EPV0101

Mania induced after corticosteroid treatment: a case report

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Introduction: Corticosteroids are drugs widely used in clinical practice for their anti-inflammatory and immunosuppressive properties. Despite their beneficial effects, a high association of these drugs with neuropsychiatric adverse effects such as psychosis, mania, depression, delirium or increased risk of suicide, among others, has been observed. We present the case of 54-year-old man who started treatment with hydroaltesone 20 mg/8h after undergoing surgery for a pituitary macroadenoma who began with maniform clinic.
Objectives: To know the prevalence, risk factors and treatment of mania as a side effect of corticosteroid drugs.
Methods: Presentation of the case and review of the available literature on the risk of developing mania after corticosteroid treatment.
Results: Several studies confirm that the incidence of psychiatric adverse effects after the use of corticosteroids is around 6% if we refer to severe reactions; 28% moderate reactions; and 72% if we consider milder reactions. The direct relationship between these drugs and affective symptoms ranges in rates between 1-50% of cases, the most frequent being depression and mania. The risk of mania after treatment with corticosteroids is 4-5 times higher than if we compare it with a group of population not exposed to these drugs. There is a dose-response relationship, increasing the risk from a daily dose of 40 mg/day, with an average duration of symptoms of around 21 days. Female sex seems to be a risk factor in relation to the fact that diseases requiring this type of treatment are more common in this gender. As first-line treatment for mania secondary to corticosteroids, a decrease in treatment dose or its interruption, whenever possible, is proposed. Adjuvant treatment may be required, with atypical antipsychotics being the first choice.
Conclusions: Corticosteroid therapy has a direct dose-response relationship with the presence of psychiatric adverse effects such as mania. Dose and sex have been studied as possible adverse effects. Therefore, the pharmacological treatment of choice consists of a reduction in the dose of corticosteroids administered or withdrawal, if possible, and may be combined with an atypical antipsychotic such as olanzapine, quetiapine or risperidone. Re-evaluation is recommended until complete resolution of the clinical picture and then antipsychotic treatment can be progressively withdrawn.

Disclosure of Interest: None Declared

EPV0102

Hetero agressive behavior in bipolar disorder : about 30 cases

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Introduction: The social representations linked to bipolar disorder remain until today marked by unpredictability, danger and aggressiveness.
Objectives: The objectives of this study were to identify clinical and socio-demographic characteristics of a group of patients with bipolar disorder who had committed a heteroaggressive act and to establish the relationship between these characteristics and the risk of recurrence of violence
Methods: We conducted a descriptive and analytical study, including the files of 30 patients with bipolar disorder and hospitalized for heteroaggressive behavior.
We collected the data related to the socio-demographic, anamnestic and clinical characteristics of the patients.
Results: The average age of patients was 40.87 years, with extremes ranging from 25 to 62 years. The patients were mostly male (60%), living in urban areas (80%) and single (60%). 66,67% of patients in our sample were professionally active.
Half of the patients in our study were consumers of alcohol or cannabis. The majority of patients were on sodium valproate (66.7%), a long-acting neuroleptic (60%) and a benzodiazepine (56.7%).
Heteroaggressive behavior was in most cases physical (63.3%), having taken place in the patient's home (66.67%) and directed towards a family member in an impulsive context (53.33%). 63.3% of patients reoffended their act of violence.
We found statistically significant correlations between the recurrence of heteroaggressive behavior and advanced patient age (p=0.01), male sex (p=0.05), illiteracy (p=0 .04) and unemployment (p=0.04).
Our study also showed that the recidivism of violence was significantly correlated with the criminal history of the patients (p=0.04) as well as the consumption of alcohol and cannabis (p=0.01). The number of recurrences was proportionally correlated to the duration of consumption.
Recurrence of violence was also significantly higher in patients with psychiatric comorbidity (p=0.01) and poor treatment compliance (p=0.04).
Finally, the number of recurrences of heteroaggressivity was proportionally correlated to the number of hospitalizations ($p=<10^{-3}$).
Conclusions: Heteroagressive behavior in patients with bipolar disorder is not only attributable to mental illness but also to the intertwining of several risk factors. The prevention of violence requires the identification and management of these risk factors.

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