ommended by NICE, an adaptation of these interventions in the treatment of adults with ADHD and IDD has potential.
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**EV753**

## Think fast, treat faster – a case of a treatable rapidly progressive dementia

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*Introduction* Rapidly progressive dementias (RPD) are conditions that develop over days, weeks or months, which could be treatable if diagnosed in the acute phase.
*Clinical case* A 62-year-old man with personal history of type 2 diabetes, started complaining of fronto-temporal headache, nausea and sub-febrile temperature. He went to his family doctor who prescribed ciprofloxacin 500 mg bid. Later on, he had difficulty to sleep and referred complex visual hallucinations. His family noted involuntary movements of the left upper limb and that he became more clumsy needing help for daily life activities. He went to our hospital one week later. He was apyretic and hemodynamically stable. On neurological examination, he had executive and visuospecial dysfunction, left limbs bradykinesia and ipsilateral limb ataxia. Involuntary movements of his left upper limb resembled alien limb phenomena. Complete blood count, complete metabolic panel, iron, folic acid, vitamin B12, anti-neuronal antibodies were normal. HIV, hepatitis B and C serologies were negative. Cerebrospinal fluid study showed 4 cells (100% mononuclear), normal glucose and protein levels, negative bacteriological exam but positive Herpes Simplex-1 Virus (HSV) DNA. Brain CT and MRI showed signs of ischemic microangiopathic leukoencephalopathy. He started treatment with acyclovir 30 mg/kg/d IV and quetiapine 100 mg id. His symptoms improved but he remained with a mild mnesic cognitive deficit and bradykinesia that stayed stable 3 years later.
*Conclusion* This case exemplifies atypical HSV-1 encephalitis, one cause of RPD, that an early recognition is essential to reduce its associated morbidity.
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## Effectiveness of cognitive behavioral therapy in the treatment of a phobic disorder in a patient with Down syndrome and early Alzheimer's disease

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*Introduction* Down syndrome was clinically described the first time in France by Esquirol (1838) followed by Down (England, 1866), to the identification of a chromosomal abnormality in 1959 (trisomy 21), which is the most common abnormality in neurodevelopmental disorders. Life expectancy increased from 9 years in 1929 to 55 currently. This is a common cause of mental retardation, and few tools are suitable for the care of these patients, including patients with Alzheimer's disease (prevalence of 55% between 50 and 59) or depression (prevalence 30%). No study evaluates the effectiveness of cognitive and behavioral therapy (CBT) in patients with Down syndrome but it is known to be effective in Alzheimer's patients. Some cases have been reported on the efficacy of CBT on phobias in patients with intellectual disability.
*Objectives and aims* To evaluate the efficacy of CBT in the treatment of a specific phobia in a patient with Down syndrome and early Alzheimer's disease.
*Method* Literature review and clinical case of a 51-year-old patient, hospitalized under constraints for behavioral disorders (agitation, body treatments refusals).
*Results* By adapting CBT techniques to the problem of intellectual disability, treatment against the phobia was effective with clinical improvement, which allowed a return home.
*Conclusion* The tools provided by CBT are suitable for the treatment of anxiety disorders in patients with intellectual disability, especially in patients with Down syndrome. Psychiatric disorders are under-diagnosed in these patients and under-treated. CBT is an aid to the treatment. It may allow the dismantling of symptoms and reduce behavioral problems.
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## Cretinism muscular hypertrophy: An unorthodox reflection

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The Kocher Debre Semelaigne Syndrome (KDSS) is also known as cretinism muscular hypertrophy. It is an unusual presentation in intellectually deficit children, commonly associated with congenital or iatrogenic hypothyroidism. The incidence of KDSS is less than 10%. It is more common in males, consanguineous marriage and age range from 18 months to 10 years [4]. The creatinine phosphokinase (CPK) is usually elevated [5]. It might be misdiagnosed particularly when other classical features of hypothyroidism are not dominant at first presentation. We present a case of 15-year-old intellectually deficit female. Her epilepsy had been managed on phenytoin for a decade. She had rigidity, leg cramps, malaise, oliguria, fever, myxedema, delayed deep tendon reflexes, calf muscle hypertrophy and agitation. Her agitation was controlled by haloperidol, which worsened the condition by altering her mental status. The patient was initially managed on line of Neuroleptic Malignant Syndrome due to raised CPK of 40,680 IU/L and mixed presentation. Nevertheless, no significant change was noticed until thyroid profile was done to exclude alternative resources. Thyroid stimulating hormone (TSH) was 74.5 IU, free T3 1.22 ng/dL, and free T4 0.43 ng/dL. Thyroxine was started along with change in antiepileptic and recovery was observed within five days. This case report highlights the inconsistent finding from previously reported cases of KDSS. The female gender, non-consanguineous marriage, slightly delayed onset with primarily neuromuscular symptoms, and raised CPK is not the frequent demonstration in KDSS. On parallel, thyroid work-up is not routinely done, which can lead to misdiagnosis and mismanagement.
References not available.
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