500 mg/day were initiated. He was also diagnosed with a M. kansasii lung infection, with radiological findings of past tuberculosis disease. Before the microbiological confirmation, it was necessary to start rifampicin, requiring an increase in doses of both psychotropic drugs. Review: (1)Comorbidity of mycobacterial infections and schizophrenia. Several studies have shown that people with severe mental illness have higher rates of tuberculosis compared with the general population. Although the relationship between tuberculosis and M. Kansasii infection is known, few literature is available with regard to the association of M. Kansasii and schizophrenia. (2) Interactions between antipsychotics and mood stabilizers with rifampicin. Rifampicin is mainly metabolized by CYP3A4 and transported by P-glycoprotein. Add-on with rifampicin have been reported to reduce clozapine and olanzapine plasma levels (despite both are metabolized by CYP1A2), reduce haloperidol and risperidone levels (possible role of P-glycoprotein in this interaction), as well as for valproate.
Conclusions: Treatment of comorbid infections in people with schizophrenia remains a challenge. Antibiotics used to treat mycobacterial infections can modify the pharmacokinetic of psychotropic drugs.

Disclosure: No significant relationships.
Keywords: schizophrénia; Mycobacterium; infection; therapeutic drug monitoring

EPV0127

Dissociative disorder following preeclampsia: A case report

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Introduction: Preeclampsia is a new-onset hypertension with new-onset proteinuria after 20 weeks gestation. Scarce evidence regarding psychiatric effects of preeclampsia is available.
Objectives: To describe a case of a pregnant 24 year-old patient with a premature cesarean section in context of severe preeclampsia and dissociative symptoms.
Methods: Patient referred to a third-level hospital for cesarean section due to a severe preeclampsia at week 32, in whom magnesium sulfate, labetalol perfusion and betamethasone are started. In the puerperium period only labetalol up to 300 mg/6h is maintained.
Results: Due to the appearance of pulsating headache and photophobia, a computerized tomography is conducted, showing bilateral insular and occipital hypodensity related to vasogenic edema. High blood pressure is maintained (177/121 mmHg) despite antihypertensive treatment. A magnetic resonance imaging and an ophthalmologic exam do not show significant abnormalities and blood pressure is stabilized with treatment. However, the patient refers new-onset auditory imperative hallucinations and suicide thoughts, being referred to our Acute Psychiatric Ward for clinical assessment and intervention. Treatment with risperidone 2 mg is started. The day after her admission, she does not refer psychotic symptoms, explaining depersonalization symptoms in the previous 5 days, seeing herself having to choose a knife to commit suicide. After discharge, she maintains reiterative dreams in which she falls down from a building, not presenting dissociative symptoms during the day.
Conclusions: Further evidence regarding psychiatric effects of preeclampsia is needed in order to study the consequences of edema and pharmacological treatment. Blood pressure and psychiatric symptoms monitoring after preeclampsia should also be considered.

Disclosure: No significant relationships.
Keywords: preeclampsia; Perinatal Mental Health; dissociative disorder; hypertension

EPV0129

Toothache

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Introduction: Mental retardation (RM) is defined as by a deficient intellectual capacity as well as by alterations of the adaptive capacity that are externalized in two or more functional areas (Personal autonomy, Communication, Orientation in the environment, Work and Free time).
Objectives: Present a patient with a severe behavioural disturbance with an associated intellectual deficit, who remained hospitalized for 2 months and after observing an oral alteration her symptoms improved.
Methods: A descriptive study of a clinical case
Results: 54-year-old woman, single. You have a moderate intellectual disability. In January 2019, she began mental health consultations with a diagnosis of adjustment disorder, on treatment with aripiprazole 5 mg/day, mirtazapine 15 mg/day, lorazepam 0.5 mg/day and dipotassium clorazepate 10 mg/day. Went to the emergency room with mutism, hyporesponsiveness and refuse to intake, having lost 25 kg in 6 months. Abdominal and thoracic CT and upper gastrointestinal endoscopy without significant findings. Consultation with otorhinolaryngology, dermatology, traumatology without significant findings. Odontostomatology consultation: Deep cavities are observed, so it is necessary to carry out extractions of the pieces in poor condition. After this intervention, the patient returns to accept oral intake.
Conclusions: People with intellectual disabilities have a wide range of medical problems that in many cases are directly associated with the underlying disease or syndrome and, in others, with poor physical health due to problems in basic self-care skills or the ability to express verbally. Usually, the first manifestation of pain is an alteration in behaviour, which must be taken into account when making a differential diagnosis.

