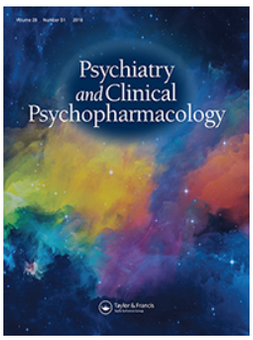

Taylor & Francis
Taylor & Francis Group

Psychiatry and Clinical Psychopharmacology

ISSN: 2475-0573 (Print) 2475-0581 (Online) Journal homepage: https://www.tandfonline.com/loi/tbcp21

Case Reports Presentations

Mustafa Dinçer, Cemil Çelik, Elif Ecem Helvalı, Şahin Bodur, Emine Tuğçe Akçaer, Serdar Süleyman Can, Görkem Karakaş Uğurlu, Sümeyye İslamoğlu, Semra Ulusoy Kaymak, Yasemin Taştorun, Oğuz Peker, Ali Çayköylü, Zehra Ece Soğucak, Aslı Sürer Adanır, Esin Özatalay, Arif Önder, Abdurrahman Erdem Başaran, Ayşen Bingöl, Berhan Akdağ, Murat İlhan Atagün, Yakup Doğan, Öznur Bilaç, Canem Kavurma, Gülseren Taşkıran, Aybike Erdem, Zehra Başar Kocagöz, Adnan Özçetin, Ahmet Ataoğlu, Merve Çavdar Toraman, Özgen Özçelik, Hüseyin Kara, Talya Tomar, Buket Cinemre, Yusuf Tokgöz, Taner Öznur, Abdullah Bolu, Özcan Uzun, İkbal İnanlı, Deniz Altunova, Ali Metehan Çalışkan, İbrahim Eren, Tüba Şerife Elmas, Yasemin Gökçenoğlu, Saliha Çalışır, Ali Baran Tanrıkulu, Şenay Yıldız Bozdoğan, Fatma Şahin, Ceren Çamur, İbrahim Gündoğmuş, Abdulkadir Karagöz, Ayhan Algül, Ebru Doneray, Ipek Percinel Yazici, Kemal Utku Yazici, Aslı Adanır, Yetiş Işıldar, Ebru Sağlam, Ayhan Bilgiç, Betül Akbaş, Çağla Çelikkol, Seher Serez Öztürrk, Hilal Seven, Dudu Demiröz, Seda Özbek, İsmet Esra Çiçek, Fatma Coşkun, Ömer Faruk Akça, Doğa Sevinçok, Çağdaş Öykü Memiş, Burcu Çakaloz, Bilge Çetin İlhan, Tuba Şerife Elmas, Azra Sehure Yaşar, Nafiye Yağlı, Osman Ak, Recep Başaran, Mehmet Murat Balcı, Mehmet Murat Kuloğlu, İbrahim Taş, Sehure Azra Yaşar, Mustafa Çağrı Yıldız, Ebru Çiftçi, Hasan Ali Guler, Ali Kandeger, Dilara Guler, Serhat Turkoglu, Önder Küçük, Ferhat Yaylacı, Handan Özek Erkuran, Betül Kurtses Gürsoy, Seher Serez Öztürk, Berrin Ünal, Gizem Aral, Evrim Özkorumak Karagüzel, Demet Sağlam Aykut, Filiz Civil Arslan, Ezgi Karagöz, Neslihan Emir İnaloğlu, Necati Uzun, Mutlu Muhammed Özbek, Mustafa Tolga Tunagür, Bilge Doğan, Levent Sevinçok, Abdullah Akgün, Kamil Nahit Özmenler, Tayfun Kara, İsmail Akaltun, Ayşe Erdoğan Kaya, Esra Yazıcı, Muhammed Nurullah Sezer, Çağlar Turan, Engin Sert, Yusuf Ezel Yıldırım, Pınar Çetinay Aydın, Sevilay Kunt, Tonguç Demir Berkol, Erman Esnafoglu, Öznur Adıgüzel, Serhat Tunc, Hamit Serdar Basbug, Selçuk Dalyan, Şermin Bilgen Ulgar, Hamza Ayaydın, Sema Bozbey, Merve Yazıcı, Çiğdem Yektaş, Enes Sarıgedik, Mehmet Asoğlu, Betül Uyar Ekmen, Hasan Akçalı, Cuma Taş, Cansu Mercan Işık, Belde Demirci, Seda Aybüke Sarı, Ayla Uzun Çiçek, Ezgi Eynalli, Ozge Metin, Perihan Cam Ray, Aysegul Yolga Tahiroglu, Gonca Gul Celik, Tuğçe Akçaer, Elif Merve Kurt, İbrahim Özkan Göncüoğlu, İsmail Ak, Merve Tsakir Chasan, Lut Tamam, Soner Çakmak, Mehmet Emin Demirkol, Erdem Örnek, Ayşe Sakallı Kani, Volkan Topçuoğlu, Rukiye Çolak Sivri, Nihal Yurteri Çetin, Merve Sertdemir, Emre Ürer, Gökçen İlçioğlu Ekici, Birim Günay Kılıç, Keziban Turgut, Canan Kuygun Karci, Ayse Avci, Azra Yaşar, Sümeyra Elif Kaplan, Hazal Muhsinoglu, Alper Zıblak, Ayşe Nur İnci Kenar, Cantekin Can, Canan Kuygun Karcı, Gamze Kutlu, Çağlar Soykan, Cansu Pınar Şen, Mehmet Fatih Ceylan, Selma Tural Hesapçıoğlu, Özden Şükran Öneri, Abdullah Karataş, Hatice Altun, Umut Karaaslan, Nurdan Kasar, Nilfer Şahin, Damla Balkan, Aslıhan Okan İbiloğlu,

Yıldız, Ebru Çiftçi, Hasan Ali Guler, Ali Kandeger, Dilara Guler, Serhat Turkoglu, Önder Küçük, Ferhat Yaylacı, Handan Özek Erkuran, Betül Kurtses Gürsoy, Seher Serez Öztürk, Berrin Ünal, Gizem Aral, Evrim Özkorumak Karagüzel, Demet Sağlam Aykut, Filiz Civil Arslan, Ezgi Karagöz, Neslihan Emir İnaloğlu, Necati Uzun, Mutlu Muhammed Özbek, Mustafa Tolga Tunagür, Bilge Doğan, Levent Sevinçok, Abdullah Akgün, Kamil Nahit Özmenler, Tayfun Kara, İsmail Akaltun, Ayşe Erdoğan Kaya, Esra Yazıcı, Muhammed Nurullah Sezer, Çağlar Turan, Engin Sert, Yusuf Ezel Yıldırım, Pınar Çetinay Aydın, Sevilay Kunt, Tonguç Demir Berkol, Erman Esnafoglu, Öznur Adıgüzel, Serhat Tunc, Hamit Serdar Basbug, Selçuk Dalyan, Şermin Bilgen Ulgar, Hamza Ayaydın, Sema Bozbey, Merve Yazıcı, Çiğdem Yektaş, Enes Sarıgedik, Mehmet Asoğlu, Betül Uyar Ekmen, Hasan Akçalı, Cuma Taş, Cansu Mercan Işık, Belde Demirci, Seda Aybüke Sarı, Ayla Uzun Çiçek, Ezgi Eynalli, Ozge Metin, Perihan Cam Ray, Aysegul Yolga Tahiroglu, Gonca Gul Celik, Tuğçe Akçaer, Elif Merve Kurt, İbrahim Özkan Göncüoğlu, İsmail Ak, Merve Tsakir Chasan, Lut Tamam, Soner Çakmak, Mehmet Emin Demirkol, Erdem Örnek, Ayşe Sakallı Kani, Volkan Topçuoğlu, Rukiye Çolak Sivri, Nihal Yurteri Çetin, Merve Sertdemir, Emre Ürer, Gökçen İlçioğlu Ekici, Birim Günay Kılıç, Keziban Turgut, Canan Kuygun Karci, Ayse Avci, Azra Yaşar, Sümeyra Elif Kaplan, Hazal Muhsinoglu, Alper Zıblak, Ayşe Nur İnci Kenar, Cantekin Can, Canan Kuygun Karcı, Gamze Kutlu, Çağlar Soykan, Cansu Pınar Şen, Mehmet Fatih Ceylan, Selma Tural Hesapçıoğlu, Özden Şükran Öneri, Abdullah Karataş, Hatice Altun, Umut Karaaslan, Nurdan Kasar, Nilfer Şahin, Damla Balkan, Aslıhan Okan İbiloğlu, Abdullah Atli, Rabia Erdogan, Esra Yazici, Tugba Mutu, Ozlem Akcay Ciner, Ali Savas Cilli, Atila Erol, Esra Porgalı Zayman, Cengiz Darılmaz, İsmail Reyhani, Rıfat Karlıdağ, Kübra Yıldırım, Yunus Emre Dönmez, Serdar Karatoprak, Özlem Özcan, Ali Hakan Öztürk, Özden Şükran Üneri, Perihan Turhan Gürbüz, Mustafa Uğurlu, Özlem Doğan, Tahir Kurtuluş Yoldaş, Nuran Bilgen, Vesile Altınyazar, Muhammed Mutlu Özbek, Ebru Ulu, Esra Demirci, Sevgi Özmen, Ümit Haluk Yeşilkaya, Ozge Sahmelikoglu Onur, Omer Akay, Yasin Hasan Balcioglu, Fatih Oncu, Çiğdem Toklu Yalvaç, Ümit Işık, Erol Erkan, Mehmet Hamdi Örüm, Tezan Bildik, Mahmut Zabit Kara, Helin Yılmaz, Hasan Akın Tahıllıoğlu, Aysun Kalenderoğlu, Oğuzhan Bekir Eğilmez, Murat Eren Özen, Yaşar Kapıcı, Ümit Kılıçoğlu, Murad Atmaca, Gulgaz Karimova, Asiye Arıcı, Feyza Hatice Sevgen, Zehra Alğan, Fadime Dalboy, Mehmet Ak, Faruk Uğuz, Kübra Kılınç, Fatih Hilmi Çetin, Serhat Türkoğlu, Semra Yılmaz, İbrahim İbiloğlu, Mustafa Özkan, Osman Bertizlioğlu, Ece Merve Yazar, Ahmet Özercan, Mehmet Kemal Kuşçu, Muhammet Akbolat, Gazanfer Ekinci, İpek Midi, Fatih Mücahit Harmankaya, Adem Aydın, Neslihan Yazar, Busra Bahar Ataoğlu, Neşe Yorguner Küpeli, Necati Serkut Bulut, Kaan Kora, Cihad Yükselir, Serkan Zincir, Dilşad Yıldız Miniksar, Pelin Çon Bayhan, Faruk Pirinççioğlu, İsmail Karka, Meltem Göbelek, Öznur Akıl, Sümeyra Güngören, Deniz Deniz Özturan, Zeynep Bebek Yılmaz, Derya Deniz Kürekçi, Aykut Özturan, Mihriban Ünay, Hasan Mervan Aytaç, Nazan Aydın, Can Tuncer, Volkan Seneger, Burcu Bakar Kahraman, Selma Hilal Avcı, Hasan Turan Karatepe, Mehmet Arslan, Sıla Çalışkan, Yusuf Çokünlü, Zeynep Yücehan, Seher Serez Öztrük, Hatice Yardım Özayhan, Özlem Karakaya, Gökçen Turan, Burak Elbeyli Ahmet, Safiye Bahar Ölmez, Merve Çavdar, Evrim Aktepe, Pınar Aydoğan Avşar, Yakup Erdoğan, Özlem Beğinoğlu, Rümeysa Yeni Elbay, Hayriye Hızarcıoğlu Gülşen, Arzu Yılmaz, Yasemin İmrek, Mesut Sari, Büşra Pala, Yusuf Öztürk, Güler Göl, Mehmet Akif Cansız, Uğur Savcı, Berna Gündüz Çıtır, Hatice Aksu, Sema Çam Salihoğlu, Nurhak Çağatay Birer, Güler Özkula, Ercan Altınörs, Fatih Baz, Mesut Yıldız, Leyla Bozatlı, Hasan Cem Aykutlu, Işık Görker, Oğuzhan Sapdüzen, Çiçek Hocaoğlu, Alphan Anak, Mesut Yılmaz, Yeliz Doymaz, Ece Ayyıldız, Mehmet Baltacıoğlu, Selvi Ceran Kayıpmaz, Ali Ercan Altınöz, Arzu Oğuz, Sema Çam Salihoglu, Hacer Gizem Gerçek, Mehmet Ayhan Cöngöloğlu, Emre Subas, Selin Alkan, Suat Yalcin, Suleyman Donmezler, Sevilay Umut Kilinc, Burcu Hamurisci Yalcin, Guliz Ozgen, Ahmet Turkcan, Ayse Ceren Kaypak, Nese Yorguner Kupeli, Ali İnaltekin, İbrahim Yağcı, Yüksel Kıvrak, Emine Füsun Akyüz Çim, Leyla Delikanli, Mustafa Tuncturk, Oguz Bilal Karakus, Ali Guven Kılıcoglu, Gul Karacetin, Merve Okuyan, Halil İbrahim İvelik, Burak Okumuş, Rukiye Tekdemir, Memduha Aydın, Nihal Taştekin, Betül Kırşavoğlu, Murat Yalçın, Sibel Ayvaz, Ayşe Gülşah Kırımlı, Ayşegül Taşdelen Kul, Huda Pasli, Mine Ozkan & Ferda Volkan (2018) Case Reports Presentations, Psychiatry and Clinical Psychopharmacology, 28:sup1, 114-270, DOI: 10.1080/24750573.2018.1467600

To link to this article: https://doi.org/10.1080/24750573.2018.1467600

Published online: 13 Jun 2018.

PSYCHIATRY AND CLINICAL PSYCHOPHARMACOLOGY, 2018
VOL. 28, NO. S1, 114–270
https://doi.org/10.1080/24750573.2018.1467600

Taylor & Francis
Taylor & Francis Group

CASE REPORTS PRESENTATIONS

10th International Congress on Psychopharmacology & 6th International Symposium on Child and Adolescent Psychopharmacology

[Abstract:0103][Mood disorders]

A forgotten diagnosis: funeral mania

Mustafa Dinçer[a], Cemil Çelik[b], Elif Ecem Helvalı[c] and Şahin Bodur[a]

[a]Department of Child and Adolescent Psychiatry, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey; [b]Department of Psychiatry, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey; [c]Psychology Department, Başkent University, Ankara, Turkey

E-mail address: mustaa63@hotmail.com

ABSTRACT

Grief mania that is evaluated as psychogenic mania in the literature is related to manic episode that emerges after the loss of a loved one. There are not many cases that associate causality of beginning of mania and mourning in the literature. It is known that mania is induced by traumatic events but the cases that do not suit stages of development of grief process are evaluated as pathological grief. In this case, the woman who experienced manic episode after her son's death is presented. This case is prepared because mania should be considered as possible grief reaction.

Case presentation: A patient who is 40 years old, married, mother of 4 children is brought by relatives because of aggressiveness, tension, insomnia for 4 days, fast and talk a lot and nonsense laughing attacks. She was presented to hospital for stressful life events 2 years ago and started to be on medication (escitalopram 10 mg) because of depression and fibromiyaliji diagnosis. She used medication for 1.5 years and she did not use any medication for the last 6months. There is no history for mental disorder in her family. Psychological examination: her interest for the environment was increased, self-care ability got better, her temperament was cheerful, her sociability was respectful, amount of talking and tone of voice increased, mimic and gesture was appropriate for her temperament, sleeping decreased, thought flow increased and achieved goal of conversation late. Moreover, there were grandiose delusions and hypervigilance, affect was close to euphoria, her psychomotor behaviours increased and social functioning decreased. According to biochemical and radiological workup, there was no pathological situation. The client started to use Lithium 900 mg/day and Olanzapin 10 mg/day because of the bipolar disorder diagnosis. The patient's blood lithium level was 0.8mEq/L and lithium was used 1200 mg/day and then 10 days later the patient's blood lithium level was 0.72 mEq/L. According to clinical observations, the patient's manic symptoms remained. Furthermore, the patient started to cry occasionally after 1 month and her grandiosity disappeared. The patient was discharged from the hospital after 45 days. The patient met the criteria for manic episode in DSM 5. The patient did not take any medication for last 6 months. Thus, it is considered that this situation was not induced by medication. It puts the patient into risk group because she was treated for depression before but it is not considered as bipolar depression because there were psychiatric history in the family and depression that experienced 2 years ago was related to stressful life events. It is considered that this case experienced grief/funeral mania because there was contiguity between loss of her son and manic episode, the patient did not react this way to previous challenging life events and the patient was outside of the ordinary 5 stages of grief process.

KEYWORDS

Funeral; mourning; mania; bereavement; bipolar disorder

[Abstract:0104][Dementia syndromes]

A case of frontotemporal dementia with multiple psychiatric symptoms

Emine Tuğçe Akçaer[a], Serdar Süleyman Can[a], Görkem Karakaş Uğurlu[a], Sümeyye İslamoğlu[a] and Semra Ulusoy Kaymak[b]

[a]School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey; [b]Ankara Atatürk Research and Training Hospital, Department of Psychiatry, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Frontotemporal dementia is the second most common cause of dementia in the general population between 45 and 64-year-olds. Frontotemporal dementia is usually presented with behavioural and personality changes, executive dysfunctions and language difficulties. In the beginning of disease, the clinical picture of frontotemporal dementia is very heterogeneous and it may have atypical presentations like psychotic symptoms. It was reported that %13–14 cases of frontotemporal dementia had psychotic symptoms at the onset or during the course of diagnosis. The overlapping symptoms between psychosis and frontotemporal dementia may worsen the prognosis of disease. Here we describe a case of frontotemporal dementia with psychotic symptoms.

Case presentation: A 59-year-old, female patient with auditory and visual hallucinations, delusion of persecution, aggressiveness to her husband, aphasia, phonemic paraphasia was admitted to our outpatient clinic. His psychiatric symptoms dated 2 years ago and represented with hallucinations and delusions. 9 years ago, she had diagnosed with Alzheimer's disease because of progressive amnesia. After she diagnosed with Alzheimer's disease, she put on treatment with memantine 10 mg/day and piracetam 800 mg/day. 5 years ago, the symptoms of aphasia, hypophonia, phonemic paraphasia were found with her progressive amnesia. But her symptoms were fluctuating over time with treatment. 2 years ago, hallucinations like talking with stranger people not to give a harm to children whom she met, were added her symptoms. Her first psychiatric presentation and admission was at the age of 57 with hallucinations and delusional symptoms. The escitalopram 20 mg/day and mirtazapine 30 mg/day treatments were added in her memantine and piracetam treatments. But patient's symptoms were leading disturbance in functionality with progressive pattern. Because of aphasia, paraphasia, and psychotic symptoms and aggressiveness to her relatives, functionality of patient was disturbed seriously. Frontotemporal dementia has insidious onset and slow progression. From a clinical point of view, psychiatric symptoms can be seen in every stage of this type of dementia, which usually worsen the prognosis of disease. Because of these reasons, detailed neuropsychiatric approach is necessary for providing comprehensive care to patients.

KEYWORDS

Aphasia; hallucination; frontotemporal dementia; psychiatry; symptom

[Abstract:0105][Eating disorders]

ECT's effects on eating disorders

Mustafa Dinçer[a], Cemil Çelik[b], Yasemin Taştorun[a] and Elif Ecem Helvalı[c]

[a]Department of Child and Adolescent Psychiatry, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey; [b]Department of Psychiatry, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey; [c]Başkent University, Ankara, Turkey

E-mail address: mustaa63@hotmail.com

ABSTRACT

The etiopathogenesis of anorexia nervosa (AN), bulimia nevroza (BN) and binge eating disorders (BED) are still unknown with high morbidity and mortality, abnormal eating behaviours and various behaviours to avoid weight gain due to wrong body sensation. In particular, changes in adiponectin, leptin, and ghrelin occur in patients with eating disorders, and are thought to contribute not only to a changing energy balance but also to homeostatic conditions, as well as sustained starvation and intense eating episodes. There is not yet a clear consensus in the therapies and there are only case reports on the efficacy of ECT when it is stated that antidepressants are among the treatment options of antipsychotics and ECT. In this case, we present a patient treated with pharmacological and ECT therapy followed by a concurrent obsessive-compulsive disorder (OCD), a subtype of severe AN binge-eating/purging type.

