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**Introduction** Differentiating between bipolar (BD) and schizoaffective disorder (SAD) can be challenging, especially during early stages of the illness.

**Objectives** Comparing clinical profiles and socio-demographic characteristics of patients diagnosed with BD and SAD.

**Methods** The study, conducted between 2014–2016, included 67 inpatients from the Timisoara Psychiatric Clinic, diagnosed with either BD ( $n=35$ ) or SAD ( $n=32$ ), according to ICD-10 criteria. The following parameters were analyzed: number of episodes, number of times hospitalized, onset age, frequency and nature of psychotic symptoms, family history of psychiatric disorders and socio-demographic characteristics (age, sex, marital status). Data were obtained by direct interview and patient files. Symptom severity was measured with Brief Psychiatric Rating Scale (BPRS).

**Results** There were no significant differences between the two samples regarding age or sex distribution. Schizoaffective patients were more frequent unmarried ( $P=0.007$ ). Onset age was significantly lower in SAD patients (22.41 years for SAD, 28.36 years for BD). SAD patients had the highest number of episodes and needed more frequent hospitalization. Bipolar patients had higher percentage of family history of affective disorders when compared to schizoaffective patients (41% versus 36%). Hallucinations were more frequently found in schizoaffective patients than in bipolar patients ( $P=0.004$ ). We found no significant differences between the two samples regarding the presence or the type of delusions. The SAD sample had significantly higher BPRS total scores than bipolar patients ( $P=0.035$ ).

**Conclusions** Although this study revealed numerous similarities between BD and SAD, it also identified differences that may be helpful in establishing the correct diagnosis.

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#### EV0071

### Temporality in mania: Phenomenological, neurobiological and therapeutic consequences

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Manic disturbances of temporality are underemphasized in present-day accounts. For example, they are not included among criteria for manic episodes in DSM or ICD. Nonetheless, as already claimed by Binswanger (1964), aberrant temporality is core to the disorder. Persons with mania live almost exclusively in the present and hardly into the future. Especially in the larger scheme of things, their future is already here. There is no “advancing, developing or maturing,” anticipations have been achieved, and all that I strive for is present – if you will just get out of my way! A half century ago, Binswanger spelled out this temporal foundation for mania and summed up consequences. The manic self, not living into the future, “is not, to borrow a word, an existential self.”

This presentation will describe phenomenological characteristics of such a manic self and then present correlating findings from contemporary neuroscience. Importantly, such findings clarify present

and future therapeutic interventions. Of critical importance is manic chronobiology: clocks in our brains afford receptor sites for the lithium ion. At these sites, lithium potently inhibits the circadian rhythm regulator glycogen synthase kinase 3 and alters the biological cascade that follows. By taking a close look, we can comprehend implications for mania as well as for treatment with lithium: Neurobiologically, lithium disrupts manic rhythm dysregulation and restores a more “normalized” temporality. The consequence is no less than the return of the existential self.

A receptor mechanism of action for lithium additionally portends future specific and safer treatment options “after lithium.”

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#### EV0072

### Putting it all together: How disordered temporality is core to the phenomenology and neurobiology of mania

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Disturbances of temporality in mania, underemphasized in present-day accounts, are nonetheless core to understanding both the phenomenology and the neurobiology of the disorder:

– phenomenology: already in 1954, Binswanger had articulated that persons with mania live almost exclusively in the present and hardly at all into the future. Especially in the larger scheme of things, their future is already here. There is no “advancing, developing or maturing,” anticipations have already been achieved, and all that I strive for is basically present if you will just get out of my way! A half century ago, Binswanger summed up the consequence of manic temporality: the manic self, not living into the future, “is not... an existential self.” This presentation will further describe phenomenological characteristics of such a self in mania;

– findings from contemporary neuroscience correlate remarkably well with the above phenomenology, importantly clarifying present and future therapeutic interventions. Of critical importance in mania, clocks in our brains afford receptor sites for the lithium ion. Once bound to the receptor, lithium potently inhibits the circadian rhythm regulator glycogen synthase kinase 3 (GSK3) and profoundly alters the biological cascade that it initiates. In this presentation, by taking a close look, step-by-step, we will clarify how lithium disrupts mania rhythm dysregulation and restores a more “normalized” temporality. The consequence is no less than the return of the existential self. We will also briefly glance, in this presentation, at the window that lithium cellular efficacy offers for treatment options “after lithium.”

