that time with a diagnosis of autism. At the age of 7, risperidone had been started due to patient's aggressive behavior, causing partial reduction of complaints. At the age of 10, methylphenidate had been started, which was then not continued due to increase in obsessive behavior. Risperidone treatment had been continued for a long time due to aggressive behavior of the patient. Admittance of the patient to our clinic was in 2015,when he was 19 years old because of his physically aggressive behavior such as hitting, biting, throwing objects to another person, repetitive and stereotypic behavior, irritability, hyperactivity and attention deficits, and social impairment. For hyperactivity, methylphenidate treatment was restarted and gradually increased to 54 mg/day, but discontinued after the emergence of OCS. Paroxetine 20 mg/day was added to his treatment with a gradually increased to 40 mg/day due to OCSs not having resumed immediately after the discontinuation of methylphenidate. OCSs recessed in the following weeks.

OCSs are rarely reported in patients treated with psychostimulants, i.e. within only a few case reports of patients who developed OCS with stimulant medications. The increase in OCDs with methylphenidate in our patient's history also provided information on possible temporal correlation between the onset of OCS and methylphenidate, due to which methylphenidate was stopped. As the symptoms were ceased with methylphenidate treatment, methylphenidate-induced OCS was diagnosed. Perseverative behavior is not characteristically related to autism, i.e. patients of ASD are characterized to "start" an action and cannot stop. Both of these behaviors can occur and may be sensitive to drugs, but in that sense they are different. Perseverative behavior typically responds better to antipsychotics, while SSRIs treat obsessive behavior more effectively. Therefore, if OCS occurs after the onset of a psychostimulant drug, the OCSs should be suspected to be due to that stimulant. In such cases, discontinuation of methylphenidate may be considered as first choice dealing with OCS. However, if OCSs persist, addition of anti-obsession agents such as SSRIs may be considered.

KEYWORDS

Psychostimulants; side effect; stereotypic behaviors; aggression

[Abstract:0448] [ADHD]

Methylphenidate-induced priapism in a boy resolved with switching to atomoxetine

Özalp Ekinci, Büşra Üstündağ, Bilge Didem Öztürk, Muhammet El Beyati and Ibrahim Adak

Department of Child and Adolescent Psychiatry, Erenkoy Research and Training Hospital for Psychiatry and Neurology, Health Sciences University, Istanbul, Turkey

ABSTRACT

Priapism is a persistent unwanted erection that is not linked with sexual stimulation. A number of previous case reports have shown priapism with methylphenidate (MPH) use, especially in adolescence and preadolescence period. In all of these cases, the unwanted erections ceased after the medication was discontinued and no further attention-deficit/ hyperactivity disorder (ADHD) medication was initiated. Hereby, we present the case of a 6-year-old boy who had nightly priapism episodes with OROS-MPH and resolved with switching to atomoxetine.

Case presentation: A 6-year-old medically healthy boy admitted with attention problems and hyperactivity symptoms. He was diagnosed with ADHD-combined type and was prescribed 18 mg/day OROS-MPH. Two weeks later, family communicated and reported nightly penile erection episodes since the initiation of MPH use. The adverse reaction, which was accompanied with pain, may be best described as mild priapism. The patient was promptly referred to urology department. Urological evaluation did not reveal any hormonal/ structural abnormalities which might cause priapism. With the suspect of a medication-induced adverse reaction, MPH was discontinued. After the discontinuation of MPH, priapism resolved within a week and did not recur at the 3th week follow-up. Since ADHD symptoms were severe and impaired school functioning significantly, 10 mg/day atomoxetine was initiated. 3 weeks later, family communicated and priapism or any other impairing adverse effect was not reported. To the best of our knowledge, this case is the first example of the safe use of atomoxetine in a child who experienced priapism with MPH. The mechanism of action of both medications should be taken into account when interpreting the adverse reaction. Since MPH's main mechanism of action is the reuptake inhibition of dopamine, it may be proposed that MPH-induced priapism was probably mediated via excessive dopaminergic activity. Although atomoxetine was also reported to cause priapism in the literature, its general mechanism of action appears to be theoretically opposite. Atx selectively inhibits the reuptake of noradrenaline. It has been shown that noradrenergic activity contributes to detumescence, and thus priapism is unexpected with atomoxetine. The possible impact of Atx in the risk of priapism will be clarified with future studies.

KEYWORDS

Methylphenidate; priapism; atomoxetine

[Abstract:0450] [Psychopharmacology]

Venlafaxine-induced aquagenic syringeal acrokeratoderma: a very rare case-report

Filiz Kulacaoğlu[a] and Evsen Atici Altunay[b]

[a]Department of Psychiatry, Cerkezkoy State Hospital, Tekirdag, Turkey; [b]Department of Dermatology, Biruni University School of Medicine, Istanbul, Turkey

ABSTRACT

Aquagenic syringeal acrokeratoderma (ASA) is an acquired or hereditary keratoderma of unknown etiology. It is characterized by abnormal thickening of the skin on the palms and soles. Patients with ASA complain sensation of burning, stinging localized to the palms and rapidly develop white to translucent papules on their palms following immersion in water. Several pathogenic mechanisms have been proposed. Drug-induced cases of ASA of the palms have been reported, associated with rofecoxib, celecoxib, aspirin, and in one case, tobramycin used for cystic fibrosis. Venlafaxine is a selective serotonin-norepinephrine reuptake inhibitor (SNRIs) that is often used for a number of psychiatric-related conditions such as major depressive disorder and anxiety. Here we report an case of venlafaxine-induced ASA.

Case presentation: A 27-old woman with a history of depression reported palmar eruption and wrinkling of the palms complain that upon exposure to water after starting the SNRI venlafaxine. The patient noticed pain and lesions symptomatic after exposure to water within 5 min. The lesions resolved within one hour after drying her hands. She had no family history of similar symptoms and she had no personal and family history of cystic fibrosis. She wasn't using any other medication. It was reported that sensation of burning and wrinkling began after she started venlafaxine and worsened after she titrated to her maintenance dose from 37.5 mg

KEYWORDS

Venlafaxine; aquagenic syringeal acrokeratoderma; dermatological side effects

to 75 mg daily. 2 weeks after discontinuing venlafaxine, resolution of the symptoms has been examined. This is the first case report reporting venlafaxine-induced aquagenic syringeal acrokeratoderma. Clinicians should be aware that although skin lesions due to venlafaxine is a rare problem, if patients receiving venlafaxine have this complaint, it should not be overlooked.

[Abstract:0451] [Schizophrenia and other psychotic disorders]

Cotard's syndrome: a case report

Tuğba Koca Laçin, Halil Özcan and Nilifer Gürbüzer

Department of Psychiatry, Ataturk University School of Medicine, Erzurum, Turkey

ABSTRACT

Cotard's Syndrome (CS) is a rare clinical event first described by neurologists and psychiatrists Jules Cotard's in 1880 and is characterized by nihilistic, immortality, hypochondriac delusions, intense anxiety, and depressive symptoms. Already the rare CS is also rare in the context of schizophrenia. Some authors have reported CS and psychotic depression in 3 of 479 Mexican patients (0.62%) with primary psychiatric disorders, including 150 patients with schizophrenia. In 2013, Stompe and Schanda examined 346 schizophrenia cases and found 3 patients with CS (0.87%). So, in this presentation our aim is to discuss a case in which our case diagnosed CS.

Case presentation: A 25-year-old university graduate, single, male patient was admitted to our outpatient clinic, believing that he was rotting and dead; He was admitted to the hospital with complaints of being followed, thinking that bad thing will happen to him, frequently checking his face in the mirror, sniffing his body, irritability, and insomnia. According to the anamnesis obtained from the patient himself and his family; We have learned that he had no psychiatric complaints, his complaints started 5 years ago in the form of social isolation, he changed his job frequently and his family (near grade 3) had a history of schizophrenia. In the psychological examination; his mood was depressive, nihilistic, hypochondriac, persecution and reference delusions; visual, auditory and olfactory hallucinations; insomnia, intense anxiety, and psychomotor agitation was present. The patient was diagnosed with CS concurrently with schizophrenia. Brain MRI was reported as normal. Positive and negative syndrome scale (PANSS) Total: 121 points. Treatment was started with olanzapine 10 mg/day. The patient's complaints were not regressed and the olanzapine dose was increased to 20 mg/day. The patient, who had a partial regression in his complaints and symptoms, was added fluoxetine 20 mg/day due to depressive symptoms. There was a significant improvement in his complaints and sings after 3 weeks of combination therapy with olanzapine 20 mg/d ay with fluoxetine 20 mg/day. The total PANSS on discharge was 72 points. CS is divided into three types according to clinical symptoms: CS is divided into three types according to clinical symptoms: Psychotic depression consisting of patients with melancholia and nihilistic delusions; Cotard's type I patients with pure nihilistic, hypochondriac delusions, where affective symptoms are not apparent; and Type II Cotard's patients characterized by a mixed group of anxiety, depression, auditory hallucinations, and nihilistic delusions related to existence. There are data to use different treatment strategies according to these clinical subtypes. In the literature, there are also case reports indicating that antidepressant and antipsychotic combination therapies are beneficial. Our case was consistent with Cotard's type II due to both depressive symptoms and intense anxiety, auditory hallucinations, and nihilistic delusions, and there was a significant improvement with 3 weeks of olanzapine 20 mg/day and fluoxetine 20 mg/day combination treatment. In the literature, there are combinations of antipsychotics and antidepressants for the treatment of CS, but this is the first report showing the efficacy of olanzapine and fluoxetine combination.

KEYWORDS

Cotard's syndrome; schizophrenia; olanzapine; fluoxetine

[Abstract:0453] [Schizophrenia and other psychotic disorders]

Dopamine dysregulation syndrome in Parkinson's disease: a case report

Seher Serez Öztürk, Hatice Yardım Özayhan, Azra Yaşar, Dudu Demiröz, Nafiye Yağlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Parkinson's disease (PD) is a neuropsychiatric disorder characterized by motor and non-motor symptoms. Dopamine-dysregulation syndrome (DDS) is an uncommon complication of the treatment of Parkinson's disease, characterized by addictive behavior and excessive use of

KEYWORDS

Parkinson's disease; dopamine dysregulation syndrome; psychosis

dopamine medication. In this presentation, we discussed the case in which DDS developed after the use of compulsive levodopa.
Case presentation: 60-year-old male patient, married, and has 3 children. He was diagnosed as Parkinson's 15 years ago and started to get medical treatment. He has got complaints of low level of skepticism, touchiness and telling about non-existing events for 10 years. Since he has thought that medicines do not provide benefit in the last 3–4 years, there have been terms when he has used Parkinson's medicines more or irregularly. Within this time, he has got outpatient and inpatient treatment in neurology department in various hospitals. 15 months ago deep brain stimulation was administered to him. 8 months ago he had complaints, continuing around 1.5 month, such as insomnia, hypersexuality, unsuitable sexually explicit speaking, weird behaviors, skepticism, touchiness, seeing images, nervousness, aggression and trying to throw his spouse down from the balcony. Upon the patient's family's lodging a complaint, the patient was legally hospitalized. The patient, whose last treatment was in the way levadopa+karbidopa+entekapon 100/25/200 mg 6 × 1, levadopa+benserazid 125 mg 5 × 1, venlafaxine 150 mg 1 × 1, was held a consultation with neurology. The treatment of the patient was arranged as levadopa+benserazid 125 mg 6*1, levadopa+karbidopa+entekapon 100/25/200 6*1,amantadin sulfate 100 mg 4*1, modafinil 200 mg 1*1,venlafaxine 75 mg/day and olanzapine 2,5 mg/day. The patient, whose psychotic symptoms were regressed, was discharged from hospital. DDS is an iatrogenic disease seen in 3–4% of Parkinson's patients using dopamine replacement treatment (DRT). Although it leads to serious dyskinesia, patients take, compulsively, DRT at far higher amounts than those which can keep under control motor symptoms. For the DDS diagnosis to be made, symptoms such as aggression, intolerance, sleep disorder, hypomanic or manic symptoms, psychotic symptoms, hypersexuality and pathological gambling that dramatically disturb functionality should be available at least for 6 months. Since the treatment of the DDS is hard after it has developed, in every Parkinson's patient risk factors should be well handled. In our case, the DDS table has come out after the use of compulsive levodopa and symptoms have become uncontrollable. Our patient's having early age of disease onset, using high doses of anti-Parkinson's medicine and having depression in his back-story have been considered as DDS risk factors. While DDS is seen in very small part of Parkinson's patients, it can lead to serious medical, social and legal results in terms of patients and patients' relatives. Thus risk factors in the DDS development and the DDS- related behaviors must be discussed with patients and patients' relatives routinely and at certain intervals. Patients taking DA or high dose L-Dopa treatment should be followed with a special attention.

[Abstract:0454] [Addictions]

False positive toxicologic screening of amphetamine and ecstasy (MDMA) following bupropion use

Seher Serez Öztürk, Hatice Yardım Özayhan, Dudu Demiröz, Sehure Azra Yaşar, Ali Baran Tanrıkulu and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT
Bupropion is an antidepressant of the aminoketone class. It is structurally related to the phenethyamines, a class of compounds that include amphetamines. Owing to its unique mechanism of action and favorable side effect profile, bupropion is increasingly being prescribed as an antidepressant and is also being used to treat nicotine dependence. Immunoassays dominate urine drug screens (UDSs) because they are simple to use, easy to automate and provide rapid results Unfortunately, they are subject to cross-reactivity with structurally related and unrelated compounds potentially yielding false-positive results. We report a case of patient who had a positive toxicology screen for amphetamines and ecstasy (MDMA) with initiation of therapy with bupropion.
Case presentation: 33-year-old single male patient who has a alcohol dependence syndrome for about 20 years with several short episodes of soberness. Later, some repetitive hospitalization cases of the patient, who has re-started alcohol use, in external center and in our hospital are available. The patient, who is also followed with the diagnoses of antisocial personality disorder and depressive disorder got treatment most recently 3 months ago by staying in our hospital. Naltrexone implantation was planned for the patient whose last treatment was risperidone 2 mg/day mirtazapine 45 mg/day, venlafaxine 150 mg/day, quetiapine 550 mg/day, hydroxyzine 50 mg/day, bupropion 150 mg/day and acamprosate 333 mg 3 × 2 tb. In the analysis of urine toxicology during hospitalization made in advance of naltrexone implantation, amphetamine and MDMA ecstasy became positive. In repetitive analyses of urine, amphetamine and MDMA ecstasy continued to come out positive. In the follow-up, bupropion was stopped. After the urine analysis made one week after stopping bupropion, amphetamine and MDMA ecstasy came out negative. The patient received

KEYWORDS
False-positive; bupropion; amphetamine; ecstasy

naltrexone implant. Acamprosate was ended and the patient was discharged, with the present treatment, from hospital. Many pharmaceutical and over-the-counter (OTC) medications have been previously reported in the literature to cause a false-positive result for amphetamines on urine drug screen. Antihistamines, antipsychotics, and antidepressants are among the most well-known prescription and OTC medications that can cause false-positive urine drug screens. The drug bupropion (an atypical antidepressant that inhibits norepinephrine and dopamine reuptake at the synaptic cleft) is primarily used to treat depression and smoking cessation, but may also be used off-label to treat ADHD. In a number of recent case reports, it has been implicated as an etiology of false-positive amphetamines on urine drug screen. In our case report, we found both ecstasy and amphetamine false positivity secondary to bupropion. Therapeutic use of bupropion may cause of false positive urine drug screens for amphetamines and ecstasy. Clinicians should be aware of the high false positive rate of the amphetamine and ecstasy (MDMA) screen.

[Abstract:0455] [Psychopharmacology]

Symptomatic esophagitis with methylphenidate in a boy with epilepsy and attention-deficit/ hyperactivity disorder

Ibrahim Adak, Cemre Yasoz, Burcu Yuce, Bilge Didem Ozturk Tunali and Ozalp Ekinci

Department of Child and Adolescent Psychiatry, Erenkoy Research and Training Hospital for Psychiatry and Neurology, Health Sciences University, Istanbul, Turkey

ABSTRACT

Esophagitis is defined as the inflammation of the esophagus. Clinically, dysphagia, heartburn, nausea and vomiting are frequent symptoms. Causes of esophagitis include stomach acids backing up into the esophagus, infection, allergies and oral medications. Considering medications, methylphenidate treatment has never been reported to cause esophagitis. Here, we present a 10 year old boy with diagnoses of epilepsy and ADHD who developed symptomatic esophagitis after adding methylphenidate to lamotrigine and levetiracetam treatment.

Case presentation: A 10 year old boy using lamotrigine and levetiracetam treatment for epilepsy was admitted for attention deficit problems. He was given a diagnosis of ADHD. Upon history, it was revealed that lamotrigine and levetiracetam treatment improved his epileptic seizures without any significant adverse effects. We added 10 mg/day short acting oral methylphenidate to lamotrigine and levetiracetam treatment for his ADHD symptoms. With methylphenidate treatment his ADHD symptoms showed significant improvement but he reported nausea, vomiting and heartburn symptoms. Then he was referred to pediatric gastroenterology department. As a result of detailed physical examination and some investigations like gastroscopy, esophagitis was diagnosed. No organic, infectious, allergic or dietary pathology detected to cause esophagitis. It was thought that the cause of the esophagitis could be methylphenidate treatment and recommended to terminate the drug treatment. After discontinuation of methylphenidate, esophagitis symptoms disappeared. Because of the significant improvement on ADHD symptoms, the child's family started to give short acting methylphenidate to the child after some time. But with methylphenidate, esophagitis symptoms appeared again. The child stopped taking the drug and the esophagitis symptoms disappeared. Methylphenidate has been the first line psychopharmacological treatment in children and adolescents with ADHD. Nausea, decreased appetite, weight loss and sleep disturbances are most frequently reported adverse effects during methylphenidate treatment.

A literature review revealed no reports of methylphenidate related esophagitis in children and adolescents with diagnosis of ADHD. Therefore, to our knowledge, this is the first reported case of methylphenidate related esophagitis in a child. Emergence of esophagitis with methylphenidate at 2 different trials and disappearance with medication discontinuation at the second trial may suggest a strong causal link between methylphenidate and esophagitis in this case. However, despite this causal link, it is unclear through which pathophysiological mechanisms methylphenidate could cause this side effect. A possible mechanism may be the tissue damage, that is caused by the contact of the drug and the lining of the esophagus. Whatever the pathophysiological mechanism could be, the clinicians should be familiar about the possibility of esophagitis in children treated with short acting methylphenidate. In such cases, clinicians may order a pediatric gastroenterology consultation. Alternative medications for ADHD including atomoxetine may be considered in case of need.

KEYWORDS

Esophagitis; methylphenidate; attention-deficit/ hyperactivity disorder

[Abstract:0457] [Schizophrenia and other psychotic disorders]

22q11.2 Deletion with schizophrenia: a case report

Işık Batuhan Çakmak, Hasan Kaya, Şahin Gürkan and Erol Göka

Psychiatry Department, Ankara Numune Research and Training Hospital, Ankara, Turkey

ABSTRACT

We present a case of 33-year-old Turkish man who presented with psychotic features and is recently diagnosed with schizophrenia who also had an incidental radiological finding of cavum septum pellucidum et vergae variation on cranial magnetic resonance imaging (MRI) scan.

Case presentation: The patient had broad nasal root and hypertelorism and previously had a total correction operation for tetralogy of Fallot (TOF) which can be linked to 22q11.2 deletion. The genetic testing discovered the 22q11.2 deletion, which is consistent with the DiGeorge syndrome. High prevalence of cavum septum pellucidum is reported in patients with 22q11.2 deletion syndrome and cavum septum pellucidum is more prevalent in patients with schizophrenia. Also there is evidence that TOF and 22q11.2 deletion are linked. Given the fact that post-operative TOF complete correction period may be similar to those of some subtle schizophrenic signs, it is important that clinicians should be cautious for the detection of DiGeorge syndrome and development of psychosis; hence, patients could be diagnosed and may be treated earlier.

KEYWORDS

22q11.2 deletion; schizophrenia; tetralogy of Fallot; cavum septum pellucidum

[Abstract:0459] [Psychopharmacology]

Oral aripiprazole-related extrapyramidal symptoms recovered after switching to injectable aripiprazole: a case report

Uğur Takım, Celaleddin Kartal and Hacer Akgül Ceyhun

Department of Psychiatry, Ataturk University School of Medicine, Erzurum, Turkey

ABSTRACT

It is critical to improve medication adherence in patients with psychosis in order to enhance outcomes. Aripiprazole is a partial dopamine agonist with low sedation, relatively favorable metabolic profile and a tendency to lower, rather than raise, prolactin. Aripiprazole long acting injection (ALAI) is a suspension of crystalline aripiprazole in water which takes 5–7 days to reach steady state after an initial intramuscular injection. Monthly injections achieve steady state in four months. ALAI is generally well tolerated. Literature searches show contradictory results about comparison between side-effects of ALAI and oral aripiprazole. In our case, contrary to the literature, although there was a side effect with the use of oral aripiprazole, no extrapyramidal side effects were observed with the injectable form. In this respect, we aimed to draw attention to this case.

Case presentation: 20 years old farmer and unmarried male patient with primary school education level. The patient's first complaints started at the age of 18; with thoughts that people will hurt him, and they talk about him, auditory hallucinations like hearing gunshot sounds, insomnia and loss of appetite. The patient was prescribed olanzapine 5–10 mg/day, lorazepam 2 mg/day with diagnosis of psychotic disorder. After 3 weeks of olanzapine 5–10 mg/day treatment, patient discontinued his medication; signs like social isolation, affective blunting, avolition and alogia were found to be added to the previous symptoms at his outpatient clinic visit. The patient was started on aripiprazole 10–20 mg/day. After 7 days of treatment, drug-induced akathisia was observed and Barnes Akathisia Rating Scale (BARS) was measured as 11, biperiden 2 mg/day was prescribed. With the regression of drug-induced akathisia, biperiden treatment respectively reduced and discontinued after 2 months of treatment. Due to the medication non-adherence of the patient, long-acting injection of aripiprazole 400 mg/m was started. Three injection of aripiprazole 400 mg/ month were performed, no extrapyramidal side effects were observed during follow-up.

Conventional antipsychotic-related akathisia is often associated to D2 receptor blockade in mesocortical pathway. This mechanism is likely to be responsible for akathisia secondary to aripiprazole treatment. Literature searches in respect to comparison between extrapyramidal side-effects (EPSE) of ALAI and oral aripiprazole pointed out that although some researches state similar EPSE, a research which consists of 843 patients showed that ALAI has more such side-effects. In our case, while oral aripiprazole caused drug-induced akathisia, long-acting injection of aripiprazole did not cause any side-effect. Extrapyramidal side-effects which are derived from antipsychotic agents are among the main factors for non-adherence to treatment. In this case study, we aimed to draw attention to ALAI treatment which can increase the compliance to treatment.

KEYWORDS

Oral aripiprazole; aripiprazole long acting injection (ALAI); extrapyramidal side effects

[Abstract:0460] [Schizophrenia and other psychotic disorders]

A possible water intoxication-induced sudden epileptic seizure in a psychotic patient

Ayinzeliha Matsar and Ayşe Nur İnci Kenar

Pamukkale University, School of Medicine, Psychiatry, Psychosis Service, Denizli, Turkey

ABSTRACT

Psychogenic polydipsia (PPD) is a condition characterized by polyuria and polydipsia due to psychiatric reasons. PPD is seen in 6–20% of psychiatric patients and in 25% of schizophrenia patients. PPD can progress to hypotonic encephalopathy, respiratory arrest and coma. Water intoxication is hyponatremic encephalopathy when water consumption exceeds the maximum renal clearance capacity. Water intoxication develops in 1.9% of psychosis patients. In this case, we aimed to present a case of epileptic seizure which is thought to be related to water intoxication in a psychosis patient.