Case presentation: A 26-year-old female patient was admitted in our clinic to DSM-5, the AN binge-eating/purging type comorbid OCD. Upon examination of the patient, the following things were noted: cachectic and mild hirsutism, poor self-care, focus on eating thought and

KEYWORDS

Adiponectin; anorexia nervosa; binge eating disorder; bulimia nervosa; ECT; ghrelin

false bodily sensation and not being insightful, BMI: 15.91 kg/m2, in the bilateral Russel's signs, erosion due to vomiting in the upper palate, vomiting on the cheeks (parotids) and submandibular region. The patient's routine examinations had normal limits except for hypoglycaemia. Treatment with 3-weeks titration was performed with fluoxetine (60 mg) and aripiprazole (15 mg). The patient's initial glycaemic value ranged from 25 to 38, but recently reached 78–92. Pathologic values were also present in the HPA axis, radiological examinations were within normal limits. 10. post-ECT patient was BMI: 19.72 and vomiting was completely discontinued. 14. after ECT, there was melena bleeding and HPA axis values returned to normal. After 1 week, the patient met criteria for eating disorder, except for E criteria, according to DSM 5. 18. After ECT, the patient was discharged with BMI: 22.83. 20. after the ECT, patient's ocd symptoms completed but BED symptoms continued. It has been suggested that leptin, ghrelin, and adiponectin may be involved in eating habits in patients, changes in HPA axis, normalization of glycaemic follow-up, and normalization of BMI. In the literature, ghrelin declines in patients on the 2nd day after ECT and the total cholesterol level increases while no change in leptin level is observed. According to this, when we administered each ECT in our patient, the ghrelin level of the patient decreased, which decreased GH and CRH, and increased serotonin. With decreased CRH, ACTH decreased and returned to normal. AN is low in fat tissue and the level of adiponectin in plasma is higher than BED. As a result of our treatment, adiponectin level and insulin sensitivity decreased and glycaemia levels could be normalized. This suggests that there is a paradoxical relationship between ghrelin, leptin, adiponectin, GH, CRH mechanisms. In this case, when combined with pharmacologic therapy with ECT, complete recovery of comorbid OCD in our patient was observed and it was assessed that more case reports and literature studies were needed.

[Abstract:0117][Dementia syndromes]

Late onset psychosis or dementia

Serdar Süleyman Can, Oğuz Peker, Emine Tuğçe Akçaer, Sümeyye İslamoğlu and Ali Çayköylü

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Dementia is a clinical syndrome with progressive cognitive decline and prominent deficits in memory, attention, executive functions, judgement, abstract thinking, and problem-solving. Also psychotic symptoms such as persecutory beliefs and visual and auditory hallucinations can be seen in every stage of dementia. Here, we aim to present a patient with psychotic symptoms and probable diagnosis of dementia.

Case presentation: A 78-year-old female patient was presented with irritability, suspiciousness, hearing voices like crepitation, visual hallucinations, smacking of mouth consistently to our psychiatry clinic in 2016. First application of the patient was in 2012 with psychotic symptoms. Medical evaluation at the hospital revealed that laboratory tests were within normal ranges. Her magnetic resonance imaging reported as showing 'periventricular white matter hyperintensities'. The patient was diagnosed with unspecified non-organic psychosis and put on treatment with olanzapine 2.5 mg daily. Her complaints remained and olanzapine treatment was regulated as 5 mg/day. After 2 months, the patient discontinued her treatment. Patient's symptoms like anhedonia, depressed mood, social isolation, suspiciousness, irritability, and insomnia remained. But, the patient did not present to any psychiatry clinic with these symptoms until 2016. When the patient presented with these symptoms to psychiatry clinic in 2016, she was diagnosed with psychotic depression and put on treatment with escitalopram 20 mg daily and sülpiride 50 mg daily. However, after a few months, the patient discontinued her treatment. After few months, the patient was presented to another psychiatry clinic; then she was diagnosed with unspecified non-organic psychosis and treated with risperidone 1 mg daily. The patient received risperidone treatment for 3 months. During the months, no significant evolution observed. At the last visit of her, a comparative evaluation was realized. Physical and neurological examinations were normal. Neurocognitive assessments showed multiple dysfunctions and a magnetic resonance imaging scan of the brain revealed a discrete cortical atrophy, bilateral periventricular, and supraventricular white matter hyperintensities, increases in T2 signal intensity of scattered white matter areas, especially at the left frontal region. Quetiapine 25 mg daily was prescribed for psychotic symptoms. Detailed neurocognitive assessment is planned after recovery of psychotic symptoms. Schizophrenia is a heterogeneous disease with a large variety of cognitive disabilities like intellectual and executive dysfunctions. A differential diagnosis between schizophrenia and dementia subtypes is difficult to determine. Neurocognitive or neuroimaging assessment is important for differential diagnosis but can be insufficient for precise diagnosis. Multidisciplinary approach has important implications for management and prognosis of patients.

KEYWORDS

Dementia; late onset; neurocognition; psychosis; schizophrenia

[Abstract:0118][Psychopharmacology]

Angioedema and urticaria associated with fluoxetine in a preadolescent boy

Zehra Ece Soğucak[a], Aslı Sürer Adanır[a], Esin Özatalay[a], Arif Önder[b], Abdurrahman Erdem Başaran[c] and Ayşen Bingöl[d]

[a]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey; [b]Department of Child and Adolescent Psychiatry, Manisa Psychiatry Hospital, Manisa, Turkey; [c]Department of Pediatrics, Akdeniz University School of Medicine, Antalya, Turkey; [d]Department of Pediatric Allergy Immunology, Akdeniz University School of Medicine, Antalya, Turkey

E-mail address: ece_randa@hotmail.com

ABSTRACT

Angioedema is defined as the increased permeability and dilatation of the capillaries in the deep dermis or subcutaneous or submucosal tissues and leads to localized swelling often affecting the upper respiratory and gastrointestinal tracts. Here we report a 10-year-old boy manifested urticaria with fluoxetine, showed recovery after the cessation of the drug, and manifested urticaria and angioedema after the re-prescription of it.

Case presentation: A 10-year-old boy presented to our paediatric emergency unit with diffuse itchy skin lesions (Figure 1) and swollen lips and tongue (Figure 2). His parents reported that he was on fluoxetine 10 mg treatment for 12 days, and he had mild urticarian lesions for 2 days. Within a few hours the lesions had spread to all of his body and he started to have difficulty in breathing because of swollen lips and tongue. Examinations and questioning of the patient and parents ruled out foodstuffs, insect bites, pollens, physical exercise, NSAIDs, novel stressors, infection, food supplements or medications except fluoxetine. Hereditary angioedema was ruled out by a negative family history and normal C4 and C1 inhibitor levels. Upon questioning and medical reports, it was learned that he presented to the emergency unit with diffuse urticaria 2.5 years ago, while he had been taking fluoxetine 10 mg for 15 days. His lesions had healed up in 2 days with prednisolone and pheniramine and cessation of fluoxetine. His lesions were attributed to fluoxetine treatment once more and intravenous prednisolone and pheniramine were given and fluoxetine was stopped. Angioedema remitted quickly then. There are three main forms of angioedema: Extrinsic factor-induced angioedema, angioedema with C1-INH deficiency and idiopathic. Drug-induced angioedema is classified in the extrinsic factor-induced angioedemas and divided into 3 categories depending on the mechanism. The first group is IgE-mediated immediate hypersensitivity reactions. The second includes the adverse reactions to NSAIDs. Thirdly, ACEI-induced angioedema is kinin-dependent and without urticaria. To differentiate a kinin-dependent angioedema from the others, it is useful to determine as if angioedema is accompanied by urticaria or not. Here, we report a case of angioedema in a preadolescent, thought to be associated with fluoxetine. Correlation of occurrence of urticaria with the use of fluoxetine in the absence of comorbid illness or concurrent medications, disappearance with discontinuation; and reoccurrence (this time with angioedema) with the repeated use of it strongly suggest that the case was associated with fluoxetine. We considered it as allergic, as it was accompanied by urticaria. There is only one other case of angioedema accompanying urticaria with high dose fluoxetine. The other case, reporting angioedema with 10 mg/day, is without urticaria and thought to be pseudoallergic. Our case is unique in this respect, as the angioedema developed with therapeutic doses and thought to be allergic. Clinicians should be aware of such rare but potentially life-threatening adverse effects of SSRIs and monitor patients closely.

KEYWORDS

Fluoxetine; child; side effect; angioedema; urticaria

[Abstract:0121][Psychopharmacology]

Bruxism associated with fluoxetine in 4 children

Berhan Akdağ, Aslı Sürer Adanır and Esin Özatalay

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

E-mail address: bakdag853@gmail.com

ABSTRACT

Nocturnal bruxism (NB) is an involuntary mandibular movement with tooth grinding during sleep. Bruxism has a multifactorial aetiology, and it can be a rare adverse effect of selective serotonin re-uptake inhibitors (SSRIs). Although there are reports of bruxism associated with fluoxetine in adults, there is only one case, as far as we know, in an adolescent. Here we report a case series of bruxism associated with fluoxetine in 4 children ages 6–11.

KEYWORDS

Bruxism; child; fluoxetine; side effect; treatment

Case presentations: 4 patients (aged 6, 8, 8 and 11 years), who have been followed in our outpatient clinic with anxiety disorders, significantly responded to the fluoxetine, but 2–4 weeks after the initiation of treatment, NB was reported by their caregivers. They were referred to a dentist, but there was no clinical finding of chronic bruxism. The bruxism was thought to be related to fluoxetine. In one case, a quick recovery was observed in anxiety symptoms; so in the 3rd month, fluoxetine was stopped and bruxism ceased. The other three cases, parents of whom were very satisfied with the fluoxetine treatment and did not want to stop it or add another psychiatric drug for the bruxism, are still on fluoxetine treatment and have been followed by a dentist. But the severity of bruxism was observed to decrease gradually by the time. Bruxism has been discerned to be a special form of akathisia. It has been hypothesized that serotonergic drugs mediate excessive serotonergic action on mesocortical neurons arising from the ventral tegmental area leading to dopaminergic deficit, which causes akathisia-like movement of jaw muscles. In the case of drug-induced bruxism, addition of buspirone or gabapentin, reduction of dose, or cessation of the drug are usually advised, and in one of our cases, bruxism ceased after the drug was stopped. But in other 3 cases, as fluoxetine was significantly beneficial to the patients and because of their parents' worries about adding buspirone to their treatment, we preferred to continue fluoxetine, and observed that bruxism had decreased by the time. So if there are no severe consequences of bruxism, waiting may be another option. Bruxism is rarely associated with SSRIs; however, it may result in severe consequences as destruction of tooth structure, irreversible harm to the temporomandibular joint, and severe myofascial pain. Thus, clinicians should be aware of this adverse effect of SSRIs.

[Abstract:0122][Mood disorders]

Treatment-resistant depression associated with sacred journey

Serdar Süleyman Can, Oğuz Peker, Murat İlhan Atagün and Sümeyye İslamoğlu

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

The aetiology of depression includes biological, psychological, and social factors. It is well known that psychosocial interventions have an important place in treatment along with different medical treatment options. In this case, we present a patient followed up with medical depression, whose symptoms of depression was regressed after her umrah visit to the holy places.

Case presentation: SK, who is 63 years old, married, housewife, and having 4 children, was first admitted to outpatient psychiatry clinic of another centre with complaints of unhappiness, dissatisfaction, loss of interest, insomnia, widespread body pain and headache, in 2002. She was diagnosed with depressive disorder due to exposure to psychosocial stressors, her treatment was started with fluoxetine at a dose of 10 mg/day; eventually the dose was increased up to 40 mg/day at follow up in the outpatient clinic and the treatment was continued until 2010. In 2010, fluoxetine treatment was replaced with citalopram at a dose of 20 mg/day, because her complaints continued. She admitted to our psychiatric outpatient clinic, in June, 2015, because his complaints persisted, even though she stayed on citalopram 20 mg/day between 2010 and 2015. The dose of citalopram treatment was increased to 40 mg/day on her first admission to our clinic. Since she did not benefit the treatment with citalopram 40 mg/day for one year, the dose was gradually reduced and citalopram treatment was discontinued and sertraline treatment was started at a dose of 25 mg/day and increased to 50 mg/day. After trazodone, 50 mg was added for insomnia complaints and the complaints regressed. The clinical course of the patient was evaluated by clinical interviews and Montgomery and Asberg Depression Scale. The test score was in the range of 33–38, by February 2017. The test scores lowered to 12, and she had no active complaints for 2 months after her umrah visit to the holy places, on February 2017. After 2 months, she was admitted to another outpatient psychiatric clinic because her complaints relapsed. The sertraline treatment was increased up to 150 mg/day and alprazolam 0.5 mg/day was added for the treatment of anxiety. Eventually, S.K admitted to our psychiatric outpatient clinic on November 2017, and because sertraline 150 mg/day dose was increased 1 week ago, we decided to wait for an effective period of time in order to see the clinical effect.

There are many treatment options available for the treatment of depressive disorders. By the virtue of the multiplicity of options, care must be taken in deciding which treatments will be administered, in what frequency and in what order. Psychosocial interventions also hold an important place among the treatment options. Psychosocial interventions are aimed at improving psychological and social aspects and preventing relapses.

KEYWORDS

Depression; holy; journey; sacred; treatment

[Abstract:0124][Psychopharmacology]

Acute dystonia due to discontinuing of methylphenidate treatment: A case

Yakup Doğan, Öznur Bilaç, Canem Kavurma and Arif Önder

Manisa Mental Health Hospital, Department of Child and Adolescent Psychiatry, Manisa, Turkey

E-mail address: drykpdgn@gmail.com

ABSTRACT

The acute dystonic reaction is usually a side effect of an extrapyramidal system, which usually occurs suddenly due to antipsychotic and antiemetic drugs. Acute dystonia is described as sustained abnormal postures or muscle spasms that is observed mainly in the head and neck area. In this poster, we want to present a case with acute dystonic reaction in the head and neck area due to discontinuation of methylphenidate.

Case presentation: A 6-year-old girl was referred to our outpatient clinic by her parents who complained of her excessive and inappropriate hyperactivity, failure to fulfil assigned duties and responsibilities, not obeying the class rules, having difficulty listening to her teacher. The girl was diagnosed as suffering from attention-deficit/hyperactivity disorder (ADHD) according to DSM-5 criteria. The patient was prescribed methylphenidate 10 mg/day. After one month of medication, the methylphenidate dosage was increased to 20 mg/day. Approximately 10 days after the increasing dose, a significant decrease in appetite was delayed and stopped the medication by the family. Her family noticed on the 2nd day of drug withdrawal that her speech was impairing and could not speak after a while, and chewing and swallowing functions was disappeared. Her parents also complained about episodes suggestive of dystonia in the form of torticollis, facial muscle spasm, and oculogyric crisis. The drug was given to the patient again because of the story of symptoms suspected when methylphenidate was discontinued. Her symptoms reduced again after methylphenidate treatment. Long-acting methylphenidate was started at a dose of 2*10 mg/day and her family reported that her ADHD symptoms reduced and there have been no signs of dystonia. A large number of drugs can cause acute dystonic reactions at the treatment dose. It is most commonly caused by antipsychotic and antiemetic drugs. In the literature, there were 3 rebound dystonia cases when methylphenidate treatment was discontinued during the use of antipsychotic and methylphenidate. In our case, an acute dystonia was detected when methylphenidate treatment was discontinued, although there was no use of antipsychotics. There was a dramatic improvement when the treatment was restarted.

KEYWORDS

Attention-deficit disorder with hyperactivity; extrapyramidal tracts; dystonic disorders; methylphenidate; spasm

[Abstract:0130][Psychopharmacology]

N-acetylcysteine treatment in autism spectrum disorder: a case

Arif Önder[a], Öznur Bilaç[a], Aslı Sürer Adanır[b], Yakup Doğan[a] and Canem Kavurma[a]

[a]Manisa Mental Health Hospital, Department of Child and Adolescent Psychiatry, Manisa, Turkey; [b]Akdeniz University Hospital, Department of Child and Adolescent Psychiatry, Antalya, Turkey

E-mail address: arifonder86@gmail.com

ABSTRACT

Autism spectrum disorder (ASD) is a neurodevelopmental syndrome that is defined by deficits in social reciprocity and communication, and by unusual restricted, repetitive behaviours. Although there are many different drugs approved by the Food and Drug Administration (FDA) in order to reduce the aggression associated with autism, but there is no medication that improves ASD basic symptoms. Despite all psychotropic medications given in severe cases, aggression may continue. N-acetylcysteine (NAC) is a precursor of glutathione (g-glutamylcysteinylglycine, GSH). There are many publications that NAC is extremely reliable for child and adolescent.

Case presentation: A 16-year-old male adolescent with autism was taking many different drugs and special education with complaints of hyperactivity and aggression. His weight was 108 kg and he was prescribed aripiprazole 20 mg/day, quetiapine 800 mg/day, haloperidol 20 mg/day, biperiden 3 mg/day and diazepam 15 mg/day. Previously, risperidone, olanzapine, mirtazapine, sertraline, haloperidol, chlorpromazine, alprazolam, and zuclopentixol storage treatments were prescribed in high doses. There has never been a period that he used less than four

KEYWORDS

Acetylcysteine; adolescent; aggression; autism spectrum disorder; psychotropic drugs

psychotropic drugs in the past 4 years. In the psychiatric examination in November 2017, it was observed that the morbid obese boy was hyperactive, had meaningless noises, and had a bite-and-hit behaviour when he was blocked. His parents reported that he had not benefited from the medication for 6 months. NAC treatment (600 mg) was started at a dose of 2 * 1. 2 week later, his family reported significant improvement in symptoms and there has never been any hitting behaviour in the last week. In the psychiatric examination, significant improvement of his hyperactivity was observed and the treatment was continued. Haloperidol dose was reduced to 10 mg/day in December. Current medication was aripiprazole (20 mg/day), quetiapine (800 mg/day), haloperidol (10 mg/day), diazepam (15 mg/day) and NAC (1200 mg/day) and there have been no problems. Dysfunctional glutamatergic neurotransmission has been implicated in pervasive developmental disorder. N-acetylcysteine is also a glutamatergic modulator and antioxidant, although it is used with many different indications for the treatment of a wide range of disorders as lung disorders, heavy metal and paracetamol poisoning. It has been shown that it reduces aggression in autism in a small number of studies wherein glutamatergic modulator effect is considered. Additional use of NAC with risperidone has been shown to reduce signs of aggression. In studies, NAC was generally given alone or in combination with low-dose (1–2 mg) risperidone in the 2–12-year-old group. There are limited studies in the literature related to combined NAC therapy with multiple drug use in the older than 12-year-old group. It may be useful to use NAC in addition to ASD patients who have not benefited from other therapies. Future studies are definitely needed to observe the effects and side effects of treatment.

[Abstract:0140][Anxiety disorders]

Hyperglycaemia associated with sertraline in a 13-year-old Type I diabetic girl

Aslı Sürer Adanır[a], Gülseren Taşkıran[b] and Aybike Erdem[a]

[a]Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey; [b]Antalya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Health Sciences University, Antalya, Turkey

E-mail address: ayb.erdem@gmail.com

ABSTRACT

Selective serotonin reuptake inhibitors (SSRIs) are used as a first-line treatment for anxiety disorders and depression in children and adolescents. Generally the somatic side effects of SSRIs are mild and include nausea, insomnia, sedation, and headaches, but they are also found to interfere with blood glucose metabolism, paradoxically increasing the risk of both hyper- and hypoglycaemia. Here, we report a case of sertraline-induced hyperglycaemia in a diabetic girl.

