

EPP0558

Delirium and dementia retrospective cohort study

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Introduction: Delirium is common and is associated with many adverse short-term consequences as increased hospital costs, health care complications, and increased mortality. Long-term cognition consequences on delirium have not been well synthesized and quantified.

Objectives: Our study aims to determine the relationship between an episode of delirium and subsequent dementia and death over five years.

Methods: Postoperative delirium, previous psychiatric disorders, *mental health* service use, and *death data* collected from a cohort of inpatients diagnosed with delirium that requires psychiatric attendance in a general hospital were analyzed. Between 2009 and 2011, we started a follow-up of 91 patients aged 65 years or older at baseline for 60 months.

Results: Five patients (5.4%) were diagnosed with dementia previously. During the first year, 35 patients without previous dementia (40.6%) died. More than half of the one-year survivors (27; 52.9%) were diagnosed with dementia at the follow-up. Differences in age (79.5 vs 80.3; $Z=-0.07$; $p=0.93$), survival time (54.8 vs 48.8; $Z=1.30$; $p=0.19$), postoperative delirium rates (74%vs66.6%; $\chi^2=0.33$, $DF=1$, $p=0.56$) and mental disorder antecedents were not found. Patients with dementia after delirium were more likely to be attentive in mental health services (48.1vs16.6%; $\chi^2=5.666$, $DF=1$, $p=0.017$).

Conclusions: In our study, delirium is an important risk marker for dementia and death and is significantly associated with the long-term cognitive decline in surgical and non-surgical patients. Subsequent follow-up in *mental health* service could help detect dementia after episodes of delirium and lead to fewer potentially harmful interventions such as hospitalization or antipsychotic medication. An important question to determine is whether delirium is simply a risk marker for dementia or whether the delirium could cause neuronal damage leading to dementia.

Disclosure of Interest: None Declared

EPP0559

Diphenhydramine-induced delirium on top of HIV-associated neurocognitive disorder

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Introduction: HIV-associated neurocognitive disorder has been less frequent in recent years due to the availability of anti-retrovirals. However, in the Philippines, persons with HIV are diagnosed late resulting to cases of HIV-associated neurocognitive disorder. With higher incidence of depression and anxiety in this population, difficulty sleeping becomes a prominent symptom and diphenhydramine is a common non-prescription nighttime sleep aid being given.

Objectives: To present a case of diphenhydramine-induced delirium after a patient with HIV-associated neurocognitive disorder.

Methods: This a case report.

Results: Mr. JR., a 38-year-old person living with HIV and no past psychiatric history, presents with acute onset altered mental status, suicidal attempt, and jerking movements of the neck and extremities. He has been having bouts of diarrhea, fatigue, weight loss, and forgetfulness for a year before he was diagnosed with HIV-AIDS with CD4 count of 59 cells/mm³. At this time, he already had blurring of vision, poor sleep, weakness, poor concentration, and increasing severity of forgetfulness. He also started to have depressed mood and anhedonia but no suicidal ideations. He was eventually started on antiretroviral (ARVs) which are lamivudine, tenofovir, dolutegravir and antibiotics targeting opportunistic bacteria – Isoniazid, Moxifloxacin and Clindamycin. A few days after, he started to have jerking movements of the neck and extremities contributing further to poor sleep. Upon consult with a local clinic to address his sleep, he was prescribed with Diphenhydramine and after taking 50mg dose that evening, he started to have disorientation, paranoia, command auditory hallucinations resulting to a suicidal attempt, on top of the jerking movements, which prompted consult to the emergency room and subsequent admission. Initially assessed as central nervous system infection and focal seizure, CSF fluids studies and EEG were done showing normal findings. Started on Sodium Valproate + Valproic acid 500mg IV twice daily and Olanzapine 2.5mg twice a day, on top of his previously mentioned ARVs and antibiotics, the disorientation, auditory hallucinations, and myoclonic jerks mood resolved after five days. Five months on ARVs, he has no recurrence of myoclonic jerks, disorientation or psychosis, with memory and concentration improved, euthymic mood, and was able to resume work as an engineer.

Conclusions: Diphenhydramine is a common nighttime sleep aid. Due to its anticholinergic effect, cases of delirium were reported for doses 300mg to 1,000mg per day. For Mr. JR, the mere 50mg dose of diphenhydramine caused disorientation and psychosis as his co-occurring HIV-associated neurocognitive disorder made his brain “delirium-ready”. Diphenhydramine is a relatively safe drug however not getting a thorough medical history may inadvertently cause harm to patients who are medically ill and frail.

Disclosure of Interest: None Declared

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Introduction: Acute clinical deterioration in hospital inpatients can be caused by a range of factors including dementia, delirium, substance withdrawal and psychiatric disturbance, creating challenges in diagnosis, often requiring a management plan with input from multiple disciplines. Staff forums and broader literature have confirmed that healthcare staff working in non-mental health settings, may not be as skilled in recognising and managing early signs of emerging and/or escalating clinical agitation. The BoC RRT