Case presentation: The case is a 37-year-old male patient treated and followed up for 18 years with a diagnosis of psychosis. He was hospitalized for psychotic relapse. The case was using clozapine (300 mg/day), valproate (1000 mg/day), amisulpride (1200 mg/day), biperiden (6 mg/day), risperidone (50 mg/15 days) and zuclopenthixol (400 mg/15 days). The case was examined because of vomiting on the 10th day of hospitalization. The plasma Na value was 119 mmol/L (136–145) and the urine Na value was 33 mmol/L (54–150). Other renal function tests were normal. Nephrology consultation was requested. It was observed that the patient drank 9 liters of water per day. On the days of liquid restriction, the Na value remained within the normal range. Case had an epileptic seizure on the 14th day of her hospitalization, which lasted for 30 s. After the seizure, consciousness was closed and respiratory arrest developed. The case was taken to intensive care. On the same day serum Na value was measured as 120 mmol/l. Neurology consultation was requested for an epileptic seizure etiology. There was no better reason to explain epileptic seizure with the examinations performed. In differential diagnosis; pseudohyponatremia was excluded with normal lipid, protein and glucose levels. Inadequate Antidiuretic Syndrome was not considered because of the low urinary density and Na value. Diabetes Insipidus, an important cause of polydipsia, has been removed due to increased urinary and serum Na levels due to fluid restriction. The hypopituitarism was excluded due to ACTH value of 107 mg/L (0–46). The case was evaluated with nephrology and neurology and the epileptic seizure was thought to be related to water intoxication.

In the literature, when the psychosis cases of PPD are examined; The majority of cases were diagnosed with PPD following hyponatremia-related symptoms, particularly seizures during psychotic exacerbation. In some studies, it was claimed that psychosis and polydipsia may have similar pathophysiological mechanisms and that polydipsia may be related to psychotic exacerbation periods because of the regulation of the thirst center with dopamine. In this case, polydipsia was observed during the psychotic exacerbation period. Among other hypotheses, drinking behavior is considered to prevent anticholinergic side effects of psychotropic drugs. This case also used clozapine and biperiden, whose anticholinergic activity was strong. Although polydipsia is common in psychosis patients, it is often ignored. Clinicians should be considered epileptic seizures by water intoxication in patients psychosis. Fatal complications can be reduced by early diagnosis and intervention.

KEYWORDS

Psychosis; psychogenic polydipsia; water intoxication; seizures

[Abstract:0461] [PTSD]

Acute onset tic-like motor symptoms in an adolescent case with posttraumatic stress disorder

Gözde Kandemir, Selma Tural Hesapçıoğlu, Mehmet Fatih Ceylan and Özden Şükran Üneri

Department of Child and Adolescent Psychiatry, Ankara Yildirim Beyazit University, Ankara, Turkey

ABSTRACT

Movement disorders are common, complex and heterogeneous group of disorders in childhood and adolescence. Motor stereotypes, tics, seizure, chorea and myoclonus are some of them. Conversion disorder can also be seen with different motor and sensory symptoms which makes the differential diagnosis even more difficult.

In our case, tic-like motor symptoms which started in late adolescence will be discussed in the context of accompanying posttraumatic stress disorder, dissociative symptoms and conversion disorder.

Case presentation: A 17-year-old male presented with complaints of involuntary body movements in the form of jerks in hands, arms, shoulders and spasms on face, which started

KEYWORDS

Adolescent; conversion; tic-like; trauma

45 days ago. The movements were 2–3 times a day, extending from 1 min to 1–2 h, with making the patient feel intense tension beforehand and cause self-injury several times. History and psychiatric evaluation of the patient revealed a history of chronic domestic physical violence in childhood, flashbacks about traumatic memories related to his grandfather's death, sleep disturbance, anxiety and dissociative symptoms accompanying attacks. It was observed that tic-like movements could partially control during the interviews and increase with emotional stressors. The patient's EEG and brain MRI results were reported as normal and epilepsy and organic factors were excluded. It was learned that olanzapine (10 mg/day), risperidone (2 mg/day), and sertraline (50 mg/day) were administered in a combined manner for 25 days, but did not work and the symptoms were gradually worsened. The patient had no family history of tic disorder and no psychopathology was described in the family. The patient was diagnosed with Post Traumatic Stress Disorder and concomitant movement disorders were evaluated as conversion disorder. During the follow-up period, the patient was given risperidone 3 mg/day and sertraline 100 mg/day with additional supportive psychotherapy regarding emotion identification, verbal expression, coping skills and traumatic experiences related to etiology of conversion. At the 6th month of the treatment, the symptoms were regressed, dissociation and conversion attacks disappeared, and tics were rarely observed as mild jerks on shoulders. Conversion disorder can mimic many different clinical pictures, sometimes also causing exacerbation of existing symptoms. Studies have been shown that functional impairment of striatotalamic cycles which control sensory and motor functions and voluntary motor behavior plays a major role in the pathophysiology of both tic disorders and conversion disorder. This situation leads to diagnostic confusions about symptoms that are very similar. In our case, the clinical appearance of involuntary movements, the feeling of tension and restlessness similar to the sensory phenomenon, the inability to control the patient, the pain caused by severe contractions suggest the diagnosis of tic disorder. However, the absence of any response to high dose antipsychotics used for approximately 4weeks, the unexpected late-onset of tic-like movements, the absence of a family history, the disappearance of movements when the attention was directed during the interviews, the favorable treatment response with SSRI treatment and psychotherapy were evaluated in favor of conversion disorder. It is considered that a good differential diagnosis is important in order to protect people from unnecessary high dose antipsychotic intake and to obtain the necessary medical assistance for the underlying psychopathology.

[Abstract:0462] [Psychopharmacology]

Anejaculation with vortioxetine treatment: a case report

Mehmet Güneş, Fırat Şiyar Kalkan, Mahmut Bulut and Mehmet Cemal Kaya

Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Vortioxetine is a new antidepressant for the treatment of major depressive disorder, 5-HT3, 5-HT7 and 5-HT1D receptor antagonist, 5-HT1B receptor partial agonist, 5-HT1A receptor agonist and serotonin reuptake inhibitor. Vortioxetine increases serotonergic, noradrenergic, dopaminergic, glutamatergic, cholinergic and histaminergic activity in the brain. Its side-effect profile is similar to SSRIs, however the side effects such as sexual and sleep disturbance are rare. The relationship between sexual dysfunction and depression is reciprocal. While the risk of sexual dysfunction of patients with depression increases by 50–70%, the risk of depression of patients with sexual dysfunction increases by 130–200%.

Case presentation: A 33-year-old male patient married, has two children. Due to premature ejaculation, he consulted his urologist. No organic pathology was found in the examinations of the patient and a medıcıne was given by the urology consultant and told him that medicine might cause decrease in sexual drive. The patient was referred to us for sexual therapy because he did not want to use the medicine. In the first examination of the patient, it was learned that the patient had complaints of premature ejaculation since he was sexually active and after the onset of depressive complaints, the coitus time had decreased to approximately 5 s. Antidepressant treatment was offered to patient to decrease depressive complaınts after that sexual therapy was planned. The patient was started on vortioxetine 10 mg/day. After 1-month follow-up, the patient's depressive complaints continued partially and the dose of vortioxetine was increased to 20 mg/day. The patient was admitted to the clinic with anejaculation after 2 weeks. His complaint had started on the day of the dose was increased and continued for 2 weeks. He stated that ejaculation didn't occurred after almost 2 h of sexual activity. No organic pathology was found in the repeated his examinations. Vortioxetine treatment was discontinued and planned monitoring him without medicine. After 3 weeks, the patient's complaints of anejaculation regressed, the patient was able to have sexual activity for about 7–8 min, and his depressive complaints regressed. Vortioxetine, moclobemide, trazodone and agomelatin are seen as medicine that don't cause significant impairment in sexual function. Female patients may hide sexual problems which develop

KEYWORDS

Vortioxetine; depression; anejeculation

before treatment or during medication because of neglecting female sexuality. Therefore, it should be taken into account that female patients may not be able to tell their sexual side effects ıf not questioned by psychiatrist. Sexual dysfunction is frequently seen in patients with depression and medicines usually affect sexual function negatively. so Psychiatrists, tend to medicate with low side effects or without sexual side effects especially for patients with pre-treatment sexual dysfunction. Although vortioxetine is a safe antidepressant in terms of the sexual side effect, anejaculation occurred after vortioxetine treatment in our case. As far as we know, this is the first case of anejaculation with vortioxetine in the literature. Extensive studies are needed to clarify the sexual side effects of vortioxetine.

[Abstract:0463] [Movement disorders]

Aripiprazole-ınduced rabbit syndrome: a case report

Dudu Demiröz, Hatice Yardım Özayhan, Zeynep Yücehan, Nafiye Yağlı, Seher Serez Öztürk and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Deparment of Psychiatry, Konya, Turkey

ABSTRACT

Rabbit syndrome is one of the rare extrapyramidal side effects that was first described in 1972 and triggered by antipsychotics. It is characterized by rapid, smooth, rhythmic movement of the perioral muscles in the vertical axis at a frequency of about 5 Hz, similar to the chewing movement of a rabbit. Rabbit syndrome may occur at any time during antipsychotic use, and will be cured when the drug is discontinued. In this case aripiprazole-induced rabbit syndrome will be discussed.

Case presentation: We report a 40 years old male patient. His initial complaints began 20 years ago as nervousness, aggression, mobility, decreased need for sleep, auditory-visual hallucinations, and referential delusions. These symptoms were commended as manic episode and he was diagnosed as bipolar disorder. He has had many hospitalizations until now and has received many different treatments. He had manic episodes 8 times and depressive episodes 2 times, and attempted suicide during his depressive course. The last treatment of the patient was lamotrigine 200 mg/day and valproic acid 1000 mg/day and risperidone 4 mg/day. As the patient did not want to use risperidone, he stopped using it by himself. He has been admitted to our clinic with complaints of irritability, aggression, inability to control his anger, reduced need for sleep, persecution and referential delusions. The patient, who was hospitalized with manic episode diagnosis, was still taking valproic acid 1000 mg/day and lamotrigine 200 mg/day. Aripiprazole added to the existing treatment of the patient and increased to 20 mg/day gradually. Long acting injectable aripiprazole treatment was started according to aripiprazole usage manual. Long acting injectable aripiprazole 400 mg was administered once to the patient. In the follow-up, four weeks after the injection, patient had fast, smooth, rhythmic movements of the perioral muscles similar to the chewing movement of a rabbit. This condition was evaluated as rabbit syndrome due to aripiprazole use. Rigidity, akathisia and different EPS findings were not observed in the patient. Aripiprazole dose was gradually reduced and stopped during follow-up. Biperiden 4 mg/day and diazepam 10 mg/day was added to the treatment. During follow-up, rabbit syndrome was regressed within 8 weeks. Rabbit syndrome is commonly associated with treatment with first-generation antipsychotics. Aripiprazole induced rabbit syndrome, which is one of the second generation antipsychotics, has been found in literature as case reports. In our case, the onset of rabbit syndrome after long acting injectable aripiprazole was evaluated as aripiprazole-induced rabbit syndrome. Although studies with aripiprazole have shown a low liability for extrapyramidal side effects, the present case emphasize the need for caution when treating patients.

KEYWORDS

Aripiprazole; rabbit syndrome; rhythmic perioral tremor

[Abstract:0465] [Mood disorders]

A case of atypical kleptomania responding to depression treatment

Sehure Azra Yaşar, Berrin Ünal, Osman Ak, İbrahim Taş, Zeynep Yücehan, Deniz Altunova, İkbal İnanlı and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital, Department of Psychiatry, Konya, Turkey

ABSTRACT

The essential feature of kleptomania is a recurrent failure to resist impulses to steal objects not needed for personal use or for monetary value. In people with kleptomania, life-long major mood disorder comorbidity is frequently diagnosed. In this case report, we want to be

KEYWORDS

Kleptomania; depression; treatment

highlighted with major depression and late onset kleptomania comorbidity and kleptomania symptoms disappear with the heal of depression.

Case presentation: 42 years old, married female patient with two children was admitted to our outpatient clinic with complaints of the desire to steal irresistibly various objects that are remarkable and sized can fit in her pocket; guilt and regret for stealing. During the assessment of mental status, she was informed that her complaints of unhappiness, loss of motivation, anxiety, nervousness, social withdrawal were also present. She had a history of recurrent depressive symptoms and symmetry with order obsessions about 10 years prior to the stressful life event. For four months, she had been using escitalopram 20 mg/day. Three months ago, she stealing behavior; the first one she stole the pencil sharpener and the second one she stole the buckle and the chocolate. In the meantime, even though she had the money to pay for these items, but she was stealing. The patient was hospitalized because of requesting inpatient treatment. Hamilton Depression Rating Scale score was 36, Hamilton Anxiety Rating Scale score was 34 and Yale Brown Obsession Compulsion Rating Scale score was 24. In the MMPI assessment, severe skepticism, defensive, reflecting, low self-value and low empathic characteristics were reported. Major depression and kleptomania were diagnosed according to DSM-5 criteria. The OCD diagnosis was not made considering the fact that the duration of the obsessions could not cause problems during the day and functionality. Treatment was regulated by sertraline (titrated up to 150 mg/day), aripiprazole 2.5 mg/day and quetiapine 25 mg/day. After one month of inpatient treatment, Hamilton Depression Rating Scale score was 20 and Hamilton Anxiety Rating Scale score was 14 in the pre-discharge evaluation. She said there was no impulse to steal. In the follow-up of the outpatient clinic, bupropion 300 mg/g was added to the treatment because of residual depressive symptoms. It was learned that she did not want to steal or act after discharge. A tentative diagnosis called "mood disorders spectrum" of kleptomania, OCD, eating disorders, and mood disorders it was suggested that it could be handled within the group. Some of the suggestions for clarifying kleptomania are concomitant disturbances or symptoms with kleptomania, it has been demonstrated by using the results of these treatments. She was pleased with the patient stealing behavior. This pleasure was thought to have an effect on reducing depressive symptoms. The risk taking behavior during the act of stealing is an important stimulus and depressant-reducing effect. The traumatic experiences of the patient during childhood are also important in terms of pointing to kleptomania psychosocial etiology. It is remarkable that kleptomania has started at an advanced age in our case.

[Abstract:0466] [Psychopharmacology]

Congenital malformation due to antiepileptic polytherapy: a case report

Safa Güney, Merve Durgunlu and Serap Sarı

Department of Psychiatry, Atatürk University School of Medicine, Erzurum, Turkey

ABSTRACT

The treatment of bipolar disorder (BD) during pregnancy and breast-feeding presents countless clinical challenges. Many mood stabilizers are associated with increased risk of congenital malformations; nonetheless, stopping treatment may increase the risk of mood-episode relapses. In this case, we describe the case of a child born with congenital malformations whose mother used divalproex sodium, lamotrigine and clozapine for bipolar disorder during pregnancy.

Case presentation: 35 years old woman diagnosed with BD for about eleven years. She had never smoked, used alcohol and had no drug abuse. She has four children. The first three pregnancies were planned and divalproex sodium treatment was discontinued before these pregnancies and her first three children are healthy. Her last pregnancy was not planned and the last child, who described in this case, has congenital malformations. She took divalproex sodium (1000 mg/day), lamotrigine (50 mg/day) and clozapine (100 mg/day) up to the 14th gestational week. When we learned that she was pregnant, we discontinued the divalproex sodium treatment and prescribed folate. She was in remission through the remaining pregnancy time. Her offspring born with cleft palate, toe hypoplasia, and bilateral hand aplasia. Except for the malformations, the baby was healthy. The present literature showed that, compared with unexposed pregnancies, a significantly increased risk of malformations occurred in infants exposed to polytherapy of lamotrigine and valproate, but not when this drug was combined with AEDs other than valproate.

In studies about teratogenic effects of lamotrigine, the dosage of lamotrigine is over 100 mg/day usually. But, due to the interaction of divalproex sodium with lamotrigine may have increased teratogenic effects of lamotrigine. However, in the literature, no teratogenic effect due to clozapine used during pregnancy has been reported. For many years, it has been taught that the fetal risks from prenatal exposure to two or more antiepileptic drugs (AEDs) are significantly greater risks, the risk of malformations increased with the addition of each anticonvulsant drug. Counseling for fetal risks related to AED polytherapy should be based

KEYWORDS

Pregnancy; bipolar disorder; polytherapy; anticonvulsants; antipsychotics; teratogenicity

on specific drugs in combinations. AED polytherapy that include valproate pose a higher risk to the fetus than those without this drug. In addition, higher frequency of unplanned pregnancies was found among women with bipolar disorder. Unplanned pregnancies may have negative effects on women and her child, and may lead to unaware embryo-fetal exposition to drugs with a teratogenic risk like most of AEDs. Therefore, it is important to use appropriate contraceptive methods in people with bipolar disorder in reproductive age. It should be noted that patients compliance with contraceptive methods may not be good and unplanned pregnancies may occur.

[Abstract:0470] [Schizophrenia and other psychotic disorders]

Clozapine in Parkinson's disease psychosis

İsmail Peker, Ahmet Özercan and Rümeysa Taşdelen

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Psychotic symptoms in Parkinson's disease (PD) are relatively common and, in addition to creating a disturbance in patients' daily lives, have consistently been shown to be associated with poor outcome. Our understanding of the pathophysiology of psychosis in PD has expanded dramatically over the past 15 years, from an initial interpretation of symptoms as dopaminergic drug adverse effects to the current view of a complex interplay of extrinsic and disease-related factors. The use of anti-PD medications (particularly dopamine receptor agonists) has been the most widely identified risk factor for PD psychosis.

Case presentation: A 53-year-old male, married, retired due to disability, with a 16-year history of PD, was presented to the psychiatry clinic at Marmara University Pendik Research and Training Hospital with the complaints of paranoid delusions which was started 5 years ago and exacerbated in last 2 years, depressive symptoms which were supervened these delusions for 6 months and resulted in suicidal thoughts. These psychotic symptoms began after L-dopa therapy gradually. General physical examination and systemic examination were within normal limits, except for the presence of resting tremors in hands and dyskinesia.

Routine investigations which included complete blood count, biochemistry, liver function tests, and renal function tests were within normal limits. Initially, the total PANSS score was 73, with subsection scores of 19, 20, and 34 on the positive, negative, and general psychopathology subscales, We began treatment with quetiapine and escitalopram, respectively titrating to 500 mg and 20 mg daily. Sınce paranoid delusions and suicidal thoughts were resolved within 8 weeks, he was discharged from the hospital. Following discharge, during weekly outpatient examinations entire delusions and depressive complaints aggravated and readmitted to inpatient clinic. The total PANSS score was 60, with subsection scores of 16, 16, and 28 on the positive, negative, and general psychopathology scales, at a quetiapine dosage of 500 mg daily at the second hospitalization. Escitalopram was switched to sertraline and quetiapine was switched to clozapine because of his severe dyskinesia and relapsing depressive and psychotic symptoms. In addition to disappearance of dyskinesia, paranoid delusıons and depressıve symptoms were successfully controlled with the treatment regimen of clozapine 400 mg/day, sertraline 100 mg/day, L-dopa 500 mg/day. At 6th week, the total PANSS score was 50, with subsection scores of 14, 12, and 24 on the positive, negative, and general psychopathology scales, respectively, at a clozapine dosage of 400 mg daily. Clozapine, a dibenzodiazepine derivative, is the only second-generation antipsychotic fully recommended for the treatment of psychosis in PD according to a 2007 meta-analysis. Levodopa-induced dyskinesias (LID) are a disabling side effect of long-term levodopa therapy in Parkinson's disease (PD).Clozapine induced a significant reduction in the duration and severity of LID in parkinsonian patients with severe LID and motor fluctuations. LID are thought to result from an increased dopaminergic transmission in the striatum induced by chronic dopaminergic treatment, and the ability of clozapine to reduce LID in PD could be related to the high potency with which it is able to block D1 receptors.

KEYWORDS

Antipsychotic agents; antipsychotics; clozapine; Parkinson disease; psychosis

[Abstract:0471] [Mood disorders9

A case report of arachnoid cyst and bipolar disorder

Özge Şahmelikoğlu Onur, Suat Yalçın, Pelin Özkara Menekşeoğlu and Büşra Güney

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Arachnoid cysts are benign and space-occupying lesions containing cerebrospinal fluid. Their clinical manifestations may vary according to the size of the cyst and the interaction between the cyst and surrounding neuronal structures. Mental disorders rarely accompany the clinical picture and most of the cases remain symptom-free unless determined by radiological examinations accidentally. Although there are some cases reported in the literature about the comorbidity of psychosis and arachnoid cysts, so far no case has been reported about the comorbidity of bipolar disorder and arachnoid cysts. Here we present a male patient with bipolar disorder associated with an arachnoid cyst.

Case presentation: A 53 year-old female patient was admitted with complaints of increased amount of speech and religious activities, decreased need for sleep and aggression. In her background there were diagnosis of Arachnoid cyst at the age of 25, followed by behavioral changes, depressive symptoms and recurrent suicide attempts. She was hospitalized in psychiatry clinic 10 years ago with the diagnosis of Depression. In psychiatric examination grandiosity, megalomaniac and mystical delusions and in appropriate laughs, flight of ideas were noted. In Cranial MRI an arachnoid cyst in occipital lobe located in posterior fossa detected. The patient met DSM-5 criteria for Manic Episode and started haloperidol 10 mg/day, biperiden 5 mg/day injection and quetiapine 100 mg/day p.o. treatment. Within one week her symptoms gradually improved and started risperidone 4 mg/day and valproic acid 1000 mg/day as oral treatment. Based on this case it might be suggested that psychiatric disorders such as bipolar disorder should be assessed cautiously in Arachnoid cyst patients due to development of mood symptoms.

KEYWORDS

Arachnoid cyst; bipolar disorder; comorbidity

[Abstract:0472] [Mood disorders]

Asystole during electroconvulsive therapy sessions: case report

Gizem Gülpamuk and Memduha Aydın

Department of Psychiatry, Selcuk University School of Medicine, Konya, Turkey

ABSTRACT

Electroconvulsive therapy (ECT) is known as a safe treatment for psychiatric illnesses. Severe complications during ECT are rare. Asystole is one of these serious complications of ECT. Asystole is defined as electrical pauses of greater than 5-seconds that can be mortal despite the low mortality of ECT. ECT has biphasic cardiological effect. The electrical stimulation causes parasympathetic response and asystole occurs shortly after the electrical stimulation during the seizure's tonic phase. During the epileptic clonic movement, sympathetic hypertonic phase occurs. The most common form of asystole associated with ECT is post stimulus asystole. In this report, a patient who developed asystole during ECT and continued treatment without any problem will be presented.