Case presentation: A 13-year-old girl with Type I diabetes mellitus (DM) was referred to our outpatient unit with anxiety symptoms. She had a good glycaemic control. Sertraline treatment was initiated at 25 mg/day and increased to 50 mg in a week. In her control visit one month later, her symptoms were ameliorated significantly but her mother reported severe deterioration in her glycaemic control, despite the doubling of insulin dose and a strict diet. As she had accompanying flu symptoms (but not taking any medication for it), sertraline was stopped for a week and her glucose level normalized in 3 days. Then sertraline was initiated again and her fasting glucose level swiftly increased to 150 and then to 190 in 2 days, and returned to normal levels again, with the cessation of the drug. SSRIs are found to be related both with hyper- and hypoglycaemia. After the administration of SSRIs, strengthened serotonergic activity usually results in increased insulin sensitivity, with a consequent reduction of plasma glucose levels. This mechanism has been observed both in studies with diabetic rodents and also with diabetic patients, and some cases of hypoglycaemia following SSRI (fluoxetine and sertraline) initiation have been published. However, there are also some reports of hyperglycaemia linked to paroxetine, fluvoxamine, fluoxetine, and escitalopram, and one case report of hyperglycaemia after sertraline. But hyperglycaemia in children with any of SSRIs was not reported before, our case is unique in this respect. Although the mechanisms which determine hypoglycaemia are more clear today, the altered glycaemic control with hyperglycaemia should also be considered. Studies on animals suggested that SSRIs might induce hyperglycaemia by the stimulation of 5-HT receptors-both central and peripheral. The stimulation of the 5-HT receptors are thought to be related to the inhibition of insulin release due to adrenaline release from the suprarenal glands. SSRIs should be ruled out as a possible cause of hyperglycaemia in both diabetic and nondiabetic individuals presenting with recurrent episodes of hyperglycaemia. Clinical trials are needed to evaluate this effect of SSRIs in this respect.

KEYWORDS

Anxiety; hyperglycaemia; sertraline; diabetes mellitus; side effects

[Abstract:0147][Psychopharmacology]

Chronic lithium intoxication without expected side effects: a case report

Zehra Başar Kocagöz, Adnan Özçetin, Ahmet Ataoğlu and Merve Çavdar Toraman

Düzce University School of Medicine, Düzce, Turkey

E-mail address: zehrabasarkocagoz@outlook.com

ABSTRACT

Lithium are important agent useful in the acute and maintenance treatment of bipolar disorders. Lithium was used in depression patients in the 19th century at psychiatry. It is restricted for a period of time when poisonings are observed during its use. Lithium's therapeutic range is narrow. Lithium side effect are beginning at indicate levels above 1.5 mEq/L. There are two types of lithium poisoning(LP); acute and chronic poisoning(CLP). At acute poisoning there is a high dose intake accidentally or voluntarily. Besides CLP is caused by dose increase, deterioration of kidney function, and slow metabolism. In the literature, toxic symptoms have been described even in normal and low lithium levels. Although the level of lithium in our case has risen to toxic levels, no symptoms have been observed. The case is intended to be presented for this reason.

Case presentation: 55-year-old woman, married, housewife. The patient was followed for 2 years with a diagnosis of bipolar affective disorder by us. The last she came to policlinic with desire to sleep, lack of energy, inability to do housework, and unhappiness. She was hospitalized due to treatment incompatibility and lack of family support. She could not do housework. In the past, there was two mania, three depression, and a psychiatric hospitalization story.

In the mental condition examination of the patient, there were sluggish her outlook. There was depressed mood and affect. There were inability thoughts and monophobia in thought content. Her attention and concentration decreased. There was an increase in sleep and a decrease in appetite and desire. Hamilton depression score (HDS) was 38. 1th day of hospitalization valproic acid + sodium valproate (750 mg/day), lithium (1200 mg/day), bupropion (150 mg/day), quetiapine (200 mg/day) were started. TSH was high in routine analysis; so levothyroxine (100 mg/day) was started the patient. 5th day of hospitalization lithium blood level (LBL) was sent. LBL was 1.68 mE/L. There was no new developed indication of lithium poisoning (gastrointestinal system, neurological, or renal function). Lithium is a drug that must be used by monitoring. Çolak Oray et al., in a retrospective study of 18 lithium poisoning cases presented to the Dokuz Eylül University School of Medicine between 1993 and 2010, reported that all chronic poisonings were over 40 years of age and most of the cases had multiple drug use. At least one neurological symptom was observed in all of those who exceeded the lithium-level therapeutic upper limit in cases of CLP in the study. In addition to the many side effects of lithium, neurological side effects also tend to occur in normal lithium values. This is explained in the literature by the use of antipsychotic medication along with advanced age and lithium suppression in dopamine transmission. A case with all side effects of lithium below normal value (0.3 mEq/L) was reported in the literature. Considering the age of our case and the use of antipsychotic in combination, neurological and other side effects facilitating agents were present but no anticipated side effects. We think that monitoring is important even though there are no clinical symptoms.

KEYWORDS

Chronic lithium intoxication; lithium interval; lithium side effect; monitoring; multidrug use

[Abstract:0149][Neuroscience: Neuroimaging-Genetics-Biomarkers]

Electroconvulsive therapy in a depressed patient with skull defect

Emine Tuğçe Akçaer, Serdar Süleyman Can, Semra Ulusoy Kaymak, Sümeyye İslamoğlu and Ali Çayköylü

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Electroconvulsive therapy is a treatment option in patients with severe or drug-resistance depression and it is safe when used with general anaesthetics and muscle relaxants. Several contraindications like the presence of CNS neoplasms or a history of neurosurgery were reported for ECT treatments. This restriction is based on the risk of transient increase in intracranial pressure that occurs with the combination of these conditions and ECT treatment. But recent studies showed that ECT may be safely administered to patients with a

KEYWORDS

Defect; depression; electroconvulsive therapy; skull; treatment

history of neurosurgery or presence of CNS neoplasm without increased intracranial pressure. Here, we report on the successful administration of ECT to a depressed man with right parietal craniotomy after train accident.
Case presentation: Mr C was 41-year-old man admitted to psychiatry clinic with recent suicide attempt. He had several depressive episodes which are treated with paroxetine and sertraline treatments. At the time of the admission our hospital he was taking paroxetine, mirtazapine, and alprazolam treatments, but still had suicidal thoughts. Then the patient was hospitalized in our psychiatric ward. The patient was examined in our institute in April, 2017. He reported feeling depressed and inadequate, had ideas of guilt and suicide, woke in early hours of the morning, social isolation, and reported loss of appetite and loss of libido. His score on the Hamilton Rating Scale for Depression (HRSD) was 48 and met DSM-5 criteria for major depression. He also had a severe delusion of inadequacy although he had a good carrier in his business life. Because of feeling inadequate, patient had belief that he deserves to die. On physical examination, he had a palpable skull depression on his left parietal region. The patient had a train accident when he was 11-year old and he had a craniotomy after that accident. An MRI scan of the brain showed the craniotomy defect in right parietal bone and tissue loss in the adjacent temporoparietal region. MRI also reported subcortical white matter gliosis in left frontal region. His paroxetine treatment changed with venlafaxine 225 mg/day, and the mirtazapine 30 mg/day treatment remained the same. The valproic acid 1000 mg/day is added his treatment. But with these treatments patient's feeling of inadequate and depressed mood unchanged, ECT was considered. A neurosurgical service was consulted to assess the condition of the patient to undergo ECT safely and to help with the case management. There were no radiological signs of increased intracranial pressure and the neurosurgery consultation noted that ECT was not a risky procedure in this patient. After signed informed consent was obtained from the patient, ECT was performed with bilateral electrode placement. He did not show any neurological side effects after treatment. He received a total of 8 successful ECT treatments in 3 weeks. After the ECT treatment his Hamilton Rating Scale for Depression was 14 and his mood improved near baseline. If there are no signs of increased intracranial pressure, ECT with proper electrode placement can be given safely to patients with a history of craniotomy.

[Abstract:0150][Schizophrenia and other psychotic disorders]

Use of long-acting atypical antipsychotic in the elderly: a case report

Serdar Süleyman Can, Murat İlhan Atagün and Sümeyye İslamoğlu

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT
The pharmacokinetic and pharmacodynamic difficulties about drug usage in elderly patients is a compelling subject when it is necessary to use antipsychotic and this issue challenges the clinician. The difficulty increases in patients that already has a diagnosis of psychiatric disorder and refuses to use oral drugs. Because, the need for usage of long-acting antipsychotic drug occurs. In addition to the general side effects of the first and second generation antipsychotics, the increased risk of sudden death and stroke in elderly patients is an important issue. In this article, long-acting antipsychotic drug usage is presented in a 77-year-old patient under treatment of schizophrenia.
Case presentation: 77-year-old female patient had been brought to the psychiatry clinic by her relatives 4 years ago. Patient locked herself to her house by thinking that her husband poisoned her daughter, who died 15 days before the administration to the clinic because of renal failure. Therefore, she had been brought to the hospital with the help of her son. So as the treatment of delusions of persecution and reference the patient had been hospitalized. The patient who had been treated with the diagnosis of schizophrenia for 50 years, has tried so many antipsychotics and couldn't be able to continue the treatment regularly due to having side effects and no insight in this process. For treatment, paliperidone (6 mg/day) has been administered orally and 2 weeks later as the patient was showing no side effects, paliperidone palmitate long-acting treatment had been ordered.75 mg paliperidone palmitate injection had been done at 1st and 8th days and 1 month later the patient had been discharged with remission of the disease. The patient had a continued state of well-being in the 3rd year follow-up; so one year ago the treatment was rearranged as 50 mg/month. And the state of well-being still continues. Non-adherence with medication in schizophrenia is an important subject. This condition is also referred as "pseudo resistance." As a consequence, we believe that proper dosage of long-acting atypical antipsychotic drug use in elderly patients at clinical practice should be kept in mind.

KEYWORDS
Antipsychotic; case; elderly; long acting; schizophrenia

[Abstract:0154][Psychopharmacology]

Nocturnal encopresis after methylphenidate use in a seven-year-old boy

Arif Önder[a], Aslı Sürer Adanır[b], Canem Kavurma[a], Öznur Bilaç[a] and Yakup Doğan[a]

[a]Manisa Mental Health Hospital, Department of Child and Adolescent Psychiatry, Manisa, Turkey; [b]Akdeniz University Hospital, Department of Child and Adolescent Psychiatry, Antalya, Turkey

E-mail address: arifonder86@gmail.com

ABSTRACT

Encopresis is defined by involuntary or intentional recurrent faecal incontinence according to the DSM-5. Although the exact aetiology of encopresis was not known, studies showed that it was associated with a large number of psychiatric disorders. But nocturnal encopresis is often caused by an organic cause and requires detailed medical examination. This article will discuss the occurrence of nocturnal encopresis after the use of methylphenidate.

Case presentation: M.U.B. is seven years old. He is a student in the second class. He came to the outpatient clinic with his mother because of complaints of inattention, hyperactivity, and academic failure. It was observed that he was very active and constantly spoiling the goods on the table in the policlinic. He spelled out and read slowly when he wanted to read. The story taken from her mother showed that he had been active since kindergarten, there had been a lot of complaints from the school due to his hyperactivity in first grade. No illness was described in the general medical story. His developmental stages were normal. He gained toilet training in time. There was no medical or psychiatric illness in the family. In the next interview, he was diagnosed ADHD – Combined Type and Specific Learning Disorder after evaluating Teacher Information Form, Turgay Disruptive Behavior Disorders Screening Scale and intelligence test results. Long-term methylphenidate treatment started with 10 mg after blood transfusion, blood pressure and height weight measurement. We learned that hyperactivity and attention problems decreased in the control after two weeks but he started to defaecate every night when he took the drug. Constipation was not described. A week after the medication was discontinued, there is no repetition of the complaint about the defaecation. Methylphenidate treatment was resumed after the neurology and paediatric consultation requested no abnormality. Because the complaint of defaecation restarted after a week, the treatment was stopped and the treatment with atomoxetine was switched on. After one month of treatment with atomoxetine, we learned that attention and hyperactivity problems decreased and now he was compatible in school. Later on, he never had a complaint of defaecation again in his next controls. We are still following him regularly in our outpatient clinic. To our knowledge, the present case is the first case where nocturnal encopresis is seen after methylphenidate used in the literature. In the cases with attention-deficit/hyperactivity disorder and comorbid encopresis, the efficiency of the methylphenidate treatment has been showed in both the symptoms of attention-deficit/hyperactivity disorder and encopresis. There is a case report showing the effect of methylphenidate in imipramine and sertraline resistant encopresis without attention-deficit/hyperactivity disorder. Methylphenidate is believed to provide this effect on encopresis with executive functions, impulse control, and increased awareness of internal stimuli. It is unclear which mechanism of methylphenidate treatment led to nocturnal encopresis in our case. However, the reduction in complaints with the withdrawal of methylphenidate and recurrence in complaints after we restart methylphenidate shows that that side effect is caused by methylphenidate treatment.

KEYWORDS

Attention-deficit disorder with hyperactivity; child; encopresis; faecal incontinence; methylphenidate

[Abstract:0159][Schizophrenia and other psychotic disorders]

Pulmonary thromboembolism after the use of rısperıdone: a case report

Özgen Özçelik[a], Hüseyin Kara[a], Talya Tomar[b] and Buket Cinemre[a]

[a]Department of Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey; [b]Akdeniz University School of Medicine, Antalya, Turkey

E-mail address: drozgendeu35@yahoo.com

ABSTRACT

Substance use can lead to various psychiatric diseases; patient's life quality can be affected negatively. One of the clinical situations that Meyer described in 1986 between substance use and psychopathology is "Psychiatric symptoms or disorders resulting from substance abuse or addiction." One of these is the psychotic disorder due to substance use. In the

KEYWORDS

Antipsychotics; embolism; pulmonary; risperidone; side effect

recent years, atypical antipsychotics have been used more frequently than typical antipsychotics in the psychotic disorder due to substance use. This article aims to discuss the occurrence of pulmonary embolism following the use of repository preparation and oral tablets of risperidone in an inpatient who was followed up for substance-induced psychosis in the psychiatric clinic of the Akdeniz University.
Case presentation: 20-year-old male patient, single, did not complete high school. He was brought to the emergency room with complaints like keeping talking with himself, susceptibility to family members, no sleep, staring into vacancy for the last 15 days. He stated that a pill came into his mouth once while he was drinking water, but he did not know who put it in, also sometimes he keeps talking to himself about God and heaven, but he doesn't remember any reasons for it. He was hospitalized with pre-diagnosis of psychosis. In his history, the use of cannabis and ecstasy was present 2–3 years ago. He stated that he did not use them in the near past and olanzapine, aripiprazole, quetiapine, Risperdal were the drugs that he used. Tobacco and alcohol use were present. His speech speed, rhythm, and amount decreased; depressive mood, blunted affect, scepticism, delusions, decreased psychomotor activity, which hasn't got suicidal homicidal thoughts but describes disconnection in associations and auditory hallucinations, were detected in the mental status examination. The treatment started with Depakine 500 mg 2 × 1, Risperdal tablets 4 mg 2 × 1, and Risperdal repository preparation 50 mg in 15 days. After the second injection of Risperdal repository, he stated that he had acute chest pain and weakness. Immediately, patient hooked up to ECG machine. Cardiac enzyme test ordered for the patient who had sinus arrhythmia and his heart rate was about 45. Because of the suspicion for pulmonary embolism, D-dimer test was ordered, and it was high. Due to this, CT angiography was done and subsegmental pulmonary embolism was found in the right lower lobe. Treatment started as heparin 0.6cc twice per day and patient's sinus arrhythmia cleared up. Risperidone is the preferred treatment in acute and chronic schizophrenic psychoses and in psychotic situations involving positive-negative symptoms, but its side-effects can be mortal. Clozapine was the first of atypical antipsychotics that was observed a relationship with venous thromboembolism. Generally, antipsychotic agents are associated with increased aggregation of platelets. Conversely, in vitro studies have shown no direct effect of risperidone on fibrinolysis, plasma coagulation, and platelet function. But since atypical agents show high affinity to serotonin receptor type 2, serotonin-related platelet aggregation may be affected. We aim to reconsider venous thromboembolism as one of the side-effects of antipsychotic drugs and its development mechanisms.

[Abstract:0160][Psychopharmacology]

Tardive oculogyric crisis during treatment with amisulpride

Yusuf Tokgöz, Taner Öznur, Abdullah Bolu, Cemil Çelik and Özcan Uzun

Department of Psychiatry, Gulhane Research and Training Hospital, Health Sciences University, Ankara, Turkey

E-mail address: tbptokgoz@gmail.com

ABSTRACT
Tardive Oculogyric Crisis (OGC) is a dystonic syndrome that occurs following long-term dopamine receptor antagonist use. Tardive dystonic syndromes commonly develop due to high potency antipsychotics. When such an adverse effect occurs, treatment is usually switched to an atypical antipsychotic (commonly clozapine). Even so, cases of atypical antipsychotic-related OGC cases have been reported. OGC cases linked to olanzapine, aripiprazole, clozapine, and amisulpride have been described in the literature. Pathophysiology of the syndrome is still not clear. Some relevant risk factors have been defined. This presentation will examine an OGC case that occurred with amisulpride.
Case presentation: The patient, Mr E., has been started on amisulpride treatment with a diagnosis of schizophrenia following a 10-year history of psychiatric complaints. The dose was increased incrementally. The patient started exhibiting OGC after 6 months of 400 mg/day amisulpride treatment. Treatment was quickly switched to clozapine. The symptoms of OGC are still ongoing. Patient is currently receiving 600 mg/day clozapine, and the psychotic symptoms are still in remission. While treatment can be achieved by switching to atypical antipsychotics in some patients with OGC; some OGC cases (like ours) can develop because of atypical antipsychotics. There is even a case report of OGC starting after discontinuation of amisulpride. All these facts lead us to the conclusion that OGC might be caused by a receptor-level dysregulation rather than by a pharmacologic origin.

KEYWORDS
Amisulpride; cases; crisis; oculogyric; tardive dystonia

[Abstract:0161][Mood disorders]

Clozapine treatment of rapid cycling bipolar disorder: a case report

İkbal İnanlı, Deniz Altunova, Ali Metehan Çalışkan and İbrahim Eren

Konya Research and Training Hospital, Konya , Turkey

E-mail address: denizaltunova@hotmail.com

ABSTRACT

Rapid Cycling Bipolar Disorder (RCBD) is a rare psychiatric disorder that is characterized by at least four affective episodes manic, hypomanic or major depressive during the past twelve months. From the perspective of pathophysiology, multiple factors have been hypothesized that include genetic factors, thyroid dysfunction, menstrual disturbance, circadian rhythm disturbances and psychotropic medications. Rapid cycling is an independent predictor of inadequate treatment response in patients with BD and is associated with greater morbidity vs. non-rapid-cycling disease. We present the case of severe, treatment-resistant RCBD that responded to clozapine.