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#### EV0073

### Antidepressants induced mania in patients with diagnosed unipolar depression: Case report and literature discussion

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The association of antidepressant therapy with mania in people being treated for unipolar depression reinforces the importance of further clarification of this effect, since it has a huge implication in treatment approach and outcome. With this main objective, authors propose to make retrospective sociodemographic and clinical characterization of a group of patients with antidepressant induced mania in diagnosed unipolar depression, admitted in inpatient unit of Psychiatry and Mental Health Department of Centro Hospitalar de Trás-os-Montes e Alto Douro. Authors also aim to identify features that may increase the risk for mania or hypomania in people who present with an episode of depression, which can guide clinical orientation and improve outcome.

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EV0074

### Clinical differences between unipolar and bipolar depression

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**Introduction** Epidemiological studies indicate that the majority of patients with bipolar disorder are diagnosed many years later. Unipolar depression represents the most frequent misdiagnosis.

**Objectives** This study aimed to examine the symptom profiles of depressed patients in order to identify clinical specificities of bipolar depression.

**Methods** A total of 31 depressed patients were recruited from psychiatry outpatient department of Hedi Chaker university hospital in Sfax (Tunisia), during October and November 2016. Unipolar and bipolar patients were compared on a broad range of parameters, including sociodemographic and clinical characteristics. Depressive symptoms were rated using the Montgomery Asberg Depression Rating Scale (MADRS) and Bipolar Depression Rating Scale (BDRS).

**Results** The total sample comprised 31 patients with 16 men and 15 women. It involved 20 with unipolar depression and 11 with bipolar depression. Patients with bipolar depression had more family history of bipolar disorder ( $P=0.037$ ) and a triggering factor had been identified less often ( $P=0.03$ ). MADRS scores were similar in bipolar and unipolar patient (median score 28.22 versus 28.36;  $P=0.964$ ). BDRS scores were significantly higher in bipolar depressed patients (median score 33 versus 25;  $P=0.01$ ). The mixed subscale (item 16 to 20) scores were particularly higher (median 6 vs. 1.2;  $P\leq 0.01$ ) especially concerning irritability ( $P=0.001$ ). Increased motor drive ( $P=0.004$ ) and agitation ( $P=0.008$ ).

**Conclusion** Our findings suggest that the presence of mixed symptoms is very important to recognize depressed patients as having a bipolar disorder. We also recommend routine use of the BDRS for patients presenting for treatment of depression.

**Disclosure of interest** The authors have not supplied their declaration of competing interest.

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EV0075

### A case report of patient who had two manic episodes with psychotic features induced by nasal decongestant

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**Objective** Phenylephrine, pseudoephedrine and ephedrine are the sympathomimetic drugs that have been used most commonly in oral preparations for the relief of nasal congestion. These drugs stimulate the central nervous system that is affected by the alpha and beta adrenergic agonism. Sympathomimetic agents used in the treatment of flu and common cold with ephedrine and pseudoephedrine are case reports. That the manic and psychotic episodes are triggered. In this article, we would like to present a bipolar manic disorder with two manic episodes and both of them triggered by influenza drugs.

**Case** A 25-year-old man patient was admitted to psychiatric outpatient clinic with increasing complaints such as increasing energy, speaking much, decreasing sleep, increasing the libido after using the flu drug that prescribed to him containing phenylephrine. Also, 2 years ago, he has manic attack triggered after the flu drug.

**Discussion** In recent years the study of epilepsy and bipolar disorder in common suggests that bipolar disorder may affect the kindling phenomenon. In our case, two of reasons in the neurobiology of developing manic attacks the kindling phenomenon is likely to be effective. First, the possibility of using cold medicine containing ephedrine or pseudoephedrine in the first manic episode, in the second manic episode having spent the attack with FAQ stimulant effect of lower phenylephrine. Second, in the first episode after using the 5–6 tablets developing manic attacks. In the second attack to be triggered with just 2 doses may indicate the effect of kindling.

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## e-Poster viewing: child and adolescent psychiatry

EV0076

### Posttraumatic stress disorder symptoms and related factors after circumcision operation performed with general or local anesthesia

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**Objective** Elective circumcision operation for male children can affect their psychological status.

**Aim** We aimed to investigate the traumatic effect of the circumcision procedure and the predictive factors that could contribute to this effect.

**Method** One hundred and thirty-four children who admitted to urology and child surgery clinics to perform a circumcision procedure were included in the study. The whole group was divided into two groups including general anesthesia (GA) ( $n=71$ ) and local anesthesia (LA) ( $n=63$ ) groups. The procedure was performed under general and local anesthesia in the relevant groups. All of the participants filled the Child Depression Inventory (CDI), State (SA), and Trait (TA) Anxiety and Childhood Anxiety Sensitivity index (CASI) before the operation, and the Child Posttraumatic Stress Reaction index (CPSRI) 1 month after the operation.

**Results** CDI, CASI and TA scores of the children were similar in both groups, however, SA scores of the LA group were higher than GA group ( $P<0.001$ ), and CPSRI scores of the GA group were