Results: After a few days of high intensity treatment, speech reappeared in form of one- word sentences and proceeded to the ability to have short conversations. Mobility increased, starting from severe gait disorder, including the use of a wheelchair and emerged to the ability of walking up to 50 metres. Additionally, the undirected vocalizations improved and were reduced. In addition, hearing ability improved during the four-week treatment.
Conclusions: This case highlights the impact of deprivation in demented patients. Especially it shows that these symptoms can be reversible under a high intensity multimodal and multi- professional treatment within a few weeks. Therefore, stimulus shielding, should be carefully evaluated in order to prevent deprivation – and thus deterioration of the symptoms – in demented patients.

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Practice recommendations to manage Alzheimer's disease based on the targeted behavioral and psychological symptoms

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Introduction: Behavioral and psychological symptoms (BPS) of Alzheimer's disease, known as neuropsychiatric symptoms, involve a range of symptoms that include agitation, psychosis (hallucinations, delusions), affective symptoms (depression and anxiety), apathy, and sleep disturbances. These behavioral and psychological symptoms harm the patients' daily lives and significantly burden their families. Managing BPS of Alzheimer's disease requires a targeted approach focused on each symptom to achieve a better therapeutic response.
Objectives: Providing practice pharmacological recommendations targeted to each of the behavioral and psychological symptoms of Alzheimer's disease.
Methods: A literature review was conducted using Medline via PubMed, Embase, PsycINFO, and Cochrane databases until September 2023.
Results: There is a consensus in the literature that non-pharmacological approaches should be recommended as the first-line treatment for most behavioral and psychological symptoms of Alzheimer's.
Second-generation antipsychotics (risperidone and olanzapine, with improved efficacy; aripiprazole and quetiapine, with better tolerance) are recommended for severe agitation states with a risk of self or hetero-aggression, as well as for persistent psychotic symptoms in Alzheimer's disease. The benefit-risk balance of these agents must be assessed, with close monitoring of heart arrhythmias, metabolic risk, orthostatic hypotension, and extrapyramidal symptoms. The recommendations suggest tapering antipsychotics within the first three months of their prescription. Selective serotonin reuptake inhibitors (SSRIs) such as Escitalopram, Citalopram, and Sertraline can be considered a therapeutic option for persistent affective symptoms (depression and anxiety) with significant functional impairment or suicidal risk, severe apathy, or constant agitation. Minimum effective doses are recommended for Escitalopram and Citalopram due to the risk of QT interval prolongation. There is limited evidence regarding the effectiveness of benzodiazepines, mood stabilizers, cholinesterase inhibitors, and memantine for various behavioral and psychological symptoms; the benefit-risk ratio and therapeutic response do not support the prescription of these agents. Melatonin and Mirtazapine have limited benefits for sleep disturbances, while benzodiazepines, antihistamines, and antipsychotics should be avoided.
Conclusions: The pharmacological approach should target a thorough clinical assessment of the psychopathological dimensions of behavioral and psychological symptoms of Alzheimer's disease. The prescription should be based on evaluating the benefit-risk balance and adherence to literature recommendations for patient safety.

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Mania and alzheimer disease, review and case report

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Introduction: There are numerous organic causes that can be related to affective symptoms such as neurological, metabolic, infectious and pharmacological. Neurological conditions associated to affective symptoms include vascular lesions, tumors, infections, seizures and dementia. Within cognitive impairment conditions, depressive symptoms are more frequent in vascular dementia and Alzheimer disease, and behavioral or manic symptoms in frontotemporal dementia although we cannot rule out less common associations.
Objectives: To review about organic mania due to dementia
Methods: We carry out a literature review about organic mania accompanied by a clinical description of one patient with manic symptoms and cognitive impairment.
Results: A 80-year-old male was admitted to the short-term hospitalization unit from the emergency department due to maniform symptoms. He had believed for weeks that he was millionaire and capable to cure all the diseases in the world, reason for which he had given away many of his belongings and had tried to register the patent for his invent. He also had future plans to invest all the money he earned from the patent in the construction of roads in Latin America. He had not previous history of mental illness. Neurological study concluded a diagnosis of Alzheimer disease. It was treated as a manic episode with a mood stabilizer and antipsychotic, with partial resolution of the condition.
Conclusions: It is common to find depressive symptoms in cognitive disorders. Although manic symptoms are much more frequent in frontotemporal dementia or other organic disorders, we can also