Case presentation: Patient is a 53-year-old, married, female, diagnosed with BD. Over the next 3 days she developed symptoms of mania with hyper-irritability, high energy, decreased need for sleep, and increase in goal-directed activity and psychotic symptoms such as grandiose and persecutory delusion, She was more talkative and admitted to racing though. Patient who received BD 10 years ago had multiple episodes of manic and depressive episodes. Particularly in the last four years, the number of episodes increased and the patient was admitted to the hospital due to manic and depressive episodes 11 times and four times serious suicide attempt was made. Since the patient was diagnosed, has used lithium, quetiapine, olanzapine, risperidone (oral or depot) and valproic acid. Even if patients' treatment adherence is occasionally impaired, she used treatments regularly, with effective dose and duration. We agreed RCBD which patient had minimum of 4 mood episodes in the past 12 month period, which included mania, hypomania, and depression symptoms along with partial remission for at least 2 months as per family due to DSM-5 criteria, and treatment-resistant. In this admission, AB was started on clozapine 25 mg, quetiapine 400 mg, and lorazepam 4.5 mg. Regular monitoring of renal and liver function, blood sugar level and CBC was performed to monitor the side effects of the medications. Clozapine was gradually titrated and reached 400 mg on hospital day, and patient showed significant improvement in her symptoms of manic and psychotic. She was discharged at the 6th week of hospitalization with clozapine 400 mg/day and quetiapine 300 mg/day. It was determined upon the last examination that she had been on treatment with clozapine for one year, had a manic episode due to her withdrawal of clozapine and near-total improvement, and symptomatic healing was complete during inter-episode period. Clozapine, an atypical antipsychotic, is primarily used for the treatment of treatment-resistant schizophrenia, and may also have a role in other treatment-resistant psychotic conditions, such as schizoaffective disorder and psychotic mood disorders. Furthermore, the many studies suggest that clozapine may be particularly effective in the treatment of medication-resistant unipolar depression and bipolar disorder. RCBD is a complex, often severe and disabling psychiatric disorder and it often poses a therapeutic challenge. We believe that clozapine may be a safe and effective therapeutical tool for the mid- and long-term treatment of RCBD.

KEYWORDS

Bipolar disorder; clozapine; rapid cycling; treatment; remission

[Abstract:0164][Mood disorders]

St. John's wort-induced mania: a case report

Tüba Şerife Elmas, Yasemin Gökçenoğlu, Saliha Çalışır, Ali Baran Tanrıkulu, Şenay Yıldız Bozdoğan and İbrahim Eren

Department of Psychiatry, Health Sciences University Konya Research and Training Hospital, Konya, Turkey

E-mail address: tubaserife@gmail.com

ABSTRACT

Herbal preparations are known to many people as natural and safe. St. John's wort (SJW) is a popular herbal product often self-prescribed for depression. Hyperforin and hypericin (components of St. John's wort) inhibit synaptosomal serotonin, noradrenaline, and dopamine uptake [1]. Also, SJW has been used traditionally for the treatment of neuralgia, fibromyalgia, menopausal neurosis, anxiety, depression and in topical preparations for the treatment of wounds. Many studies have shown that St John's wort is superior to placebo in the treatment of mild-to-moderate depression [2]. We report a case of mania induced by Hypericum perforatum (SJW).

KEYWORDS

St. John's wort; self-medication; herbal products; side effects; bipolar disorder

Case presentation: A 38-year-old female presented with symptoms such as self-laughing, restlessness, mobility, doing too much work, increasing religious habits, reading a lot of books, making lots of shopping, scepticism, vulnerability, irritability, insomnia, rapid speech, increased sociability and sexual interest, and cheerfulness, which has persisted for the last 2 weeks. The patient was brought to the outpatient clinic by her relatives and was hospitalized for close follow-up and treatment. She had taken SJW every night during the last month for depressed mood, in the form of herbal tea. On psychiatric examination, increased self-care, showing age, mood was irritable, affective lability, amount of speech and speed increased, associations scattered, activity increase towards purpose, sleep-appetite deteriorated, no perceptual pathology was detected, psychomotor activity increased, flow of thought accelerated, grandiose and mistic deliriums were detected. Her physical and neurological examinations were unremarkable. Laboratory results were normal. The case was diagnosed as manic episode. The treatment of the patient with olanzapine 7.5 mg/day was regulated. It was suggested not to use SJW. Most patients with bipolar disorder experience an 8- to 10-year delay in proper diagnosis; many patients (approximately 25%) presenting initially with depression will have occult bipolar illness. Alternatively, these patients may have simply cycled through depression to mania as part of their underlying illness. SJW seems to be developing symptoms of the disease and speeding up the cycle [3]. In our case, absence of a known psychiatric illness of the patient, manifestation of manic symptoms after the use of SJW, and a depressive episode prior to presentation are proper to the literature. We aimed to increase awareness of psychiatric side effects of herb. Although the mechanism of St. John's wort is not yet fully understood, St. John's wort carefully should be used, especially in patients with bipolar disorder.

References

[1] Henderson L, Yue QY, Bergquist C, et al. StJohn'swort (Hypericumperforatum): druginteractionsandclinica-loutcomes. Br J Clin Pharmacol. 2002;54:349–356. doi:10.1046/j.1365-2125.2002.01683.x

[2] Barnes J, Anderson LA, Phillipson JD. St John's wort (Hypericum perforatum L.): a review of its chemistry, pharmacology and clinical properties. J Pharm Pharmacol. 2001;53:583–600.

[3] Lish JD, Dime-Meenan S, Whybrow PC, et al. The national depression and manic-depression association (DMDA) survey of bipolar members. J Affect Disord. 1994;31:281–294.

[Abstract:0166][Psychopharmacology]

Folic-acid-deficiency-induced leucopenia before clozapine treatment

Serdar Süleyman Can, Murat İlhan Atagün, Fatma Şahin, Sümeyye İslamoğlu and Ali Çayköylü

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Clozapine, an atypical antipsychotic, is the only antipsychotic whose effectiveness on resistant schizophrenia has been shown with certain evidence. Side effects due to clozapine usage are seen, such as sedation, hypotension or hypertension, tachycardia, hypersalivation, fever, nausea, weight gain, metabolic side effects, decrease in threshold level of epilepsy, and hematological side effects. The most important side effects restricting usage and could be fatal are leucopenia and agranulocytosis.

Case presentation: 61-year-old, female patient, had been followed by diagnosis of schizophrenia; have presented with erotomaniac, persecutive delusions and audiovisual hallucinations. She has had several long-term psychiatry hospitalizations, even though she used several different types of antipsychotic combinations for last six months, she was using amisulpride 1200 mg/day, haloperidol 10 mg/day, risperidone consta 50 mg/15days but her erotomaniac, persecutive delusions were continuing. It is planned to start clozapine treatment after ceasing current medication. However, in the routine blood test results, WBC value was found to be 2580 and for this reason, she was consulted to hematology department. The plan of clozapine initiation was postponed. Lymphopenia was detected in peripheral smear. According to the results of the recommended test, ANA value is positive (borderline), and folic acid level was dramatically low. Because of ENA profile is normal, Rheumatology department did not have additional recommendation. Considering the fact that low level of WBC is related to low level of folic acid, folate replacement of the patient was started with suggestion of hematology department. Gradual increase of WBC is recorded in the second week of folic acid replacement. The most important function of folic acid in the body is synthesizing purine and thymine, and these are used for DNA synthesis. In the folic acid deficiency, the structure of DNA and RNA are effected, and blood cells' production decrease. Not only RBC but also WBC decrease. There is an increase in WBC value after 2 week usage of folic acid. In conclusion, folate levels were needed to be considered in the patients who have deficiency of WBC before clozapine treatment.

KEYWORDS

Clozapine; folic acid; leucopenia; schizophrenia; treatment

[Abstract:0167][Other]

Misophonia: a disorder of the modern world

Murat İlhan Atagün, Serdar Süleyman Can and Sümeyye İslamoğlu

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT
Chewing, coughing, breathing, and typing are activities that produce low level sounds and these audible activities are frequently encountered in the society. These background sounds are usually ignored in public places or at home. Some people may not ignore and perceive these sounds and become disgusted. Reasons of disgust are distraction and anger. Anger might be followed by an urge to leave the environment or intercept the background noise. Sensitivity to the group of background noise is called misophonia.
Case presentation: It was aimed to present and discuss two cases of misophonia in this presentation. The first case was a young man with generalized anxiety disorder. He was also suffering from misophonia and misophonia-triggered anger. He reported that particularly his family life was devastated because of his anger. The second patient was suffering from obsessive-compulsive disorder and misophonia. She reported that she was counting to ten, breathing slowly or leaving the environment as soon as possible, if she cannot relax. She was frequently listening to music with headphones to avoid from disgusting sounds. Both patients reported that they could not express themselves during their disgust, because of inhibiting themselves due to the fear of being called crazy. Current classification systems have not defined misophonia yet. However, misophonia might be a dimensional concept and dysregulation of emotions (anger). Quality of life in patients with misophonia might be disturbed more than patients without misophonia. This symptom/dimension should be further examined since it deteriorates clinical course of disorders.

KEYWORDS
Anger; case; generalized anxiety disorder; misophonia; obsessive-compulsive disorder

[Abstract:0172][Eating disorders]

Avoidant/restrictive food intake disorder after grief reaction

Yusuf Tokgöz, Abdullah Bolu, Taner Öznur, Cemil Çelik and Özcan Uzun

Gulhane School of Medicine, Department of Psychiatry, Health Sciences University, Ankara, Turkey

E-mail address: tbptokgoz@gmail.com

ABSTRACT
Avoidant/restrictive food intake disorder (ARFID) began to take place in feeding and eating disorders with DSM-5. A case with ARFID which started after grief reaction will be discussed in this poster presentation.
Case presentation: A 72-year-old female patient was admitted to our clinic because of disgust from eating, no eating, and sleep disturbances. It is understood from the story that she lost her husband about a year ago, had depressive symptoms that started afterwards, started the pathological grief process and recovered with the treatment. However, with this process, it is understood that the patient has an eating disorder with complaints of disgusting from food and avoidance from eating despite of the absence of depressive symptoms. The patient has a history of depressive symptoms which responded to SSR1 treatment with 6 months, about 10 years ago. Patient's mental status examination: Though content is concentrated on disgusting taste and smell of foods. There wasn't any psychotic symptoms. Behaviours were distorted in the style of avoiding food intake. Mirtazapine was started with 30 mg/day dosage because of AFRI. Psychiatric control was recommended monthly.
AFRID is mostly seen in young patients. Starting in elder ages and after grief reaction is very different and rare. This case presentation aims to contribute to the literature.

KEYWORDS
ARFID; avoidant; food intake disorder; grief; restrictive

[Abstract:0174][Psychopharmacology]

Extremely high prolactin level due to risperidone in a chronic renal failure patient

Serdar Süleyman Can, Murat İlhan Atagün, Ceren Çamur, Görkem Karakaş Uğurlu and Sümeyye İslamoğlu

School of Medicine, Department of Psychiatry, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Hyperprolactinemia, an important side effect of antipsychotic treatment, clinically is defined as serum prolactin levels higher than 18 ng/mL for men and 30 ng/mL for women. This condition causes gynecomastia, galactorrhea; sexual dysfunction, infertility, oligomenorrhea, and amenorrhea and also leads to osteoporosis by decreasing bone mineral density. The mentioned important side effects may cause patients not to continue the treatment.

Case presentation: 30-year-old, married, primary school graduate, female patient. For 1 year, the patient is undergoing haemodialysis therapy because of chronic renal failure. Her first symptoms appeared as dullness, pessimism, sensitiveness when she was 24 years old. At the age of 27, Olanzapine 20 mg/day had been prescribed to the patient, whose present complaints expanded with the recently exhibited complaints such as thought of being followed (persecutory delusion), visual and auditory hallucinations, and thinking oneself as a Saint (grandiose delusion), by her consultant psychiatrist under the diagnosis of schizoaffective disorder. This treatment had been associated with poor adherence as she could not be able to detect a benefit from the medication. The patient, having the behaviour of hurting herself by hitting her head against walls, had been admitted to the hospital for medical treatment regulation. Olanzapine dosage had been reduced to 10 mg/day and then stopped. Risperidone 1 mg/day had been initiated and gradually increased to 4 mg/day. Initial serum prolactin level of the patient had been measured as 47 ng/ml on 1st day of medication and scaled up to 1350 ng/ml on 10th day control. So Risperidone therapy had been discontinued by consulting to Endocrinology Department. On following days, the levels of the drug had been evaluated as 1225 ng/ml and 1025 ng/ml respectively on the 1st and 2nd days of dosage reduction. The patient, continued displaying psychotic symptoms, had been started on aripiprazole 15 mg/day. As a result, it is recommended to pay attention to the use of antipsychotics drugs, increasing the blood levels of prolactin in patients with diseases as chronic renal failure elevating the levels of that hormone in blood.

KEYWORDS

Antipsychotics; hyperprolactinemia; prolactin; renal failure; risperidone

[Abstract:0178][Psychopharmacology]

Risperidone-induced pretibial oedema: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT

Risperidone that combines potent D2 and 5-HT2 receptor antagonism is a widely prescribed atypical antipsychotic agent that can be effective in especially schizophrenia and bipolar disorder. The most common side effect is known as weight loss and sedation. However, there have been recent reports of possible oedema as a side effect. In this article, we present a case of pretibial oedema that risperidone is added to the current treatment and recovers after it has been discontinued.

Case presentation: A 63-year-old man with a 16-year history of bipolar disorder and on a maintenance dosage of trifluoperazine (2 mg/d) and valproic acid (1000 mg/d) was admitted to our psychiatric clinic because of restlessness. Examination of his medical history was unremarkable, is remission of bipolar disorder. His laboratory results, chest radiograph, ECG, and electroencephalography were all normal. We replaced the trifluoperazine with risperidone 2 mg/d. By the end of this 3-day period, although his complaints improved, a 3+ pretibial oedema developed in both the patient's tibia without pain. His complete blood count, kidney function tests, liver function tests, thyroid function tests, protein, electrolytes, and sedimentation were tested repeatedly, but there is no explanation for the oedema. A consultation with nephrologist, endocrinologist, and cardiology remained normal. We suggested that his oedema might have been due to risperidone. We discontinued

KEYWORDS

Adverse effect; bipolar disorder; pretibial oedema; risperidone; side effect

risperidone, and the oedema completely reduced within 5 days. We introduced aripiprazole (5 mg/d) and his oedema did not recur. According to Naranjo algorithm, probable of adverse reaction due to risperidone-induced pretibial oedema: 5–8 = Probable adverse effects were identified. This patient had no previous physical illness, including cardiac, renal disease, and hypertension and developed pretibial oedema when he was administered risperidone. After the end of the risperidone, oedema reduced. We have yet to find another alternative cause that more clearly describes the development of oedema in our patient. The route of administration, the route of the solution and the temporal relationship revealed a negative reaction after the treatment of risperidone. However, the aetiology of patient's pretibial oedema remains unclear. Therapeutic efficacy of risperidone on renal and peripheral vessels has been suggested in possible mechanisms. In addition, allergic reactions to non-therapeutic components of risperidone should always be considered. Since an open mechanism of risperidone-induced pretibial oedema is not known, further studies are needed to determine dose dependence, risk factors, and potential mechanisms and the appropriate treatment modality for this condition. We think that the current article will warn physicians treating with risperidone to be careful with oedema.

[Abstract:0179][Psychopharmacology]

Fluoxetine-induced symptomatic hyponatremia in the young woman: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT

Introduction: SSRIs are often prescribed antidepressants in everyday practice. Fluoxetine (an SSRI) is used for the treatment of depression, anxiety disorder, obsessive-compulsive disorder, and bulimia nervosa. Fluoxetine (an effective and well-tolerable antidepressant) has the favourable adverse effect profile. The most common side effect of it are nausea, headache, diarrhoea, and insomnia. Sedation and orthostatic hypotension are less common as side effects. But in the literature, hyponatremia due to fluoxetine use has not yet been reported in young patients without risk factors. Here, we report a case of Fluoxetine associated with hyponatremia with 40 mg/d of fluoxetine taken for 2 weeks with no other concomitant drugs and no known risk factors in a 35-year-old-female. This article is an attempt to add to this available literature.

Case presentation: Ms D is a 35-year-old, female, single, graduated from college, and works as a nurse. She was admitted to our outpatient clinic with depressive symptoms such as sad mood, poor sleep quality, anhedonia, easy fatigability, lack of interest, lack of confidence, death wishes and, according to the DSM-5 criteria, diagnosed depressive disorder. Fluoxetine 20 mg/d. was ordered to the patient and it was titrated up 40 mg/d in three weeks. Her laboratory studies was normal and she had no history of vascular/cardiac/kidney risk factors. She had no other concomitant drugs. She had a body mass index of 24.8. Investigations on the day of admission were as follows: serum sodium: 137 mEq/l; serum potassium: 5 mEq/l. ECG was normal. After 2 weeks of excretion at 40 mg, the patient was brought to the emergency room with unconsciousness, nausea, vomiting, pain in the muscles, and malaise. Examination of the cardiovascular systems and ECG and tension arterial and pulse were within normal limits. Central nervous system examination revealed no focal neurological deficit. The other examinations were normal limits. In her laboratory tests, serum sodium was 130 mEq/l. Other electrolytes were within normal limits. The patient treated with intravenous normal saline infusion. Serum sodium measurements were done when left from emergency room: day 138 mEq/l on day 7, 137 mEq/l. because there was no other evidence to explain the cause of hyponatremia, fluoxetine was thought to be associated with the use, and fluoxetine intake was discontinued. Serum sodium level was within normal limits in subsequent controls. Hyponatremia is a rare side effect of fluoxetine and is mostly seen in the elderly population. We think that the cause of hyponatremia is fluoxetine because the temporal relationship is considered and that hyponatremia improves after fluoxetine is discontinued. It is suggested that fluoxetine-induced hyponatremia is a syndrome of inappropriate antidiuretic hormone. Elderly patients and patients using diuretics are at risk. Physicians prescribing fluoxetine, especially for elderly patients and taking diuretics, should be aware of the possibility of hyponatremia presenting with symptoms of consciousness.

KEYWORDS

Antidepressant; depression; fluoxetine; hyponatremia; side effect

[Abstract:0180][Psychopharmacology]

As a psychiatric emergency, metoclopramide-induced oculogyric crisis: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT

Introduction: Side effects of drugs affecting the central nervous system may require an emergency psychiatric approach. Acute dystonia, a type of extrapyramidal side effects that occur with a variety of medications, seems to be frequent. Dystonia that is resulting in twisting, repetitive, and abnormal positions is a movement disorder, including involuntary, sustained, or spasmodic contractions of muscle groups. The oculogyric crisis is a type of acute dystonia seen with frequently used drugs and is common with the use of metoclopramide. Metoclopramide is a dopamine antagonist that is widely prescribed in nausea and vomiting caused by enteritis in clinical practice. We present a case of metoclopramide-induced oculogyric crisis reaction in a setting which was managed with an anticholinergic drug.

Case presentation: The patient was 19-year-old, female, single, and student. She was consulted by the department of internal medicine with the complaint of crying, anxiety, and involuntary right and upward swings of the eyes. She was kept under observation due to vomiting and abdominal pain in the service. The patient's vital values were normal and complete blood count, liver and kidney function tests, ECG and electrolytes were normal. Ophthalmologist's eye examination was normal. The patient was able to bring her eyes to normal, but she slipped shortly. She also had a lot of pain and crying. It was learned that the patient received intravenous 5 mg of metoclopramide 10 minutes before. The vomit had passed, but her complaints began. We decided that oculogyric crisis reaction originated from metoclopramide because the complaints began suddenly after the intake of metoclopramide. Therefore, 5 mg biperiden intramuscularly was administered to the patient and after 15 minutes the complaints of the patient disappeared. There was no problem following the patient. Our patient's sudden onset of symptoms, rapid progression and rapid response to biperiden suggested metoclopramide as a cause of oculogyric crisis. When the literature is examined, there are cases of acute dystonia and oculogyric crisis originating from metoclopramide. According to this case, this side effect is dose-independent and there is evidence that it may be familiar. The most likely mechanism of metoclopramide-induced oculogyric crisis is that metoclopramide causes extrapyramidal side effects due to altered dopaminergic-cholinergic balance in nigrostriatum. It produces acute dystonic reactions via a nigrostriatal dopamine D2 receptor blockade, which suggests that it results in excessive striatal cholinergic response. Metoclopramide is a drug that is often prescribed as antiemetic. This article aims to increase clinicians' awareness of the side effects of continuous medications and the way they are treated.

