intractable nausea and vomiting, colic abdominal pain and restlessness related to chronic cannabis use. Antiemetics commonly fail to alleviate the severe nausea and vomiting. A very particular finding is the symptomatic relief with hot water. Antipsychotics (such as haloperidol), benzodiazepines and/or capsaicin cream appear to be the most efficacious in the treatment of this unique disorder. Precisely, it has been studied that transient relief of symptoms with topic capsaicin or hot water share the same pathophysiology. Nevertheless, abstinence from cannabis remains the most effective way of mitigating morbidity associated with CHS.

Objectives: The objective is to study this phenomenom in our hospital and to alert of its existence in order to avoid a suspected misdiagnosis and overdiagnosis.

Methods: We report a case series of seven patients who attended the Emergency Room (ER) of a third level hospital located in Cantabria (Spain) where a psychiatric evaluation was demanded.

Results: The reasons for consultation were agitation and/or compulsive vomit provocation and showers. They were all women, with a median age of 29 years (range 21 to 38), who all smoked cannabis and in probable high doses (seven to up to twenty joints per day, information was missing in three of the patients) and probable long duration of consumption (more than nine years up to twenty-three, information was missing in three of the patients).

One of the most striking findings is the time to diagnosis, being the median of years of more than eight (range from two to twenty-one). In all of the cases there is a hyperfrequentation to the ER for this reason (not counting other emergency centres we have in Cantabria which we don´t have access to), being the average of almost twenty-two times (thirteen up to thirty times), not diagnosing it until last visits. Another interesting fact is that Psychiatric evaluation is done approximately in a third of the visits, being the department that makes all of the diagnosis except in one case. In all of the cases there are a lot of diagnostic orientation doubts from different medical departments, being the two most common psychiatric misdiagnosis: *Other Specified Anxiety Disorder* and *Other Specified Feeding or Eating Disorder*. Two of the patients were hospitalized in an acute psychiatric unit for this reason, one of them nine times and the other patient, twice.

Conclusions: CHS has a very particular presentation which makes its recognition very simple. From our experience, it is an unknown entity for most of the doctors, something that needs to change in order to make a correct therapeutic management. Larger studies need to be done to make this findings more solid and for further information.

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Risks Associated with Prescribing Zolpidem: A Case Report and Literature Review

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Introduction: Zolpidem is a nonbenzodiazepine, which acts as a sedative- hypnotic that binds to GABA (A) receptors at the same location as benzodiazepines and increases GABA effects in the central nervous system (Kovacic *et al.* Oxidative medicine and cellular longevity 2009, 2(1), 52–57). Literature shows that behavioral changes including amnesia, hallucinations, and other neurocognitive effects are some of the known side effects (Edinoff *et al.* Health psychology research 2021, 9(1), 24927). We present a case about Ms. A, a female in her sixties with a history of major depressive disorder with psychotic symptoms who was brought into the hospital by the EMS under police custody after stabbing her granddaughter with a knife. During the evaluation she was dissociating with impaired memory of the circumstances of her presentation. Collateral information about Ms. A revealed that she had no history of being violent, or any history of psychoactive substance use. Ms. A's home psychiatric medications consisted of Sertraline 100mg, Bupropion 150 mg, Zolpidem 5mg.

Objectives: To better understand the potential risks with prescribing zolpidem in patient with insomnia.

Methods: In depth literature review about zolpidem. In addition, observation of Ms. A in the emergency with a full medical workup including but not limited to urine drug screen, brain imaging, lumbar puncture, etc.

Results: Ms.A medical workup was positive for a urinalysis revealing asymptomatic bacteriuria and she was treated empirically with cefdinir. Her medication regimen consisted of Bupropion 150 mg and Sertraline 100m, both daily. Zolpidem was discontinued and changed to Clonazepam 0.5mg for insomnia. She was also started on Olanzapine 5mg in the AM and 10mg in the PM. Her mental status was noted to have improved after discontinuation of Zolpidem. Patient received one dose in the hospital but after two days since discontinuation her mental status improved. Upon literature review previous reports have been published citing cases of patients on Zolpidem physically acting out while sleeping in a parasomnia-like behavior, with no recollection of memories upon awakening. (Inagaki *et al.* Primary care companion to the Journal of clinical psychiatry 2010, 12(6)). There are case reports of Zolpidem associated homicide (Paradis *et al.*The primary care companion for CNS disorders 2012, 14(4).

Conclusions: One limitation of our study is the patient was noted to have a sudden change in behavior with altered mental status which may be attributed to an underlying asymptomatic bacteriuria. It should be noted that this may have been an incidental finding. This does not exclude the possibility of Zolpidem as the primary cause of the change of her altered mental status or further exacerbating the change in her mental status. Though Zolpidem can be therapeutic and safe, we as clinicians have to be aware of the potential side effects of Zolpidem when prescribing medications.

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