Objectives: To present a case of Mirtazapine-induced psychosis in a patient with severe malnutrition, and with no history of psychosis and despite on sedating antipsychotic.
Methods: This is a case report.
Results: Ms. NC, a 40-year-old female with major depressive disorder, anorexia nervosa, stimulant use disorder, and sedative, anxiolytic, hypnotic use disorder with no history of psychosis even when intoxicated or during withdrawal, was admitted for involuntary inpatient psychiatric care for detoxification and management of severe malnutrition. Ms. NC has always been conscious with her weight growing up but it was only during the COVID-19 pandemic that excessive preoccupation with weight and symptoms of clinical depression were noted. Ms. NC restricted her diet and engaged in excessive exercise resulting to BMI of 16.1. She started use cocaine and diazepam daily to address the weight and mood, and sleep and anxiety, respectively. Due to a suicidal attempt, consult was done with a psychiatrist, and patient was eventually maintained on Mirtazapine 30mg and Gabapentin 100mg which addressed the mood and sleep. Despite improvement in mood and decrease in use of cocaine and diazepam, patient started to use methamphetamine around once a week. Despite with euthymic mood, preoccupation with weight resurfaced. After a few months, she restricted her food intake to only four times a week with no binge-eating or purging resulting to BMI to 13.8. Upon admission, Mirtazapine 30mg was continued and Gabapentin was increased to 300mg. Special care in her food intake was done to prevent refeeding syndrome. Benzodiazepine withdrawals symptoms were minimal. She has normal values for electrolytes, liver function tests and creatinine. On the first days of admission, she was noted to be irritable and was mostly asleep. On the fifth hospital day, she started to have difficulty sleeping and was placed on Olanzapine up to 10mg and Gabapentin 600mg but no improvement in sleep. On the tenth hospital day, Mirtazapine was increased to 45mg and later in the night, had visual and auditory hallucinations and paranoia. Upon discontinuation of Mirtazapine and initiation with Clozapine up to 75mg, the psychosis resolved after five days.
Conclusions: Mirtazapine-induced psychosis may be seen in patients with severe malnutrition. Despite its advantages in terms of weight gain and sleep, psychiatrists should be wary of this possible side effect when initiating or increasing Mirtazapine for patients with severe malnutrition.

Disclosure of Interest: None Declared

EPV0854

BILATERAL TEMPOROMANDIBULAR JOINT DISLOCATION AND ANTIPSYCHOTIC TREATMENT: A CASE REPORT

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Introduction: Acute dystonia is a type of extrapyramidal effect that is produced by the blockade of dopaminergic D2 receptors typical of antipsychotics. There is a subtype acute dystonia called oromandibular, which produces perioral manifestations. In extreme cases it can even produce temporomandibular joint dislocation, bilateral being more frequent than unilateral. In this abstract it is presented the clinical case of a 22-year-old female who attended to the Emergency Department due to a bilateral temporomandibular joint dislocation that was finally attributed to antipsychotic treatment.
Objectives: The objective of the clinical case is to point out the importance of examination and clinical history for psychiatric diagnosis.
Methods: Review of various scientific articles related to acute dystonia.
Results: It is a report of a 22-year-old female with no medical-surgical or psychiatric history who was imprisoned for legal conflicts. During her stay in prison, she presented reactive depressive and anxiety symptoms, receiving antidepressant and anxiolytic treatment. After two months in prison, she was released and, two days after her release, she attended to the Emergency Department due to rigid akinetic symptoms, drowsiness, mutism and urination difficulties. Complementary tests revealed bilateral temporomandibular joint dislocation, with no other organicity wich could justify the rest of the symptoms, so she was admitted to the Acute Psychiatry Unit for study.
During her admission, the physical examination (akinetic rigid picture, muscle contraction and galactorrhea) raised the possibility that it was extrapyramidal symptomatology secondary to antipsychotic treatment. Given that suspicion, intramuscular biperiden 5 mg/ml was administered, improving the condition in two hours. In a second time, the initial anamnesis was redone; the patient added that during her stay in prison she had presented psychomotor agitation for which she had recieved an intramuscular treatment that she was not able to specify. All this information confirmed the initial suspicion; it was extrapyramidal symptomatology induced by antipsychotic treatment. Thus, treatment with oral biperiden 4 mg/12 hours was continued and the condition completely remitted in five days.
Conclusions: In this abstract it is presented the case of a bilateral temporomandibular joint dislocation induced by antipsychotic treatment. Although it is a rare presentation, other cases like that have been described in the literature, specifically with the use of haloperidol, risperidone, amisulpride and aripiprazole. Given the high frequency of adverse effects of antipsychotics, it is essential that psychiatrists remain trained in their prediction and management.

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A case of phentermine-induced psychosis: the need for caution for drug-drug interactions

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Introduction: Phentermine is a sympathomimetic amine that the U.S Food and Drug Administration has approved for short-term use in the treatment of obesity. However, there have been case reports of phentermine being associated with neuropsychiatric symptoms, and thus caution is needed to avoid drug-drug interactions when prescribing phentermine (Nathan PJ, *et al.* CNS