Disclosure: No significant relationships.
Keywords: mental disability; mental retardation

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EPV0130

Lithium toxicity. A case report

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Introduction: Lithium is widely used in the treatment of the bipolar disorder. Once introduced, it is necessary to carry out an adequate control of the therapeutic range, since it is potentially toxic, and can affect various organs.
Objectives: To present the case of a patient suffering from lithium poisoning and to review the symptoms of lithium poisoning.
Methods: A descriptive study of a clinical case and review of the literature
Results: 49-year-old woman, married. Diagnosed with bipolar disorder. She went to the emergency room due to a low level of consciousness, kidney failure, trembling of the limbs, hyperthermia and leukocytosis. In the last two weeks, the patient has reduced her intake of food, not water, finding herself more and more shaky and less reactive. Lithium in blood at admission 1.71, so conventional dialysis was performed with a progressive decrease into 0.65. On examination, he is practically mutist, bradypsychia with a significant response latency. Clinical judgment: Accidental lithium poisoning.
Conclusions: The primary site of toxicity is the central nervous system and clinical manifestations vary from asymptomatic supratherapeutic drug concentrations to clinical toxicity such as confusion, ataxia, or seizures. Severe lithium neurotoxicity occurs almost exclusively in the context of chronic therapeutic administration of lithium and rarely results from acute ingestion of lithium, even in patients currently taking lithium. As such it is an iatrogenic illness, occurring in patients who have identifiable clinical risk factors: nephrogenic diabetes insipidus, older age, abnormal thyroid function and impaired renal function.

Disclosure: No significant relationships.
Keywords: lithium toxicity; bipolar disorder; lithium

EPV0131

Psychiatric comorbidity in a patient with opsoclonus-myoclonus syndrome. differences in the transition from childhood to adulthood: A case report

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Introduction: Opsoclonus-Myoclonus syndrome (OMS), also known as Kinsbourne syndrome, is a paraneoplasic pediatric condition characterized by erratic eye movements and generalized myoclonus. Previous studies have described a wide range of psychiatric comorbidities in children with this syndrome. Cognitive impairment (especially intellectual capacity and language), affective symptoms (irritability, poor mood regulation) and behavioral problems are the most frequent presentations (1). However, there is a lack of literature describing the progression of this symptoms when the patient reaches the adulthood.
Objectives: To illustrate the psychiatric comorbidity of an adult patient with Opsoclonus-Myoclonus syndrome.
Methods: We present one case-report and literature research of the topic.
Results: We present a 18 year old girl diagnosed with OMS and Graves-Basedow hyperthyroidism. During her childhood she started presenting attention and comprehension difficulties. She was diagnosed with an Attention Deficit Hyperactivity Disorder (ADHD) and started treatment with methylphenidate. She completed elementary and secondary education. During the adulthood, the main psychiatric comorbidity was related to affective symptoms. We observed an impaired mood regulation, hypothymia, anhedonia, and frequent episodes of irritability, which persisted after the thyroid regulation. This caused incremented anxious symptoms and insomnia that were treated with mirtazapine and lormetazepam. After some weeks, she fulfilled criteria of a depressive episode and we started antidepressant treatment with vortioxetine.
Conclusions: - Adult patients diagnosed with OMS during childhood can persist presenting ADHD as a comorbidity. - Affective symptoms, and even a major depressive episode, should be considered during the follow-up of this population. Insight of the cognitive limitations could be a risk factor for a depression.

Disclosure: No significant relationships.
Keywords: neurology; Affective disorders; ADHD

EPV0132

How to deal with refractory risk factors that depend on behavior?

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Introduction: Health-related behavior correlates in critical ways with the current epidemic of chronic diseases. Modifiable behaviors increase the risk of chronic disease. Despite there are well-identified behaviors, efforts at behavior change are clinically-challenging and frequently ineffective.
Objectives: We aim to establish how the current evidence and latest neuroscientific knowledge about behavioral change allow the most reliable assessment of patients with refractory health-related behaviors that negatively impact health outcomes.
Methods: We performed a literature review using Pubmed databases and UpToDate. The search included "behavioral change" and "health-related behavioral change"[MeSH Terms].
Results: Habitual behavior consists of behavioral patterns operating below conscious awareness and acquired through context-dependent repetition. Behavioral change is a complex multi-level

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