KEYWORDS
Adverse effect; dystonia; metoclopramide; oculogyric crisis; psychiatric emergency

[Abstract:0181][Psychopharmacology]

Sertraline-induced hair loss: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT

Hair loss is a side effect of drugs often seen but it is difficult to say that you are often seen with psychotropic drugs. Hair loss is rarely seen with antidepressants that we often use in clinical practice. SSRIs are antidepressants used in many psychiatric disorders, including depression, anxiety, OCD, and panic disorder. A large number of antidepressant-induced hair loss cases have been reported in the literature. Drug-induced hair loss is reversible and heals without scarring. But before you make a decision, it is necessary to rule out all pathologies that affect hair loss. (hyperthyroidism, hypothyroidism, trichotillomania, hormonal disorders hypothalamic-pituitary-gonadal axis, iron, copper, zinc, menopause, oral contraceptives, and

KEYWORDS
Alopecia; antidepressant; hair loss; sertraline; side effect

use of other drugs). Here, we describe the case of a postpartum depressed woman who complained of hair loss with sertraline, but not with paroxetine.
Case presentation: Mrs. P, a 31-year-old woman, graduated university, and works a doctor. She was admitted to our outpatient clinic with complaints of unhappiness, reluctance, fatigue, and crying. According to DSM 5 criteria, after the clinical interview she was diagnosed with postpartum depression and was first treated with sertraline progressively increased to 50 mg/d. The Hamilton Depression Scale (HAM-D) and Hamilton Anxiety Scale (HAM-A) scores were 42 and 45, respectively. Her medical history had no traits, no personality disorder, and no medication. She received sertraline (50 mg/d) during a total of 8 weeks. There was a decline in complaints at the check-up examination (HAM-D and HAM-A is 24 and 26, respectively) but she noticed hair loss when she comped or washed her hair. The patient's laboratory tests and dermatologist examination were normal and there were no factors that could explain hair loss. Paroxetine 10 mg/d was initiated with patient's sertraline being reduced because the patient found hair loss unacceptable. After four weeks the hair loss stopped completely and did not recur. According to the Naranjo Side Effect scale, it was considered as a possible side effect. In the present case, we recommend that sertraline be used as a possible cause of hair loss because the patient has arrived after using sertraline for hair loss awareness and there is no other explanation for hair loss. In addition, all of the hospital's laboratory tests and dermatology consultations were normal. Although there is limited information on drug-induced hair loss, there are case presentations in the literature. The mechanism of sertraline-induced hair loss is not clear, but the most likely mechanism is that direct toxic effects of sertraline on the hair follicle matrix can be considered as the cause of hair loss. It is thought to be mostly recycled. Drug-induced hair loss is not considered much by clinicians, even if it is important to discourage treatment by patients. Clinicians should also be cautious about cosmetic side effects in terms of continuing treatment of patients. More studies are needed to better understand sertraline-induced hair loss.

[Abstract:0182][Psychopharmacology]

Effect of vortioxetine on cognitive functioning: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT
Introduction: Alzheimer's disease is becoming more prevalent with the increasing frequency of it. Although the decline in cognitive function with age is considered normal, it is important to determine where Alzheimer's begins. It is also important to be able to differentiate Alzheimer's from other neurological and psychiatric diseases, especially depressive disorders.
Vortioxetine with multimodal activity is a new antidepressant used to treat depressive disorder. It is also known to be a curing effect of cognitive functions. Vortioxetine, which is a safe antidepressant that is well tolerated, is currently only indicated for depressive disorder.
In this article, we present an improvement with the use of vortioxetine in a patient who has received two years of Alzheimer treatment and does not benefit.
Case presentation: A 50-year-old, married, graduated university, work as a teacher woman with a 2-year history of memory impairment presented with worsening forgetfulness, confusion, reduced speech, lack of enjoyment. She had used memantine 5 mg/d and donepezil 10 mg/d for two years, recommended by the neurologist for Alzheimer's treatment. The patient's Mini Mental status Examination (MMSE) score (20/30) represented a two-point deterioration in two years. Also, her Hamilton Depression Scale (HAM-D) and Hamilton Anxiety Scale (HAM-A) scores were 17/53 and 13/56, respectively. The patient had without a family history of dementia. There was no organic pathology that could explain the patient's complaints. After detailed psychiatric examination, her Alzheimer's drugs stopped because it was thought no effective. The patient was diagnosed with depressive disorder and a multimodal antidepressant, vortioxetine 10 mg/d was started and titrated 20 mg/d after two weeks. After six weeks of control the patient learned that his complaints were significantly reduced and he felt better. Such that, her MMSE, HAM-D, and HAM-A were 27/30, 11/53 and 6/56, respectively. All tests at the 12th week of the study were within normal limits and the patient had no complaints. In the presented case, although the patient was treated for two years with the diagnosis of Alzheimer's, the patient showed a decline in cognitive function. And the patient's complaints passed after three months of treatment with 20 mg/d of vortioxetine. The temporal relationship between the decompression of the patient's complaints and the onset of vortioxetine may show us that vortioxetine has a positive effect on cognitive function. On the other hand, the continuation of cognitive dysfunction in spite of the Alzheimer's treatment of the patient may suggest that the diagnosis of the patient is wrong.

KEYWORDS
Alzheimer's; antidepressant; cognitive functions; demans; vortioxetine

Recent studies on animals and humans show that vortioxetine has a positive effect on specific cognitive functions. it is suggested that this different effect is due to different mechanism of action and multimodal activity compared to other antidepressants. Clinicians should be more careful in distinguishing between dementia and depression, which will increase the quality of treatment for patients and prevent unwanted outcomes. In addition, for the effect of vortioxetine on the destruction of Alzheimer's cognitive functions, further and controlled studies are needed.

[Abstract:0183][Psychopharmacology]

Sulpiride-induced prostatism in young patient: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT

Prostatism, which affects the quality of life negatively, is an uncomfortable condition. Although in males the frequency increases with age, sometimes it can be seen as a side effect of drugs. There are reports in the literature that they appear to be side effects of psychotropic drugs such as venlafaxine and milnacipran. But prostatism due to use of sulpiride has not been reported yet. Sulpiride, a selective dopamine D2 receptor antagonist, has antipsychotic and antidepressant properties.

Here, we report to that sulpiride-induced prostatism in young male.

Case presentation: The patient, a 20-year-old single male, visited Sultan Abdulhamid Han Research and Training Hospital-Istanbul in November 2017 with a chief complaint of suffering from accident and amnesia. Before coming to psychiatry, he had visited other clinics such as neurology and neurosurgery for the same complaints. In spite of memory test and brain MR results and assurance from physicians, the patient still insisted that he suffered from complaints. Due to persistent fear of loss of memory, the patient was finally referred to our psychiatry clinics for psychiatric evaluation. He was admitted to the psychiatric clinics for further evaluation and management then started to escitalopram 10 mg/d and sulpiride 50 mg/d. After two weeks on medication, his fear of accident and loss of memory subsided but he started to complain waiting for urination to start, interrupted urination, dripping at the end of urination, and disrupted forward projection of urine. After internal and urology consultations and laboratory tests, we think that the cause of prostatism may be sulpiride. The sulpiride was stopped and the complaints of the patient were over in less than 1 week. According to the Naranjo causality scale, this side effect was probably induced by sulpiride. It is true that male patients but not young male, but it is not clear whether this is due to the severity of the medications or the illness. The presented patient developed prostatism while in early remission, suggesting that it was unlikely to be due to illness. Prostatism was found to appear with the initial 50 mg/d, with subsequent dose discontinuation led to its disappearance. Temporal relationship and passing of symptoms after medication suggest that the cause of prostatism is sulpiride.

Sulpiride does not have adrenergic and cholinergic effects like some antipsychotics. Some animal studies suggest the role of D1 and D2 receptors on urinary reflexes. Further studies are needed to characterize sulpiride-induced prostatism. Also, clinicians should consider the risk of prostatism when prescribing sulpiride, which is often used in elderly patients.

KEYWORDS

Antipsychotics; prostatism; sulpiride; side effect; young patient

[Abstract:0184][Psychopharmacology]

First-episode psychosis-induced withdrawal of pregabalin abuse: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: dribrahim06@gmail.com

ABSTRACT

Pregabalin is a novel isomer of gamma-aminobutyric acid (GABA) which is a major inhibitory neurotransmitter in the brain used for treating neuropathic pain, fibromyalgia, generalized anxiety disorder, and partial seizures in daily medical practice. It has a potential addiction risk

KEYWORDS

Addiction; anxiolytic; first episode psychosis; pregabalin abuse; withdrawal

due to its anti-glutamatergic effects. Nevertheless, abrupt discontinuation of this substance may lead to a situation that suggests physical dependence such as insomnia, nausea, headache or diarrhoea. But there is no information on the occurrence of psychosis in the literature due to the rapid discontinuation of pregabalin.
Case presentation: It is presented a 20 years-old patient with first episode psychosis due to withdrawal high dosage pregabalin, who lacks describable signs of withdrawal, including but not limited to, crucial psychiatric examination findings of paranoid ideation, auditory hallucinations, self-mutilative actions, mutism, and suicide attempt. The close temporal relationship between the rapid discontinuation of a relatively large dose of pregabalin and the onset of the symptoms as well as the singularity of the first episode psychosis suggest a causative role for pregabalin. As far as we know, this is the first case of psychosis due to the rapid withdrawal of pregabalin in the literature. We think that this clinical picture may guide clinicians to recognize acute pregabalin withdrawal.

[Abstract:0185][Psychopharmacology]

Auditory and visual hallucinations associated with OROS-methylphenidate but not observed with use of short-acting methylphenidate: a case report

Ebru Doneray, Ipek Percinel Yazici and Kemal Utku Yazici

Department of Child and Adolescent Psychiatry, Firat University School of Medicine, Elazig, Turkey

E-mail address: dr_ebrualkan@hotmail.com

ABSTRACT
In the case report, a male diagnosed with attention-deficit/hyperactivity disorder (ADHD) without any hallucination as a result of using short-acting methylphenidate but having auditory and visual hallucination associated with OROS-methylphenidate therapy was discussed.
Case presentation: An eight-year-old male was admitted to our outpatient clinic with his parents with the complaints of hyperactivity, impulsivity, poor concentration, speaking during the lessons, restiveness, and refusal to obey rules. The patient was diagnosed with ADHD in the wake of his clinical examination, and OROS-methylphenidate was administered. At the third day of drug-therapy, he was admitted to our clinic when he said that there were people in his room that he did not recognize, the voices were coming from other rooms, and there were insects and snakes under his bed and inside the house, after 8–10 hours of drug intake. He had no history of any psychotic disorder in his background or family history. His medical examination did not detect any organic disorder. The patient had a score of 6 on the Naranjo Adverse Drug Reaction Probability Scale, which indicated a "probable" relationship between hallucinations and OROS-methylphenidate. The drug therapy was discontinued. Hallucinations were disappeared following the discontinuation of the therapy. He was admitted to our outpatient clinic after two weeks with the complaints of severe ADHD symptoms. He had severe impulsivity and risky behaviours. As a result of all examinations, it was decided to administer short-acting methylphenidate instead of atomoxetine by considering the requirement of a short-acting drug therapy. The short-acting methylphenidate 3×5 mg/day (15 mg/day) was started. In his control examination after 10 days, there were no complaints of hallucination. As the patients benefited from the treatment, the drug dose was increased to 20 mg/day. Patient did not describe any hallucination with the dose of 20 mg/day. He has been still followed-up in our clinic. Methylphenidate might cause hallucination by increasing synaptic dopamine levels. In the literature, there are studies reporting psychotic symptoms associated with the use of both long-acting and short-acting methylphenidate. Either OROS-methylphenidate or short-acting methylphenidate has been used in the current reports. In our patients, both drugs were used on various but recent dates, and while auditory and visual hallucinations had arisen with use of OROS-methylphenidate, no hallucination was observed during the use of short-acting methylphenidate. Moreover, it was interesting that the hallucinations appeared after 8 to 10 hours of drug intake. Hallucinations might be associated with the second peak of OROS-methylphenidate in the body. This finding gave rise to thought that drugs with different production and releasing mechanisms might cause different side effects even if they contain the same active substance. It may be important that clinicians must pay attention to the undesired side effects of the different forms of the same active substance. It is required to perform more studies about this issue.

KEYWORDS
ADHD; auditory hallucination; child; methylphenidate; visual hallucination

[Abstract:0189][Other]

ECT application in early-onset catatonia

Arif Önder[a], Aslı Sürer Adanır[b], Canem Kavurma[a], Yakup Doğan[a] and Öznur Bilaç[a]

[a]Manisa Mental Health Hospital, Department of Child and Adolescent Psychiatry, Manisa, Turkey; [b]Akdeniz University Hospital Department of Child and Adolescent Psychiatry, Antalya, Turkey

E-mail address: arifonder86@gmail.com

ABSTRACT

Electroconvulsive Therapy (ECT) is an effective treatment method for the treatment of psychiatric disorders. Although studies have shown that ECT have same effects on children and adolescents as adults, the use of ECT in children and adolescents is rare. However, studies on the use of ECT in adolescents began in the 1980s and were found to be more effective than psychopharmacology alone in the appropriate patients evaluated for diagnosis, weight of symptoms and unresponsiveness to psychopharmacology.

Case presentation: Ö.Ç. is a 15-year-old female patient. She had a long-term follow-up with mild mental retardation and psychosis in a university hospital. She has been directed to our service after refusing to take the nutrition and fluid for the last 3 weeks, staying in the same position for a long time, severely decreasing the amount of speech, inactivity, repetitive aimless movements. She has been complaining of self-talk, imagination, inward closure for the last 2 years and has been using olanzapine 20 mg/day as a diagnosis of schizophrenia. It was observed that she did not respond to questions in her examination and she was sitting still in a chair with the exception of his constantly shaking his head. Her affect was limited and her psychomotor activity was too low. The content of her thought could not be evaluated. She was admitted to our service with the diagnosis of catatonia. There was no pathology in the laboratory tests and neurological examination. We started lorazepam 7.5 mg/day. After a week, there was no clinical remission so we started ECT after anaesthesia and neurology evaluation. Bifrontal bilateral application started with 40 percent electric dose. In every application, it increased by 20% and reached 160%. With three sessions and 80 percent dosing, the patient's oral food intake resumed. Posture and stupor disappeared. Because the residual symptoms of schizophrenia persisted, ECT continued until the 12th session. The dose went up to 180 percent. Side effects were not observed during ECT. The CGI-SI score administered during the hospitalization period decreased from 7 to 5. The CGI-GI score was 3. After the twelfth session, the patient was discharged with quetiapine 600 mg/day and aripiprazole 30 mg/day for follow-up. Although ECT has been shown to be effective and reliable in clinical conditions such as major depression, bipolar disorder and schizophrenia in adolescents, concerns about possible adverse effects on the developing brain, lack of experience, negative perceptions of families about ECT made its use very rare when compared to adults in western societies.

In our case meeting the criteria for catatonia, it was observed that ECT therapy was complemented with significant benefit and low-grade side effect in accordance with the literature. ECT is a treatment with effective and low side effect profile in treatment-resistant cases. ECT treatment should be evaluated among the options and administered in the treatment of adolescents patients. In addition, it will be useful for clinicians to increase their knowledge and experience in ECT and to provide the conditions for ECT in child and adolescent psychiatric clinics.

KEYWORDS

Adolescent; catatonia; child; electroconvulsive therapy; schizophrenia

[Abstract:0190][Other]

Administration of electroconvulsive therapy in an adolescent with bipolar disorder

Arif Önder[a], Aslı Adanır[b], Canem Kavurma[a], Öznur Bilaç[a], Yakup Doğan[a] and Yetiş Işıldar[a]

[a]Manisa Mental Health Hospital, Department of Child and Adolescent Psychiatry, Manisa, Turkey; [b]Akdeniz University Hospital Department of Child and Adolescent Psychiatry, Antalya, Turkey

E-mail address: arifonder86@gmail.com

ABSTRACT

Electroconvulsive Therapy (ECT) is an effective treatment method for the treatment of psychiatric illnesses. The use of ECT in children and adolescents is rare. However, studies on the use of ECT in adolescents began in the 1980s and were found to be more effective than psychopharmacology alone in the appropriate patients evaluated for diagnosis, weight of symptoms, and unresponsiveness to psychopharmacology.

KEYWORDS

Adolescent; bipolar disorder; child; electroconvulsive therapy; inpatients

Case presentation: 16-year-old male patient was brought to our outpatient clinic because of aggression, hyperactivity, decrease in the amount of sleep, and increase in the amount of speech. In his story, we learned that he had been living in a state of residence since he was five years old, he had never had a psychiatric complaint, and his complaints started as aggression for the first time of his life. Increase in the amount of speech, grandiosity, increase in psychomotor activity, acceleration in associations was confirmed in the examination. He was admitted to our service with a diagnosis of bipolar disorder manic episode. He received 36 points in the Young Mani rating scale (YMRS). He did not benefit Valproic acid 1000 mg/day, quetiapine 800 mg/day, lorazepam 5 mg/day treatment. Then we added risperidone 6 mg/day, haloperidol 20 mg/day and chlorpromazine 100 mg/day to this treatment but after 2 months there was no clinical remission. So we started ECT after anaesthesia and neurology evaluation. We discontinued all his medication except risperidone. Bifrontal bilateral application started with 40 percent electric dose. In every application, it increased by 20% and reached 160%. The score of YMRS was 30 before the ECT. But it reduced to 22 points after 6 sessions. After the eighth session, the score of YMRS decreased to 4 points and so ECT was finished. There were no side effects during the ECT except short-term amnesia. The CGI-SI score administered during the hospitalization period decreased from 6 to 1. The CGI-GI score was 1. After 1 week of follow-up, the patient was discharged with 6 mg/day of risperidone and 600 mg/day of quetiapine. There was no new attack on the patient who had been following up in our outpatient clinic for nine months.
Although ECT has been shown to be effective and reliable in clinical conditions such as major depression, bipolar disorder and schizophrenia in adolescents, concerns about possible adverse effects on the developing brain, lack of experience, negative perceptions of families about ECT made its use very rare when compared to adults in western societies. After evaluating diagnosis, severity of symptoms, and pharmacotherapy response criteria, ECT can be used in appropriate patients. In our case it was observed that ECT therapy was complemented with significant benefit and low-grade side effect in accordance with the literature. ECT is a treatment with effective and low side effect profile in treatment-resistant cases. ECT treatment should be evaluated among the options and administered in the treatment of adolescents patients. In addition, it will be useful for clinicians to increase their knowledge and experience in ECT and to provide the conditions for ECT in child and adolescent psychiatric clinics.