Case presentation: 62 years old, married, female patient. She was hospitalized with diagnosis of depression. Her complaints were distress, anxiety, anhedonia, sadness, fatigue and insomnia on admission. At the age of 55, she was first diagnosed with depression after having been diagnosed with colon cancer. Different treatment agents were used in medical treatment of the patient during nearly 2 years. All drugs except fluoxetine were stopped due to side effects. The patient partially tolerated fluoxetine therefore the treatment was continued with fluoxetine for about a year. The patient had no complaints until 4 years after treatment was terminated. Four years later depressive symptoms recurred after having been diagnosed with cancer in the oropharyngeal region. Lorazepam 0.75 mg/d were used for anxiety. Fluoxetine suspension 20 mg/d, venlafaxine 37.5 mg/d, mirtazapine 45 mg/d were used for depressive symptoms at different times. The patient was only able to take lorazepam and mirtazapine as they are oral fast dissolving drug formulation. Mirtazapine dose (7.5 mg/d) was not sufficient for improving depressive symptoms and she was not able to tolerate higher doses. ECT was started with approval of anesthesia and patient's informed consent. Laboratory findings were within normal ranges and electrocardiography showed normal sinus rhythm. Anesthesia was induced with propofol 60 mg/d and succinylcholine (40 mg/d) was used for neuromuscular blockage. Bilateral stimulus was delivered at 96 mC. Sufficient duration of seizure (50-second in EEG and 40-second motor seizure) was observed. There were no complications during the first ECT session. In second ECT session after the stimulus, the patient developed a 5-second-asystole and it resolved spontaneously. The patient was consulted to anesthesia and rocuronium was used instead of succinylcholine. Before the 4th session, the patient developed tachycardia (200 bpm) and consulted to the cardiology. Prior to session the patient was given 100 mg/d β-blocker. ECT was continued and completed successfully without cardiological side effects in other sessions. Patient's depressive symptoms improved after ECT. Asystole is a rare and potentially tolerable side effect of ECT that requires special attention. Risk factors as patient's age, bilateral placement and subconvulsive stimulus should

KEYWORDS

Asystole; electroconvulsive therapy; depressive disorder; side effects

be evaluated before the treatment. In the case of asystole, most authors recommend continuing the ECT with supportive medications as atropine and β-blockers. Anesthesiologists and psychiatrists are able to master asystole side effect of ECT with an interdisciplinary approach.

[Abstract:0473] [Psychopharmacology]

Galactorrhea associated with sertraline use

Özge Şahmelikoğlu Onur, Pelin Özkara Menekşeoğlu, Büşra Güney and Suat Yalçın

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Hyperprolactinemia has been reported as a side effect during the treatment with selective serotonin reuptake inhibitor (SSRI). Galactorrhea due to SSRI has been thought as a result of direct stimulation of serotonin to prolactin release or indirect effect of serotonin as dopamine antagonist. A case of galactorrhea associated with sertraline for the treatment of depression will be reported.

Case presentation: A 25 year-old married, female patient presented to our clinic with the complaints of anhedonia, avolition, insomnia, decreased appetite. In her psychiatric examination depressed mood and affect, longed reaction time, decreased self-care, decreased psychomotor activity, decreased amount of speech were noted. She was diagnosed as Major Depressive Disorder according to DSM-5 and started 50 mg/day. On the 5th day of the treatment, galactorrhea occurred, and sertraline treatment was discontinued. She recovered from this adverse effect just after cessation of the sertraline. One week later she has been introduced, citalopram at a dose of 20 mg/day which resulted in total remission of her symptoms within a month. Subtle differences in between SSRIs which are believed to have same mechanism of action for depression globally may display different effects on prolactin levels due to diversity of their other receptor interactions. Based on this case, physicians should be aware of galactorrhea during the treatment of sertraline and prescribe their drugs to the patients accordingly.

KEYWORDS

Galactorrhea; sertraline; SSRI

[Abstract:0478] [Demential syndromes]

The importance of differentiating diagnosis between dementia and pseudodementia on the diagnosis and treatment in an elderly patient

Yusuf Ezel Yıldırım, Tonguç Demir Berkol, Atike Çıta and Pınar Çetinay Aydın

Department of Psychiatry, Bakırkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, Istanbul, Turkey

ABSTRACT

Depression and dementia are the most common psychiatric syndromes in the elderly. Dementia syndrome refers to a mental disorder with the presence of findings of more than one cognitive domain, and that they have reached a level that would disrupt the usual functioning in daily life. The similarity of depressive manifestations with symptoms of dementing disorders, for example, loss of interest, decreased energy, agitation or psychomotor retardation, and apathy often poses diagnostic problems. Some elderly depressed patients develop a dementia syndrome that improves or completely subsides after remission of depression. This syndrome has been termed pseudodementia. Abnormal executive function, processing speed, and working memory may persist after remission of mood symptoms in many patients with geriatric depression. Therefore the clinician must have a comprehensive anamnesis from patient and patient's relatives, detailed evaluation and frequently apply to neuropsychological assessment to make a differential diagnosis.

Case presentation: 72-year-old male patient was admitted to our psychiatric ward with symptoms of inflated self-esteem, decreased need for sleep, increased energy, meaningless and pressered speech. It was learned that the patient started to complain about forgetfulness 2 years ago and he was prescribed Memantine by the neurology specialist. During the follow-up, the symptoms of loss of interest, psychomotor retardation and apathy started and Escitalopram added to his treatment. In the psychiatric examination of the patient, short-term and long term memory impairment was detected as well as his complaints at admission. Cranial MRI revealed partial empty sella and multiple ischemic gliotic foci. EEG was considered within normal limits. Neuropsychological test (NPT) was performed for detailed evaluation after the patient's low score (19/30) in the Mini-Mental State Examination. In the NPT, moderate verbal and non-verbal memory impairment

KEYWORDS

Dementia; pseudodementia; elderly patient

accompanied by difficulty in sustaining attention and findings related to impairment of visuospatial function and frontal axis were determined. Aripiprazole treatment was prescribed at the discharge and in follow-up it was stated that the affective symptoms improved and the complaints about forgetfulness continued while decreasing partially. Although dementia and mood disorders are included in two different diagnostic categories, detailed evaluation is required due to the high co-existence of these two entities in the elderly population. The manic episode that induced after the use of antidepressant, which was initiated for the social withdrawal symptoms of the demential process before the hospitalization in our case, reveals how far these two diseases can be intertwined. In the patient's family history, the presence of Alzheimer's Disease in his mother and presence of bipolar disorder in his elder sister complicate the clinical situation. Despite the improvement of affective symptoms in the follow-up, persistence of forgetfulness indicate the presence of both diseases in our patient. Detailed evaluation of dementia and depression in the elderly patient group is important for addressing the disease process. Treatments initiated for these diseases should be monitored closely, and drug doses should be kept at the minimum effective level. It should be considered that the diagnosis of depression may be a result of dementia and should be evaluated with cognitive tests.

[Abstract:0480] [Schizophrenia and other psychotic disorders]

Bupropion-induced psychotic disorder with well response to paliperidone

Nurullah Yavaş, Atila Erol, Esra Yazıcı, Ahmet Bülent Yazıcı and Ayşe Erdoğan Kaya

Department of Psychiatry, Sakarya University School of Medicine, Sakarya, Turkey

ABSTRACT

Bupropion is a common used antidepressant with fewer side effects, it also known to be one of safety medication during bipolar disorder and psychosis. Bupropion induced psychosis or manic shift is rare. We present a bupropion induced-psychotic episode in this case report.

Case presentation: A 20 year-old male patient was brought to psychiatry outpatient clinic by his relatives with the complaints of difficulty in falling asleep, speaking and laughing by himself, believing that he will be harmed by other(s), hearing commenting voices since two weeks. He had been using to cannabis and synthetic cannabinoid since 7 years until last month when he presented to the addiction outpatient clinic. He did not use cannabis, synthetic cannabinoid, or any substance after that day. After 10 days from this first admission he was ordered with Bupropion HCl as part of his treatment but the patient told that the took the dosage in more than suggested (approximately 600 mg/day) and in the first week after prescription the psychotic complaints were started. When he admitted to our psychiatry clinic at the psychiatric examination he was oriented and cooperated, decrease in amount and spontaneity of speech, inexpressive affect, persecutory delusions, auditory hallucination consisted of commenting on himself and his girlfriend. Patient's judgment ability and insight was lost. The patient was hospitalized with the preliminary diagnosis of drug-induced psychotic disorder. Hemogram, biochemical analysis and MRI of the patient did not reveal any organic pathology that could cause psychosis. Due to vitamin B12 levels were 147 ng/L. Vitamin B12 replacement was performed. Urinary substance screening test results were negative. Paliperidone 3 mg tablets were started on the first day of hospitalization and gradually increased to 9 mg. Psychotic symptoms that started to settle at the first 2 days and completely disappeared on the 10th day of his admission. There are case reports of psychotic symptoms during Bupropion use in the literature. Golden et al. reported 4 cases of psychotic symptoms characterized by auditory hallucinations as a result of the use of Bupropion. In a case series, an organic mental disorder characterized by visual hallucinations and illusions in 3 cases who used Bupropion was presented. Also tactile hallucinations occurred in the form of insect crawling characterized by tingling during Bupropion use was reported in patients with post-traumatic stress disorder. In the case, the onset of psychotic symptoms approximately 1 month after discontinuation of the substance removed the diagnosis of substance-induced psychotic disorder. B12 vitamin deficiency is chronic condition and the possibility of B12 causing acute psychotic symptoms is thought to be very small. This case is diagnosed as Bupropion induced Psychotic Disorder and characterized by persecutory delusions, interpretive auditory hallucinations, and a manifestation of drug-induced psychotic disorder with well response to paliperidone. Bupropion should be used with caution in individuals with psychotic history and psychotic susceptibility and patient should be informed about risks. This case was well treated with paliperidone, paliperidone may be a good choice for treatment in bupropion induced psychosis.

KEYWORDS

Bupropion; paliperidone; psychosis

[Abstract:0481] [Psychopharmacology]

Colchicine-related depressive symptoms in a child

Fatma Benk Durmuş, Canan Yusufoğlu and Özalp Ekinci

Department of Child and Adolescent Psychiatry, Erenkoy Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Colchicine is used in the prevention and treatment of Familial Mediterranean Fever. It is a plant alkaloid and has neurotoxic properties. To the best of our knowledge, in the literature, although colchicine has been reported to cause psychiatric complaints such as anxiety, no information has been found that triggers depressive complaints. We presented a case in which he had no psychiatric complaints before using colchicine and started depressive complaints after using colchicine.

Case presentation: A 11 year-old boy was admitted to the child and adolescent psychiatry clinic with the unhappiness, lack of energy, internal distress, insomnia, diminished interest in activities, suicidal ideas complaints and diagnosed with major depressive disorder. Family reported that his complaints began after the colchicine was prescribed for Familial Mediterranean Fever (FMF) 9 months ago. The patient had a chronic abdominal pain for three years before the FMF was diagnosed. His past medical history revealed that he had undescended testis and appendicitis surgeries but there was no reduction in abdominal pain complaints. He had no recent history of infection, metabolic disorder or head trauma. After medical evaluation and genetic screening, he was diagnosed with FMF and colchicine was administered in the dosage of 1.5 mg/day. The patient's abdominal pain responded well to colchicine treatment. When he was diagnosed with FMF, he had no psychiatric symptoms and there was no past psychiatric history.

After two weeks of colchicine treatment, patient was reported to have presenting symptoms. He was firstly admitted to a child and adolescent psychiatry clinic in another hospital for these complaints and he was prescribed on fluoxetine in the dose of 20 mg/day. Despite the use of fluoxetine 20 mg/day for 1,5 month, there was no reduction in his complaints, so fluoxetine was switched to sertraline in the dose of 50 mg/day which was gradually increased to 100 mg/day. After using sertraline in dose of 100 mg/day for 10 days, he attempted suicide by throttling his throat in the school toilet, stating that "he was bored". Therefore the family had presented to the emergency service and risperidone was initiated in the dose of at 1 mg/day and sertraline was discontinued. He was admitted to our outpatient clinic with malaise, unhappiness, lack of energy, internal distress, insomnia and decreased academic success complaints and he was not taking any medical treatment. The patient was diagnosed with major depressive disorder, and taking into account his previous treatments, escitalopram was initiated in the dose of 10 mg/day and trazodone was added to the treatment in the dose of 50 mg/day at nights. The patient was admitted to psychiatric evaluation after ten days. Depressive symptoms were greatly reduced. Follow-up and treatment of the patient continues in our clinic. This case was discussed in the light of the literature.

KEYWORDS

Child; colchicine; depressive disorder

[Abstract:0484] [Autism]

Autistic regression in Di George syndrome: a case report

Merve Sarraf, Zehra Algan and Özlem Özel Özcan

Department of Child and Adolescent Psychiatry, Inonu University School of Medicine, Malatya, Turkey

ABSTRACT

Di George Syndrome (DGS) is the most common a microdeletion syndrome that occurs due to the loss of a region at 22q11.2 during embryogenesis. In children and adolescents with DGS, a range of neurodevelopmental and psychiatric disorders are reported. Several studies support a relationship between this syndrome and autism spectrum disorder (ASD) but a scarce number of cases have been reported. In this presentation, we will review the clinical approach regarding the case and medical treatments we follow in our clinic with the preliminary diagnosis of autistic regression.

Case presentation: A 6-year-old girl was referred to our clinic with complaints of decrease in social interaction, communication and eye contact and repetitive hand and mouth movements. In the patient's history, she had been followed with a diagnosis of DGS for 6 years, had been receiving special education due to moderate cognitive retardation and benefitted from special education. In the psychiatric evaluation, verbal- nonverbal communication and cognitive functions were retarded, eye contact, sharing emotions and social communication interaction were limited, psychomotor activity was increased, she was

KEYWORDS

Autism; Di George syndrome; regression

shaking objects in her hand and mouth, she was mimicking rabbit with mouth, and stereotypes and fine motor retardation have been detected. Previously, she had been referred to pediatric neurology with the same complaints; neurologic examination and EEG / MR were evaluated as normal. In our clinic, she was monitored weekly with the diagnosis of regressive type atypical autism. Aripiprazole oral solution was started for stereotypic movements and irritability. Two months later, melatonin tablets were added and some behavioral regulations were recommended. In the follow up sleeping and eating problems were improved and irritability, rejection of drugs, and stereotypes were decreased, though continued. Improvements were observed in eye contact, social communication and taking orders. In addition, the patient began to point her requests, give short answers to the questions, and was able to count up to 20. In the follow up, 4 months later, she was redirected to pediatric neurology, due to the frequent sleep disturbances, crying crises, and onset of her previous complaints. The patient was neurologically normal (EEG was normal). As the drug efficiency decreased, melatonin treatment was continued with the risperidone oral solution. The results with risperidone treatment were better than aripiprazole treatment. Significant improvements in aggression and agitation, irritability, rejection of eating, sleep disturbances and inadequacy in sharing feelings were observed. ASD and a series of neurodevelopmental and psychiatric disorders have been reported in 15–50% of DGS. Several studies have shown that individuals with DGS have ASD-like symptomatology, and even when there is no diagnosis of ASD, significant social and communication disorders and limited and repetitive behaviors occurred. There is still a question of whether they qualify for a diagnosis of ASD with greater frequency than the general population. The case reports of the children with the diagnosis of common developmental disorders in DGS may contribute to the formation of future scientific research hypothesis. A better understanding of etiopathogenesis of ASD may help obtaining preventive measures, early diagnosis and treatment, and reducing the potential development of psychiatric diseases.

[Abstract:0490] [Mood disorders]

Electroconvulsive therapy maintenance for major depressive disorder: a report of two cases

Özge Fındıcaklı, Naile Özge Özyurt, Sinay Önen, Kamil Mert Angın and İbrahim Taymur

Department of Psychiatry, Health Sciences University Yuksek Ihtisas Research and Training Hospital, Bursa, Turkey

ABSTRACT

Electroconvulsive therapy (ECT) is the most effective therapy for remission of depression but 40–60% of patients are suffering from relapses in the period following the acute effect of ECT, even if psychopharmacological treatments are proceeded. Continuation ECT (C-ECT) is a course that begins after the index course and lasts up to 6 months, and is enable to prevent relapse of the depressive episode. Maintenance ECT (M-ECT) is a course that begins after the end of C-ECT and is intended to prevent recurrence of the episode. M-ECT is administered at regular intervals ranging from 1 week to 1 month. In the present paper, our aim is to discuss the individual applications of continuation and maintenance ECT in major depressive disorder. **Case presentation**: Case 1 is a 76 year-old women had been followed up with depression for 5 years. Despite the efficient dose and duration of antidepressant treatment she did not have any satisfactory benefit. She was admitted to our inpatient clinics with an increase in depressive complaints in the 4 month period after her discharge. She was administered 7 sessions of ECT and a significant benefit was observed. Two months after the end of ECT the severity of depressive symptoms was increased and 7 sessions of ECT was performed again. Six sessions of weekly ECT and subsequently 8 sessions of biweekly ECT was administered. When ECT procedure was switched from weekly to biweekly, her complaints were worsened. So, 7 sessions of index course was performed. ECT intervals were arranged with clinical examination and depression assessment scales. Currently, the patient is being followed-up with M-ECT and psychopharmacotherapy. Case 2is a 39 year-old women who had been followed up with depression. The treatment history revealed that effective doses and duration of antidepressant treatments were administered at the last 4 year of clinical follow-up. The patient was hospitalized with an increase in the severity of depressive complaints. Seven sessions of ECT were performed. A significant benefit was observed and thus it was decided to continue with C-ECT. Weekly ECT for 2 months, biweekly ECT for 2 months and monthly ECT for 8 months was performed consecutively. During M-ECT pharmacologic treatment was continued in the same doses. M-ECT was carried on for 12 months and remission was sustained. Strong evidence for efficacy, reliability and application of M-ECT could not be obtained due to lack of randomized double-blind controlled studies. The standard approaches for determining the indication, application schedule, the duration of procedure, the augmentation of psychotropic medication and how to monitor treatment could not be clearly determined. Determining the assessment scales with clinical response is

KEYWORDS

Electroconvulsive therapy; depression; maintenance

thought to be an appropriate guide to decide the termination of M-ECT as done in these two cases. It can be claimed that M-ECT is a cost-effective treatment method when individual protocols are identified.

[Abstract:0491] [Mood disorders]

Late-onset bipolar disorder: a case report

Muhammet Akbolat, Ümmühan Ceviz Özkal and Volkan Topçuoğlu

Department of Psychiatry, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey

ABSTRACT

Bipolar disorder (BD) is a chronic mental illness with the peak age of onset between 20 and 40 years. The majority of patients suffering from bipolar disorder have an onset prior to the fifth decade of their lives. However, a significant number of patients have onset of illness after age 50, commonly referred to as late-onset bipolar disorder. Age of onset can have a significant impact on the nature and course of bipolar illness.

Case presentation: A seventy one year-old, female subject was brought to the emergency department by her family and referred to our Psychiatry Clinic with the chief complaint of not being able to sleep. She presented to her psychiatrist complaining of feeling tired and "washed-out". She had difficulty getting off to sleep for about four weeks, but felt restless during the day. Straightforward, everyday tasks became a challenge and she occasionally became tearful. She spent most of her time alone in her room. Her self-care and hygiene were poor. On a mental status examination, the patient appeared notably detached and aloof toward the examiner. She exhibited little eye contact. The patient was depressed and tired, although she had a normal range of affect. Her thought processes are linear and logical. The patient described no thoughts of self-harm. Also she denied suicidal or homicidal ideation and she did not report delusions or hallucinations. Psychomotor retardation was noted during the mental status examination. Her physical examination and laboratory studies were unremarkable. Neurological examination was also normal. Besides, neuroimaging studies excluded neurological mania. Drug usage wasn't mentioned. She does not have a family history of affective illness. She was admitted to our psychiatric ward. Escitalopram, an SSRI antidepressant was prescribed. She developed mania while taking the antidepressant. The patient exhibited a continuously and abnormally irritable mood for at least one week. She presented with religious and sexual preoccupations, inflated self-esteem and grandiosity, reduced requirement of sleep, racing thoughts and psychomotor agitation. Her speech was spontaneous and effusive. Her affect was wide ranging and labile. Secondary precipitants, such as drugs, infections, metabolic disturbances, neoplasm, epilepsy, infections, and toxins were excluded. Eventually, a diagnosis of late-onset bipolar disorder was made with no accompanying major axis I diagnosis. Valproic acid and sodium valproate, a mood stabilizer medication was started 1000 mg per day. Based on this case, we emphasize the importance of examination of differential diagnosis in elderly patients with depression. Also this case presentation demonstrates that the clinicians should have mania in mind amongst the geriatric depression. Our case should alert clinicians to the possible onset of mania in older adults.

KEYWORDS

Bipolar disorder; geriatric psychiatry; mania

[Abstract:0492] [Sleep disorders]

Klein-Levine syndrome: a case study

Volkan Şahin, Ayşe Pınar Vural and Şafak Eray

Deparment of Child and Adolescent Psychiatry, Uludag University School of Medicine, Bursa, Turkey

ABSTRACT

Kleine-Levin syndrome (KLS) is a rare sleep disorder characterized by periods of excessive sleep, voracious eating (megaphagia), sexual disinhibition and mental disturbances. The duration of attacks may range from several days to several weeks and their frequency varies from one to twelve in a year. The patient is arousable from sleep but tends to be intensely irritable and truculent. Mental abnormalities may antedate each episode and may also persist for weeks thereafter. We aimed to discuss a girl with KLS and treatment of it.

Case presentation: A 14-year-old girl admitted to the emergency department with complaints of sleeping for 4 days. After exclusion of organic causes a psychiatric evaluation was made. The patient, belonging to poor socioeconomic background, with no family psychiatric illness, presented with complaints of excessive sleep, divorced parents, increased appetite and

KEYWORDS

Kleine-Levine syndrome; sleep disorder; megaphagia; hypersomnolence; adolescent

excessive irritability of one year duration. The onset was insidious and gradual in progression and was noted by parents initially. The patient was euthymic at the interview. No prominent depressive cognitions were noted, no evidence of psychosis was seen. The patient had sleep attacks lasting four to seven days a month for the past year. When someone wanted to wake her up, she couldn't wake up and couldn't answer the questions asked. When she woke up, she was eating excessively. The patient was treated for severe depressive disorder 2 years ago. She has a history of suicide attempt by taking medication in the last year and 25 days treated in the intensive care unit.

There was no psychiatric disorder in the family history. Detailed medical evaluation including neurological examination and laboratory tests were done which revealed no significant findings. Radiological investigations were normal, EEG was normal study and all other detailed reports too were not significant. The patient was followed in the outpatient clinic. Methylphenidate treatment was applied and after a week all symptoms disappear in a week. The diagnosis of KLS is based on clinical features alone, as there are no specific laboratory tests that can help in establishing the diagnosis of KLS. As seen in this case, the patient had symptoms of hypersomnolence which is the most prominent symptom reported during each of the episodes. Other behavioral disturbances as noted in this syndrome like suicidal tendencies, motor retardation, pathological guilt. vivid imagery, visual and auditory hallucinations, features reported elsewhere, were not reported during or between attacks of hypersomnolence in the patient described. The prominent symptoms of Narcolepsy which is seen commonly with this disorder were not observed in this patient. Precipitating factors that have received consideration are hot weather, head trauma, post flu, and encephalitis among others but none were clearly recognized in this case. KLS has been tried many medical treatments. We used methylphenidate in the treatment of our case. In the literature, reports about the KLS in child and adolescent psychiatry are limited. In conclusion, our case report aims to increase clinicians' awareness regarding the diagnosis and treatment of KLS in adolescents.

