Portugal and It's Drugs Policy - What Changed?

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Aims. The authors intend to briefly review the literature regarding the progress of substance misuse rates and harms, the support available and reflect on the current national situation. We aim to better understand the changes in policies and services, and their impact to see what can be learned from the Portuguese experience.
Methods. A narrative literature review was carried out by the authors using the keywords "addiction" "drugs policy" "Portugal" "drug use". The authors declare no conflicts of interest.
Results. The end of the dictatorship in 1974, the reopening of borders, and the return of white Portuguese from former colonies, were all associated with a dramatic increase in substance misuse in Portugal. In the 1990's it is estimated that 0.5%-1% of the population was using heroin at the time, with extremely high rates of HIV and Hepatitis in intravenous drug users.

At the start of this period, healthcare services were poorly organized, resources for substance misuse services were limited, legislation was punitive, and there was a general understanding that drug addiction was a consequence of a moral failing. A change in paradigm occurred in the late 1990's and new legislation introduced in 2001, which along with the growth in services to support substance misusers dramatically reduced the rates and negative outcomes of substance misuse.

Of note, new HIV diagnoses due to injecting and overdose rates dropped significantly in the XXI century and decriminalization did not lead to an overall increase in substance misuse.
Conclusion. The pivotal shift in the understanding of the nature of addiction as an illness lead to a profound change in interventions to mitigate this overwhelming problem that affected Portugal by the end of the XX century. We hope that by sharing this experience this will improve interventions around the world to support substance misusers and public health.

Amblyopia: An Uncommon Presentation of Paediatric Conversion Disorder

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Aims. Conversion disorder is common among children and adolescents, particularly in non-Western societies like in Bangladesh. Diverse presentation of the disorder makes it difficult to diagnose which ultimately may lead to poor prognosis.
Methods. Patient X is a 10-year-old girl, a 5th grade student, hailing from a District town, Bangladesh, attending child and adolescent consultation services with the complaint of sudden loss of vision in both eyes for 3 weeks. Earlier, she underwent thorough examination and investigation and intervention by the different specialists (GP, ophthalmologist, and neurologist). At one point she was given zero power glasses. Her symptom was then fluctuating. She was not attending school as she was away for treatment purposes. X complained of not seeing lines of books when her parents tried to persuade her to do schoolwork at home. Eventually she was referred for psychiatric evaluation after no improvement. Assessment was completed and parental discord, violent act of father towards mother, overprotective as well as inconsistent parenting, attention seeking behaviour of X were identified. General and systemic examinations were normal. Her finding was inconsistent with any physical disorder. Investigation was normal. Thus, diagnosis of conversion disorder was given. General treatment (reassurance, psychoeducation, adopting daily life programme) along with specific treatment (symptom reduction by suggestion, relaxation, and family therapy) were provided. Improvement was noted during the follow-ups.
Results. The conversion disorder of this girl happened at her period of transition from childhood to adolescence. Psychopathology of hysteria still is not clear despite huge research efforts. Based on psychodynamic explanations, the core psychopathologies of her symptoms are primary gain - resolution of her witnessing severe parental discord that she failed to cope with happened through her presenting symptoms without awareness though later she does in awareness; secondary gain- she receives additional reinforcement in the form of extra care, parental help seeking behaviour, unnecessary interventions, demand fulfilment that mostly present in awareness. Other psychopathologies are conversion- the patient's psychological distress converted to presenting somatic symptoms through an intrapsychic process; repression-la belle indifference of the patient has developed through a process of displacing distressful experience, from awareness that gives relief to the distress.
Conclusion. Manifestations of conversion disorder can simply be explained as cry for help, give indication of the problem areas, help in understanding personality traits, making intervention and prevention plans. Early identification of stressors is crucial for the treatment of this disorder.

Mania With Psychotic Symptoms a Rare Clinical Presentation of Fahr's Disease- a Case Report

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Aims. Fahr's disease is a rare neurodegenerative disease with radiological findings of symmetrical and bilateral idiopathic calcifications of the cerebellum, periventricular white matter, and basal ganglia, characterized by the presence of neuropsychiatric symptoms.
Methods. We report a case of a 46-year-old male who presented with psychomotor agitation, aggression, restlessness, irritability, decrease need for sleep and psychotic symptoms including grandeur and mystical delusions. He had a previous history of an admission 4 years prior with a similar presentation. Computed tomographic scan of the patient demonstrated a bilateral calcification of globus pallidus. Laboratory investigation was unremarkable. Due to agitation, the patient started treatment with Haloperidol 10 mg and Levomepromazine 25 mg presenting resulting in important extra-pyramidal symptoms (EPS), namely marked motor rigidity. Subsequently, a switch was made to Olanzapine 5 mg with persistence of clinically significant EPS. A final switch was made to Aripiprazol 15 mg (gradually titrated)

