between 2015 and 2017. Patients were divided into two groups according to DSM-5 criteria: those with bipolar disorder I or II (bipolar depression) versus those with major depressive disorder (unipolar depression).
**Results:** The mean age of our patients was 37.6 years, with a female predominance (sex-ration F/M =1.7). The age of onset of the disease was earlier in bipolar depressed patients (29.36 versus 31.89), without a significant relationship. Family psychiatric history was significantly more prevalent in bipolar disorder patients (73.5% versus 37.3%; p<0.001). Bipolar patients are more likely to be unemployed (65.3% versus 50.8%), but without a significant relationship.
Bipolar patients were more likely to be hospitalized for suicide attempts (44.9% versus 35.6%; p=0.2).
**Conclusions:** Distinguishing between major depressive disorder and bipolar disorder is important because there are differences in the optimal management of these conditions.

**Disclosure of Interest:** None Declared

## EPV0125

## Manic episode in a patient with pancreatic adenocarcinoma: a case report

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**Introduction:** Psychiatric comorbidity is common in cancer patients, emphasizing the need for comprehensive care. While depressive symptoms in pancreatic cancer (PC) have been studied, there is limited attention given to manic symptoms. This case report aims to contribute to the knowledge of PC psychiatric comorbidities by describing a case of a 61-year-old patient with stage IV PC, with no personal or family psychiatric history, who presented a sudden onset manic episode.
**Objectives:** Our goal is to contribute to the growing knowledge of psychiatric comorbidities of PC focusing on manic symptoms by describing the case of a patient with stage IV PC without previous psychiatric history who presented a sudden onset of a manic episode.
**Methods:** We describe the mentioned clinical case. We also searched for previous case reports of maniac episodes in pancreatic cancer using a PubMed query.
**Results:** The patient, a 61-year-old male with stage IV PC, presented at the Emergency Room with abrupt behavioural changes suggestive of a manic episode of two weeks of evolution. The patient had been undergoing chemotherapy and short 3-day cycles of corticosteroids for the past 9 months but had been off this treatment for 20 days when the episode began. Acute organic causes were ruled out. The patient was admitted to the psychiatric unit, where organic screening was expanded and treatment with antipsychotics and a mood stabilizer was initiated with subsequent remission of symptoms after two weeks.
This article describes the case of a man with a PC diagnosis who had no prior psychiatric history and was admitted to the inpatient psychiatry unit due to a manic episode involving high-risk behavioral disturbances and megalomaniac psychotic symptoms. Several factors may have contributed to the onset of these symptoms, including corticosteroid use after chemotherapy and certain chemotherapy agents. However, due to temporal factors, these factors do not fully explain the episode.
The exact biological mechanisms behind the manic symptoms remain unknown, but hypotheses include gene-environment interactions in bipolar disorder and immunodysregulation related to the production of inflammatory cytokines. We found in the literature four cases that have reported new-onset mania as an initial symptom of PC, but the causal relationship is unclear.
**Conclusions:** Notably, this case differs from others due to the rapid remission of symptoms and the use of lithium therapy. While the underlying mechanisms are still unclear, this case contributes to understanding this rare complication of PC and may help in developing consensus on clinical management. Future research will further explore the pathophysiology of psychiatric symptoms in PC and appropriate therapeutic approaches.
This case shows a manic episode as a rare psychiatric complication in PC. In the literature reviewed, four other similar cases have been observed.

