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.

Disclosure of Interest: None Declared

EPV0671

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

Y. Ouazzani Housni Touhami[1,2,3]*, E. Layoussifi[1,2,3] and R. Benjelloun[1,2,3]

[1]Faculty of Medicine, Mohammed VI University of Health and Sciences; [2]Psychiatry Department, Cheikh Khalifa International University Hospital and [3]Psychiatry Department, Mohammed VI International University Hospital, Casablanca, Morocco
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1322

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.

Disclosure of Interest: None Declared

EPV0672

Mania and alzheimer disease, review and case report

M. Garcia Moreno[1]*, A. De Cos Milas[2], L. Beatobe Carreño[2], P. Del Sol Calderón[1] and A. Izquierdo de la Puente[1]

[1]Psychiatry, Hospital Universitario Puerta de Hierro Majadahonda and [2]Psychiatry, Hospital Universitario de Móstoles, Madrid, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1323

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

find them in patients with Alzheimer disease. Since there is no specific curative treatment for this disease, concomitant psychopharmacological treatment is recommended if manic symptoms appear.

Disclosure of Interest: None Declared

EPV0673

Differential diagnosis between frontotemporal dementia and bipolar disorder, review and case report

M. García Moreno[1]*, A. De Cos Milas[2], L. Beatobe Carreño[2], P. Del Sol Calderón[1] and A. Izquierdo de la Puente[1]

[1]Psychiatry, Hospital Universitario Puerta de Hierro Majadahonda and [2]Psychiatry, Hospital Universitario de Móstoles, Madrid, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1324

Introduction: Dementia can present with psychiatric symptoms even before the cognitive impairment, which makes difficult to establish an adequate diagnosis. There have described symptoms of this type in vascular dementia, frontotemporal dementia, Alzheimer disease and Lewy bodies dementia. Frontotemporal dementia has a prevalence of 9-20% and it`s the third in frequency among degenerative dementia. It appears before the age of 65 years old and is more common in men. Two variants have been described, linguistic and behavioral. The behavioral one has usually an initial psychiatric presentation, with behavioral disorders, disinhibition and personality changes. Therefore it`s important to make an adequate differential diagnosis with late onset bipolar disorder.
Objectives: To review about frontotemporal dementia and its differential diagnosis with late onset bipolar disorder.
Methods: We carry out a literature review about frontotemporal dementia and its differential diagnosis with late onset bipolar disorder, accompanied by a clinical description of one patient with behavioral disturbance and language disorder.
Results: A 59-year-old female was admitted to the short-term hospitalization unit from the emergency department due to behavior disorder. She had no relevant personal or familiar psychiatric history up to two years before when she received diagnosis of bipolar disorder. She presented behavioral disorganization, psychomotor restlessness, verbal aggressiveness, verbiage, insomnia and decreased intake. Psychopathological examination became difficult due to her language disorder since she presented an incoherent speech with paraphasias and loss of the common thread. Neurological study guided diagnosis to frontotemporal dementia even though they left the psychopharmacological treatment to our discretion. Olanzapine 5 mg twice a day was initiated, and behavioral improvement was observed. However, the patient maintained a significant functional impairment.
Conclusions: Psychiatric presentation is frequent in dementia, even before cognitive failures which makes essential an exhaustive differential diagnosis. It`s important to consider the diagnosis of frontotemporal dementia in those patients who debut with behavioral disturbance in the 50s. Psychopharmacological treatment is only symptomatic so functional recovery should not be expected.

Disclosure of Interest: None Declared

EPV0674

Navigating Neurocognitive Territory: Late-Onset Bipolar Disorder Insights

D. V. Cotovio*, F. Agostinho, M. R. Resende, R. S. Lousada, R. S. Nogueira, F. A. Silva and M. M. Melo

Departamento de Psiquiatria e Saúde Mental, Hospital Beatriz Ângelo, Loures, Portugal
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1325

Introduction: Affective disorders are associated with cognitive deterioration, manifested by an increased risk of developing dementia. Late-onset bipolar disorder (BD) establishes a dynamic interaction between dementia and BD, considering its particular manifestations in old age.
Objectives: Provide a comprehensive overview of the clinical and epidemiological attributes specific to late-onset BD, elucidating its interplay with dementia.
Methods: We conducted a literature search on PubMed in August 2023, using the following terms: late-onset bipolar disorder AND dementia. Only systematic reviews and meta-analysis were included with no year or language restrictions. Three articles were eligible for this review: two systematic reviews and one meta-analysis.
Results: Late-onset BD can be defined as a secondary condition and may result from an expression of lower vulnerability to BD, when compared to early-onset BD. On the other hand, late-onset BD may be conceptualized as a subtype of pseudodementia, or even considered a risk factor for dementia. In fact, this particular association with dementia supports the existence of a specific class of BD, i.e. BD type VI. Such diagnostic overlap might be explained by common factors that have been associated with both BD and dementia, such as cardiovascular risk factors, systemic inflammation, stress and levels of baseline cognitive reserve. Despite the commonalities, other aspects, such as family history and prior history of a mood disorder, may help to make the differential diagnosis between late-onset BD and dementia.
Conclusions: There is a diagnostic challenge between dementia and the neurocognitive decline associated with BD, particularly in the case of a late-onset BD. Although the available evidence is limited, current evidence demonstrates that BD can indeed be seen as a risk factor for dementia. Therefore, cognitive impairment in individuals with BD should not be overlooked.

Disclosure of Interest: None Declared

EPV0675

Factors associated with psychotropics adverse effects in elderly psychiatric inpatients

W. Abid, M. Turki, B. Ben jmeaa, A. Zribi, M. A. Megdiche*, S. Ellouze, N. Halouani and J. Aloulou

Psychiatry B department, Hedi chaker university hospital, sfax, Tunisia
*Corresponding author.
doi: 10.1192/j.eurpsy.2024.1326

Introduction: Adverse effects (AEs) of psychotropic drugs are more frequent and potentially more dangerous in elderly subjects