[Abstract:0191][Tic disorders]

Coprolalia successfully treated with aripiprazole in a child with Tourette syndrome

Ebru Sağlam and Ayhan Bilgiç

Department of Child and Adolescent Psychiatry, Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey

E-mail address: ebrusglm55@gmail.com

ABSTRACT
Tourette syndrome (TS) is a neurodevelopmental disorder that is characterized by multiple motor tics and one or more vocal tics. Coprolalia (involuntary expression of socially inappropriate words or swearing), which is a complex vocal tic and one of the most distressing symptoms in TS. Coprolalia is closely related with poor quality of life and its treatment is usually difficult. Herein, we present an 8-year-old boy with TS who displayed complete remission after aripiprazole for coprolalia.
Case presentation: An 8-year-old boy referred to the outpatient clinic with complaints of eye blinking, throat clearing, sniffing, involuntary expression of swearing, inattention, decreasing in school success and deteriorations in friendship. The child was diagnosed with Tourette syndrome according to DSM-5, and haloperidol commenced at 0.6 mg/day. At the second visit, 4 weeks later, motor tics had disappeared completely, but no improvement was observed with this medication for vocal tics and coprolalia. Haloperidol dose was increased to 0.9 mg daily, but his parents quit the drug without the physician's permission due to the side effects of haloperidol, including increased appetite and weight gain. Three months later, the patient and his parents again admitted to our clinic because his symptoms were worsened. Aripiprazole was started a dose of 2.5 mg daily and titrated to 5 mg daily the following week. After 2 weeks, there was approximately 50% reduction in the patient's complaints and aripiprazole was raised to 7.5 mg/day. In the 6th week of aripiprazole treatment, the motor, vocal tics, and coprolalia completely disappeared. Because coprolalia is more common in adults, we have limited information about the treatment of coprolalia in children. The efficacy of aripiprazole has been confirmed in tic reduction by different placebo-controlled studies in childhood. However, no data were available regarding the effects of aripiprazole on coprolalia in this age group. To our knowledge, this is the first report indicating the effect of aripiprazole on childhood coprolalia.

KEYWORDS
Aripiprazole; childhood; coprolalia; haloperidol; Tourette syndrome

[Abstract:0193][Psychopharmacology]

Fluoxetine-induced sleep bruxism treated with buspirone in a six-year-old girl

Betül Akbaş and Ayhan Bilgiç

Department of Child and Adolescent Psychiatry, Necmettin Erbakan University Meram School of Medicine, Konya, Turkey

E-mail address: betullakbas@gmail.com

ABSTRACT

Sleep bruxism is the repetitive jaw muscle activity, including clenching, gnashing, and grinding of teeth during sleep. It may be triggered by various agents, including selective serotonin reuptake inhibitors (SSRIs). So far, clinicians have little evidence regarding the treatment of sleep bruxism, especially in childhood. We report a child with separation anxiety disorder (SAD) who completely treated with buspirone for fluoxetine-induced sleep bruxism.

Case presentation: A six-year-old girl was admitted to our outpatient service with a complaint of school refusal. The patient often cried when her parents insisted on going to the school. In addition, she could not staying alone at home and sleeping alone. In consequence of the psychiatric assessments, she was diagnosed with SAD according to the DSM-5 criteria. Fluoxetine 7.5 mg/day was started, and excepting school refusal, her SAD symptoms had improved noticeably. However, the patient started to grinding and clenching her teeth during sleep. Treatment was continued because of the partial benefit of fluoxetine in anxiety symptoms, and the dose was gradually increased to 20 mg/day. Buspirone 5 mg/nightly was added because sleep bruxism was quite intense. The sleep bruxism was resolved in a few days and was not observed during three-month follow up. No side effect was observed with buspirone during the treatment.

The SSRI-induced bruxism mechanism is uncertain; however, the association between serotonin and dopamine that regulate motor pathways has been suggested to play a role in SSRI-induced bruxism. It has been suggested that the increase of serotonin in synapses prevents the release of dopamine from the mesocortical region and results in dopaminergic deficiency that causes bruxism. Like our case, in various case presentations, buspirone, a full agonist at presynaptic 5-HT1A receptors and a partial agonist at postsynaptic 5-HT1A receptors, have been observed to ameliorates bruxism. Due to its partial agonistic activity on the postsynaptic 5-HT1A receptors, buspirone competes with serotonin to bind to 5-HT1A receptors. Increased dopaminergic activity with this mechanism may be an important factor to ameliorate SSRI-induced bruxism. Clinicians should be aware of that SSRIs can cause bruxism and buspirone can be an important and reliable alternative for the treatment of SSRI-induced bruxism in children.

KEYWORDS

Anxiety disorder; buspirone; child; fluoxetine; sleep bruxism

[Abstract:0194][Autism]

Irritability, aggressive behaviours and excessive masturbation successfully treated with fluoxetine in an adolescent with autism spectrum disorder and coexisting depression

Çağla Çelikkol and Ayhan Bilgiç

Department of Child and Adolescent Psychiatry, Necmettin Erbakan University Meram School of Medicine, Konya, Turkey

E-mail address: dr.cagla90@gmail.com

ABSTRACT

Approximately 70% of the children with autism spectrum disorder (ASD) have comorbid psychiatric conditions such as attention-deficit hyperactivity disorder, depression and anxiety disorders (1). Different from other children, symptoms of these conditions can be vague in children with ASD, especially if the child has coexisting intellectual disability. Thus, the diagnosis and treatment of comorbid conditions can be difficult in ASD subjects (2). Here, we present an adolescent with ASD and comorbid depression who displayed significant benefits from fluoxetine for him irritability, aggressive behaviour and excessive masturbation.

Case presentation: A 16-year-old male patient with ASD and intellectual disability was referred to our clinic for an increase in his aggressive and self-destructive behaviours and irritability during the last two months. Additionally, his parents describe crying episodes which lasted for about twenty minutes almost every day and excessive masturbation for two months (Clinical Global Impressions-Severity subscale = 5). He had been using

KEYWORDS

Autism spectrum disorder; depression; irritability; fluoxetine; masturbation

aripiprazole for about 5 years due to irritability. At first, haloperidol was added to his treatment for one month; however, no improvement was observed. When taken more history, a decrease in activity level was detected while the patient did not show behavioural problems. The clinical picture was regarded as depression, haloperidol was terminated and fluoxetine 20 mg/day was started. After the treatment, masturbatory behaviour completely ended after 1 week, and did not recur during the patient's two months follow-up. His other symptoms, including irritability, aggression, low activity level, and self-destructive behaviours diminished significantly (Clinical Global Impressions-Improvement subscale = 2). Depression is a common psychiatric disorder in both adults and adolescents with ASD (3,4). The most common clinical features of ASD patients with depressive disorder are depressive mood, loss of interest in areas of interest and activities, appetite and sleep changes, aggression, and self-harm (5). Cognitive problem shave difficulties in expressing themselves and depressive mood can manifest themselves with different complaints (6). Physicians should be careful to arrange treatment by considering depressive disorder in children with ASD and intellectual disability.

[Abstract:0196][Mood disorders]

A case of late onset bipolar disorder with mega cisterna magna

Seher Serez Öztürrk, Hilal Seven, Dudu Demiröz, Seda Özbek, İsmet Esra Çiçek and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

E-mail address: seherserez@gmail.com

ABSTRACT

Mega cisterna magna (MCM) is a developmental variation of the posterior fossa characterized by expansion of the cisterna magna with morphologically intact vermis and cerebellar hemispheres. It is a part of "Dandy-Walker Malformation" and there are case reports about association with MCM and affective disorders and it is suggested that any cerebellar dysfunction due to MCM may cause or contribute to the appearance of affective symptoms. In this article, we report a case of bipolar disorder with late onset and associated with MCM

Case presentation: In a 65-year-old male patient not having any psychiatric illness history before, depressive symptoms and nihilistic delusions started 3 years ago. He benefitted from sertraline and olanzapine and continued about a year. After about 1.5 year from the first symptoms, a manic episode occurred, the mood symptoms were regressed within about 1 month with olanzapine and valproate, and the dose of olanzapine was discontinued by decreasing gradually. In the brain MR of the patient, the cystic appearance having 24 × 30 mm axial diameter and 43 mm craniocaudal length in retrocerebellar area in posterior fossa and a MCM were detected. Bipolar disorder is a chronic and life-long condition which is characterized by shifts in energy level, mood state, behaviour and psychotic symptoms such as hallucinations and delusions. The cerebellum is suggested to interfere in the pathophysiology of bipolar disorder. It has connections through thalamus to several brain regions such as dorsolateral prefrontal cortex, medial frontal cortex, anterior cingulate and the posterior hypothalamus, which are all associated with behaviour and cognition. In this case, cerebellar dysfunction due to MCM may cause or contribute to the appearance of affective symptoms. This report suggests that any dysfunction in cerebellum might contribute to the occurrence of some affective and psychotic symptoms seen in bipolar disorder

KEYWORDS

Bipolar disorder; cerebellum; late onset; manic episode; mega cisterna magna

[Abstract:0198][Sleep disorders]

Melatonin treatment for nightmares in an adolescent: a case report

Fatma Coşkun and Ömer Faruk Akça

Department of Child and Adolescent Psychiatry, Necmettin Erbakan University Meram School of Medicine, Konya, Turkey,

E-mail address: drfcoskun@hotmail.com

ABSTRACT

Approximately 50% of children have sleep problems (1). Sleep problems can lead to daytime sleepiness, behaviour problems, irritability, reduced academic performance, and behavioural problems in children (1). Parasomnias such as sleepwalking, sleep terror, and nightmare

KEYWORDS

Adolescent; melatonin; nightmares; parasomnia; sleep disorders

disorder are common sleep disorders in children (1). Nightmares are recurrent episodes of awakening from sleep, remembered intensely by dreams, including fear, anxiety, anger, sadness, and other dysphoric feelings (2). It typically occurs during the REM period, especially during the second period of sleep (2). Nightmares are immediately remembered after sleep (2). It is most commonly seen in childhood and most often between the ages of 3–6 years (2). Clinically, living with fear/horror when children sleep though they are very anxious; they tell their dreams in detail (2). In post-traumatic stress disorder and anxiety disorders, the nightmares are more frequent (2). Psychotherapies are frequently used in treatment (2). In the literature; guanfacine, cyproheptadine, and prozasıne (3) are used for the treatment of the nightmares. Our goal on this report is to present an adolescent case whose nightmares have improved dramatically with melatonin treatment.

Case presentation: A 13-year-old boy admitted to our outpatient clinic with complaints of nightmares which occurs almost every night for almost 2 months. The patient wakes up with fear because of the nightmares and he feels fatigue during all day. He remembers the nightmares after awakening and tells his mother. He described difficulty in paying attention to his lessons because of tiredness and being sleepy in daytime. Melatonin treatment was started for the nightmares with the dose of 3 mg/d. Within a few days of the treatment, the patient's complaints improved significantly. One month after the treatment started, the patient left treatment because his complaints were completely resolved. He has been followed for about 8 months without medication and he did not report any complaints about the nightmares.

Nightmare disorder is one of the parasomnias that usually occur in REM period of the sleep during early morning hours (1). In some cases, no treatment is needed and nightmares show improvement spontaneously (2). However, psychopharmacological treatment or psychotherapies are used in cases where the complaints are chronic or severe (2). In a meta-analysis investigating the effect of melatonin on sleep disorders, melatonin was found to be effective in jet lag, insomnia, and sleep problems in shift workers (4). In a case report, melatonin is reported to be effective in sleep terrors, which is known as a parasomnia (5). In our present case, an adolescent boy with severe nightmares – affecting his daily life – showed dramatic improvements after melatonin treatment. Further research on children and adolescents is needed to increase our knowledge of this subject.

[Abstract:0210][Psychotherapies]

Acceptance and commitment therapy experience in an adolescent patient with social anxiety disorder, panic disorder, and major depression

Doğa Sevinçok[a], Çağdaş Öykü Memiş[b] and Burcu Çakaloz[c]

[a]Dr. Behcet Uz Child Diseases and Pediatric Surgery Research and Training Hospital, Department of Child and Adolescent Psychiatry, Izmir, Turkey; [b]Department of Psychiatry, Adnan Menderes University, Aydin, Turkey; [c]Department of Child and Adolescent Psychiatry, Pamukkale University, Denizli, Turkey

E-mail address: dsevincok@hotmail.com

ABSTRACT

Acceptance and commitment therapy (ACT) is a kind of third wave cognitive behavioural therapy (CBT) which focuses on the problem of psychological inflexibility. ACT has a growing empirical base demonstrating its efficacy in the treatment of several anxiety symptoms among adults. Preliminary research evidence supports the use of ACT among young people with some anxiety disorders, depression, anorexia, and chronic pain. There is a little research examining the efficacy of ACT in children and adolescents with anxiety. Here, we present a case with a diagnosis of social anxiety disorder (SAD), major depression (MD), and panic disorder (PD) in whom we administrated ACT.

Case presentation: H.G, 15 years old girl admitted to our outpatient clinic mainly with arousing of anxiety when talking to people, and when alone outside which began at 10 years old. She had also some depressive symptoms since eight months after she witnessed a violent fight between her parents. She also experienced recurrent panic attacks since nine months. Her pretreatment scores of Child Depression Inventory (CDI), Panic Agoraphobia Scale (PAS), and Liebowitz Social Phobia Scale (LSPS) were 33, 43, and 135, respectively. Fluoxetine (10 mg/d) was started, and discontinued one week later due to side effects.

Because of higher number of symptoms, comorbidity, prominent cognitive fusion, lack of value clarity, and experiential avoidance, we decided to work with ACT also benefiting partly from some aspects of classical CBT. We focused on assessment for three sessions. Together with metaphors, psychoeducation was administrated about thoughts-emotions-behaviours, normal and pathological anxiety, SAD, and PD. Hexagonal model of ACT, which includes cognitive fusion, experiential avoidance, lack of value clarity, and

KEYWORDS

Acceptance; adolescent; anxiety; commitment; depression

conceptualized self, have been built together. As an alternative to psychological inflexibility, we worked with acceptance, cognitive defusion, values, contextualized self, and mindfulness. After 10 sessions, the scores of CDI, PAS, and LSPS decreased to 15, 35, 80, respectively. Since we observed that her panic symptoms did not improve sufficiently with ACT, we planned to use conceptualization according to Clark's Model, behavioural experiments, and interoceptive exposure for the therapy of panic disorder. ACT works to modify the function of internal experience such as supporting individuals to recognize thoughts for what they are, and simply the thoughts are not necessarily the truth and thus reduce their bearing on behaviour. ACT aims to increase psychological flexibility by assisting individuals to live valued meaningful lives, whereas other therapies focus on altering the content, frequency and form of thoughts, feelings and sensations. There is limited data regarding the application of ACT to adolescents. Here, we presented a case whose SAD and MD benefited from ACT. We employed six core therapeutic processes in a 'hexaflex' model, including 'acceptance,' 'defusion,' 'values,' 'committed action,' 'the present moment' and 'self-as-context' in increasing psychological flexibility. Our case demonstrated that ACT might be effective in the treatment of SAD and MD. However, we observed that ACT may not be as efficious as CBT in psychotherapy of PD. Further research in clinical adolescent series to assess the efficacy of ACT are required.

[Abstract:0213][Psychopharmacology]

Peripheral oedema due to clozapine: a case report

Saliha Çalışır, Bilge Çetin İlhan, Yasemin Gökçenoğlu, Tuba Şerife Elmas, Azra Sehure Yaşar, Nafiye Yağlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

E-mail address: drscalisir@gmail.com

ABSTRACT

Clozapine is known to be superior to other antipsychotics in treatment-resistant schizophrenia. However, the presence of potentially fatal side effects such as agranulocytosis and epileptic seizures, myocarditis, orthostatic hypotension, sedation, weight gain, and sialorrhea limit the widespread use of clozapine. Side effects such as ischemic colitis, paralytic ileus, hematemesis, gastroesophageal reflux, priapism, urinary incontinence, pityriasis rosea, diffuse erythema, pulmonary thromboembolism, and angioneurotic oedema have also been reported as 'rare' or 'very rare'. Among psychotropic drugs, there are several reports that atypical antipsychotics [1] may lead to peripheral oedema. A limited number of studies clozapine-related peripheral oedema are available [2]. In this case, peripheral oedema due to clozapine will be discussed.

Case presentation: A 28-year-old male patient admitted to our psychiatric clinic, followed by the diagnosis of schizophrenia. He appealed with exacerbation in the complaints of suspiciousness, unwillingness to leave the home, reluctance, weakness, and tiredness. Intended for aetiology, complete blood count, thyroid function tests, vit B12, folate, and ferritin levels were normal. The patient's previous paliperidone 12 mg/day treatment was planned to be gradually phased out and clozapine started. On the 4th week of treatment (clozapine 250 mg/day), there was widespread, godet-free oedema, especially on the face and feet, with marked oedema in the distal phalanges of both hands. There was no redness, ulceration or discoloration with the oedema. In routine blood tests, haemogram, liver function test, renal function test, complete urine examination, thyroid function test, sediments, CRP, IgM, IgG, C3c, and C4 were within normal limits, IgE:551 U/ml was detected. The IgE value remained above 500 U/ml for about 3 weeks. Dermatology and rheumatology were consulted. RF, ANA, and anti-Ds-DNA tests were negative. There was no history of urticaria or angioedema in the patient's background and family history. He did not describe medicine and food allergy. Laboratory tests for urticaria and angioedema were normal. The patient had no history of infection. Clozapine treatment was gradually stopped and aripiprazole treatment was started. Intravenous prednisolone and antihistaminic agents were started. Oedema was decreased 7 days after the drug cut. After the drug withdrawal, oedema disappeared and there was no other reason to explain the oedema, suggesting that the oedema is due to clozapine. It is proposed to replace the drug with another antipsychotic when such side effect is encountered, but it is suggested to be gradually reduced [3]. Our case is important to warn clinicians about peripheral oedema due to clozapine. The sensitivity of clinicians to side effects that may occur during the use of clozapine and the rapid intervention during possible side effects may reduce morbidity and mortality associated with clozapine treatment.

KEYWORDS

Antipsychotic; clozapine; oedema; peripheral oedema; side effect

References

[1] Terao T, Kojima H, Eto A. Risperidone and allergic reactions. J Clin Psychiatry. 1998;59:82–83.
[2] Durst R, Raskin S, Katz G, et al. Pedal edema associated with clozapine use. Isr Med Assoc J. 2000;2:485–486.
[3] Yalug I, Ozten E, Evren Tufan A, et al. Bilateral pedal edema associated with olanzapine use in manic episode of bipolar disorder: report of two cases. Prog Neuropsychopharmacol Biol Psychiatry. 2007;31:1541–1542.

[Abstract:0214][Psychopharmacology]

Clozapine-induced thrombocytopenia: a case report

Saliha Çalışır, Bilge Çetin İlhan, Tuba Şerife Elmas, Yasemin Gökçenoğlu, Osman Ak, Recep Başaran and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: drscalisir@gmail.com

ABSTRACT

Clozapine, an atypical antipsychotic agent known to be superior to typical antipsychotics in treatment-resistant schizophrenia cases [1], is known to have potentially dangerous effects on white blood cell function and the relative absence of extrapyramidal side effects. Commonly reported haematological side effects of clozapine include agranulocytosis, neutropenia, leukocytosis, and eosinophilia. Thrombocytopenia is rarely reported as a complication of clozapine treatment. This can sometimes lead to life-threatening conditions such as cerebral haemorrhage [2]. In this article, we present a case of thrombocytopenia associated with clozapine treatment in a patient with schizophrenia.

Case presentation: A 43-year-old male patient admitted with schizophrenia, a 25-year history of illness, multiple hospital admissions, did not benefit from various antipsychotic treatments. The last treatments the patient used (Paliperidone 12 mg/day and clozapine 400 mg/day) due to the absence of significant decline in clinical findings (no resumption of positive symptoms and PANNS: 92) were planned to increase clozapine treatment. Before clozapine was increased, the patient was consulted for hematology; platelet count: 146 K/μ (150–450). Hematology did not show any disadvantage in performing clozapine dose increase by making regular haemogram follow-ups. When we reached clozapine dose of 700 mg/day, decrease in platelet count to 105 K/μ (150–450) parallel to dose increase was observed. In patients with accelerated platelet reduction, clozapine was reduced to 500 mg/day, the falling curve slowed and the platelet count reached 135 K/μ (150–450). No evidence of bleeding due to thrombocytopenia was observed in the patients. Pathophysiology of hematologic side effects due to psychotropic drugs may be due to different mechanisms such as bone marrow suppression, destruction of cells related to immunity, and direct bone toxicity [3]. The presence of other clinical factors should be examined in patients with psychotropic medication and hematologic problems. These factors include the presence of other therapeutic agents such as anaemia due to malnutrition, medical illnesses and NSAID drug use. The use of psychotropic drugs in liver diseases can cause haematological problems. These factors are excluded in our case. Although there is no clear consensus as to the relationship between clozapine-dose and thrombocytopenia, in our case, following the dose increase in clozapine, a rapid decline in the platelet count and then the platelet count remained constant after dose reduction of clozapine, supports that the dose-related of thrombocytopenia.