[Abstract:0499] [Neuroimaging, genetics, and biomarkers]

Anti-NMDA receptor encephalitis in psychiatry: a case report

Muhammet Akbolat[a], Cansun Şahin Çam[a], Humay Ismayilzade[b] and Ümmühan Ceviz Özkal[a]

[a]Department of Psychiatry, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey; [b]Department of Neurology, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey

ABSTRACT

Anti-NMDA receptor encephalitis is an autoimmune disorder in which antibodies attack NMDA (N-methyl-D-aspartate)-type glutamate receptors at central neuronal synapses. Symptoms include a highly characteristic set of neurologic deficits, but also prominent psychiatric manifestations that often bring mental health professionals into the course of care. Distinct phases of illness have become increasingly appreciated, and include a range of psychiatric symptoms, short-term memory loss, seizures, autonomic instability and abnormal movements early in the course of the disease followed by more severe fluctuations in consciousness with neurologic involvement, and ultimately protracted cognitive and behavioral deficits. Young women are most commonly impacted and an ovarian teratoma is sometimes associated with the syndrome. Patients respond well to immunotherapy, but psychiatric symptoms can be challenging to manage.

Case presentation: Twenty five-year-old female, lives with her family in Istanbul, was referred because of psychiatric symptoms such as anxiety, unhappiness, and sleep abnormalities. Sertraline 100 mg per day was started. On the third week of treatment, abrupt onset of change of personality and behavior, irritability, anxiety, agitation, aggressive behavior, delusional thoughts, paranoia, catatonia, disinhibition, change in speech, visual hallucination, cognitive impairment, disorganized thought and behavior was recorded. She was brought to the emergency department by her family. Her blood tests were normal. A lumbar puncture was performed. There were cerebrospinal fluid (CSF) abnormalities. High levels of CSF lactic acid dehydrogenase (LDH) activity were found. While the normal range for a protein level is 15–45 milligrams per deciliter (mg/ dL), the CSF protein level was elevated in her CSF (58 mg/dl). Because the patient's conscious state and Glasgow Coma Scale became lower, she was transferred from neurology ward to intensive care unit. There were T2-FLAIR hyperintense signal changes in her temporal lobes. EEG abnormalities were recorded; the EEG showed diffuse slowing. Encephalitis associated with etiologies of infection, toxin, metabolic and autoimmune was excluded. Anti-NMDA receptor (NR1) IgG antibodies detected in serum confirmed the diagnosis of anti-NMDAR encephalitis. She died due to nosocomial infection. We present an important case of Anti-NMDA receptor encephalitis after the devastating loss of a young female while evaluating encephalitis. Psychiatric symptoms in this case was attributed to the encephalitis. Our case should alert clinicians to the possible onset of a wide range of psychiatric disorders, including disorders such as psychotic and

KEYWORDS

Anti-NMDA receptor; encephalitis; psychiatry

catatonic phases. Our results show that rapid progression to other psychiatric and neurological symptoms may be a sign for encephalitis, especially among young people, and even among those who have not had a history of mood, anxiety, or alcohol disorder before. Also this case presentation demonstrates that the clinicians should have encephalitis in mind amongst the possible psychiatric reactions.

[Abstract:0503] [OCD]

Escitalopram use in a toddler with obsessive-compulsive disorder

İsranur Yenen, Esra Çöp and Özden Şükran Üneri

Department of Child and Adolescent Psychiatry Ankara Children's Hematology Oncology Research Hospital, Ankara

ABSTRACT

Obsessive-compulsive disorder (OCD) is a common neuropsychiatric disorder characterized by the presence of obsessions and/or compulsions that are time-consuming and cause distress or interference in the patient's life. It's diagnosed in children but rarely before 5 years. Usage of SSRIs in preschool children with OCD remains highly controversial, due to the lack of data on safety and efficacy. A case of OCD in a 32-month-old male treated with escitalopram is reported here. To the best of our knowledge, this is the youngest case (32 months old) of OCD treated with escitalopram in the literature. The aim of this case report was to examine the efficacy of treatment with escitalopram in preschool OCD.

Case presentation: The present case report is about a 32-month-old male brought to our hospital by his mother due to repetitive behaviors, his wishes of giving orders to others and managing them, saying the same sentence repeatedly until hearing the "just right answer", involving relatives in his rituals. Complaints first started in the form of touch compulsions 10 months before application. The type of compulsions changed over time and the frequency of compulsions gradually increased. The tile stones on the floor had to be pressed according to certain rules and the whole family had to walk the same way with it. He had to get out of the stairs properly by pressing certain points and also was forcing his family to do the same. If not, they were starting the ritual from the beginning. We diagnosed OCD according to Diagnostic and statistical manual of mental disorders, 5th edition, text revision (DSM-5-TR) criteria and symptoms of OCD were assessed with the Children's' Yale-Brown Obsessive-Compulsive Scale (CY-BOCS). The CY-BOCS compulsions subscale scores were significantly improved one month after. Diagnostic and therapeutic dilemmas in such cases are discussed. Literature about the psychopharmacological treatment of preschool OCD is limited. Among the limited number of case reports in the literature, fluoxetine and sertraline were reported as generally well-tolerated and effective. There were only a few reports using escitalopram. In the literature, there is a retrospective case series related to this subject consisting of eleven cases, where improvement in symptoms is reported with escitalopram treatment in the five of six cases diagnosed with OCD. Symptoms of behavioral disinhibition were reported as the most frequently observed side effects. The effect of escitalopram on preschool children was imprecisely understood. To the best of our knowledge, our case is the youngest patient to receive escitalopram for preschool OCD in the literature.

KEYWORDS

Escitalopram; preschool; obsessive-compulsive disorder; child; very young onset

[Abstract:0505] [Addictions]

Oxybutynin-induced psychosis: a case report

Dudu Demiröz, Nafiye Yağlı, Seher Serez Öztürk, Zeynep Yücehan, Bilge Çetin İlhan and İbrahim Eren

Health Sciences University, Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Oxybutynin hydrochloride has direct antispasmodic effect on smooth muscles. It also inhibits the muscarinic effect of acetylcholine on smooth muscles. It is used in the elimination of urination problems due to bladder instability. It can be used at a dosage range of 5–20 mg/day. In this presentation, a case of oxybutynin induced psychotic disorder will be discussed.

Case presentation: A 35-year-old divorced man who was suffering from irritability, aggression, auditory and visual hallucinations, delusions of persecution, talking about things that were not with visited our outpatient clinic. The patient had no known organic disease. He had no history of substance abuse other than alcohol. He had been using alcohol for about 8 years. The patient had been using oxybutynin tablets for euphoria for the last two years. Previously used a less amount of, but for the last 6 months, 20–30 parts (80–120 mg/day) of high doses, he used oxybutynin. We learned that the patient used 100 tablets on the day of visited our clinic. Lab

KEYWORDS

Oxybutynin; psychosis; abuse

investigations (including routine hemogram, biochemistry and serology) were normal. No substance was detected in the urine. In mental state examination; There were visual and auditory hallucinations inappropriate affect, self-talk and laugh, persuasion and reference delusions. He was diagnosed with oxybutynin-induced psychosis. The emergency department discharged the patient after symptomatic intervention. After discharge, the patient's psychotic complaints regressed in 1 week. The patient was then treated for oxybutynin and alcohol abuse, and was discharged with sertraline 50 mg and mirtazapine 30 mg daily. The mainstay of pharmacological treatment of overactive bladder (OAB) is anticholinergic therapy using muscarinic receptor antagonists. Muscarinic receptors in the brain play an important role in cognitive function, and there is growing awareness that antimuscarinic OAB drugs may have adverse central nervous system (CNS) effects, ranging from headache to cognitive impairment and episodes of psychosis. Anticholinergic agents such as oxybutynin pass the blood-brain barrier. And increases neurotransmitters such as dopamine, serotonin, GABA if used for a long time. After exposure to the drug it causes an increase in the amount of dopamine in the mesolimbic dopaminergic pathway extending from the nucleus accumbens from the ventral tegmental area. The desire to take medication consolidates and this is an important factor in the development of pathway dependence. When anticholinergic agents are taken in high doses; deterioration in cognitive functions, confusion, lethargy, excitability, coma, impaired memory, disorientation, agitation, pressurized speech, incoherence, signs of inhibition in the parasympathetic nervous system occur. In addition, delirium, the most common visual acuity, hearing and touch hallucinations, paranoid thoughts, may occur due to decreased cholinergic activity and increased dopaminergic activity. The symptoms of psychosis appeared only in the period when oxybutynin was used. There was no sign of psychosis in the follow-up of the patient. We thought the current situation was due to the high dose use of oxybutynin.

[Abstract:0506] [Autism]

Autism and bipolar disorder comorbidity: a case report

Hasan Durak[a], Mehmet Cemal Kaya[b], Süleyman Kızıldağ[a], Mehmet Güneş[b], Mahmut Bulut[b] and Tuğba Yüksel[a]

[a]Department of Child and Adolescent Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey; [b]Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that starts early in life and lasts for a long time with social relationships, communication, behavioral, repetitive movements and delay in cognitive development. Bipolar Disorder (BD) is one of the most common psychiatric disorders associated with autism spectrum disorder. The case is discussed with the literature.

Case presentation: A 30-year-old male was ill, and he was admitted to the clinic voluntarily. According to anamnesis taken from himself and his family; the last three months increase in the amount of speech, "five hundred lovers, I know God's job," in the form of increase in sexual and grandiose and sexual conversations, decreased need for sleep was described. It was learned that he had no similar symptoms or depressive symptoms before. In the psychiatric examination, it was observed that the patient could not stand, talked and had stereotypic behaviors. Consciousness is clear, orientation is complete. His mood was hyperthymic and affect was compatible. He was distracted, his judgment was off. Increased speech volume, sexual expression and echolalia were detected. His social communication was inappropriate. The patient did not describe delusions and hallucinations, there were no suicidal thoughts. In her medical history, it was learned that her speech started at the age of 7–8 and she had limited communication with her peers, she had been taking sodium valproate for epilepsy until she was 2 years old and had meningitis when she was 1 years old. In her family history, it was learned that her mother had depressive symptoms during pregnancy but she did not receive treatment. His father's cousin was diagnosed with autism. According to DSM-5 criteria; the patient was admitted to the psychiatric clinic with the diagnosis of Bipolar Disorder Manic Attack (BB) and Autism Spectrum Disorder (ASD). Complete blood count, biochemistry tests, hormone profile evaluated in normal range. Cranial MRI and EEG reported as normal. The patient was started as risperidone 6 mg/day, sodium valproate 1000 mg/day, biperiden 2 mg/day, on the continuation of complaints, risperidone was increased to 8 mg/day; quetiapine 100 mg/day added. The patient was followed up in a psychiatric clinic for 1 month, gradually decreased complaints, young mania scale was measured as 10. The patient was followed up as an outpatient with these drugs. ASD has been associated with other psychiatric disorders in adulthood, although it comes to mind in child and adolescent psychiatry practice. For this reason, childhood and adolescence clues must be captured for diagnosis. ASD and BAB comorbidity is seen as %7. The comorbidity of ASD and BAB leads to significant impairment in functionality. The presence of comorbid psychiatric comorbidity in patients with ASD makes treatment difficult, therefore our case is important.

KEYWORDS

Autism; bipolar disorder; comorbidity

[Abstract:0511] [ADHD]

A rare side effect due to methylphenidate: periorbital swelling and bruising: a case report

Merve Sarraf and Özlem Özel Özcan

Department of Chıld and Adolescent Psychiatry, Inonu University School of Medicine, Malatya, Turkey

ABSTRACT

Attention-deficit/ hyperactivity disorder (ADHD) is a lifelong neurodevelopmental disorder characterized by inattentiveness, hyperactivity and impulsivity. Pharmacotherapy is considered to be the primary treatment modality, due to the neurobiological origin of the disease. Psychostimulants are the most frequently used drugs in ADHD treatment and a variety of side effects related to the use of these drugs. In the literature, there are limited reports related to ocular involvement, and side effects such as periorbital swelling and bruising have not been reported. We will discuss a case of bilateral periorbital swelling and bruising with controlled release methylphenidate 20 mg.

Case presentation: A 10 years old male patient with Down syndrome admitted to the pediatric psychiatry outpatient clinic with complaints of quick boredom, difficulty in concentrating, distractions, mobility, irritability, physical aggression, and poor school compliance. Short-acting methylphenidate 10 mg/day was started with the diagnosis of ADHD combined type with mild mental retardation. Although, there were no side effects with short-acting methylphenidate, treatment was switched to 10 mg/g methylphenidate-controlled release tablet due to insufficient clinical response and the dose was set to 20 mg/day. There were no side effects other than nausea with a long-release tablet at a dose of 10 mg/day. Although a better response to treatment was achieved with 20 mg/day, the patient developed periorbital swelling and bruising approximately two years after the dose increase, which could be observed in physical examination. His parents stated that this side effect did not occur on weekends when he did not take the medication. The patient was referred to eye and dermatology clinics and he was normal in eye and dermatological examination. He had no known drug or food allergy. The dose was reduced to 10 mg/day and the patient was followed-up. After reduction of the drug dose, periorbital swelling and bruise improved. This condition was considered to be a side effect of methylphenidate because this condition wasn't present on weekends and improved after the dose was reduced. Although the stimulants are effective in 70–80% of ADHD cases, 20–30% of cases do not response sufficiently or the treatment cannot be continued due to side effects. In addition to common side effects such as insomnia, loss of appetite, abdominal pain, gastrointestinal disorders, headache and dizziness, less frequent side effects are also reported. In the literature, there are limited reports related to ocular involvement, including diplopia, blur vision, difficulties in visual adaptation, mydriasis, visual disturbance, glaucoma and cataract. In this case, the occurrence of periorbital swelling and bruising in the second year of treatment, lack of a history of trauma or allergy and the reduction of dose, normal eye and dermatology examination, and improvement after reducing the dose of the medication, suggest that periorbital swelling and bruising are side effects of methylphenidate. According to our knowledge, periorbital swelling and bruising is rare but important side effect due to methylphenidate. Clinicians should be aware that stimulant medications may cause periorbital swelling and bruising and this may affect treatment compliance and efficacy.

KEYWORDS

Attention-deficit/ hyperactivity disorder; methylphenidate; periorbital swelling; bruising

[Abstract:0512] [Psychopharmacology]

Aripiprazole-induced parkinsonism in diagnosed with bipolar disorder: a case report

Nafiye Yağli, Seher Serez Öztürk, Dudu Demiröz, Sehure Azra Yaşar, Saliha Çalışır and İbrahim Eren

Health Sciences University, Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Drug-induced parkinsonism (DIP) is the most common movement disorder caused by drugs that affect dopamine receptors. Typical antipsychotics, also known as neuroleptics, are the most common causes of DIP. However, atypical antipsychotics, which were thought to be free from, can also induce parkinsonism. Aripiprazole is a novel atypical antipsychotic drug that is reported to be a high-affinity D (2)-dopamine receptor partial agonist. Because of this, it has less susceptibility than typical antipsychotics for inducing parkinsonism.

Case presentation: A 64-year-old female patient had been using lithium for 20 years with a diagnosis of bipolar disorder. Aripiprazole was added to the treatment 1 year ago.

KEYWORDS

Aripiprazole; biperiden; bipolar; parkinsonism; pharmacotherapy

aripiprazole dose was 15 mg per day when the patient presented to our outpatient clinic. One month before she started to walk slowly, with blank starting looks, reduced speech volume, and shaking in the hands. Clinical examination revealed severe hypertonia in all four limbs throughout the entire range of movement, suggesting extrapyramidal rigidity. Walking was with a shortened stride and a flexed posture. Arm swing is reduced, with an intermittent resting tremor in the left hand and severe hypomimia. Lab investigations (including routine hemogram and biochemistry) were normal. She was diagnosed as drug-induced parkinsonism and biperiden was administered orally 4 mg/day and aripiprazole was stopped. Five days later, she showed marked improvement on the extrapyramidal side effects (rigidity, bradykinesia, and tremor). The treatment of the patient was continued with lithium and there were no additional problems. Few reports of Parkinsonian symptoms with aripiprazole have been published in the adult population. Being a woman in the development of drug-induced parkinsonism risk. When the case reports about aripiprazole and parkinsonism are evaluated, the majority of them are women. It is thought that aripiprazole excretion from kidneys is decreased in females compared to males and therefore increased risk of parkinsonism.

Aripiprazole is usually associated with a low incidence of extrapyramidal symptoms. So far, little is known about the pathophysiology of parkinsonism and the possible role of aripiprazole. So, we must take into account parkinsonism and other movement disorders even when prescribing low-risk drugs with low doses.

[Abstract:0514] [Schizophrenia and other psychotic disorders]

Cotard syndrome developed after radioactive iodine treatment

Ahmet Şahin Şahİn, Mehmet Güneş, Mehmet Cemal Kaya and Mahmut Bulut

Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Cotard syndrome (CS) is a mental disorder which the patient thinks he is dead. It is a kind of delusion that called nihilistic delusion or rejection. Patients are mostly middle or advanced aged women. Although rare, male and young /adult cases have been reported. In our case, we present a patient with Cotard syndrome which developed after radioactive iodine treatment. **Case presentation**: A 41-year-old woman who lives in Diyarbakir, has not known substance use history, including smoking. She had goiter in her story. She was graduated from high school and she was not working. She had no psychiatric application before. There is no one in her family had psychiatric illness. She received radioactive iodine treatment three months before she presented to the outpatient clinic. After about 1 month of radioactive iodine treatment, decrease in self-care, the inability take pleasure in life and to find the power to do her daily life was observed. Her eating ability decreased and she was feeling very anxious. She was saying that her hands, her feet her heart got rotten, later she said that her limbs and heart died out. She was saying she had diabetes and hypertension. She said that her hand, feet and head area were surgically removed. She was saying that gas was poured under her skin and burned. She was afraid to come across the mirror because of her thoughts about her body was rotten. Finally, because the patient expressed her thoughts about she was actually dead, her relatives bring her to our outpatient clinic. In terms of organic pathology; we worked on MRI of the brain, blood, biochemistry, hormone profile and vitamin levels. Blood values and MRI of the brain results were normal. Patients were treated with paroxetine 20 mg/day and risperidone 1 mg/day. For the next controls we saw that the nihilistic delusions, the anhedonia and the evolution had been partially reduced. The treatment was followed by paroxetine 20 mg/day and risperidone 2 mg/day. CS disease table was first defined by Jules Cotard in 1880. CS has been associated with many psychiatric and organic pathology. Psychiatric disorders that reported to be seen with CS include psychotic depression, schizophrenia, bipolar disorder, Capgras syndrome. In organic diseases, dementia, neurosyphilis, viral encephalitis, arterio-venous malformations, migraine, epilepsy and brain tumors are seen with CS. Patients with Cotard syndrome may show different symptoms. These symptoms mostly include depressive state (89%), nihilistic delusions (86%), anxiety (65%), strong feeling of guilt and sinfulness (63%), thoughts of immorality (55%), hypochondriac delusions (58%). There are no detailed studies in the psychopharmacological treatment of Cotard syndrome. Different antidepressants and antipsychotics have been used as single or combined treatment and good results have been reported in the drug studies. The most positive results were obtained with ECT applications and seem to be the most effective treatment method for today. In our case; the depressive mood, anxiety and nihilistic hypoxia, which began after radioactive iodine treatment was characterized. What makes this phenomenon worthwhile is CS which developed after radioactive iodine treatment.

KEYWORDS

Cotard syndrome; psychosis; radioactive iodine

[Abstract:0515] [Psychopharmacology]

Restless leg syndrome developing due to usage of mirtazapine

Nafiye Yağli, Zeynep Yücehan, İlkin Karaarslan, Dudu Demiröz, Saliha Çalışır and İbrahim Eren

Health Sciences University, Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Restless leg syndrome (RLS) is an illness of which its etiopathogenesis is not known clearly, frequency has been increasing gradually in recent years, and which impairs the quality of life by affecting the sleep pattern severely. Restless Leg Syndrome [RLS] manifests itself as an unusual discomfort in the legs particularly during night sleep or taking a rest. Abnormal sensation felt in extremities leads to an irresistible urge to move and motor disturbance. In this paper, we present RLS case which developed due to usage of mirtazapine. Patient' complaints ended, after this treatment were ceased. As a result, an increase in RLS risk should be considered in occasions when clinicians prefer mirtazapine treatment such as insomnia.

Case presentation: The patient is a 58-year-old female who presented to our outpatient clinic with the diagnosis of major depressive disorder according to DSM-5. Patient who has been receiving sertraline and aripiprazole with doses of 100 and 5 mg/day respectively one year, was not being followed-up regularly. The patient had complaints such as suicidal thoughts and insomnia. The sertraline dose of the patient was elevated to 150 mg/day and aripiprazole was stopped. Mirtazapine with a dose of 15 mg/day was added to the treatment of the patient due to complaints on the follow-up after a month. On the next one month follow up after the mirtazapine administration, patient stated that she suffered from insomnia, restlessness on legs, urge to move her legs and she had ceased the medication after 5 days. Her complaints were recovered after the cessation of the mirtazapine administration. The biochemistry, blood glucose, hemogram, iron, ferritin, transferrin level, renal hepatic test results, thyroid function tests, B12, and folic acid levels of the patient were all within normal range. Patient was evaluated by the departments of neurology and internal medicine and no peripheral neuropathic or vascular disease were found. There were no similar complaints before the mirtazapine treatment. Sertraline dose was elevated to 200 mg/day. RLS symptoms were not recurred during this period. Depressive symptoms of the patient remitted and treatment have been proceeding for one year. In our case, the symptoms have been considered as a result of mirtazapine administration due to occurrence of the symptoms after the initiation of mirtazapine treatment, recovery of the symptoms after cessation of mirtazapine, absence of and organic disease causing RLS, normal lab results, and lack of similar picture in patient's history. The patient has been using sertraline and aripiprazole for one year and no RLS symptoms were reported since then. In literature, a few cases of RLS related with the mirtazapine was reported. The pathophysiology of antidepressant-induced worsening of RLS remains unclear, but dopaminergic hypofunction combined with serotonergic and noradrenergic hyperfunction has been proposed as a possible cause. RLS may cause depression or anxiety as well as sleeping disorder and affect the quality of life. Considering this reported side effect, especially in patients who was administered antidepressant, would be important for treatment follow-up and early diagnosis and treatment compliance in case this adverse effect is ensued.

KEYWORDS

Antidepressant; dopaminergic hypofunction; insomnia; mirtazapine; restless leg syndrome

[Abstract:0519] [Psychopharmacology]

Development of enuresis secondary to risperidone: two case reports

Mustafa Akan[a], İlknur Ucuz[b] and Özlem Özel Özcan[b]

[a]Department of Psychiatry, Inonu University School of Medicine, Malatya, Turkey; [b]Department of Child and Adolescent Psychiatry, Inonu University School of Medicine, Malatya, Turkey

ABSTRACT

Risperidone is an atypical antipsychotic that can be used safely in many different clinical conditions in children and adolescents. The most frequently reported side effects include weight gain, sluggishness and increased appetite, in the patients. Although, enuresis due to risperidone, in children and adolescents, is a rare clinical entity, there are few case reports in the literature. We also present two cases of enuresis following risperidone treatment.

Case presentation: Two cases that were followed up in Inonu University School of Medicine Child and Adolescent Psychiatry Unit were evaluated retrospectively.

Case 1: A 14-years-old girl had been followed up with the diagnosis of post-traumatic stress disorder and major depression in our clinic. She had a history of primary enuresis nocturna, but had been recovered several years before she was brought to us. She was treated with

KEYWORDS

Risperidone; enuresis; child; adolescent; psychiatry

fluoxetine (20 mg/day) and aripiprazole (5 mg/day) for approximately 1 year. The patient developed enuresis nocturna after the risperidone treatment was started, and enuresis improved after the dose of risperidone was decreased to 0.5 mg/day.