and a mood stabilizer was started (Sodium Valproate), with full clinical remission within a month and no signs of EPS.
Results. The age of onset of manic symptoms in this patient is not suggestive of bipolar disorder (average age onset 25). On the other hand, Fahr's disease usually presents within the 4th and 5th decade of life. The clinical presentation usually involves motor symptoms (movement disorder and Parkinson like symptoms) and dementia, but purely psychiatric presentations have been described. The localization of calcifications also seems to have a clinical correlation, as Pallidal calcifications as the ones identified in our patient have been associated with manic symptoms. Idiopathic forms in which no metabolic or other underlying causes are identified, treatment is usually symptomatic, but one has to be cautious because these patients have an increased sensitivity to neuroleptics and can thus easily develop EPS.
Conclusion. Psychiatrists should consider Fahr's disease as a differential diagnosis in a manic episode, especially with a late age of onset, which is not suggestive of a bipolar disorder. This case also further emphasizes the importance of neuro-imaging in psychiatry and underlines the importance of a careful treatment approach in this type of patients because of an higher risk of developing EPS.

Who Let the Dogs Out? a Case of Delirium Induced by Lyme Borreliosis in a Patient With a Severe Intellectual Development Disorder

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Aims. Lyme borreliosis is caused by certain genospecies of the Borrelia burgdorferi sensu lato complex, which are transmitted by hard ticks of the genus Ixode. The most common clinical manifestation is erythema migrans, an expanding skin redness that usually develops at the site of a tick bite and eventually resolves regardless of antibiotic treatment. It may result in a range of clinical manifestations involving different organ systems, and can lead to persistent sequelae in a subset of cases.
Methods. We describe a case of a 47-year-old male, with severe intellectual development disorder (IDD), who presented with behavioural changes, aggressiveness, psychomotor agitation and confusion. 15 days prior to admission in the psychiatry ward he had recurred several times to the emergency department with similar clinical presentation, and had been discharged following adjustments to his medication. After showing no improvement and no response to treatment he was admitted. He then presented fever and laboratory study (LS) revealed increased inflammatory markers. His family also informed he came from a rural area and had contact with wild dogs. No tick bite or erythema was identified during physical examination. Nevertheless a serologic study for Borrelia burgdorferi was performed and turned out positive. An antibiotic regimen was administered and and the patient's symptoms fully remitted 48 hours after treatment was initiated.
Results. Borreliosis usually presents erythema at the site of the tick bite which could have already resolved when the patient was examined. It was first assumed that the clinical manifestations were part of his psychiatric condition. An infectious etiology was presumed after the onset of fever and increased inflammatory markers were identified. Given the patient's context, Borrelia in particular was considered a likely hypothesis. This case illustrates the difficulties of differential diagnosis inherent to patients with IDD, both because of the pathology itself, which can mask such clinical manifestations as delirium, and of the stigma associated with mental health patients, which frequently cuts the diagnostic work-up of organic causes short.
Conclusion. This case highlights the clinical challenge patients with IDD represent. Differential diagnosis can be elusive, especially in the context of infectious diseases like borrelia, as they can present with unspecific clinical manifestations in this subgroup of patients, and hence why a complete and thorough clinical evaluation is essential. This case also illustrates that mental health patients suffer from stigma: Being branded a "psychiatric patient" created a 16-day delay between onset of symptoms and appropriate treatment initiation- antibiotics.

Chronic, Unipolar, Treatment-Resistant Mania: A Case Report and Literature Review

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Aims. Chronic mania is variably defined but classically recognized as the presence of manic symptoms for more than 2 years without remission. The reported incidence ranges between 6–15% among all patients with bipolar disorders. Although it has been described in psychiatry literature for a long time, it has not yet found a place in current nosological systems
Methods. We present a 32-year-old single and unemployed man who is supported by his family and living with a sudden-onset, continuous illness of 12 years' duration characterized by a resistant and markedly euphoric and expansive mood with grandiose delusions. Other features such as distractibility, pressured speech, racing thoughts and psychomotor disturbance remain significant but vary and are more responsive to medical interventions. Psychotic symptoms are largely confined to mood-congruent delusions, grandiose and religious, and are reported to have followed the mood disturbance from early on. There is no history of substance use, past psychiatric or medical illness, or head trauma and no evidence of a neurological cause on workup. This gentleman has been treated with a range of mood stabilizers and antipsychotics and two courses of ECT over the years. In the recent years, he has been on a combination of Clozapine, Valproate, and Pregabalin with relatively favorable but inadequate response and limited functional improvement.
Results. Chronic mania lasting for 12 years, in the absence of an organic cause, despite the use of a wide gamut of modern psychotropics, alone and in combination with ECT, and with adequate compliance is an exceptionally rare entity. It poses manifold challenges both in terms of diagnostic considerations and therapeutic approaches. The overlap of symptoms of mania, schizophrenia, and schizoaffective disorders along with chronicity adds a particular layer of complexity. The hallmark of chronic mania is euphoric and expansive mood along with grandiose delusions and the presentation is relatively less centered on sleep disturbance, hypersexuality, and psychomotor agitation as compared to an acute manic episode. It is distinguished from schizophrenia spectrum disorders as it lacks flat or inappropriate affect, incongruent delusions and disorganized thought. Course of illness, prior mood