KEYWORDS

Clozapine; haematological; platelet; side effects; thrombocytopenia

[Abstract:0215][Psychopharmacology]

Aripiprazole-induced allergy: case report

Hüseyin Kara[a], Özgen Özçelik[a], Mehmet Murat Balcı[a], Mehmet Murat Kuloğlu[a] and Talya Tomar[b]

[a]Department of Psychiatry, Akdeniz University, Antalya, Turkey; [b]Medical School, Akdeniz University, Antalya, Turkey

E-mail address: kayfen_huseyin@hotmail.com

ABSTRACT

There are many unwanted side effects of antipsychotics which are being used in the treatment of psychiatric diseases. The most common side effects are dermatological side effects. Most of them are benign and can be easily treated.

This article aims to discuss the dermatological side effect observed as a result of the addition of

KEYWORDS

Allergy; antipsychotics; aripiprazole; drug-induced; hypersensitivity

aripiprazole to the treatment of a patient who was admitted to the psychiatric outpatient clinic of Akdeniz University and who is being followed up with major depression and obsessive-compulsive disorder diagnoses.
Case presentation: 46-year-old, female, married with one child, retired. She had been treated at another centre for 16 years with major depression and obsessive-compulsive disorder diagnoses. She stated that she used fluoxetine 20 mg/day and had no complaints for the last 1 year, but she had been involuntarily pulling her hair for the last 1 month and therefore presented to our outpatient clinic. The patient's treatment was arranged as fluoxetine 40 mg/day and aripiprazole 5 mg/day. She presented to our outpatient clinic 10 days after the onset of aripiprazole again with complaints of swelling on her lips, wanting to move, being energetic, constantly cleaning and menstrual irregularity, and aripiprazole was cut off. In the following control, the patient stated that her complaints cleared up and the swelling on her lips went down by itself within 3 days. Rare hypersensitivity reactions such as anaphylactic reaction, angioedema, laryngospasm, itching, or urticaria have been reported in people exposed to aripiprazole. Aripiprazole was cut off and a topical retinoic acid was administered in a patient developed a papulopustular acneiform rash on the forehead and nasal bridge 10 days after the onset of aripiprazole. It has been seen that acneiform rash was cured with mild scarring 10 days after aripiprazole was cut off. The drugs that the patient used in the past and dermatological side effects that occurred against them should be questioned before starting a psychotropic drug treatment. In addition, the patient should be informed about the dermatological side effects that may develop. Patients should be followed up for dermatological reactions that may develop after starting a treatment. If a reaction occurs against the drug, the situation should be evaluated by cooperating with a dermatologist; if necessary, the drug should be cut off and divert to a different group.

[Abstract:0218][Addiction]

Drug-induced skin picking associated with tactile hallucination due to methamphetamine

İbrahim Taş, Sehure Azra Yaşar, İkbal İnanlı, İbrahim Eren and Mustafa Çağrı Yıldız

Konya Research and Training Hospital, Department of Psychiatry, University of Health Science, Konya, Turkey

E-mail address: abraham21tas@gmail.com

ABSTRACT
A substantial proportion of substance users experience psychosis. Use of cocaine, amphetamines, cannabis, and alcohol seems to be associated with greater risk for psychosis. Methamphetamine-induced hallucinations are predominantly auditory (experienced in 85% of cases of methamphetamine psychosis), visual (46%), and tactile (21%). Dopaminergic agonists increase skin tenderness symptoms. Cocaine and methamphetamine increase dopamine in the ventral striatum, leading to withdrawal behaviour in people without skin irritation [1]. In the case of substance use disorder, the use of methamphetamine and cocaine may cause a feeling of traveling under the skin of the skin in the body, resulting in a skin tear. There is considerable variability in both the dose required (55–640 mg) and the onset of psychotic symptoms (7 minutes–34 hours post-dose) [3]. Psychotic symptoms deteriorate with increased duration and frequency of methamphetamine use [1,2].
Case presentation: A 22-year-old female patient with a history of multiple substance use for 8 years had regular and frequent use of drugs. 1 week ago subcutaneous buprenorphine naltrexone implantation was administered for treatment in the external centre. Opioid and methamphetamine positivity was determined in urine toxicology. On physical examination of the patient, there were excoriations in both hand extender area and both leg flexor area. The patient had methamphetamine again after discharge from our hospital. A recurrent urine test revealed methamphetamine positive and a number of new lesions in his hands and feet. It was learned from the patient that after the use of methamphetamine, the skin feels like an insect wandering under the skin, and that it is sending the skin with the discomfort it gives. During periods when the substance was not affected, the patient had no skin-binding behaviour. There are many cutaneous signs of substance abuse. It should be taken into account that injection marks, skin infections, pigmentation disorders, vasculitic lesions due to substance use, as well as exocorations due to skin pricking behaviour may be considered. Clinicians need to recognize these signs to properly diagnose and treat these patients. Cutaneous signs provide clinical clues about substance use in the general patient population and in the case of patients who use drugs, they can give an opinion to the doctor about whether they continue to use the substance.

KEYWORDS
Methamphetamine; skin picking; tactile hallucination; drug-induced; cutaneous signs

References

[1] Sekine Y, Minabe Y, Ouchi Y, et al. Association of dopamine transporter loss in the orbitofrontal and dorsolateral prefrontal cortices with methamphetamine-related psychiatric symptoms. Am J Psychiatry. 2003;160:1699–1701.

[2] Zweben JE, Cohen JB, Christian D, et al. Psychiatric symptoms in methamphetamine users. Am J Addict. 2004;13:181–190.

[3] Chen CK, Lin SK, Sham PC, et al. Pre-morbid characteristics and co-morbidity of methamphetamine users with and without psychosis. Psychol Med. 2003;33:1407–1414.

[Abstract:0219][Schizophrenia and other psychotic disorders]

Due to hallucinations, there is a schizophrenic patient with respiratory arrest after foreign body swallowing

Saliha Çalışır, Bilge Çetin İlhan, Tuba Şerife Elmas, Yasemin Gökçenoğlu, Mustafa Çağrı Yıldız, Recep Başaran and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: drscalisir@gmail.com

ABSTRACT

In patients with schizophrenia, the risk of violence, suicidal tendency, and self-destructive behaviour are higher than in the general population. These behaviours may be in the direction of the patient's hallucinations or delusions. Other factors that increase the risk of suicidality in schizophrenia include the onset of illness, the severity of illness, being single, being unemployed, and having a significant loss [1].We wanted to emphasize the risk of a chronic schizophrenic patient, during his hospitalization, severe positive symptoms and swallowing foreign body, and a dangerous behaviour due to auditory hallucinations.

Case presentation: Mr A, 54-year-old male patient with schizophrenia, was admitted to the hospital emergency service with complaints of swallowing foreign objects such as money, screws, and wet wipes, and there were cigarette burns in some parts of the body. Examination was started with a direct radiograph in patient who had swallowed a foreign body. Wet wipes and 2 pieces of iron money were removed by endoscopy. Follow-up was recommended for faecal excretion of the screws. Patient was admitted to the psychiatric service with an acute psychotic exacerbation. His psychiatric examination revealed that he did not cooperate, his emotional state was euthymic, his affect was limited, he was negativist, his impulse control decreased, his judgment was impaired, and his insight was absent. The patient said that he had swallowed foreign bodies due to the auditory hallucinations' orders. Haloperidol deconate (200 mg/month) was used as a treatment. The patient was planned for ECT. On the third day of the hospitalization, the patient was suddenly fainted and the first intervention was done. The patient's airway was opened and the vein path opened. Intraoral aspiration was performed. Oxygen support was provided. The patient underwent 112 emergency services for further examination and treatment. Respiratory arrest occurred in the emergency department. The patient was intubated. He was admitted to the intensive care unit. And in the deep tracheal aspiration made, 2 wet wipes were removed. After 5 days, the anaesthesia was extubated from the intensive care unit and the discharge was planned and transferred to the psychiatric service. Studies examining the relationship between positive and negative symptoms of schizophrenia, self-destructive behaviour and suicide have shown different results. Heila et al. studied 92 suicide cases and found that about four-thirds of suicides occurred in the active phase of the disease, and that 1 in 10 patients had suicide-requiring auditory hallucinations [2]. Kelly et al. in the majority of patients with schizophrenia observed behaviours such as attempting suicide; weakness in thought control, inculcation of thinking, disintegration in association, and idea flight [3].

KEYWORDS

Foreign body swallowing; hallucinations; respiratory arrest; schizophrenia; emergency

References

[1] Remschmidt H, Theisen F. Early-onset schizophrenia. Neuropsychobiology. 2012;66:63–69.

[2] Limosin F, Loze JY, Philippe A, et al. Ten-year prospective follow-up study of the mortality by suicide in schizophrenic patients. Schizophr Res. 2007;94:23–28.

[3] Kelly DL, Shim JC, Feldman SM, et al. Lifetime psychiatric symptoms in persons with schizophrenia who died by suicide compared to other means of death. J Psychiatr Res. 2004;38:531–536.

[Abstract:0220][Schizophrenia and other psychotic disorders]

Cannabis-induced psychosis: a case report

Yasemin Gökçenoğlu, Bilge Çetin İlhan, Saliha Çalışır, Tuba Şerife Elmas, Ebru Çiftçi and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: ysmngokcenoglu@gmail.com

ABSTRACT

Cannabis is a psychoactive plant that contains more than 500 components, of which 104 cannabinoids have presently been identified. In the pathophysiology of developing psychotic disorder due to cannabis use, investigators have studied the cannabinoid 1 receptor (CB 1), which is particularly intense in the lateral putamen, pallidum and substantia nigra, and is affected by cannabis preparations [1]. Reported specific changes in the regional intensity of CB 1-receptors in patients with psychosis after cannabis use [2].

Case presentation: A 19-year-old male patient, a student, living in Ankara was brought to the psychiatry clinic by his family. He presented with the complaints of scepticism, susceptibility, increase the amount of speech, flight of associations, grandiosity, talking about things that did not happen. From the history, it was learned that the patient had been using cannabis for about 1 month. There was no history of psychiatric disorder, the complaints of the patient started after using cannabis. With the pre-diagnosis of substance use-related psychotic episodes, the patient's treatment started with olanzapine 10 mg/day. After the antipsychotic treatment, the patient's psychotic symptoms were decreased and the cannabinoid metabolites were negated in urine, he was discharged at the request of his family. After 15 days of the discharge, the patient who did not use olanzapine and continued to use cannabis presented with more severe complaints than first admission. He has psychotic and hypomanic symptoms such as irritability, insomnia, rapid speech, grandiosity, susceptibility, increased sociability, sexual interest, and mobility. The patient with poor compliance to treatment started taking oral paliperidone dose of 6 mg/day. After 1 week of oral paliperidone administration, side effects were not observed and paliperidone palmitate was switched on. The incidence of psychiatric disorders in patients with psychoactive substance abuse or dependence is 2.7 times greater than in non-addicted patients. Rottanburg et al. examined psychotic patients who did and did not use cannabis, and reported that there was more hypomanic features and agitation in patients using cannabis, similar to the previous study [3]. In our case, similar to the work of Rottanburg et al., hypomanic symptoms were predominant. It should not be forgotten that these patients will be able to use cannabis again after discharge and their drug compliance may be poor.

KEYWORDS

Abuse; cannabis; psychosis; substance abuse; schizophrenia

References

[1] Devane WA, Dysarz F, Johnson MR, et al. Determination and characterization of a cannabinoid receptor in rat brain. Mol Pharmacol. 1988;34(5):605–613.

[2] Dean B, Sundram S, Bradbury R, et al. Studies on [3 H] CP-55940 binding in the human central nervous system: regional specific changes in density of cannabinoid-1 receptors associated with schizophrenia and cannabis use. Neuroscience. 2001;103(1):9–15.

[3] Rottanburg D, Ben-Arie O, Robins A, et al. Cannabis-associated psychosis with hypomanic features. Lancet. 1982;320(8312):1364–1366.

[Abstract:0222][Psychopharmacology]

Clozapine-induced agranulocytosis: a case report

Yasemin Gökçenoğlu, Bilge Çetin İlhan, Tuba Şerife Elmas, Saliha Çalışır, Şenay Yıldız Bozdoğan and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: ysmngokcenoglu@gmail.com

ABSTRACT

Clozapine is an effective therapy for treatment-resistant schizophrenia. The use of clozapine is limited due to the occurrence of neutropenia, and the rare but life-threatening adverse event of agranulocytosis [1]. Commonly reported haematological side effects of clozapine include agranulocytosis, neutropenia, leukocytosis, and eosinophilia. Pathophysiology of

KEYWORDS

Agranulocytosis; clozapine; side effect; leukocyte; schizophrenia

haematologic side effects due to psychotropic drugs may be due to different mechanisms such as bone marrow suppression, destruction of cells related to immunity, direct bone toxicity [2]. Less than 1% of adult patients with schizophrenia taking clozapine develop agranulocytosis, and most of these cases occur within the first weeks of treatment [3].
Case presentation: A 37-year-old female patient was followed up with schizophrenia, for 20 years. Clozapine was cut 8 years ago due to clozapine-induced agranulocytosis. She has been taking olanzapine, risperidone, and amisulpride for 8 years. Clozapine was started again for 6 months due to increasing psychotic symptoms. Clozapine 300 mg, risperidone 4 mg, valproate 1000 mg while weekly haemogram controls (week 7) were assigned; she was admitted to the hospital upon detection of neutropenia. Patient's initial leukocyte level: 2180, and neutrophil count: 50. Clozapine was cut. Valproate was cut in the belief that it could suppress bone marrow, and lithium treatment was added because of the leukocytosis effect. In clinical follow-up, blood lithium level was 0.4. Patient was consultated with haematology and treatment using 48 million units of granulocyte colony stimulating factor (GCSF) was started. GCSF was used for 4 days. Neutrophil and leukocyte counts were followed. A granulocyte colony-stimulating factor injection was performed again after 3 days due to no increase in neutrophil count. After 3 injections, the neutrophil level was found as 5440 and leucocyte level as 9060. Leukopenia (White globe < 3000), neutropenia (neutrophil count < 1500), and agranulocytosis (<500) are rare but side effects of clozapine are life-threatening. It is recommended that the drug be changed when clozapine-induced agranulocytosis is detected. In our case, although there was a previous history of neutropenia due to clozapine, the other antipsychotics did not respond and had previously benefited from clozapine treatment, started again. Clozapine-induced agranulocytosis is a rare but side effect is fatal. Patients with a previous history of clozapine-induced granulocytosis should be cautious when initiating clozapine again and the patient's neutrophil and granulocyte follow-up should be done carefully.

References

[1] Malik S, Lally J, Ajnakina O, et al. Sodium valproate and clozapine induced neutropenia: a case control study using register data. Schizophrenia Res. 2017.
[2] Oyesanmı O, Kunkel EJS, Monti DA, et al. Hematolojik side effects of psychotropics. Psychosomatics. 1999;40:414–421.
[3] Manu P, Sarpal D, Muir O, et al. When can patients with potentially life-threatening adverse effects be rechallenged with clozapine? A systematic review of the published literature. Schizophrenia research. 2012;134 (2):180–186.

[Abstract:0225][Psychopharmacology]

Risperidone-induced maculopapular rash in a paediatric patient

Hasan Ali Guler[a], Ali Kandeger[b], Dilara Guler[c] and Serhat Turkoglu[a]

[a]Department of Child and Adolescent Psychiatry, Selçuk University, Konya, Turkey; [b]Department of Psychiatry, Isparta City Hospital, Isparta, Turkey; [c]Department of Dermatology, Afyon Kocatepe University, Afyon, Turkey

E-mail address: dr.hasanaliguler@gmail.com

ABSTRACT
The prevalence of skin reactions due to antipsychotic drugs is approximately 5%, with pigmentation changes and photosensitivity being the most common. Atypical antipsychotic medication has been reported to result in less dermatological side-effects than typical antipsychotics. Risperidone, a benzisoxazole derivative, is an atypical antipsychotic. Serotonin 5-HT 2A receptor and dopamine D2 receptor antagonism is the main mechanism of action in atypical anitpsychotic medication. Indications for the use of risperidone in childhood and adolescence include bipolar mania, schizophrenia, irritability, and aggression relating to autism and mental retardation. In this paper, we want to present our case report on maculopapular rash associated with the use of risperidone in a paediatric patient. Although cases of skin reactions due to risperidone have previously been reported in adults, this is the first reported case in childhood to the best of our knowledge.
Case presentation: A male child, aged 5 years and 8 months, was admitted to the emergency department at our hospital with acute-onset fever and a rash In his lower extremity, with complaints of insomnia, aggression, and self-mutilation. He had been initiated on 0.5 mg of risperidone solution 1.5 years ago and had been taking it every 3–4 days up until his presentation at our hospital. On examination of the patient, maculopapular skin shedding in the lower extremity and body was noted (Figure 1). He had not used medication other than risperidone in the last month. The patient's leukocyte count, liver function, urea, creatinine, sedimentation, and C-reactive protein test results were normal. The viral serologic test results

KEYWORDS
Atypical antipsychotic; maculopapular rash; risperidone; side-effect; skin reaction

were negative. The patient's risperidone treatment was stopped. Cetirizine 1 mg once a day was started in response to the dermatologic drug reaction to risperidone. The lesions regressed after two weeks and were absent four weeks after the intervention. The side-effects of drugs can be classified as either type A (dose dependent, e.g. extrapyramidal side-effects) and type B (dose independent, e.g. skin reactions). The frequency of skin reactions to risperidone has been reported to range from 2–5%. Side-effects (including consequent alopecia, increased pigmentation, erythema multiforme, photosensitivity, pruritus, and urticaria) have been observed. Side-effects occur when the antipsychotic drug or metabolite combines with a cell component and acts like a hapten, thereby stimulating the immune system. Skin reactions are more frequent in women and in those with immunodeficiency. Antipsychotic drug-induced skin reactions usually start in the upper part of the torso and gradually spread evenly over the entire body. In general, skin eruptions that begin between the 3rd and 14th days of treatment are accompanied by an elevation in body temperature. It was demonstrated in our case study that skin reactions can occur at an early age and at any time during risperidone treatment. We believe that our case is significant as it is the first reported case of a skin rash associated with the use of risperidone in a paediatric patient. In addition, the symptoms of a risperidone treatment-related skin rash are a late complication.

[Abstract:0226][Psychopharmacology]

Oropharyngeal dysphagia induced by zuclopenthixol acetate

Önder Küçük[a], Ferhat Yaylacı[b] and Handan Özek Erkuran[c]

[a]Tokat Dr. Cevdet Aykan Mental Health Hospital, Tokat, Turkey; [b]Department of Child and Adolescent Psychiatry, Tokat Gaziosmanpaşa University School of Medicine, Tokat, Turkey; [c]İzmir Dr. Behçet Uz Children Hospital, Izmir, Turkey

E-mail address: onderkucuk@gmail.com

ABSTRACT

Acute dystonic reaction is defined as extraordinary and long-lasting involuntary contraction of eye, head, neck, pharynx, larynx, limb or trunk muscles. Dysphagia is a serious condition in which swallowing problems interfere with a patient's ability to eat, resulting in aspiration pneumonia, malnutrition, choking, and asphyxia. Dopamine blockage within nigrostriatal pathways increase the odds of developing extrapyramidal side effects, including acute dystonia. This case illustrates an example of dysphagia induced by use of the antipsychotic medication zuclopenthixol acetate.

