

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 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