Case 2: A 15-years-old male patient presented to the child and adolescent psychiatry outpatient clinic, with attention-deficit/ hyperactivity disorder + conduct disorder + border-mental capacity diagnoses. She had been followed-up with atomoxetine 50 mg/day and aripiprazole 5 mg/day. Aripiprazole treatment was ceased and risperidone 1 mg/day treatment was started due to insufficient improvement in the symptoms of conduct disorder. In the outpatient clinic control, 1 week after the treatment change, the parents stated that enuresis nocturna developed 2 times/week performed. Risperidone treatment was discontinued and 2 weeks later, in the follow-up, enuresis had not developed again. This case also had a history of primary enuresis nocturna. We discussed two cases of enuresis due to risperidone treatment. Both of our patients had a history of primary enuresis in childhood and the complaints ended a few years ago. In patients receiving antipsychotic treatment, it was suggested that enuresis caused by deep sleep due to sedative effect of the medication. It has been suggested that there may be different mechanisms underlying enuresis due to risperidone, including possible seizures. The lower urinary tract is controlled by various neurotransmitter pathways including serotonergic, dopaminergic, acetylcholinergic and adrenergic pathways, which antipsychotics also have affinity. Serotonin facilitates storage of urine and prevents ejaculation; dopamine blockage in the basal ganglia can cause involuntary enuresis; acetylcholine directly affects the bladder contraction; and the adrenergic system is particularly important in regulation of the bladder output function in men. Some studies reported that risperidone, which is a strong alpha-1 adrenergic antagonist, causes enuresis and others reported that it is involved in the treatment of enuresis. In the literature, patients' history of enuresis had not been evaluated. The 2 cases we presented had a history of enuresis previously and we think that risperidone treatment triggered enuresis again. Therefore, presence of an enuresis history should be considered before starting risperidone treatment, and close follow-up is necessary regarding enuresis.

[Abstract:0520] [Psychosomatic medicine – liaison psychiatry]

Depressive comorbidity in a patient with resistant burning mouth syndrome

Ayşe Günay Arikan and Selçuk Aslan

Department of Psychiatry, Gazi University School of Medicine, Ankara, Turkey

ABSTRACT

Burning mouth syndrome (BMS) is characterized by an intraoral burning sensation that particularly affects the tongue but may also involve other areas of the oral mucosa. This condition is probably of multifactorial origin, often idiopathic. Many physical etiologic factors have been suggested, but no single theory of etiology has gained widespread acceptance. In many, no oral or other organic pathology can be identified. MS mainly affects middle-aged/ old women with hormonal changes or psychological disorders. The prevalence is estimated to be 0.7–4.6% of the general population. Psychological factors are also considered important in the etiology of BMS. Several studies have reported high frequency of psychiatric morbidity in BMS. Depression seems to be the most prevalent psychiatric disorder in patients with BMS, but symptoms of anxiety, cancerophobia and hypochondriasis are also common. The present case report concerns a female patient diagnosed with BMS and comorbid depressive symptoms.

Case presentation: A 69 year-old, married woman was referred from the algology clinic to the psychiatry because of continuous burning sensation of the oral mucosa. It developed in the morning and progressively increased in intensity throughout the day. It was aggravated by eating and talking and not relieved when taking analgesics. Her medical history revealed that the patient had lost her nephew due to firearm suicide six years ago. Shortly after, the patient experienced a mild burning sensation in her mouth which increased over time. The patient had visited neurology, algology, gastroenterology and dental clinics several times. The results of laboratory tests were normal and MRI of the brain did not show any abnormalities. She had tried many different medications, including alphalipoic acid, lidocaine (mouthwash) and amitriptyline without much success. Her current medications included 300 mg of pregabaline. In mental state examination; affect was depressed, somatic symptoms and hypochondriac preoccupation was noticed. The HAM-D score was 19 and revealed the presence of a depressive symptomatology. The HAM-A score was 18 and showed a moderate anxiety level. The patient rated the pain intensity level as 7 on a scale of 1–10.In the course of managing her symptoms duloxetine was initiated at a dose of 30 mg/ day. After 2 weeks duloxetine was discontinued due to the adverse effects such as nausea and weakness, and her depression was managed instead with Sertraline 50 mg/day. After 3 months treatment her pain score decreased to 4, HAM-D score decreased to 10, and HAM-A score decreased to 11. The patient is continued to receive treatment and under constant

KEYWORDS

Burning mouth syndrome; comorbidity; psychiatry; depressive disorder; treatment; sertraline

follow-up. Diagnosis and management of patients who have BMS is not an easy task. It is generally assumed that the chronic pain reported by patients with BMS can be attributed to psychiatric symptoms. It has been suggested that there is a correlation between psychological problems and chronic diseases; they affect and exacerbate one another. No definitive treatment for BMS has been established, to date. There are many published reports on the efficacy of SSRI and duloxetine in patients with BMS. In the present case, duloxetine was discontinued due to the adverse effects and symptoms was managed instead with sertraline. After 3 months, as promising, the patient's HAM-A,HAM-D and pain scores all decreased. It seems from these case that the clinician may consider the involvement of a psychiatrists as part of a multidisciplinary approach when managing patients who have BMS.

[Abstract:0523] [Neuroimaging, genetics, and biomarkers]

Dandy-Walker malformation with psychotic disorder: a case report

Samet Paydaş, İbrahim Taş, İsmet Esra Çiçek, Mustafa Yasin Yılmaz, Nafiye Yağlı, İbrahim Eren and Saliha Çalışır

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Dandy-Walker Malformation (DWM) is a rare congenital anomaly of unknown etiology. DWM is a developmental anomaly characterized by a neuropathological triad of cystic enlargement of the 4th ventricle, cerebellar vermis hypoplasia, and the presence of hydrocephalus. Clinically there is no specific neurological findings of this pathology.

Case presentation: Our patient is a 35-year-old primary school graduate male. He was brought with symptoms of scattered and inappropriate speech, persecutory delusions against the family, irritability, strange behavior, fear of human beings and thinking that their neighbors were talking about him, watching his house and watching him. In the patient who did not have psychiatric problems for the last six months, social withdrawal and self-care decreased. Later, his hallucinations, strange speeches and behaviors emerged. He was hospitalized and treated in another hospital for 1.5 month. He was discharged with haloperidol, biperiden and olanzapine four month before. He did not use medication regularly after discharge. According to information received from his family the patient did not show any advancement. In the physical examination, the consciousness was clear, the place-time-person orientation was complete, and the level of relationship was partially sufficient. His apathetic appearance was restricted, his speech was monotonous and incoherent, his associations were quite disorganized, his speech was aimless, his thought content was poor. The patient with auditory and visual hallucinations had delusions of persecutory and reference. psychomotor activity was normal. There were no neurologic deficits in his neurological examination. The EEG examination findings were normal. No pathology was found in psychiatric medical history. His magnetic resonance imaging (MRI) of the brain revealed DWM triad. Risperidone was first given and the dose was increased up to 8 mg. However, because of the lack of benefit and the development of eps due to risperidone, then paliperidone was given instead. After that, olanzapine was added to the patient who did not benefit of 12 mg dose of paliperidone. The dose of olanzapine was increased to 20 mg. Due to the lack of benefit, olanzapine and paliperidone were stopped and clozapine was given. Treatment continued with clozapine 300 mg and patient was discharged after remission of psychotic symptoms. DWM can be diagnosed by computerized tomography and Mirth most common clinical findings are; hydrocephalus, cerebellar dysfunction (ataxia, nystagmus), increased head pressure (irritability, vomiting, convulsion) and mental retardation. DWM has no specific psychotic symptom. Cerebellum has a regulatory role, either directly or indirectly, by increasing or supplementing the functions of the other brain regions. The disorder in the cerebellum may cause many psychiatric disorders. Considering motor and cognitive symptoms in schizophrenia patients; It has been suggested that cerebellar anomalies may be associated with schizophrenia symptoms. In addition, treatment options should be reviewed carefully in terms of resistance to treatment and potential side effects in the psychiatric symptoms seen in these cases.

We thought it was important to recognize this malformation because there was no symptoms in our patient's clinical examination and was resistant to many antipsychotics.

KEYWORDS

Dandy-Walker malformation; triad; magnetic resonance imaging; clozapine

[Abstract:0526] [Psychopharmacology]

Duloxetine-induced bipedal edema: a case report

Mehmet Güneş, Baran Oğur, Süleyman Kızıldağ, Mahmut Bulut and Mehmet Cemal Kaya

Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

ABSTRACT

Duloxetine is used in the treatment of major depressive disorder, diabetic neuropathy, fibromyalgia, generalized anxiety disorder and chronic musculoskeletal pain. The most prominent side effects are dizziness, nausea, headache, paresthesia, vomiting, irritability and nightmares.

Case presentation: The patient was brought to the clinic by her relatives with the complaints of constant sleep, indifference and malaise. The patient stated that they had an argument with her daughter who was diagnosed with Bipolar Disorder (BB) for the past year and that she had a bad mood for the last one month. She had feelings of worthlessness and guilt delusions due to her daughter's diagnosis of Boone month ago there was an attempt at homicide and suicide by giving an intravenous substance to her daughter and to her. She states that she wants to save herself and her daughter because life has no value anymore, she doesn't want to go out and she has no taste in life. The patient was hospitalized with a prediagnosis of psychotic depression. The patient was treated with escitalopram 20 mg 1 × 1, quetiapine 100 mg 1 × 1 mg, clonazepam morning quarter, evening 1 tablet, mirtazapine 15 mg 1 × 1. The patient's thoughts of worthlessness and guilt decreased within a month. Her appetite and sleep improved. The patient's treatment was gradually decreased in the outpatient clinic follow-up, but all of the treatments were stopped and duloxetine 30 mg 1 × 1 treatment was initiated due to the increase in depressive complaints and somatic complaints. The first dose of duloxetine in the patient's bilateral foot dorsal, ankle, bilateral hand fingers distal phalanxes painful swelling? edema? table occurred. Because of this condition, whole blood, liver function tests, kidney function tests, thyroid function tests, ECG and urinalysis were studied. No significant findings were found to explain the pathology in any of these tests. The patient's duloxetine dose was discontinued and edema was decreased. After the examinations were completed normally, duloxetine treatment was resumed and a similar table was repeated. Due to the fact that no pathology could be detected to explain this situation, it was thought that the edema table was related to duloxetine. Among the antidepressants, monoamine oxidase inhibitor tranylcypromine, phenelzine, isocarboxazid and selective serotonin reuptake inhibitors escitalopram, sertraline have been reported with edema. So far, there has not been any reports of duloxetine-induced edema in the literature. Peripheral edema can occur with many systemic diseases such as cirrhosis of the liver, kidney diseases, congestive heart failure, and many drugs such as non-steroidal anti-inflammatory drugs, steroids and antihypertensive drugs. Whole blood, liver function tests, kidney function tests, thyroid function tests, ECG and urinalysis were studied in our patient. No significant findings were found to explain the pathology in any of these tests. The patient's duloxetine dose was discontinued and edema was decreased. After the examinations were completed normally, duloxetine treatment was resumed and a similar table was repeated. Due to the fact that no pathology could be detected to explain this situation, it was thought that the edema table was related to duloxetine.

KEYWORDS

Bipedal; duloxetine; edema

[Abstract:0527] [Autism]

Autism spectrum disorder and gender dysphoria: is there a link between them?

Hicran Doğru

Department of Child and Adolescent Psychiatry, Ataturk University School of Medicine, Erzurum, Turkey

ABSTRACT

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that can cause significant social, communication and behavioral challenges. Gender dysphoria (GD) is used to describe individuals presenting with a conflict between experienced and assigned gender. Nowadays, there is a growing clinical recognition that GD have coexisting ASD. This presentation focuses on understanding the connection between ASD and GD by reviewing the conceptual background and highlighting some recent advances.

Case presentation: Patient is a 17-year-old boy, who was referred to the child psychiatry clinic when he was 4 years. At that time he was referred by his parents because of his different social relationship patterns, delay in language and some repetitive behavior. His mother reported that prenatal, perinatal and post-natal medical histories were normal. He was diagnosed with ASD at that time and referred to a educational program. At the age of 5 years, he developed attachments to some feminine toys than in masculine toys and enjoyed cross-dressing. His mother attributed this behavior to the child's relationship with sisters and did not care much about it. She focused only the treatment of autism. He resides with his parents and two sisters who are greater than him. All day, he was watching female shows and wearing women's dresses. At the age of fifteen, he shared his fantasy about his wish to be an artist like Sinem Kobal. Also, his parents were worried about his feminine hand gestures and desires about being a woman. His father was running a coffee shop. His father have started

KEYWORDS

Autism spectrum disorder; gender Identity disorder; male brain theory; psychiatric co-morbidity

to run the child in the coffee shop to become a role model and solve the identity problem. But he refused to work. Despite the treatment approaches his transsexual gender behaviors show a persistent pattern. Although the prevalence rates of GD in the general population are complex, a study reported that the prevalence rates of 6.8/100.000 for men and 2.6/100.000 for woman. Some predictive factors that are focused on for ASD traits in children diagnosed with gender dysphoria are: high birth weight, gender nonconformity, difficulties in social behavior.

In some reviews, this association is explained by the neurobiology and relationship between the child and parent. There are a few explanations for the co-occurrence between GD and ASD. "Male brain theory" is one of them. This theory suggests that the brains of men and women have two domains which are empathizing and systemizing. In autistic patients, studies assessed that empathy skills decrease and systemizing skills increase. Unfortunately the sexual development of children and adolescents with autism spectrum disorders (ASD) remain a neglected clinical issue. Further research is required for clinical treatments.

[Abstract:0528] [Psychopharmacology]

Facial edema associated with olanzapine: a case repot

İbrahim Taş, Medine Gıynaş Ayhan, Şenay Yıldız Bozdoğan, Samet Paydaş, Osman Ak and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Olanzapine is a second generation antipsychotic and it has several side effects such as weight-gain, sedation, dry mouth and constipation. It has been also reported that olanzapine may lead to peripheral edema in 3% of the cases. Here, we report a case of facial edema associated with olanzapine in a physically healthy young patient.

Case presentation: A 21-year-old female patient was admitted to the psychiatry inpatient clinic with complaints of introversion, irritability, insomnia, suspiciousness, somatic complaints, talking self-to-self. The tests (complete blood count, biochemical tests, thyroid function test, ECG) were performed to determine the etiology of the diagnosis of psychotic disorder were within normal limits. She was diagnosed with schizophrenia according to DSM-5. Risperidone 1 mg/day was started and its dose was increased to 3 mg/day. Then 37.5 mg injection of risperidone depot was added to the treatment of the patient. As the patient's complaints persisted, olanzapine 5 mg was started in addition to risperidone. In the follow-up period, the patient's psychotic symptoms were improved but risperidone was stopped due to the extra-pyramidal symptoms. Olanzapine was gradually increased to 15 mg/day. After eight days of olanzapine initiation, the patient developed swelling which was on sudden onset. Edema on facial region was gradually increased and the patient had difficulty in opening the eyes. She was evaluated by the clinicians regarding with an allergic, systemic or dermatologic disease, however, there was no positive finding which could explain the cause of facial edema. After the dose of olanzapine was reduced, facial edema began to decrease and disappeared after about a week. 3 days later olanzapine was decreased to dose of 10 mg/day and edema resolved within a week. On the next follow up, the facial edema did not recur. We think this case report is important to warn the clinicians that facial edema may occur due to olanzapine. Drug side effects such as facial edema should be considered while prescribing olanzapine. Although it is a benign and self-limited side effect, the patient may be distressed and discontinue treatment.

KEYWORDS

Olanzapine; dose-dependent; facial edema

[Abstract:0531] [Neuroimaging, genetics, and biomarkers]

Post-partum psychosis and/or multiple sclerosis: a case report

İbrahim Taş, Şenay Yıldız Bozdoğan, Medine Gıynaş Ayhan, Samet Paydaş, Mustafa Yasin Yılmaz and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Multiple sclerosis (MS) is a chronic demyelinating disease of the central nervous system. Neuropsychiatric symptoms including mood, cognitive, and behavioral abnormalities occur commonly in MS. Multiple sclerosis often occurs in young women, and the effect of pregnancy on the disease has not been clearly understood. Visual hallucinations may occur due to the localization of demyelinating plaques in MS. Schizophrenia-like psychosis have been reported in some white matter diseases such as MS.

Case presentation: A 23-year-old female patient without any history of psychiatric disease was admitted to our clinic with complaints of reluctance, malaise, delusion of reference, and

KEYWORDS

Multiple sclerosis; psychosis; neuropsychiatry; post-partum

auditory hallucinations for 1 month. The patient attempted suicide by jumping into water due to auditory hallucinations. She was depressed and hypoactive. She neglected self-care, and had delusions of persecution and reference. In the magnetic resonance imaging (MRI) of the brain, inactive demyelinating plaques were detected in the pericallosal and periventricular subcortical white matter. The patient was diagnosed with MS but no active neurological finding was detected. Lorazepam 3 mg/day, olanzapine 5 mg/day and sertraline 50 mg/day were started per oral. In clinical follow up, her psychotic complaints regressed and she was discharged. Recent epidemiological studies have found that prevalence rates of psychosis in MS are two to three times higher than in the general population. Untreated psychosis in patients with MS can adversely impact on adherence to MS treatment, levels of disability, and quality of life. The relationship between the lesions of the central nervous system and psychiatric disorders have not been well established. Some authors have suggested that there has been a correlation between temporal lobe pathologies and psychosis in MS. In women with multiple sclerosis, the rate of relapse declines during pregnancy, especially in the third trimester, and increases during the first three months of post-partum period before returning to the pre-pregnancy rate.

[Abstract:0534] [Neuroimaging, genetics, and biomarkers]

Multiple sclerosis and manic episode: a case report

İbrahim Taş, Dudu Demiröz, Şenay Yıldız Bozdoğan, Tüba Şerife Elmas, Medine Gıynaş Ayhan, İbrahim Eren and Saliha Çalışır

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Multiple Sclerosis (MS) is a chronic demyelinating disease of a the central nervous system. Neuropsychiatric symptoms are common in MS. Psychiatric disorders commonly associated with MS are depression, dysthymic disorder, bipolar disorder, anxiety disorders (generalized anxiety disorder, panic disorder), obsessive-compulsive disorder, psychosis, substance abuse and alcohol abuse. Manic or depressive episodes in patients with MS may be seen as a symptom of the disease or a concurrent diagnosis, or a side effect of a medication (e.g. corticosteroids) used for the treatment. In this case report, a patient with multiple sclerosis and manic attack was described.

Case presentation: An 60 year old, female patient was admitted with complaints of increased energy, insomnia, irritability and aggression. The patient's first mental examination; her associations were accelerated and scattered, her affect was irritated, her self-esteem increased, her thought contents were delusions of reference and persecution, and she had psychomotor agitation. She had been using beta-interferon because of the diagnosis of MS for 3 years. She was hospitalized 2 years ago due to insomnia, lack of appetite, delusions of persecution and irritability. The patient was discharged with quetiapine 150 mg/day. In 2018, the patient was re-admitted due to similar complaints. Our patient continued to use beta interferon. MRI revealed faint limited signal pathologies in the corpus callosum and focal foci (inactive demyelinating plaques) in pericallosal and periventricular subcortical white matter hyperintensities. The patient was consulted to neurology and it was thought that the patient has no active MS attack. She was diagnosed with bipolar disorder manic episode and then antipsychotic and mood stabilizing drugs (olanzapine 7.5 mg, valproate 1000 mg and quetiapine 100 mg) were started. Manic episodes may be the first presenting symptom of multiple sclerosis or a comorbid pathology or an adverse effect of pharmacotherapies used in multiple sclerosis. In a few case, it has been reported that depression or psychosis may be presented to be the first manifestation of MS without neurological symptoms. In a study of 658 patients with MS, the prevalence of bipolar disorder was 0.3%, which was significantly higher than the general population (0.2%). Bipolar disorder due to multiple sclerosis should be considered in patients with no history of psychiatric disorder, late onset or atypical features and patients who do not respond to antipsychotic treatment. There is not enough data on the efficacy of psychotropic drugs in patients with MS. The treatment should be specific to the individual.

KEYWORDS

Bipolar disorder; multiple sclerosis; neuropsychiatric symptoms

[Abstract:0536] [Addictions]

Treatment approaches in substance-ınduced psychotic disorder: case report

Burcu Güneydaş, Özlem Doğan, Merve Sarraf, Furkan Nuri Çelik, İlknur İbili Ucuz and Özlem Özel Özcan

Department of Child and Adolescent Psychiatry, Inonu University School of Medicine, Malatya, Turkey

ABSTRACT

Among adolescents, the increasing number of cases regarding the early-onset psychotic disorders, have been shown to be in parallel with increase in substance use. The most commonly used substance among psychotic patients, particularly adolescents and young adults, is cannabis. In substance-induced psychosis, the results of long term treatments are not well and number of psychotic recurrences and hospitalizations increase due to bad adherence to the treatment. In this presentation, we discussed the characteristics of the substance-induced psychotic disorder and the treatment process.

Case presentation: A 17 years old male patient was hospitalized in the "Child and adolescent Psychiatry" clinic due to development of substance-induced psychotic disorder. The patient had no history of psychopathology. His parents stated that the complaints of the patient started after consuming high-dose of "Kubar" (powdered marijuana) and "Jamaica" (synthetic cannabinoid) one week ago. In the first psychiatric examination, disorganized behaviors, irritability, disorientation and disconnection were observed. His parents also stated that he had visual hallucinations, several days ago. The patient was severely irritable and negative signs were in the forefront. The treatment was started with risperidone 1 mg/day and NAL (haloperidol, biperiden, chlorpromazine) as 3 × 1 IM injection. After two weeks of treatment, patient's orientation improved, disorganized behavior declined, and spontaneous speeches were observed. When IM injection was discontinued and risperidone 2 mg/day was started, patient's sexual desire elevated, mood elevation and the excessive speeches increased. Thereon, risperidone was stopped and the treatment was continued with NAL injection. After one week, upon the patient's improved communication and partially declined elevation, the treatment was continued with oral haloperidol 5 mg/day and biperiden 2 mg/day, and haloperidol was gradually increased to 15 mg/day. However, the patient displayed sign of EPS and the treatment was rearranged as haloperidol 7.5 mg/day and biperidene 4 mg/day. This treatment was efficient in last of days of hospitalization and the patient's disorganized behavior and increased sexual desire diminished and spontaneous speech and movements increased. Nevertheless, negative symptoms of psychosis on the patient were continuing and aripiprazole 10 mg/day was added to the treatment. The negative symptoms were significantly improved with this last arrangement and the patient was discharged with nearly full-recovery after two months of hospitalization.

In this study, we discussed the treatment and follow-up processes of an adolescent patient with substance-induced psychosis. In our case treatment with haloperidol and aripiprazole clearly improved the symptoms, whereas risperidone was not efficient. In the literature, in case series, seven of ten patients received anti-psychotic treatment and hospitalization periods varied between six and ten days. While treated seven patients recovered in five to eight days, psychosis lasted more than five months in other 3 patients.

In a case presentation reporting management of first episode of substance-induced psychosis, it was reported that the treatment with lorazepam during the acute phase yielded significant improvement and risperidone was added for symptoms of psychosis and the need for lorazepam declined, when risperidone was titrated. There is need for large studies more number of patients.