**Disclosure of Interest:** None Declared

## EPV0126

## Case Series: The use of Lithium in Bipolar Affective Disorder and End-Stage Renal Disease

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**Introduction:** Lithium is a highly effective treatment in the management of Bipolar Affective Disorder (BPAD) however it is associated with increased risk of developing chronic kidney disease. There is a lack of clear guidance on alternative approaches to managing those individuals that require cessation of lithium due to progression to end stage renal disease (ESRD).
**Objectives:** We discuss two patients with BPAD on lithium therapy who have developed ESRD. In both cases, lithium was discontinued due to ESRD, with alternatives trialled. In one case, the patient continues to be managed without lithium, whereas in the second, a decision was made to recommence lithium at a low dose. We reviewed the literature to provide meaningful context to the cases.
**Methods:** Case 1 This patient with a long history of BPAD and multiple medical co-morbidities experienced progressive decline in renal function. A decision was made to cease lithium therapy with close monitoring for signs of affective relapse. The patient was stabilised using a combination of sodium valproate and quetiapine. Since cessation of lithium, the patient has required a significant increase in support from the CMHT and more frequent admissions to manage mood and anxiety symptoms that cause significant subjective distress.

**Results:** Case 2 This patient had a long history of stable BPAD, with no episodes of illness for over 30 years. Unfortunately they developed CKD and despite a significant reduction in lithium over time, they developed ESRD requiring haemodialysis. Lithium was discontinued leading to a manic relapse of BPAD requiring a prolonged admission and a combination of carbamezapine, olanzapine, escitalopram and clonazepam to stabilise their mental state. Following discharge home, their mental state failed to reach baseline and they reported significant anxiety symptoms and memory impairment. Following protracted assessment and support they were deemed unfit for renal transplant and a decision was then made by the patient, their family, nephrology and psychiatry to recommence lithium therapy whilst on haemodialysis. Their anxiety and functioning improved significantly following the reintroduction of low dose lithium, allowing the withdrawal of other neuroleptics.
**Conclusions:** Both cases required an individual approach to balance physical and mental health considerations. There are no clear markers to predict if a patient will respond to alternative mood stabilisers, nor is there a guarantee that kidney function will improve or stop declining when lithium is discontinued. Decisions should reflect patient preference and balance risks associated with relapse and of declining ESRD.

**Disclosure of Interest:** None Declared

## EPV0127

## Sex differences in neurocognitive performance in older adults with bipolar disorder

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**Introduction:** In recent years, research has focused on the older adults with bipolar disorder (OABD), aged 50 years and over, a constantly growing population due to the increased of life expectancy. Actually, some authors suggest that these individuals constitute a distinct subtype with a specific and different needs such as seen in epidemiologic, clinical and cognitive features. Further research has revealed significant differences between females and males with BD in clinical and cognitive variables in middle-aged and young patients, but this topic among OABD population remains unclear.
**Objectives:** The aim of this study is to identify the distinctive profile in clinical, functional and neurocognitive variables between females and males in OABD.
**Methods:** A sample of OABD and Healthy Controls (HC) were included. Euthymic patients or in partial remission were included. Neurocognition was measured with a battery of tests that included premorbid intelligence quotient, working memory, verbal and visual memory, processing speed, language and executive functions. Independent t-test and Chi-squared test analysis were performed as appropriated.
**Results:** According to the analysis, statistically significant differences were seen between females and males. A more impaired cognitive profile is observed in women. They performed worse in the subscales of Arithmetic (F= 6.728, $p$ = <0.001), forward digits (F= 0.936, $p$= 0.019) and Total Digits (F= 1.208, $p$= 0.019) of the WAIS-III, in the Stroop Color Word Test, color reading (F= 0.130, $p$= < 0.001), in the Continuous Performance Test, block change measure (F= 2.059, $p$= 0.037), in the Rey-Osterrieth Complex Figure-copy (F= 0.005, $p$= 0.029) and in the Boston Naming Test (F= 0.011, $p$= 0.024). Nor significant differences were found in clinical neither in psychosocial functioning variables.
**Conclusions:** In view of the following results, and since no differences were observed between women and men in terms of clinical and functional outcomes, it could be said that the differences observed in cognition cannot be explained by disease-related factors. Furthermore, these results highlight the need to develop a gender-specific cognitive interventions in OABD population. In this way, we could have an impact on the course of the illness to reach a better quality of life.

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