Objectives The objective of this study was to look for a risky sexual behavior by evaluating sexual knowledge and sexual behavior of patients with bipolar disorder in the euthymic phase.
Methods We conducted a descriptive cross-sectional study including 30 patients diagnosed with bipolar disorder I or II (DSM-IV).
Data were obtained through a semi-structured interview evaluating the following: sexually transmitted infections, condom use, multiple sexual partners, sex under the influence of drugs or alcohol, and prostitution.
The Young Mania Scale and the Hamilton Depression Scale were used for clinical assessment.
Results The preliminary results suggest a lack of knowledge leading to a tendency to risky sexual behavior in both male and female, married and unmarried patients.
Conclusions Patients with bipolar disorder are exposed to risky and unsafe sex because of the clinical features of their disease and associated comorbidities.
Prevention and awareness of sexual risks are unavoidable in the management of these patients.
Disclosure of interest The author has not supplied his declaration of competing interest.

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EV213

Prevalence of insulin resistance and diabetes mellitus type II in bipolar disorders

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Introduction Bipolar disorder (BD) is associated with high morbidity and mortality. Patients are symptomatic almost half of their lives and experience significant disability. One subtype of BD is associated with a more chronic course, refractoriness to treatment and poor outcome. Diabetes mellitus type 2 (T2D) and insulin resistance (IR) have been identified as risk factors for this more severe form of BD.
Objectives and aims We investigated the rates of IR and T2D in patients with BD and whether this comorbidity is associated with specific clinical features of BD such as rapid cycling or treatment resistance.
Methods IR and T2D were screened in patients with BD types I or II, who were on stable treatment with mood stabilizers. The response to treatment was assessed by means of the Alda scale.
Results In a preliminary sample, we made a new diagnosis of IR in 40% of patients. The 1% of this sample had a diagnosis of T2D. The treatment response was worse in BD patients with comorbid IR or T2D as compared to those without metabolic abnormalities.
Conclusions These findings show that IR and T2D have high prevalence in BD patients and have negative impact on treatment response.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV214

First episode of bipolar depression after systemic lupus erythematosus in a 51-year-old woman

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Introduction Systemic lupus erythematosus (SLE) is a multi-system disease with a broad spectrum of clinical features and neuropsychiatric manifestations that occur in up to 60% of patients. Disease activity and treatment with corticosteroids may contribute to this higher risk. It is also known that 36% of patients with SLE and comorbid Bipolar Disorder (BD) have had their psychiatric onset after they had been diagnosed with SLE.
Method Single case report.
Results A 51-year-old woman received a diagnosis of SLE 24 months before the beginning of depressive symptoms. After her diagnosis of SLE, seven years ago, she had three suicide attempts, being diagnosed with major depressive disorder. From them on, she had crises characterized by well-defined periods of 7 to 10 days with sadness, reduced need for sleep, social isolation, irritability, anger outbursts, impulsivity, racing thoughts and suicidal ideation. After treatment with mood stabilizers (quetiapine 300 mg/day and lithium 600 mg/day), she had a substantial reduction of symptoms intensity and frequency.
Conclusion The link between immune dysregulation, autoimmunity and bipolar disorder may be closer than previously thought. Even if the autoimmune disease is not directly etiologically related to the psychiatric presentation, its detection is important due to the high morbidity and mortality, considering the current understanding that Bipolar Disease is strongly related with inflammation in central nervous system.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV215

A major depression or a bipolar disorder type 2? A cased-focussed psycopathological and psychophysiological challenge for a resident

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A 41-year-old woman is diagnosed with a major depression after a few weeks of having been operated of a stomach reduction (bariatric surgery). She goes into old antidepressant medication for a few weeks with an increasing worsening of her state, at the point she is sent to the emergency room with high irritability, intense agitation, suicide thoughts as the highlight symptoms of what we think to be a mixed episode of a bipolar disorder and how we orient the case during hospitalization. The patient follows both public and private psychiatric services and after discharge from acute hospitalization, still with residual depressions symptoms, her private psychiatrist substitutes the given treatment, including mood stabilizers, by only antidepressants. Two weeks after discharge from the hospital, the patient is relocated to our partial hospitalization resource. During her stay in our resource, we decide to keep the new treatment and diagnosis and increase the dosage of one of the antidepressants, which immediately yields to hypomania symptoms, at what we conclude that our patient is better treated as a bipolar type II with a mood stabilizer and low doses of an SRI. We find this to be an interesting case in the both psychopathological and psychophysiological point of view. To understand the case beyond clinical diagnosis, we discuss profoundly whether the bariatric surgery may have a role as a trigger.
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