KEYWORDS

Cannabis; medical treatment; psychosis

[Abstract:0538] [Stress and related disorders]

Dissociative amnesia after traumatic experience: a case report

Saliha Çalışır, Samet Paydaş, İbrahim Taş, Mustafa Yasin Yılmaz, Ali Baran Tanrıkulu and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

ABSTRACT

Dissociation is a process of independent acting of psychic functions that separate itself from the rest of the personality. The defense mechanisms in the periods of intense anxiety may appear as bringing consciousness, memory, and even personality under control. The main feature of dissociative disorders is a sudden deterioration of consciousness, memory, awareness and perception. Usually it develops secondary to the stressor experience. Common symptoms include paralysis, seizures, inability to speak, loss of sensation, visual disturbances, amnesia, trans and confusion. Patients may have a variety of symptoms and symptoms may change over time.

Case Presentation: Patient was 53 years old female who presented with the complaint of sudden inability to remember the last year of her life. In her mental state examination, self-care was partially reduced. Speech rate, quantity and tone were reduced. The affect was depressive. She was conscious, and her orientation was complete. Sleep, appetite and psychomotor activity were reduced. Her first complaint started in 2013, after stressor experience inside family (her son was imprisoned after violent behavior). Her complaints included unhappiness, malaise, unwillingness, fatigue, depressed movements, insomnia,

KEYWORDS

Comorbid conditions; depressive symptoms; amnesia; trauma

frequent headaches and forgetfulness (as if she had not lived a particular period of her life). She was hospitalized in a psychiatric clinic for 1.5 months at that time and recovered with pharmacological treatment (duloxetine, aripiprazole and alprazolam). She did not benefit from this treatment. She did not use her medication properly after discharge. She had no history of physical illness, alcohol or drug abuse. No family history. In 2018, the patient complained of the same symptoms after a stressor experience and presented to the psychiatry clinic. In our case, cranial trauma and other neurological diseases and amnesia due to alcohol-drug use were excluded (brain MRG and EEG were normal). In addition, no pathological benefit could be noticed. Venlafaxine, aripiprazole and olanzapine were initiated in our clinic to treat depression. Her amnesia disappeared at 6 weeks of supportive treatment (15 weeks after the onset of the disease). The most basic feature of dissociative amnesia is that these forgotten periods of life are often including severe traumatic experiences for patient. Dissociation helps to remove the physical and mental effects of the experienced trauma. In these patients, comorbid diagnosis should be done well and preventive treatment should be planned together with initial treatment. As It can be a real comorbidity, dissociative personality disorder (DPD) patients can only fill in the criteria of a number of psychiatric disorders. The most effective treatment of DPD is a psychotherapy. Many methods are used during the psychotherapy of DPD. A drug that affects dissociative psychopathology is not yet known. Anxiolytics and sedatives can be used as palliative. Antidepressants are used when depression is found. In our case, antidepressant treatment was started because of amnesia and depressive symptoms. It should be kept in mind that comorbid conditions affect the treatment in dissociative patients and the treatment of these comorbid conditions contributes greatly to improvement.

[Abstract:0540] [Schizophrenia and other psychotic disorders]

The Capgras syndrome: a case report

Ebru Çiftçi, Deniz Altunova, Osman Ak, Berrin Ünal, Ali Baran Tanrıkulu, Sehure Azra Yaşar, İsmet Esra Çiçek and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Capgras syndrome is a uncommon disorder characterized by delusions of delusional misidentification and associated with persistent delusions. The patient believes that a close relative, and sometimes he himself, has been replaced with identical analogies. Although it can be seen in all age groups and in both genders, it is reported to be more in women.

Case presentation: 23 years old male patient had his first complaint when he was in the military in 2015. He did not recognize his family and believed that they were replaced by other people. While he admitted to the psychiatry inpatient clinic he had delusions of referential and persecution. The patient was discharged with risperidone 8 mg/day and biperiden 4 mg/day. The patient who did not use his medication was treated in our clinic in March 2017 with the complaints of not recognizing his family and believing in that his family had been replaced by identical substitutes, nervousness, aggression, self-righteousness, increasing religious occupations, increase in the amount of speech and reduced sleep requirement. The patient whose psychotic symptoms partially regressed was discharged with paliperidone palmitate 100 mg/28 days, valproic acid 1000 mg/day, biperiden 2 mg/day. The patient, who discontinued the treatment, was treated in our clinic with similar complaints in March 2018. He was discharged with olanzapine 15 mg/day, paliperidone 12 mg/day, valproic acid 1000 mg/day. The patient was admitted to our clinic in September 2018 with the similar complaints which he had in the past. After improving of his psychotic symptoms, he was discharged with paliperidone palmitate 150 mg/28 days. In our patient, Capgras syndrome was considered in the background of schizoaffective disorder. He believed that his parents had been replaced by similar ones. These delusions were more pronounced than the persecution and referential delusions. The etiology of Capgras syndrome is unclear. While psychodynamic explanations have been made in many cases, common or localized brain lesions have been implicated in some cases. Capgras syndrome usually has been observed in cases of functional psychoses, psychiatric diseases, such as schizophrenia (paranoid) and other delusional disorders. This phenomenon has also been documented in organic conditions, including systemic infections, nutritional deficiencies, head injuries, dementias, myxedema cerebrovascular accidents, metabolic encephalopathies, and delirium secondary to epilepsy. Capgras syndrome rarely occurs in pure form and is usually associated with schizophrenia or organic psychosis. In most cases, the psychosis is of the paranoid type. Capgras syndrome can also be associated with mania and psychotic depression. Once it occurs, even in the presence of other psychotic symptoms, it tends to dominate the clinical picture. Although it is mostly seen in women, clinicians should be vigilant against the presence of this syndrome in men. In this case, it is important to give support to the family, to assess the risks of suicide, aggression and homicide and to treat it if there is an underlying disease.

KEYWORDS

Capgras; misidentification; schizoaffective disorder

[Abstract:0541] [ADHD]

Atomoxetine side effect: priapism

Ali Çakır

Department of Child and Adolescent Psychiatry, Ataturk University, Erzurum, Turkey

ABSTRACT

Priapism is painful erection of the penile tissue without any sexual stimulation. There are 3 subtypes of priapism: ischemic, non-ischemic, and stuttering. Ischemic is described as venoocclusive with low flow, whereas non-ischemic is arterial with high flow. Stuttering is characterized by intermittent painful erections with periods of detumescence. Low-flow priapism is painful and examination reveals a rigid erection whereas high-flow priapism is painless and the penis is not fully rigid. Priapism in the pediatric population is rare. The most common etiologies are sickle cell disease, malignancy, or trauma. Medications are also implicated as causes of priapism. α-Adrenergic receptor antagonists, anticoagulants, antidepressants, antipsychotics, antihypertensives, hormones, and recreational drugs have all been noted as causative agents.2 Immediate intervention is needed to prevent destructive and irreversible complications, such as erectile dysfunction, disfigurement, inability of the penis to stay erect, and related social/emotional problems. In this case report, we would like to report a 6.5-year-old autism case who presented with priapism after atomoxetine treatment. Only a few case report is available through the literature.

Case presentation: This case presented to our clinic with the symptoms of language delay, impairment in eye contact, repetitive behaviors, social isolation, hyperactivity, impulsivity. It was cleared that his diagnosis was made when he was 3 years old and the patient was put on special education treatment. However, it was clarified that his high levels of hyperactivity caused him to not benefit from special education as expected. ADHD is frequently comorbid with this disorder. Due to this ADHD like symptoms, he was given atomoxetine treatment but the patient experienced prolong painful penile erection which occurred 4 times a day and lasted approximately 10 min in the second month of atomoxetine treatment. He was consulted with pediatric urology department but no significant triggering factor was detected. Atomoxetine treatment was discontinued and his priapism was resolved. Methylphenidate treatment started on ongoing complaints The patient who had not benefited from methylphenidate for Attention-deficit/ hyperactivity disorder was started with low titration of atomoxetine treatment dose. No side effects were seen. The Naranjo's Adverse Drug Reaction Probability Scale score was 7 during his atomoxetine treatment. Consequently, we hypothesized that atomoxetine has a probable association with priapism. Atomoxetine is a selective norepinephrine reuptake inhibitor indicated for ADHD. Priapism is listed in the Warnings and Precautions section of the labeling for atomoxetine. Reports potentially linking atomoxetine with priapism are also acknowledged by the FDA, and they report that priapism from atomoxetine may be more common than priapism from the use of methylphenidate. Although this is a rare side effect, patients who use atomoxetine should be carefully monitored in this respect.

KEYWORDS

Atomoxetine; priapism; side effect

[Abstract:0543] [Schizophrenia and other psychotic disorders]

A tragedy of a patient with schizophrenia: percutaneous endoscopic gastrostomy feeding

Ahmet Özercan, Muhammet Akbolat, Neşe Yorguner and Serhat Ergün

Department of Psychiatry, Marmara University Pendik Research and Training Hospital

ABSTRACT

Extrapyramidal symptoms are commonly observed in patients using antipsychotic. Dysphagia has been reported to be a side effect of neuroleptics with or without drug-induced parkinsonian symptoms. It is known that dysphagia may lead to aspiration pneumonia, malnutrition and asphyxia. One of the treatment options for some of patients with difficulty in swallowing is placement of a feeding tube such as percutaneous endoscopic gastrostomy (PEG). Here, we report on a patient with PEG tube which is placed after antipsychotic-induced dysphagia.

Case presentation: 80 years old, married male who has been followed as schizophrenia for 60 years was admitted to general surgery inpatient clinic for percutaneous endoscopic gastrostomy placement in order to treat dysphagia. After the PEG was placed, the patient was consulted to psychiatry for appointment of guardianship. In his examination at the general surgery inpatient clinic, it was seen that he could not walk and speak clearly, had only eye contact to external stimulation. He was taking risperidone 6 mg/day, risperidone

KEYWORDS

Antipsychotics; dysphagia; gastrostomy

50 mg injection/every 2 weeks and sulpiride 50 mg/day for three years as a treatment of schizophrenia. Parkinsonian symptoms such as rigidity, bradykinesia, tremor were noted in his mental state examination and also, difficulty in oral ingestion due to dysphagia was detected. Risperidone was gradually reduced then switched to aripiprazole and also biperiden hydrochloride 4 mg/day was added to the treatment of the patient. During the 3-month follow-up period, it was noted that extrapyramidal symptoms had partially recovered, the patient started talking, walking and also oral feeding. Under the aripiprazole treatment, the patient was admitted to the psychiatric inpatient clinic for exacerbation of the psychotic symptoms. Clozapine treatment was initiated and increased to 150 mg/day. While the psychotic symptoms improved day by day, the parkinsonian symptoms of the patient were completely regressed, after that PEG was removed by the general surgeon during the hospitalization. Dysphagia is a rare adverse effect, but it is potentially dangerous for the patients using antipsychotics. Clinicians should be more careful about this side effect. Drug replacement, dose reduction, anticholinergic drug administration and switching other drug strategies should be considered before invasive medical interventions for the patients who develop dysphagia while using neuroleptics.

[Abstract:0545] [Psychopharmacology]

Olanzapine induced acute pancreatitis in an adolescent with schizophrenia

Cansu Pınar Yavaş, Selma Tural Hesapçıoğlu and Mehmet Fatih Ceylan

Department of Child and Adolescent Psychiatry, Ankara Yıldırım Beyazıt University School of Medicine, Ankara, Turkey

ABSTRACT

Antipsychotics are the basis of psychosis pharmacotherapy. There was no difference between atypical and typical antipsychotics in terms of efficacy. In terms of side effect profile, atypical antipsychotics have been shown to have fewer side effects. Olanzapine, an atypical antipsychotic agent, was developed after clozapine, a precursor agent, was found to be associated with agranulocytosis. When the general side effect profile is considered, the main adverse effects seen in patients receiving olanzapine treatment are the asymptomatic and treatment-related increase in drowsiness, weight gain and liver transaminases. In this report, acute pancreatitis is presented in an adolescent patient with schizophrenia due to olanzapine treatment.

Case presentation: A 16-year-old male patient was admitted to the outpatient clinic because of withdrawal, anxiety, presence, and feelings of objects and things he feared, and aggressive behaviors to his environment. It was learned that these complaints started 2 years ago. He was afraid that the people around would hurt him, constantly hearing the people who are following him and also he was complaining that he was seeing a little child walking around his house. His mother said that he had been talking to himself, yelling at nights, wandering around the house. In the psychiatric examination, the patient had poor self-care, had no eye contact, had a depressive mood, and withdrawn. The amount of speech was decreased; his association of ideas was regular and aim-oriented. There were intense occupations about thought hallucinations. Visual and auditory hallucinations and persecutory delusions were observed.

In his family history, the mother, mother's siblings and mother's father were diagnosed with schizophrenia.

The treatment was started with risperidone 1 mg/day and the drug dose was planned to be increased gradually. After 2 months with risperidone, his complaints were decreased but, it was switched to aripiprazole due to swelling on his breast and hyperprolactinemia. After the first month of aripiprazole treatment, when the dose was 10 mg/day, he began to experience voiding difficulty. Aripiprazole changed to olanzapine, treatment was increased gradually and when the patient was increased to 10 mg/day, it was observed that the patient's positive symptoms regressed, self-care skills increased, and spontaneous communication was initiated. On the 15th day of olanzapine treatment, the patient referred to the emergency department with acute abdominal pain. His amylase and lipase levels were found to be high, in the ultrasonographic there was congestion in the patient's liver and vena cava. The patient was diagnosed with acute pancreatitis after the other causes of acute pancreatitis are excluded the olanzapine was decided to cease. After discontinuation of the drug, biochemical values improved. Previous reports in the literature about acute pancreatitis due to olanzapine are mostly the cases with polypharmacy and the reported average age is 39. The presented case is thought to contribute to the literature due to being an adolescent, being treated with olanzapine monotherapy, the absence of any underlying organic disease history, no smoking or alcohol use, the development of acute pancreatitis in a short term as within 15 days.

KEYWORDS

Acute; adolescent; child; olanzapine; schizophrenia; pancreatitis

[Abstract:0550] [Schizophrenia and other psychotic disorders]

Delirium caused by Non-Hodgkin lymphoma: a case report

Ebru Çiftçi, Deniz Altunova, Osman Ak, Sehure Azra Yaşar, Dudu Demiröz, İsmet Esra Çiçek and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Delirium is a common neuropsychiatric syndrome that involves a number of symptoms including diffuse cognitive impairment, delusions, hallucinations, mood lability and disturbances in the sleep-wake cycle. It occurs in 10–30% of hospitalized medically ill patients. In this case report, a patient with delirium related to malignancy is presented.

Case presentation: 56 years old male patient who has a history of schizophrenia for 30 years presented to our clinic with auditory and visual hallucinations, decreased self-care, decrease in appetite, and insomnia in January 2012. He was hospitalized and he was discharged with olanzapine 30 mg/day. Hallucinations did not regress and zuclopenthixol depot 200 mg/14 days was added to the treatment. In October 2012, he presented to the hospital with complaints of talking to himself, restlessness and tremor in the hands. Clozapine was added to the treatment of the patient who was hospitalized in our clinic. Olanzapine and zuclopenthixol was discontinued. Clozapine dose gradually increased to 400 mg/day. He was discharged after his complaints had disappeared. Clozapine dose was gradually increased to 800 mg/day during outpatient follow-ups. The patient was in remission with the current treatment. One month ago, the patient had complaints of insomnia, back and neck pain, fatigue and decrease in appetite. He presented to the orthopedics outpatient clinic and was started on analgesic. His complaints did not regress, therefore he presented to internal medicine outpatient clinic. Pneumonia was diagnosed and moxifloxacin 400 mg/day was started. Her complaints did not regress. A week ago, he had complaints of non-recognition of his family, self-talk, disorganized behavior and urinary incontinence. He was admitted to our clinic with current complaints. Significant laboratory findings included CRP of 179 and sedimentation of 89 and his fever was: 38.2 C. Clozapine treatment was stopped by decreasing the dose. Ceftriaxone flk 2 * 2 gr was started in consultation with thoracic medicine. There was multiple destructive bone lesions in CT and multiple LAPs with the largest axes of 11 * 19 mm in both axilla. Brain MRI showed signal changes compatible with metastasis. The patient was discharged with haloperidol solution 1 mg/day. He was referred to oncology and diagnosed with Non-Hodgkin lymphoma. Delirium is the third most common symptom among patients with advanced cancer, after pain and cachexia. The common causes of delirium in cancer patients are metabolic disturbances such as hypercalcemia (due to bone metastases), dehydration, and hepatic and renal failure. Delirium can also be caused by drugs, e.g. opioid or benzodiazepine overdose or withdrawal or changes in drugs that the patient has already been taking over the long term, e.g. antidiabetic glycosides. Moreover, spread of the underlying disease into the central nervous system can play a role as well. Delirium is a clinical condition that requires urgent treatment because of its high morbidity and mortality. Accurate recognition of underlying causes and risk factors is essential in early diagnosis and treatment. In psychiatric patients delirium should be distinguished from the acute episode of psychiatric disease. The underlying organic causes should be investigated.

KEYWORDS

Delirium; lymphoma; clozapine

[Abstract:0552] [Psychopharmacology]

Use of clonidine in neurodevelopmental disorders: report of three cases

Rahime Duygu Temeltürk

Department of Child and Adolescent Psychiatry, Ankara University School of Medicine, Ankara, Turkey

ABSTRACT

Clonidine has been widely used in child and adolescent psychiatry, especially ADHD, ASD, ID, and TS which are recently categorized under "Neurodevelopmental Disorders" according to DSM-5. As an α2 agonist agent, Clonidine, regulates noradrenergic systems directly acting on presynaptic autoreceptors of LC neurons leading to decrease noradrenaline release, indirectly stimulates postsynaptic α2A receptors in PFC. Both mechanisms are thought to serve to reduce hyperactivity, impulsiveness and hyperarousal symptoms frequently observed in ADHD, ASD and usually comorbid disorders such as TD, CD, ODD. To demonstrate effectiveness of clonidine (IR) in practice, three cases are presented before and after clonidine treatment with description of symptoms.

Case presentation: The three cases with neurodevelopmental disorders will be presented. A 7 year-old boy, diagnosed with ASD, ADHD, TS, SSD. His parents complaint his inattention and

KEYWORDS

ADHD; ASD; clonidine; neurodevelopmental disorders; Tourette

distractibility problems during homework, disruptive and aggressive behaviors (e.g. physical hitting), involuntary motor movements (shoulder shrugging, eye blinking), disturbing noisy sounds (sniffling, grunts). Although his current medications included atomoxetine, risperidone, haloperidol, tic and hyperactivity symptoms, irritability, conduct problems have still been. To decrease aggressive behaviors, tic symptoms, we started Catapres (Clonidine IR). A 15 year-old male patient diagnosed with ID (Severe), ASD. Even though many pharmacological agents (atomoxetine, risperidone, haloperidol-biperiden) have been used, there have still been aggressive behaviors (biting, hitting), sleep disorders should be treated. To reduce undesirable behavioral problems, Catapres (Clonidine IR) was started. An adolescent boy aged-14 years has been followed at our department diagnosed with ASD, ADHD, ID (Moderate).To reduce hyperactivity complaints methylphenidate treatment was started, but had to be stopped because of restlessness and sleep disturbances. Risperidone, aripiprazole were used to decrease aggressive self-harm behaviors, motor stereotypies, insomnia could not be continued in consequence of increasing appetite, body weight. Then we decided to start "Clonidine" treatment. Before and after two months treatment we evaluated ADHD and ASD core symptoms, irritability, oppositional and conduct behaviors and severity of motor and vocal tics by (AbBC), ABC, CBCL/6-18, CPRS-R/L, YGTSS. In all cases, after clonidine treatment it was observed that rule breaking, aggressive behaviors, oppositional defiant, conduct and generally externalize problems T scores in CBCL/6-18-Parent Form were reduced (10–25%). Especially the first case diagnosed with TS displayed the best improvement. All subscale scores of CPRS-R/L decreased by 30–75%, oppositional, hyperactivity subscales and symptoms related to restless-impulsive, emotional lability and inattention, hyperactivity/impulsivity, ADHD indexes. According to AbBC, there were also significant differences in irritability, stereotypic behaviors, hyperactive/noncompliance and inappropriate speech scales with the most important changes in hyperactivity scale by 67%. In ABC, body/language use and social/adaptive skills were better (22–37%). The first case diagnosed also with TS, YGTSS motor and phonic tic scores decreased (32–50%), the degree of deterioration in functionality is reduced from 30 to 10. These findings were also supported with clinical observations. Sedation was observed in two of the cases as an adverse effect, but also as a treatment of sleep disturbances. Significant improvements in disruptive behaviors, irritability symptoms were found in all three cases diagnosed with ASD [2] and also sleep problems in second and third cases. It was also found that ADHD core symptoms, especially hyperactivity/impulsive symptoms and emotional lability, restlessness related to these, oppositional behaviors and conduct problems which are almost comorbid situations in ADHD were reduced [3]. After evaluating tic scores before and after the treatment, it was proved that Clonidine reduced tic symptoms and more useful treatment of comorbid ADHD and TS.

[Abstract:0554] [Mood disorders]

Isotretinoin-related depression: a case report

Ebru Çiftçi, Deniz Altunova, Berrin Ünal, Sehure Azra Yaşar, Dudu Demiröz, Ali Metehan Çalışkan and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

Acne vulgaris, a condition that can affect people at any age, is the most common cause of referral to a dermatologist. Isotretinoin (ITT), approved by the FDA for the treatment of acne, carries a black box warning related to the risk of depression, suicide, and psychosis. In our case, we will discuss a patient with depressive episode with recurrent suicidal interventions due to ITT use.

Case presentation: 20 year old female university student without any psychiatric disorder started ITT cap 40 mg/day due to cystic acne in September 2017. After 3 months, the patient started to complain about distractibility, unhappiness, unwillingness, and loss of pleasure in activities. The patient was admitted to the psychiatry outpatient clinic, and treatment with ITT was discontinued and sertraline was started at 50 mg/day. After 2 weeks, she had suicidal attempt with 50 sertraline drugs and was followed up for 2 days in intensive care unit. Aripiprazole 5 mg/day was added to the treatment after the suicide attempt and increased to 20 mg/day. However, the patient had suicide attempt with 114 amitriptyline (25 mg) 1 week later. She had been treated for 4 days in intensive care unit. After treatment, she was hospitalized in a psychiatric clinic. The patient was discharged with escitalopram 20 mg/day and modafinil 100 mg/day. 4 days before his admission to our clinic, he had attempted suicide with 40 amitriptyline (25 mg) again. She had been treated for 4 days in intensive care unit and then the patient was admitted to our clinic. The patient had complaints of unhappiness, unwillingness, loss of pleasure in activities, less talk, introversion, and suicidal ideation. The treatment was planned as 20 mg/day for escitalopram, 37.5 mg/day for venlafaxine and 20 mg/day for aripiprazole. The dose of venlafaxine was increased to

KEYWORDS

Isotretinoin; acne; depression; suicide

150 mg/day while the treatment of escitalopram was discontinued. Thoughts of suicide were continued and 8 sessions of ECT were performed. The patient's depressive symptoms and suicidal thoughts were regressed and the patient was discharged. ITT, a vitamin A derivative, is approved for patients with severe acne not responding to standard therapy, including systemic antibiotic therapy. Scattered case reports of mood change, depression and suicide in patients taking isotretinoin have appeared since the drug was first licensed. Most of the authors reporting single cases describe the onset of psychiatric side effects within 1 month of the beginning of treatment with isotretinoin. Depression, in particular, has been reported as early as 1 day and up to 4 months after initiating isotretinoin treatment. Despite newer data, prescribers cannot dismiss the association between isotretinoin and depression, given that the drug may modulate serotonin signaling in the brain. Regardless of the treatment selected, all involved in the patient's care must assess and monitor the psychological health of all acne patients, especially those with severe acne. Monitoring beyond the active treatment period is essential.

