Keywords "Schizophrenia" ;"Psychosis" ;"Late onset schizophrenia"
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further reading
Colijn MA et al. Psychosis in later life: a review and update. Harv Rev Psychiatry 2015;23(5):354-67.
Reinhard MM. Late-life psychosis: diagnosis and treatment. Curr Psychiatry Rep 2015;17(2):1.

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EV979

Major depressive disorder with psychotic symptoms in elderly. A case report

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Introduction The proportion of elderly people and affective syndromes are more and more common in developed countries. Elderly people have physiological conditions that may limit our intervention.
Objectives To present a case of a major depressive disorder with psychotic symptoms in a 72-year-old woman.
Methods Medline search and review of the clinical history and the related literature.
Results We present the case of a 72-year-old woman with psychiatric history of a major depressive disorder 14 years ago with ad integrum restitution after pharmacological treatment. In 2015, our patient was admitted to the psychiatry ward due to major depressive symptomatology (apathy, anhedonia, global insomnia, weight loss) that associated mood-congruent delusions (nihilistic, ruin, guilt, catastrophic) with deregulated behaviour. The patient was resistant to combined pharmacological treatment with aripiprazole, desvenlafaxine, mirtazapine and lorazepam, therefore, we decided to administer ECT, with successful results after 5 sessions. Brain tomography, blood and urine tests were normal. Clinical signs of dementia were not present.
Conclusions Inpatients with deregulated behaviour; it is important to rule out organic causes, especially in elderly, in whom dementia, brain tumors or metabolic disturbances may simulate psychiatric syndromes.
Keywords "Major depressive disorder" ;"Psychosis" ;"Late onset psychosis"
Disclosure of interest The authors have not supplied their declaration of competing interest.
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Obsessive versus delusional jealousy: Destruction in a form of creation – A review

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Introduction Jealousy is a complex emotional state and some degree is considered normal in mature love, but when does it become destructive in a relationship? There's a thin line between what is normal and what is pathologic. Pathological jealousy differs from normal by its intensity and irrationality. Obsessive and delusional jealousies are different types of pathological jealousy, difficult to distinguish, which is important, since they have different treatment. Despite the differences, both result in significant distress and carry the risk of homicide/suicide, so it's a matter deserving the psychiatrists' attention.
Objective Explore the psychopathological differences between obsessive and delusional jealousy and list the characteristics and difficulties in the approach to pathological jealousy.
Methods The results were obtained searching literature included on the PubMed and Google Scholar platforms.
Results Delusional jealousy is characterized by strong and false beliefs that the partner is unfaithful. Individuals with obsessive jealousy suffer from unpleasant and irrational jealous ruminations that the partner could be unfaithful, accompanied by compulsive checking of partners' behavior. This jealousy resembles obsessive-compulsive phenomenology and should be treated with SSRIs and cognitive-behavioral therapy. Delusional jealousy is a psychotic disorder and should be treated with antipsychotics.
Conclusion The common issue in pathological jealousy is the problem of adherence to treatment and bad prognosis. In order to achieve better treatment outcomes, we should follow-up the patient regularly. One key factor is to explore the psychopathology and motivate the sufferer for the proper pharmacological and psychotherapeutic interventions, trying to reduce the suffering caused by ideas of unfaithfulness.
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Differential diagnosis between schizophrenia and in major depression: The importance of abnormal bodily phenomena

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Introduction Anomalies of bodily experience have for long been described as relevant features of schizophrenia and major depression, yet such experiences are usually neglected in clinical examination. Bodily experience is the implicit background of our experiences against which we develop a coherent sense of self as a unified, bounded entity, naturally immersed in a social world of meaningful others. Such tacit experiential background is often perturbed in schizophrenia and major depression. Empirical research shows that patients with schizophrenia and major depression frequently present many different kinds of anomalies of bodily experience in the course of their illness.
Objective To characterize the abnormal bodily phenomena in both schizophrenia and major depression.
Aim To improve differential diagnosis based on the identification of typical features of abnormal bodily experiences in persons affected by schizophrenia and major depression and to provide supplementary diagnostic criteria.
Method Analysis of empirical and theoretical research published in the last 25 years.