[Abstract:0555] [Obsessive-compulsive disorders]

A case of severe skin picking disorder

Süveybe Yıldız[a] and Uğur Tekin[b]

[a]Department of Psychiatry, Istanbul University School of Medicine, Istanbul, Turkey; [b]Department of Child and Adolescent Psychiatry, Health Sciences University Bakirkoy, Dr. Sadi Konuk Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Skin picking disorder (SPD), is characterized by repetitive and compulsive picking of skin, leading to tissue damage. SPD has been classified under obsessive-compulsive and related disorders title in DSM-5. The most frequently used practices thought to be most effective in the treatment of skin picking disorder are cognitive behavioral techniques. However, there are cases reporting that antipsychotics can also be useful. Few studies have supported that selective serotonin reuptake inhibitors (SSRI) are effective.

Case presentation: A 17 years old, 11th-grade high school student, male patient with borderline intellectual functioning presented to our outpatient clinic with the complaint of skin picking excessively from his all hand fingers for about eleven years starting as a result of separation from his father. His family stated that he mostly picked his skin when he was under stress, when he tried to prevent himself, he would feel intense tension, irritability and when he picked the crusts, he would feel relief first, then guilt and regret. His distal phalanx and nails were seriously damaged. Behavioral recommendations were given to the patient and his family for these symptoms. He also diagnosed with generalized anxiety and separation anxiety disorders. Fluoxetine 20 mg/day and aripiprazole 1 mg/day was started as a medical therapy. The patient was referred to plastic surgery. In his follow up, skin picking was almost disappeared after treatment, however, due to his low treatment adherence his symptoms reoccurred soon. During his follow-up, fluoxetine was titrated to 40 mg/day and aripiprazole was titrated to 10 mg/day. Unfortunately, after two years, in his last visit, most of his nails were dissolved and his distal phalanxes were almost amputated. The main negative prognostic factors were ongoing stress of absence of father, borderline intellectual functioning and low treatment adherence.

KEYWORDS

Skin picking disorder; aripiprazole; fluoxetine; treatment

[Abstract:0556] [Anxiety disorders]

Resistant abdominal pain for 10 years: a case report

Dudu Demiröz, Ebru Çiftçi, Ali Metehan Çalışkan and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital Department of Psychiatry, Konya, Turkey

ABSTRACT

The medically unexplained symptoms, especially those observed in primary care, are common. Various studies have shown 19.5–57.5% of the somatic symptoms that cannot be explained medically in the complaints of primary care patients. In this case report, a patient with abdominal pain for 10 years will be discussed.

Case presentation: 78-years-old, female patient who had no additional disease other than hypertension presented with abdominal pain, fear of abdominal pain, decrease in appetite. Complaints have been occurred for 10 years. Due to abdominal pain, she had undergone surgery one year ago with the diagnosis of median arcuate ligament syndrome. After the operation, the patient's complaints persisted and no organic cause was found in his

KEYWORDS

Median arcuate ligament syndrome; somatization; venlafaxine; olanzapine

investigations. Therefore, the patient was referred to psychiatry and the last treatment of the patient was duloxetine 30 mg/day, amisulpride 200 mg/day, buspirone 5 mg/day, tramadol 100 mg/day. The patient, whose complaints continued with the current treatment, was referred to our clinic after the last general surgery visit. In the psychiatric examination, the patient's mood was depressive, she was anxious and he had thoughts about abdominal pain in his thought content. Depression and somatic symptom disorder were considered and venlafaxine 150 mg/day and olanzapine 5 mg/day were considered. In the clinical follow-up, it was observed that the patient's complaints decreased and the functionality improved. The association of somatization and depressive disorder has been proven in many clinical and epidemiological studies. Somatization and depression were considered due to the persistence of the complaints of the patient for 10 years, not to regress after 1 year before the operation, to be evaluated by different medical branches and to find no organic cause. In the elderly, mood symptoms of depression are lower. Somatic efforts and complaints are at the forefront. There is an information that venlafaxine may be useful in painful conditions. Therefore, we started treatment with venlafaxine in our case and observed clinical benefit. Somatic symptoms may be difficult to interpret at a time when physical ability decreases and diseases increase in elderly people. These may be due to an organic cause or as a symptom of a psychiatric disorder. If somatization is accompanied by depression or anxiety disorders in elderly patients, it is clear that these disorders should be treated immediately. However, sometimes somatic complaints persist even after successful treatment of depression. Despite the antidepressant treatment of depression, somatic complaints may continue. It may be necessary to apply therapy methods such as cognitive behavioral treatment. As with other psychiatric disorders in the elderly population, a period-specific approach and functionality should be addressed.

[Abstract:0560] [Movement disorders]

A case of conversion disorder similar to Meige syndrome

Özlem Akkaya and Cengiz Akkaya

Department of Psychiatry, Uludağ University School of Medicine, Bursa, Turkey

ABSTRACT

Meige Syndrome (MS) is a syndrome that starts spontaneously in 5th–6th decades. Blepharospasm and blinking are the first symptoms; during spasm, patients cannot open their eyes. Over time, spasms spread to the face, lip, jaw and neck. Complaints increase with physical activity, bright light, watching television or reading. In this study, a case of conversion disorder (CD) like MS will be discussed.

Case presentation: 65-years-old, married, male patient presented to our out-patient clinic with complaints of involuntary mouth motion, blinking and closing of his eyes for a year. He had overvalued ideas in the style of jealousy for 17 years. 2 years ago, he had started to complain about unhappiness, avolition, social withdrawal, weight loss, insomnia after a stressor. His overvalued ideas became delusional jealousy. He admitted to a psychiatry clinic a year ago with blinking complaints and he was diagnosed with Major Depression. As treatment, escitalopram was started, risperidone was added and increased to 2 mg for delusional jealousy. He used this treatment for 2.5 months. Then while watching television in evenings, he complained about involuntary movement in his mouth and eyes. He was able to open his eyes with using his fingers. Tardive dyskinesia (TD) was considered and risperidone was terminated. Cranial MRI was normal. E and B vitamins, tetrabenazine, clonazepam was prescribed, not benefited. The patient was hospitalized for differential diagnosis. In his mental examination, he had involuntary mouth and eye movements, his mood was depressive, he had anxiety about his physical symptoms. Biochemical markers were within normal limits. He was consulted to neurology. MS was considered and botulinum toxin treatment (BT) was recommended. Because of rarity of his involuntary movements in our clinic, he were followed in our outpatient clinic and BT was postponed. Depressive complaints and delusional jealousy disappeared. Involuntary movements increased at home, he was unable to open his eyes and could not take care of himself. He was hospitalized for the second time. In the interviews, he said that he had some relationship issues with his wife, he could not divorce due to pressure of society and his wife behaved better to him after he was ill. It is concluded that because he had an extramarital relationship for 2 years, he could not cope with the stress caused by this situation and CD appeared. His involuntary movements decreased and he did not need to assistance during hospitalization and discharged with venlafaxine 150 mg/day, aripiprazole 10 mg/day and clonazepam 2 mg/day. MS could be confused with neuroses and TD. TD was excluded because antipsychotic was not used enough time and dosage, the tonic spasms was longer than five seconds. MS is aggravated by emotional stress. Because complaints increased at home and decreased in the hospital, disappeared with psychopharmacological treatment and supportive interviews, and also lack of family history of movement disorder, we diagnosed CD. The differential diagnosis

KEYWORDS

Meige syndrome; tardive dyskinesia; conversion disorder

of MS is complicated. We believe that patients who are diagnosed with MS should be reevaluated in the favor of CD, this could prevent to extra BT.

[Abstract:0564] [PTSD]

The many faces of traumatic attachment: a challenge for diagnostic systems

Ecem Selin Akbaş, Tuna Çak and Fatih Ünal

Department of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey

ABSTRACT

Attachment disorder is defined in terms of markedly disturbed and developmentally inappropriate social relatedness in most social contexts which begins before the age of 5 years, persists over time, and it is assumed to originate from very depriving and pathogenic care conditions. The essential feature of disinhibited social engagement disorder (DSED) is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers. The disorder has been described from the second year of life through adolescence. Young children with the disorder fail to show reticence to approach, engage with, and even accompany adults. In preschool children, verbal and social intrusiveness appear most prominent, often accompanied by attention-seeking behavior. Verbal and physical overfamiliarity continue through middle childhood, accompanied by inauthentic expressions of emotion. In adolescence, indiscriminate behavior extends to peers. Relative to healthy adolescents, adolescents with the disorder have more "superficial" peer relationships and more peer conflicts.

Case presentation: "D" was 12 years old female, with 6 years child psychiatry follow-up, under treatment of lithium 600 mg and risperidone 4 mg. Her foreigner nurses took care of her until she was 5 and she was never breastfeed and her mother overworking. When she was 5, her parents separated and she started to live with his mother. Within a few years, D's mother asked D's father to care for her. In that period, her father hired 2 nurses for help, but because of D's aggressive behavior they resigned, so she moved to another city that her grandparents lived. "D" presented with oppositional behavior, tantrums, destructive and uncontrollable outbursts at home. Outbursts included violent behavior, such as punching her grandmother's face and body, pulling her hair, pushing her grandfather down the stairs, breaking furniture. She showed inappropriate behaviors such as swearing, defecating in the middle of room, masturbating when her grandparents and their guest were in same room. Her mood would rapidly change from rage to calmness. She continuously talked her fears about turning back to her mother's house, being harmed at school and avoided going school because "D" thought her teacher had a hostile attitude, and glared down on her during class. "D" showed no violence at school and communicated no-one but teachers. During breaks, she mentioned them her fears and family problems and showed no relief with suggestion. Her scores were very low. In her medical history, there were several hospitalizations and medications including lithium, divalproex, sertraline, quetiapine, risperidone at the same time, with no improvement.

Although both categorical and dimensional approaches have merit in describing psychiatric syndromes in youth, the DSM system uses only categorical criteria to identify psychiatric disorders. The overlap of behavioral and mood symptoms in attachment disorders make defining the boundaries challenging. In addition, in severely psychiatrically impaired youth with attachment disorders, comorbidity is the rule rather than the exception.

KEYWORDS

Adolescent; child; DSM-5; reactive attachment disorder

[Abstract:0567] [Obsessive-compulsive disorders]

Vortioxetine-induced obsessive-compulsive symptoms

Imge Coskun Pektas and Ummuhan Ceviz Ozkal

Department of Psychiatry, Pendik Research and Training Hospital, Marmara University, Istanbul, Turkey

ABSTRACT

Vortioxetine is a novel antidepressant drug approved for the treatment of major depressive disorder (MDD) in adults. Vortioxetine displays high affinity for serotonin transporter (SERT), and serotonin 5-HT3, 5HT1A, 5HT7 receptors. Functional studies showed that vortioxetine acts as a SERT blocker, a 5-HT3, 5-HT7 receptor antagonist, and a 5-HT1A receptor agonist. Short and long term clinical trials demonstrated the clinical efficacy of vortioxetine in treating depressive symptoms and cognitive deficits in MDD patients. Here, we report the case of a 20-year-old patient who presented initially with depression and later on was also

KEYWORDS

Vortioxetine; obsessive-compulsive symptoms; depression

diagnosed with obsessive-compulsive disorder. We aimed to present this case with obsessive-compulsive symptoms (OCS) due to vortioxetine use.
Case presentation: A twenty-year-old male patient was admitted to the psychiatry outpatient clinic with complaints of a depressed mood, irritability, forgetfulness, distractibility, concentration problems, worthlessness, insomnia, anhedonia and decreased interest. He stated that he had no medical problems that he was aware of and took no medications. His all routine investigations including EEG, brain MR were normal. The Minnesota Multiphasic Personality Inventory (MMPI) profile revealed the traits of cluster C (avoidant, dependent) personality disorder. We established a diagnosis of depression. Vortioxetine 10 mg administered orally once daily. After approximately three months on this treatment, the patient status worsened considerably and he started to exhibit obsessions like contamination and harm to self and others, religious or sexual themes, forbidden thoughts and symmetry urged. He exhibited compulsions like washing, checking, counting and arranging. We evaluated OCS severity with Yale-Brown Obsessive-Compulsive Scale. The vortioxetine was discontinued and the patient was started on fluoxetine 20 mg oral daily. Most of his obsessive-compulsive symptoms remitted. Some reports suggest that antiserotonergic second-generation antipsychotics (SGAs) can exacerbate OCS. De novo emergence or exacerbation of OCS during treatment with clozapine, risperidone, olanzapine and quetiapine has been described in the literature. This case report points out that vortioxetine might induce obsessive–compulsive symptoms (OCS), but longitudinal studies have to prove causality. A common condition in everyday clinical practice, OCS is triggered by SGAs. But little is known about the neurobiological basis of OCS triggered by vortioxetine. The purpose of this case report is to show the psychiatric side effects of vortioxetine. This case report emphasizes the importance of evaluating OCS in patients using vortioxetine.

[Abstract:0569] [Disrupted behavior disorders]

Effects of psychodynamic factors to impulse control disorder

Merve Gürkök, Cihat Erim, Hidayet Candan, Özgür Maden, Hazal Çelik Omar and Rüstem Aşkın

Health Sciences University, Sultan Abdülhamid Han Research and Training Hospital, Psychiatry Clinic, Istanbul, Turkey

ABSTRACT
Impulse control disorders are group of disorder that have attracted considerable interest in recent years. It is known that the impulse is an action curve to reduce the exaggerated tension caused by increased instinctual motives or reduced ego defenses against motives. Psychodynamic, psychosocial and biological factors all play an important role in impulse-control disorders; however, the primary causal agent is unknown.
Case Presentation: A 42-year-old male, university graduated patient had symptoms of getting angry easily since 2007. From his history it was understood that, the patient had been studying in military schools since the age of 14, had been exposed to psychological and physical violence at the school, and he had served in special forces between 1995–2004 years, he had entered many mortal clashes in those years, and his place of duty had been changed due to the commencement of his complaints. His complaints of having anger easily and anger control problem started after that. Especially in workplace he find himself many bad conditions because of his anger and violence tendency, although he had good relations with the people around him in his remaining times. The complaints of the patient who got married in 2004 decreased in these years, the severity of his complaints increased after the separation with his wife in 2015, he felt the motive of violence against more than 100 people in one year, he practiced violence against about five individuals in one year, he was detained in this regard and he still has trials in progress. Clinical observation of the patient who expressed depressed mood, it was observed that he had get angry easily; nevertheless, he had compatible behavior in the service and antisocial elements were not encountered. Mirtazapine 15 mg/day, sertraline 50 mg/day and risperidone 1 mg/day were started. According to the results of MMPI and BEIER tests; BEIER: Looking at the contents of the response; desperation, intense loss of life / feeling, need not to be based on age, difficulty in taking distance with mother image, inadequate and non-exhaustive father image, negative self-image, and the concern of loss of object have attracted attention. MMPI: Both neurotic and psychotic patients increased above the border, and MF decreased significantly. This type of profile is called the "bird wing profile" and may indicate borderline pathology. In our case, it was understood that the patient, who had no significant complaints in his childhood, had complaints of having easily irritability and violence after nine years of mortal conflicts which had become apparent after the separation with his wife. Although psychosocial factors that play a causal role in impulse-control disorders are associated with early life events; fatigue, constant arousal, and psychic trauma can reduce the resistance to control impulses too. Otto Fenichel associates impulsive behavior with anxiety, guilt, depression, and other painful affections and efforts to cope with action. He thought that such actions were defense against internal danger. When evaluating the patient who has impulse control disorder, this situation should be taken into consideration.

KEYWORDS
Anxiety; depression; guilty; impulse control disorder; separation anxiety

[Abstract:0575] [Psychopharmacology]

Agranulocytosis due to the use of clozapine in the treatment of the first episode psychosis: a case report

Metin Çatal, Merve Gürkök, İrem İlhan, Özgür Maden, Hazal Çelik Omar, Servet Ebrinç and Rüstem Aşkın

Health Sciences University, Sultan Abdülhamid Han Research and Training Hospital, Psychiatry Clinic, Istanbul, Turkey

ABSTRACT

Clozapine is an atypical antipsychotic that can cause hematological, sedative, epileptic side effects in treatment-resistant schizophrenia. In this paper, a case of agranulocytosis due to clozapine use in a patient with non-organic psychosis is presented.

Case presentation: 20 years old, male, 2 months old soldier, single, primary school graduate, unemployed patient who has no history of psychiatric follow-up or treatment, was referred to due to his delusional thoughts in military unit and was hospitalized to the psychiatry clinic with diagnosis of cannabis induced psychotic disorder. He thought that a camera was placed in his eyes, he was a prophet, and God communicated with him through animals. The patient's laboratory results at admission were normal. He was started on clozapine (200 mg/day) with intense paranoid, reference, and grandiose delusions. On the third day of the treatment, the dose of clozapine was increased to 300 mg/day. On the seventh day of the treatment, total white blood cell count, absolute neutrophil count and lymphocyte count decreased. Daily hemogram follow-up and discontinuation of clozapine were recommended for the patient consulted to hematology. The patient was started on haloperidol 5 mg/day and prednisolone 8 mg/day. White blood cell count decreased from 6.38 mcL to 1.81 mcL and neutrophil count from 4.35 K/mm3 to 0.23 K/mm3. The isolation measures were taken to prevent infection in the clinic. After clozapine treatment was terminated, the number of white cells and the number of neutrophils were increased. Hemogram results were found to be normal on the 30th day of the hospitalization. The patient's hemogram results were normal and he was discharged with haloperidol 15 mg/day. Agranulocytosis, which threatens life during clozapine treatment, can be seen in the treatment of resistant schizophrenia. In 0.8–3% of patients using clozapine, there is a risk of developing this side effect. Steroid therapy used during the treatment of agranulocytosis may increase psychotic symptoms. Therefore, steroid doses should be minimally administered. Typical antipsychotics are more potent than atypical antipsychotics and are frequently used in patients with agranulocytosis.

Agranulocytosis can be seen rarely in the treatment of clozapine. Steroid therapy used to correct hematological parameters may increase psychotic symptoms. In this article, we present a case of agranulocytosis during clozapine treatment in a patient with first episode psychosis. It is suggested that psychotic symptoms may increase during steroid treatment and this should be kept in mind during the adjustment of the doses of antipsychotic drugs.

KEYWORDS

Agranulocytosis; antipsychotic; clozapine; first-episode psychosis; steroid

[Abstract:0576] [Psychopharmacology]

Paroxetine-induced bruxism: case report

İrem İlhan, Hidayet Candan, Metin Çatal, Özgür Maden, Zeynep Nergiż Tellioğlu Saka and Rüstem Aşkın

Health Sciences University, Sultan Abdülhamid Han Research and Training Hospital, Psychiatry Clinic, Istanbul, Turkey

ABSTRACT

Anxiety Disorder and Depressive Disorder in a patient with paroxetine due to the use of sleep bruxism.

Case Presentation: A 42 year old, married man with no active medical conditions and no history of dental problems was seen in an outpatient psychiatry clinic for the evaluation of ongoing depression and anxiety. Recently, he was admitted to psychiatry clinic for follow-up and treatment because of increased suicidal thoughts. Paroxetine 10 mg/day and alprazolam 1 mg/day were started to the patient with intense anxiety, depressive themes and suicidal thoughts. On the 3rd day of the treatment, paroxetine dose was increased to 20 mg/day. On the 6th day of the treatment, the patient had a complaint of temporomandibular joint pain and toothache. It was learned from the information received from his companions that the patient had teeth grinding at night. Paroxetine dose was decreased to 10 mg/day and 25 mg sertraline was added to the patient who did not have any abnormalities in the routine laboratory tests. On the 3rd day, paroxetine was completely discontinued and the dose of sertraline was increased to 50 mg/day and 3 days to 100 mg/day. Paroxetine was considered as the cause of bruxism and treatment was continued with sertraline 100 mg/day and alprazolam 1 mg/day. Paroxetine is a SSRI group which is widely used in depression, obsessive-compulsive disorder, panic disorder, anxiety disorder and post-traumatic stress disorder. The side-effect profile of paroxetine, which acts by increasing the amount of

KEYWORDS

Anxiety; bruxism; depression; paroxetine; sertraline

serotonin in the synaptic range, is similar to other SSRI-group drugs. The most common side effects were dyspepsia, nausea, insomnia, dizziness and headache. There may also be other selective serotonin reuptake inhibitors, as well as paroxetine-induced sleep bruxism reports. The sleep disorder is characterized by involuntary clamping of teeth during the sleep and / or tooth grinding and is a common clinical condition due to the use of psychotropic drugs. Today, the pathophysiology is not fully understood and it is often thought that the imbalance between dopaminergic and serotoninergic systems may play a role. drug-related bruxism can lead to health problems such as loss of tooth integrity, irreversible temporomandibular joint damage, severe head and face pain. However, reports suggesting that there is a relationship between various medications and bruxism is limited to a few reports and case reports. In our case, sleep bruxism due to the use of paroxetine in a male patient was reported. It is known that it can be seen rarely. Dopamine, noradrenaline, serotonin, cholecystokinin, glutamate/NMDA, histamine, glycine, adenosine, acetylcholine, vasoactive intestinal peptide, substance P and angiotensin are likely to have effects on bruxism in neuropathic substances that affect the frequency and amplitude of rhythmic chewing muscle activity during sleep in different ways. Clinicians' knowledge of the possible side effects of paroxetine, which is frequently used, will be useful for the continuation of the treatments to be administered.

[Abstract:0577] [Disruptive behavior disorders]

Delirium due to hyponatremia after traditional medical treatment in patients with chronic renal failure: a case report

Hidayet Candan, İrem İlhan, Cihat Erim, Özgür Maden, Hakan Kullakçı, Zeynep Nergiz Telliöğlu Saka, Servet Ebrinç and Rüstem Aşkin

Health Sciences University, Sultan Abdülhamid Han Research and Training Hospital, Psychiatry Clinic, Istanbul, Turkey

ABSTRACT

Delirium is known that acute brain failure or acute psycho-organic syndrome. Delirium is a syndrome in which the brain is commonly affected in a short period of time due to any reason, and that the behavior, consciousness, attention and other cognitive abilities are severely impaired. Generally, it is characterized by a few hours to several weeks and opening and closing in consciousness during the day. Causes of delirium are brain-vascular diseases, intracranial infections, head trauma, epilepsies, infections, and various systemic diseases. It can also be seen in medical conditions that may cause metabolic deficits such as chronic renal failure (CRF). In this article, a case of delirium due to hyponatremia after traditional medical treatment is presented.

Case Report: A 38 years old, male, university graduate, married, his job was advertising. The patient did not have a history of psychiatric disease. Because of the anabolic steroid-containing substances used in sports, CRF was developed in the patient, and levels of urea and creatinine was elevated. Dialysis or transplantation treatment options have been proposed. As the patient was afraid of these two methods of treatment, he turned to traditional medical treatment. He had a hirudotherapy every three weeks and started to take herbal treatment. He was admitted to the emergency department with complaints of distractibility and disorganized speech. He was evaluated in the emergency room, and the low sodium value (Na: 120 mmol/L) was detected, but no neurological deficit was found in his neurological evaluation. Cranial CT and diffusion MRI were not detected with acute neurological pathology as well. Sodium replacement therapy was administered and dialysis treatment was performed. During the first three days, especially visual hallucinations, self-talking, disorganized behavior, decreasing sleeping were exhibited. His mental examination showed that the patient was older than his age, and that his interest in self-care and his surroundings were diminishing, reduction to speech and voice tone, conscious open, disorientation to place-time and person, reduced flow of ideas, cannot reach its purpose, idea content shallow, the associations are broken, affective anxiety, according to psychomotor activity, behaviors' were impaired in the form of agitation. His condition was consistent with "Delirium." Traditional medical treatment approaches include phytotherapy, acupuncture, apitherapy, hypnosis, hirudotherapy, and other therapies. In our country, between 14% and 37% of chronic kidney patients use herbal products. The kidneys are particularly sensitive to toxic injury due to high blood flow velocity, large endothelial surface, and high metabolic activity. Plant products may cause glomerular hemodynamic changes. Nephrotoxicity due to herbal products may be in the form of acid-base disorders, electrolyte imbalances, and decreased glomerular filtration rate. Traditional medical treatments are occasionally administered in patients with CRF. In this article, a case of delirium due to hyponatremia following these treatments is presented. Electrolyte imbalance during this kind of treatment may cause delirium. It is important to regulate nutrition and diet during treatment of CRF patients. It is recommended that this should be considered in terms of clinicians working in the field.

KEYWORDS

Chronic renal failure; delirium; hirudotherapy; hyponatremia; traditional medical treatment

[Abstract:0580] [Anxiety disorders]

Attention-deficit/ hyperactivity disorder (ADHD) comorbidity with social anxiety disorder (SAD): an adolescent case

Arzu Yavuz, Dilek Ünal and Gülin Evinç

Department of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey

ABSTRACT

Prevalence of social anxiety disorder varies between 2–9.4% in different countries which is relatively common among children and adolescents. Besides, childhood ADHD prevalence (especially attention deficit subtype) is generally found increased in SAD samples (35%) and more severe SAD symptoms are seen in the case of comorbidity with ADHD.

Case presentation: A 17 year of male patient was referred for not being able to speak in public, difficulty in establishing friendship and shyness. His symptoms started at the age of 11 and increased in high school. Firstly, he started having difficulty talking to women. Then, he became worried about all people looking at him in the crowd and he was afraid to say something stupid. Since early childhood, he was shy and avoiding from strangers. During his school life, he was hyperactive and did not have any friends. He was clever and could keep up with the class success until high school. His grades got worse in the last two years. He was forgetful and had a problem with organizing his tasks. The patient was firstly diagnosed as social anxiety disorder(SAD) two years ago and used fluoxetine 40 mg/day, moclobemide 300 mg/day, sertraline 75 mg/day before. His anxiety decreased with fluoxetine 40 mg/day but the patient stopped taking fluoxetine for not caring about his lessons with the medication. Secondly, moclobemide treatment was started. At the 3rd month of moclobemide treatment, his difficulty in socialization was still present and he began complaining about depressive symptoms. Therefore, moclobemide treatment was discontinued and sertraline treatment was started. He was also going on cognitive behavioral therapy. However, there was not any significant improvement in his social anxiety symptoms and functionality despite the combination treatment. He was evaluated again in terms of ADHD. He was diagnosed with ADHD and prescribed methylphenidate 54 mg/day besides sertraline 75 mg/day. Also, his psychotherapy process went on. Unfortunately, he had academic deficit and did not keep attending school. Afterwards, he did not use the medications properly and stopped coming to the appointments. Studies demonstrated social anxiety symptoms at children and adolescents who were diagnosed both with SAD and ADHD benefited from ADHD treatment. Also, it is important to diagnose ADHD in early ages and start ADHD treatment before the negative consequences take place in patients' functionality and life quality. Clinicians should be aware of screening ADHD symptoms in SAD and ADHD should be held in planning psychopharmacological treatments.

KEYWORDS

Attention-deficit/ hyperactivity disorder; comorbidity; social anxiety disorder

[Abstract:0584] [Psychopharmacology]

Acute laryngeal dystonia: a case report

Erensu Baysak, Gamze Sunal Yiğitoğlu, Ayşe Sakallı Kani and Ömer Yanartaş

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Antipsychotics may cause different adverse reactions within a short or long term time period. Extrapyramidal side effects comprising akathisia, tremor, bradykinesia or rigidity are more common symptoms however, acute laryngeal dystonia is a rare adverse event but may be life-threatening one when it occurs. Here, we aimed to present a case had an acute laryngeal dystonia due to haloperidol use.

Case presentation: A 21-year old, male patient who was diagnosed with an intellectual disability 16 years ago and has been following with bipolar disorder for 4 years. He was brought to the emergency department by his parents and the police with complaints which have continued for 2 months such as aggression, increased speech, decrease in need for sleep, psychomotor agitation and refusing treatment. Especially in the last 10 days, his aggression increased and before being admitted to the emergency department, the patient had attacked his father with a stone. He was taking sodium valproate 1000 mg/day and quetiapine 400 mg/day as a maintenance treatment, but he was not taking his medication regularly for the last 2 months and his parents could not persuade him to go to the psychiatry clinic. He was diagnosed with bipolar disorder, manic episode and planned to be hospitalized in a closed ward. 10 mg haloperidol and 5 mg biperiden intramuscular injections were performed for sedation. After stabilization the patient was transferred to another hospital by ambulance for closed ward hospitalization. In the ambulance, the patient had

KEYWORDS

First generation antipsychotics; extrapyramidal symptoms; laryngeal dystonia; anticholinergics

dysphonia, stridor and dyspnea, this condition was attributed to a haloperidol hypersensitivity. The patient's airway safety was ensured in the ambulance, but the patient's condition worsened after reaching the hospital. After administration of 30 mg intravenous biperiden, the patient's condition improved. Acute laryngeal dystonia generally presents itself shortly after administration of an antipsychotic. Half of the cases present themselves within the first 2 days and a majority of the cases present themselves within the first week of antipsychotic administration or after increasing the dose of an antipsychotic. Symptoms of acute laryngeal dystonia generally include dysphagia, dysphonia, slurred speech, stridor and dyspnea. The two most effective treatments of acute laryngeal dystonia are anticholinergics and antihistaminics. Despite acute laryngeal dystonia is an uncommon reaction to antipsychotic drug administration it is essential that the professionals have to be aware of this life-threatening reaction and its treatment options.

[Abstract:0585] [Anxiety disorders]

A case of phagophobia

Zeynep Beyza Sariöz Arpacioğlu and Neşe Yorguner

Department of Psychiatry, Marmara University School of Medicine, Istanbul, Turkey

ABSTRACT

Phagophobia, or the fear of swallowing foods, liquids, or pills is a form of psychogenic dysphagia that is clinically underappreciated, usually based on a fear of choking, and characterized by various significant swallowing complaints with normal physical examination and laboratory findings. Phagophobia is a rare disorder and the literature is sparse. Here, we wanted to discuss a phagophobia case.

Case presentation: 29 years old, married, high school graduated female patient; was admitted to outpatient psychiatry clinic with complaints such as fear of choking while eating, anhedonia, anxiety and depressive mood. It was learned that these complaints have started with the birth of her first baby 10 months ago. At the beginning her complaints were tightening and numbness around her mouth when she put solid food into her mouth. And now for the last 2 months these symptoms are accompanied by contraction in the whole body. At the beginning, she tried to swallow small pieces and swallow partially, as a safety seeking behavior. And for the last 2 months she has been able to get only liquid foods. When she swallows solid foods, she thinks that the food could clog the trachea and she will get choked. She thought that if she dies her baby will be alone and neglected. She did not eat solid foods, lost weight, her milk was getting less, and she felt unhealthy and like insufficient mother. She said that "I want to feel more healthy, I want to be a good mother and I want to be able to eat food". We started cognitive behavioral therapy, after excluding organic causes. Phagophobia is an uncommon phobic disorder mentioned in the International Classification of Diseases, 11th Edition and DSM-5. The most important point in the treatment of this disorder is the exclusion of organic causes. Differential diagnosis of phagophobia are; other eating disorders which includes swallowing dysfunction and conversion disorder (globus hystericus).

Although phagophobia is seen rare, it should be kept in mind as a psychological cause of dysphagia. There is no definitive treatment method for phagophobia. Cognitive behavioral techniques can be used in the treatment.

KEYWORDS

Acquired aphasia; phagophobia; choking phobia; psychogenic dysphagia; fear of swallowing

[Abstract:0590] [Psychopharmacology]

Olanzapine induced neutropenia in an adolescent: a case report

Sebile Aslı Eke[a], Meriç Menekşeli[a], Eda Kaner[a], Büşra Duran[a], Zeynep Yıldız Yıldırmak[b], Caner Mutlu[a] and Gül Karaçetin[a]

[a]Department of Child and Adolescent Psychiatry, Health Sciences University Bakirkoy Research and Training Hospital, Istanbul, Turkey; [b]Department of Pediatric Hematology, Health Sciences University Sariyer Hamidiye Etfal Research and Training Hospital, Istanbul, Turkey

ABSTRACT

Olanzapine is an atypical antipsychotic that blocks D2 and 5HT2a receptors. It is frequently used in many psychiatric disorders including psychosis in adolescents and has been shown to be effective by many studies. Dizziness, sedation, weight gain, increased risk for diabetes and dyslipidemia, extrapyramidal symptoms, abdominal pain, dry mouth, headaches are side effects that have been reported with olanzapine treatment. Also, olanzapine is reported to be associated with agranulocytosis in adolescents. In this report we present a 12-year-old

KEYWORDS

Olanzapine; antipsychotic; neutropenia; adolescent; psychosis; adverse effects

adolescent with psychosis who developed neutropenia with olanzapine treatment.
Case presentation: A 12-year-old adolescent female with psychotic disorder was admitted to inpatient child and adolescent psychiatric clinic of Bakirkoy Research and Training Hospital for Psychiatric and Neurological Diseases. The patient presented with complaints of auditory and visual hallucinations, social withdrawing and paranoid delusions. Dysphoric mood, blunted affect, decreased psychomotor activity, auditory and visual hallucinations, paranoid delusions were found in the psychiatric examination. Her complaints started about 8 months ago and she had been using olanzapine for almost a month. To rule out organic etiology blood tests were done. Complete blood count (CBC) revealed WBC of 2.78 × 103/L (reference range 3.98 × 103/L to 10.4 × 103/L) and neutrophil 0.63 x103/L (reference range 1.56 × 103/L to 6.13 × 103/L). Blood smear was performed and reviewed by consulting hematologist. Olanzapine treatment was subsequently ceased. After that WBC and neutrophil count gradually increased to normal level.

Olanzapine induced neutropenia is a rare but life-threatening complication. It has been rarely reported in adolescents. Clinicians must be careful about the patients using olanzapine who shows fever or other signs of infection.

[Abstract:0593] [Schizophrenia and related disorders]

A case report with antibiotic-related transient psychotic episode

Bedriye Özkan, Ömer Can Erişen, Mehmet Tekden, Caner Mutlu and Gül Karaçetin

Health Sciences University Bakirkoy Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Child and Adolescent Psychiatry Clinic, Istanbul, Turkey

ABSTRACT
Antibiotics can rarely cause psychiatric side effects, such as transient psychotic episode. There are some case reports of fluoroquinolones, cephalosporins, penicillins, and trimethoprim-sulfamethoxazole drugs among the antibiotics associated with this side effect.
Case presentation: Amoxicillin is a penicillin antibiotic that is used to treat many different types of infection caused by bacteria, such as tonsillitis, bronchitis, pneumonia and infections of the ear, nose or urinary tract. Here we discuss a case of an adolescent who developed transient psychotic episode after amoxicillin usage. A 15-year-old male patient referred to the emergency unit of Child and Adolescent Psychiatry Clinic in January 2019 with insomnia, loss of appetite, anxiety, hearing weird noises and suicide attempt. We have learned from patient's history that he began using amoxicillin for tonsillitis ten days ago and the symptoms have started after the third day of amoxicillin treatment. Then he has stopped to take the medicine, but symptoms have been getting worse and he has tried to kill himself by smothering with a charge cable. We have started 0.5 mg risperidone treatment, but when the patient consulted us, his symptoms had already diminished, and he recovered completely after two days. Even if the psychiatric side effects that are triggered by drugs are seen rarely, there can be serious results like suicide. It is reported that cases like these have a recurrence of the psychosis when challenged with the same antibiotic. Therefore, clinicians should be careful about the medications used by patient when psychotic symptoms rapidly emerge.

KEYWORDS
Antibiotic; psychosis; side effect

[Abstract:0595] [Mood disorders]

A case of neutropenia after the use of olanzapine in a patient with bipolar disorder

Seyma Nur Gozutok, Emine Bilgen Dogan, Omer Can Erisen, Ali Guven Kilicoglu, Bedriye Özkan and Gul Karacetin

Health Sciences University Bakirkoy Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Child and Adolescent Psychiatry Clinic, Istanbul, Turkey

ABSTRACT
Bipolar disorder(BD) is a psychiatric disorder in which feelings, thoughts, behaviors, and perceptions are altered in the context of episodes. Although atypical antipsychotics are more effective than mood stabilizers in the treatment of acute phases of disorder, metabolic side effects are more often. It is also known that atypical antipsychotics may cause a decrease in some blood parameters. In this case, our goal was to examine the case of neutropenia after use of olanzapine in a patient with bipolar disorder and to review the treatment process.

KEYWORDS
Olanzapine; neutropenia; bipolar; side effect

Case presentation: A 17-year-old 12th grade female patient was admitted emergency unit of child and adolescent psychiatric clinic of Health Sciences University Bakirkoy Research and Training Hospital for Psychiatric and Neurological Diseases with complaints of self-talk, unhappiness, increased pre-occupation with religion, decreased need for sleep, increased amount of energy and delusional beliefs which were started one week before she was hospitalized in our clinic. In psychiatric examination, she was conscious, orientated to person, place, time and she was cooperative. She looked at her stated age with decreased self-care, labile mood and inappropriate affect. Her associations tend to loosen and she lacked directedness. She had referential delusions and auditory hallucinations. She lacked judgement and her insight were partial. The patient was diagnosed as bipolar disorder, mixed episode. She was medicated with olanzapine 25 mg/day which is used by patient before hospitalization but lower doses. Quetiapine 200 mg/day was initiated and gradually increased to 900 mg/day and reduced to 300 mg/day due to reduced sedation requirement. Clonazepam 1 mg/day was initiated orally and increased to 2 mg/day. Later, reduced gradually to 0,5 mg/day. Valproate was initiated with the assumption that lithium treatment was insufficient and increased to 750 mg/day with blood level monitoring. Topiramate was stopped due to cognitive slowing. Olanzapine dose reduced to 20 mg/day upon development of dysarthria with olanzapine. Biperiden 2 mg/day was added and gradually increased up to 6 mg/day. Upon detection of neutropenia (NE: 1254/mm3, WBC: 3422/mm3) on blood tests, olanzapine was reduced to 15 mg/day. She was consulted with the Hematology Unit. It was stated that there was not a need for treatment change. Lithium 300 mg/day was added to the treatment of the patient whose neutrophil count was increasing in follow-up (NE: 1375/mm3, WBC: 2942/mm3). During their follow-up, WBC and NE (4859/mm3,2525/mm3) reached normal values. The patient, whose symptoms regressed with the current treatment, was referred to the outpatient treatment unit. This case report emphasizes the need to follow up blood counts before initiating treatment and at the time of treatment in patients on atypical antipsychotic use and points out that close follow-up of the patient is important in case of a possible decrease in blood parameters.

[Abstract:0597] [Psychopharmacology]

Antipsychotics-induced DRESS syndrome: a case report

Zeynep Celile Elmacı[a], Şakir Gıca[b], Özlem Devrim Balaban[b] and Nesrin Karamustafalıoğlu[b]

[a]Department of Child and Adolescent Psychiatry, Health Sciences University, Istanbul, Turkey; [b]Department of Psychiatry, Health Sciences University, Istanbul, Turkey

ABSTRACT

DRESS syndrome is a severe and acute drug reaction which is seen with fever, cutaneous drug eruptions, lymphadenopathy, internal organ involvement and hematologic abnormalities in peripheral blood. It's important to diagnose early, because of DRESS syndrome's mortality rates are approximately up to 10–20%. Numerous studies focused on only aromatic anticonvulsants but we want to emphasize to keep in mind and be watchful on DRESS syndrome if diffuse rash happens when using all kind of medical drugs including antipsychotics.

Case presentation: 21 years old woman was hospitalized with lack of food intake, mutism, auditory hallucinations, and decrease in psychomotor activity. Paliperidone 6 mg/day and quetiapine 150 mg/day were prescribed to our patient in other clinic 5 days before the hospitalization. She had diffuse rashes on upper and lower extremities and trunk, after she had used 2 doses paliperidone and quetiapine. Therefore, she stopped using medications. When the patient was evaluated in detail, we learned that one year ago patient had diffuse rashes, toxic hepatitis and jaundice, 15 days after from usage of carbamazepine 400 mg/day, risperidone 6 mg/day, biperiden 4 mg/day, quetiapine 100 mg/day in the treatment of depression with psychotic features and epilepsy. So, she was diagnosed with DRESS syndrome as a result of examinations. Therefore, it was learned that their medication had been discontinued for a year. She was awake but we couldn't examine orientation because of her mutism in psychiatric examination. The patient's self-care was reduced, she was reluctant to interview and had little eye contact. Her psychomotor activity was decreased. There were stereotypic movements that repeated in her hand, first to her mouth and then to her neck. She never spoke. Her affect was observed to be limited, her mood was depressed according to the story. The thought contents and delusions of the patient could not be evaluated in the first examination. According to the history, it was thought to have possible auditory and visual hallucinations. Eosinophilic leukocytosis (white blood cell: 14.55 eosinophils: 1.37) was determined in whole blood and routine biochemistry tests. There was no other significant pathology. The patient had known epilepsy for 6 years. There was not any psychiatric disease in her family, and she did not use any psychoactive substance, cigarettes or alcohol. Mortality due to internal organ involvement has been reported as 10% when no diagnosis or treatment is made in DRESS syndrome. Drugs such as carbamazepine, allopurinol, phenytoin, phenobarbital, lamotrigine, sulfasalazine, vancomycin have been

KEYWORDS

DRESS syndrome; quetiapine; antipsychotics; side effects; mood disorders

shown to be effective agents. Dress syndrome usually occurs between 2 and 8 weeks after the use of the drug, but it has been observed that the drug appeared earlier if reused. Lymphadenopathy is often accompanied. Generalized, sensitive lymphadenopathy slowly improves with discontinuation of the drug. Liver involvement is the most common internal organ involvement. Leukocytosis, eosinophilia, mononucleosis-like atypical lymphocytes are common hematological conditions. Because of acute skin rash, lymphadenomegaly and eosinophilia in 2 different regions, it was evaluated as a possible diagnosis of DRESS syndrome according to RegiSCAR criteria. Although it is not clear whether the DRESS Syndrome that is occurring for the second time in the patient is induced by paliperidone or quetiapine, it is important to show that DRESS syndrome may develop after antipsychotic use. Only one case of DRESS syndrome induced by quetiapine was reported in the literature and it was emphasized that neosensitization against quetiapine, olanzapine and amoxicillin developed after valproic acid induced DRESS syndrome. From this point of view, in our case, after carbamazepine induced DRESS syndrome, sensitivity to one of the other antipsychotics or several similar structures may be considered.

[Abstract:0641] [Schizophrenia and other psychotic disorders]

Possible involvement of inhibited mTOR signaling in de novo psychosis following the initiation of everolimus in a patient with tuberous sclerosis: a clinical vignette

Olcay Şenay[a], Yasin Hasan Balcioglu[b] and Mehmet Cem Ilnem[b]

[a]Department of Psychiatry, Istanbul Medical School, Istanbul University, Istanbul, Turkey; [b]Department of Psychiatry, Bakirkoy Prof Mazhar Osman Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Istanbul, Turkey

ABSTRACT

Tuberous sclerosis (TSc) is an autosomal dominant, neurocutaneous, multisystemic disorder and has a characteristic symptomatologic triad of adenoma sebaceum, epilepsy, and developmental delay. Mutations in both the TSC1 and TSC2 genes are the responsible genes for the occurrence of the disorder. These mutant genes lead to a hyperactivation of the mammalian target of rapamycin (mTOR), a signaling cascade involved in cell growth, proliferation, protein synthesis, and metabolism. The mTOR inhibitors, everolimus and sirolimus, are recently offered to restore pathologically up-regulated mTOR pathway in TSc. However, the neuropsychiatric side effects of these drugs are yet to be discovered.

Case presentation: Here, we reported a 22-year-old male patient, with diagnoses of tuberous sclerosis, epilepsy, learning disability, and organic personality disorder without any psychotic manifestations, who was admitted to our outpatient clinic because of disorganized behavior, hallucinations, and delusions with a recent history of hostility and aggression. The aforementioned psychotic manifestations initiated soon after he had undergone on a placebo-controlled double-blind study of everolimus 6 mg/daily for TSc for last four months. Clinical examination, laboratory screening, and magnetic resonance imaging (MRI) of the brain have not revealed any other organic causes of psychosis. His symptoms resolved over the next ten or so days with moderate doses of antipsychotics. The current case is presented in order to discuss possible underlying neuronal signaling mechanisms those may lead psychosis following a short-term mTOR inhibition treatment. Although it would be difficult to allege the direct involvement of short-term everolimus exposure in the development of psychotic symptoms, impaired protein synthesis related to the mTOR inhibition leads to impaired neuronal network and plasticity, and may predispose to the development of psychotic symptoms, consequently.

KEYWORDS

Everolimus; mTOR; neuromodulation; neuronal plasticity; psychosis

[Abstract:0777] [Psychotherapies]

Emdr therapy in a patient with traumatic grief: a case report

Meltem Göbelek, Faruk Pirinççioğlu and Mehmet Asoğlu

Department of Psychiatry, Harran University School of Medicine, Şanliurfa, Turkey

ABSTRACT

Traumatic grief is associated with symptoms and reactions that develops in people experiencing this loss as a result of sudden and violent death of a loved one. The grief after the loss is a normal and natural reaction. Traumatic grief affects the natural grief process by the fact that loss is unexpected and sudden. Eye Movement Desensitization and

KEYWORDS

EMDR; traumatic grief; psychotherapy; grief; trauma

Reprocessing (EMDR) is a method that combines elements of various different approaches, such as psychodynamic, cognitive, behavioral and client-oriented approaches. In this case report, it was aimed to emphasize the positive effect of EMDR therapy in a short time in a case diagnosed as traumatic grief.

Case Presentation: 44 year old, university graduate, health officer, female patient was admitted to the psychiatry outpatient clinic with complaints of sleep disorder, fear, distress, not enjoying life, desire to cry, introversion, and pain and palpitations in her chest. It was learned that the patient lost her husband because of a sudden heart attack 13 months ago in the hospital where she worked. It was learned that the patient had a longing for his wife, had difficulty sleeping during the night without him, had a feeling that life was meaningless and empty, had difficulty in accepting death, introversion, anger and occasional feelings of guilt. EMDR therapy was started because it would benefit the patient without active psychiatric drug use. A total of 2 sessions of weekly EMDR therapy showed a 50% reduction in the patient's complaints, as evidenced by clinical scales, and improved anxiety and depressive mood symptoms. EMDR is currently used in the treatment of many trauma-related mental disorders, particularly post-traumatic stress disorder. According to the EMDR approach, memories related to the traumatic experience are improperly stored in memory. Memories stored in this way cause non-functional responses. In this case, EMDR therapy was performed in the patient who had traumatic grief symptoms after sudden death of her husband and the patient was observed to benefit in a short time. Our patient's benefit from EMDR suggests that this therapy is an important alternative in patients with traumatic mourning. Long-term studies are needed in this field.