Case presentation: The case was a 16-year-old boy that was admitted to our inpatient unit following evaluation, where the following symptoms were prominent for the last 2 weeks, before his application to our unit: hyperactivity and restlessness, decrease in the need of sleep, being more talkative than he was normally described, much increase in his self-confidence bordering to grandiosity, auditory hallucinations, distractibility, and faster associations that seemed to be loosened and incoherent from time to time. With these symptoms present, then the case was diagnosed with Bipolar Disorder, Current Manic Episode with Psychotic Features and admitted to the inpatient unit. On the first day of inpatient treatment, as his motor hyperactivity and restlessness increased along with further decrease in his total amount of sleep and had an episode of excitation since he had not been allowed to leave the unit despite his demands to go home, an intramuscular injection containing zuclopenthixol acetate 50 mg along with 5 mg biperiden lactate was administered. Following this pharmacological intervention, the case had experienced severe sedation that had negatively affected his ability to eat his dinner followed by him aspirating the water he had been given to help him swallow his oral medications; the case was consulted to a paediatrician specialized in paediatric emergencies and was admitted to the intensive care unit of the same hospital. The case was treated with 2×5 mg/day biperiden lactate, and was readmitted to our inpatient unit since his drug-related symptomatology had diminished in 2 days. Most clinicians are aware of extrapyramidal symptoms with antipsychotics, but dysphagia due to antipsychotics is a less commonly known adverse effect. There have been other reported cases in which dysphagia was associated with both first-generation and second-generation antipsychotic use. Dysphagia is a rare adverse effect, but it is potentially dangerous to the patient. Fortunately, in most cases, this condition is reversible. Strategies to treat antipsychotic-induced dysphagia include discontinuing the antipsychotic medication, lowering the dose, and changing to another medication. All of these strategies have been found to be effective in improving dysphagia. This case illustrates the importance of knowing the different mechanisms underlying dysphagia in psychiatric patients, and good communication with gastroenterologists to establish a precise diagnosis of the disorder, and adapt the therapy.

KEYWORDS

Antipsychotic; bipolar disorder; dysphagia; dystonia; zuclopenthixol acetate

[Abstract:0228][Dementia syndromes]

Early-onset frontotemporal dementia: a case report

Betül Kurtses Gürsoy

Psikiyatri, Düzce Atatürk State Hospital, Düzce, Turkey

E-mail address: betulkurtses@yahoo.com

ABSTRACT

Frontotemporal dementia (FTD), which is caused by neuropathological and genetic reasons, is a progressive neurodegenerative disease that causes atrophy, particularly in the frontal and temporal regions of the brain. The onset age of FTD, the second most common type of dementia among presenile dementia, is generally 45–65 years. Behavioural change and speech impairment are the two most well-known clinical manifestations and are often accompanied with disinhibition, perseverations, inappropriate sexual and eating behaviours, emotional blunting, and loss of insight.

Case presentation: A 36-year-old female with primary school education was brought to the psychiatry outpatient clinic by her relatives in February 2012. She had divorced from her husband 2 years ago, which was a traumatic experience for her, and before the divorce, she was an extrovert and a communicative person who cared about personal hygiene and had normal functioning. She had no history of psychiatric illness or psychiatric treatment. After the divorce, she became introverted, uncommunicative, preoccupied, and apathetic, and several different antidepressant therapies were initiated with a diagnosis of depression. However, she did not continue these therapies. She was brought to our clinic by her relatives with worsening complaints in the following 2 years. It was found that the patient watched the environment with a blank stare but did not react, continuously repeated finger counting movement with her hand, continuously uttered a few nonsense syllables, did not respond to questions or follow commands, performed self-care with the help of her family, did not perform any task purposefully unless prompted and relieved herself only when someone took her to the toilet or ate her meal only when someone served her meal. She was hospitalized for observation, and cranial magnetic resonance imaging (MRI) was performed. After neurology consultation over MRI results, which revealed 'marked diffuse cerebral atrophy and enlargement in the bilateral hemispheric sulcus and fissures', her treatment was planned after a diagnosis of FTD was made. After approximately 6 years, when the patient was visited at home and examined, it was seen that she was bedridden, had noticeable weakness in the four extremities, had developed urinary and faecal incontinence, had stopped muttering nonsense syllables and developed mutism, and had difficulties in oral solid food intake. It is known that the life expectancy of patients with FTD is reduced depending on the phenotype (behavioural variation, semantic dementia and primary progressive aphasia), and it lasts between 3–14 years. No relationship has been found between life expectancy and sociodemographic characteristics of the patients, age at disease onset and disease severity. The most significant problem is that no effective treatment currently exists for patients with FTD. Some selective serotonin reuptake inhibitors and antipsychotic drugs are recommended in the treatment to relieve symptoms, but these treatments are known to have no effect on the prognosis of the disease (4). The present case was thought to be impressive in terms of revealing the need for an effective treatment considering onset age and disease progression.

KEYWORDS

Dementia; frontotemporal; early-onset; mutism; atrophy

[Abstract:0229][Psychopharmacology]

Nocturia related to paroxetine use: a case report

Betül Kurtses Gürsoy

Psikiyatri, Düzce Atatürk State Hospital, Düzce, Turkey

E-mail address: betulkurtses@yahoo.com

ABSTRACT

The International Continence Society has defined nocturia as the need for waking up more than once at night to urinate. Nocturia is known to have many causes such as diabetes mellitus/insipidus, prostate hypertrophy, pregnancy, renal failure, congestive heart failure psychogenic/dipsogenic polydipsia, detrusor overactivity, and urinary tract infections

KEYWORDS

Nocturia; paroxetine; depression; antidiuretic hormone; inappropriate secretion

Case presentation: A single, retired male worker aged 59 years and who was the father of one child was included. He was admitted because of his feelings of increased intolerance, extreme anger and feeling down and as he had been thinking that life is meaningless since the past month. The patient stated that he had visited a psychiatry clinic for the first time, that he had gone through similar episodes in the past 10 years due to family problems and that these periods lasted for a minimum of 2 weeks and maximum of 3 months; during this time, he was feeling down, unhappy, not enjoying life and intolerant. He stated that during these times, he would resort to violence due to his anger and that he had increased his alcohol consumption; during this time, without consulting a doctor, he used 1 mg of alprazolam (1–4 times a day). He stopped taking the medication when his complaints were resolved. The patient frequently emphasized that he came to outpatient clinic to obtain a prescription for alprazolam. A mental status examination was performed; psychometric tests were performed, and it was deemed appropriate for him to start 20 mg of paroxetine 1×1 due to his diagnosis of depressive disorder. During his follow-up examination after 1 month, it was detected that there was a prominent decrease in his complaints but he started to wake up 3–4 times a night to urinate. The patient visited the Department of Urology and Internal Medicine outpatient clinic; as no organic pathology was detected, it was decided to continue paroxetine treatment for 1 more month and to limit liquid intake within 2 h before going to sleep at night. Because nocturia persisted at the second month of treatment, it was deemed appropriate for paroxetine treatment to be stopped and sertraline treatment to be started. It was detected that the complaint of nocturia stopped within a few days after the discontinuation of paroxetine. The physiopathology of nocturia is still not completely clarified, except for patients in whom there is disruption in the liquid intake–discharge balance. Usually nocturnal polyuria is thought to be caused by the disruption of the circadian rhythm in the secretion of antidiuretic hormone (ADH). While depression is considered to be one of the risk factors for nocturia in latest studies, the aetiology of nocturia in the present case was due to the use of paroxetine, which is an antidepressant. In the literature search, although many case reports have been found regarding inappropriate ADH excretion with paroxetine use, no case reports were found with only nocturia present. The reason for this might be that this symptom is ignored during anamnesis or that patients do not consider nocturia as a complaint.

[Abstract:0231][Mood disorders]

Depression and/or dementia? A case report

Dudu Demiröz, Tuba Şerife Elmas, Seher Serez Öztürk, İkbal İnanlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: drdemiroz42@gmail.com

ABSTRACT

Dementia and depression are common psychiatric disorders that have difficulties in differential diagnosis due to loss of cognitive function, attention and perception, mood and thought disorders, decreased self-care, alteration in personality and socially and mostly together in the clinic [1].

Case presentation: A 76-year-old woman was admitted to psychiatry inpatient clinic with complaining of forgetfulness, unhappiness, unwillingness, loss of appetite and weight, less-caring herself, insomnia, hopelessness, screaming and crying, persecutive, poorness and nihilistic delusions since three months. 10 years ago, her husband died after suicide, then escitalopram treatment was started. She continued to use escitalopram in increasingly decreasingly doses for 10 years. One year ago, she presented for neurology with a complaint of forgetfulness after a stressful life event. Dementia was diagnosed and donepezil was added to the escitalopram treatment but complaints of forgetfulness continued.

The patient evaluated with the pre-diagnosis of psychotic depression, routine tests were done and normal, first Standardized Mini Mental Test Score was 28 (sMMS:28/30, HAM-D:43). The treatment of the patient was regulated as venlafaxine 37.5 mg/day, olanzapine 2.5 mg/day, donopezil 10 mg/day. Gradually, venlafaxine was increased to 150 mg/day and olanzapine to 5 mg/day. 7.5 mg of mirtazapine was added for sleep. In clinical settings, the patient's psychotic symptoms and depressive symptoms declined (HAM-D:3). Depression patients are usually aware of cognitive deficits and they complain. They do not try to hide their deficit, they show limited cooperation. They are adequate in daily activities, their functionalities are incompatible with their cognitive deficits. Dementia patients strive to collaborate and respond to clinical interviews, demonstrate behaviour in early stages to conceal and deny their losses, often "fill in the gaps" (confabulation). Patients often have no insight into their

KEYWORDS

Antidepressant; depression; dementia; cognitive function; nihilistic delusions

loss. They do not suffer from loss of cognitive function, but impairment in their daily function is noteworthy [2]. Psychotic symptoms are common in elderly depression and dementia. In depression, mostly mood compliant, guilt and sinful delusions, especially nihilistic delusions about the body, auditory hallucinations compatible with the mood (hearing voices telling the patient that she was guilty and sinful) were noted. Dementia is often accompanied by paranoid delusions and visual hallucinations [1]. When an elderly patient is diagnosed with dementia, that patient should be evaluated in terms of comorbid depression, and antidepressant treatment should be tried in suspected cases because depression may be atypical. And vise versa, depression may be a precursor to dementia [3].

References

[1] Aki-Erden O. Dİfferential diagnosis of depression and dementia in elderly. Turkish J Geriatrics Suppl. 2010;3:37–42.
[2] Sadavoy C, Jarvik LF, Grossberg GT, et al. *Comprehensive Textbook of Geriatric Psychiatry*. New York: AAGP, Norton and Company; 2004, 609–655.
[3] Petersen RC, Roberts RO, Knopman DS, et al. Mild cognitive impairment: ten years later. Arch Neurol. 2009;66 (12):1447–1455.

[Abstract:0232][Psychopharmacology]

Lithium for neutropenia caused by clozapine: a case report

Mustafa Çağrı Yıldız, İbrahim Taş, İsmet Esra Çiçek, Recep Başaran, Saliha Çalışır, Nafiye Yağlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT

Clozapine is an atypical antipsychotic medication. It is mainly used for schizophrenia that does not improve following the use of other antipsychotic medications. Clozapine is associated with a relatively high risk of low white blood cells, which may result in death. To decrease this risk, it is recommended that the blood be regularly monitored. Within the context of trials, the potentially dangerous White blood cell decline seems to be more frequent in children and adolescents and in the elderly than in young adults or people of middle age. Lithium is primarily used as a psychiatric medication. This includes the treatment of major depressive disorder that does not improve following the use of other antidepressants, and bipolar disorder. Lithium blood levels must be monitorized because of its side effects. Lithium also causes leukocytosis (elevated white blood cell count); because of this side effect, sometimes lithium is used for treatment of neutropenia.

Case presentation: The patient was a male, married, and 50 years old. He was presented to outpatient clinic of psychiatry for routine controls of schizophrenia and he had depressive symptoms. At this time, blood sample has been taken and neutrophil count was 1350 u/l. Because of this result, psychiatrist admitted the patient to psychiatry services to regulate the treatment. Firstly, lithium (300 mg/day) was ordered and blood levels had been monitorized. Lithium doses increased to 600 mg/day following lithium administration; the neutrophil count was increased to the normal range within 6 days. In the patient who had been presented with a neutropenia, clozapine treatment was then reinstated in the presence of lithium and continued without the neutrophil count dropping and last result of neutrophil count was 5500 u/l. Citalopram (20 mg/day) resulted in a decline in depressive symptoms. With this treatment, his complaints were regressed and he was discharged form hospital. Clozapine is well known as a drug that can cause blood dyscrasias, but olanzapine and other atypicals may also cause similar problems. Drugs known to cause neutropenia should not be used concomitantly with other drugs known to cause this problem. The rapid antidepressant effect of lithium carbonate is caused by its action on serotonergic neurotransmission. In many previous reports, lithium treatment was performed safely for depression. Important lessons have been learned from the haematological monitoring that is necessary with clozapine and the monitoring has been very successful in preventing deaths related to clozapine-induced agranulocytosis. Moreover, lithium induces bone marrow; so, lithium is a good choice to treat neutropenia.

KEYWORDS

Bone marrow; clozapine; granulocytosis; lithium; neutropenia

[Abstract:0233][Eating disorders]

Treatment of posttraumatic feeding disorder in a child with autism spectrum disorder

Betül Akbaş and Ömer Faruk Akça

Department of Child and Adolescent Psychiatry, Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey

E-mail address: betullakbas@gmail.com

ABSTRACT

Food refusal in PTFD (posttraumatic feeding disorder) develops after traumatic events (eg, severe blockage, choking, tube placement or forced feeding) that affect the mouth, pharynx, throat, and/or esophagus. Children may refuse to eat only solid food or to drink liquid; in some severe cases, refuse all oral feeding. There is no standardized treatment for PTFD, leading to serious consequences if untreated, but some pharmacological agents have been reported to improve PTFD in the literature.

We present the medical treatment procedures of a 5-year-old boy with autism spectrum disorder (ASD) who showed refusal of food after forced feeding.

Case presentation: A five-year-old boy with ASD who was presented to the paediatric emergency department with the complaint of refusing to eat was referred to our outpatient service. His mother reported that he had been refusing to eat or drink any foods for the 2 days after trying to force feed him. His mother defined his response to force feeding: he got on the ground and held his arms and his head while she forcibly opened his mouth and poured water into the same. After this event, he started refusing any food and became anxious and fearful. After psychiatric evaluation, aripiprazole (0.5 mg/day) was started as a drug treatment and was titrated to a dose of 1.5 mg/day in the control. At the same time, the patient began to have 1/8 of lorazepam 1 mg three times a day. After the treatment, the patient started to drink liquids within 24 hours and after a few days he started eating solid foods. Several case reports have been reported concerning PTFD treatment with medications such as lorazepam, mirtazapine, and SSRI. In our case, posttraumatic feeding disorder improved with the treatment of aripiprazole and lorazepam. Further studies are needed.

KEYWORDS

Aripiprazole; autism; food refusal; lorazepam; posttraumatic feeding disorder

[Abstract:0234][Psychosomatic Medicine and Liaison Psychiatry]

A case report of delirium caused by urinary tract infection

Mustafa Çağrı Yıldız, İbrahim Taş, Recep Başaran, İsmet Esra Çiçek, Azra Sehure Yaşar, Saliha Çalışır and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT

Delirium, also known as acute confusional state, is an organically caused decline from a previously baseline level of mental function. Delirium is probably the single most common acute disorder affecting adults in general hospitals. It typically involves other cognitive deficits, changes in arousal (hyperactive, hypoactive, or mixed), perceptual deficits, altered sleep-wake cycle, and psychotic features such as hallucinations and delusions. Delirium may be caused by a disease process outside the brain that nonetheless affects the brain, such as infection (urinary tract infection, pneumonia) or drug effects, particularly anticholinergics or other CNS depressants. Treatment of delirium requires treating the underlying cause, and multi-component interventions are thought to be most effective.

Case presentation: The patient was 65 years old male, married. The patient who had no psychiatric history presented to emergency services with his son and brother. His complaints are irritability, disorientation, memory deficit, sleep disturbance, delusions, mood lability and agitation which presented for 3 days. Diagnostic tests were administered in emergency service and their results were normal, except urinary tests. In a psychiatric interview, the patient made some complaints which were related with urinary tract infection. After urology consultation and antibiotic treatment to urinary tract, his complaints declined in 3 days and he was discharged from hospital. Delirium may be difficult to diagnose without the proper establishment of a person's usual mental function. Without careful assessment and history, delirium can easily be confused with a number of psychiatric disorders or long-term organic brain syndromes.

With the patients admitted to emergency services, clinicians must be aware of delirium because many of the signs and symptoms of delirium are also present in dementia, depression, and psychosis.

KEYWORDS

Confusional state; delirium; disorientation; infections; organic brain syndrome

[Abstract:0240][Mood disorders]

Tardive torticollis, botulinum treatment: a case report

Tüba Şerife Elmas, Yasemin Gökçenoğlu, Saliha Çalışır, Berrin Ünal, Şenay Yıldız Bozdoğan and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: tubaserife@gmail.com

ABSTRACT

Spasmodic torticollis is a chronic condition characterized by involuntary powerful dystonic contractions (spasms) of the sternocleidomastoid, trapezius, splenius, and other cervical muscles that rotate the head and neck (torticollis) or pull them to one side (laterocollis), forward (anterocollis), or backward (retrocollis). In addition, the muscle contractions cause pain by compressing the cervical vertebrae and nerve roots. *Clostridia botulinum* toxin inhibits acetylcholine release from the presynaptic neuromuscular junction membrane, and this reduces spasmodic and normal, voluntary muscle contractions [1]. We want to describe a case of tardive torticollis after antipsychotic use and improvement after botox injection.

Case presentation: A 28-year-old female patient has been followed for 8 years with schizoaffective disorder. She was admitted to our psychiatry clinic with complaints such as irritability, aggression, thinking of doing evil things against her, scepticism, susceptibility, insomnia, increased amount of speech and speed, increased mobility, escape from home, hostile attitude to the family, and harmful behaviours to the environment for 3 months. Previously she used paliperidone, risperidone, aripiprazole, and quetiapine. When she was referred to us, the last treatment included risperidone (3 mg/day) and aripiprazole (5 mg/day), but she did not use this treatment for 1 month. In the clinical follow-up of the patient, haloperidol 40 mg/day + biperiden 4 mg/day injections were made due to intense agitation and refusal to take oral medication. Zuclopenthixol acetate 50 mg i.m., was administered once for the agitation. Afterwards oral paliperidone 3 mg/day and clonazepam 6 mg/day was started. On the 15th day of treatment, a contraction (anteograd flexion) (torticollis) occurred in the neck of the patient. Haloperidol was reduced and stopped. Biperidine was increased to 6 mg/day. Once a day for 3 days, intravenous fluid containing biperiden, diazepam, and diphenhydramine was administered. Despite drug reduction, contraction persisted. Torticollis was not reduced and was consulted in physical therapy and rehabilitation. Local botox application and physical exercise were suggested. After the discharge, local botox application had a significant improvement in the patient. Despite the high cost of botox treatment, idiopathic spasmotic torticollis has been shown to be effective and provide significant relief in neck movements. The tardive dystonia patients of 50% improved with tetrabenazine, reserpine, or anticholinergic medications; follow-up showed mental or systemic side effects. Injection of type A botulinum toxin (btx) directly into spasmodic or dystonic muscles is a recently introduced but widely used treatment that has been shown to be effective and safe for idiopathic spasmodic torticollis [2]. Since our case did not respond to systemic treatments, btx injection was tried and useful. Botox injection therapy may be useful in the treatment of tardive torticollis due to antipsychotic use.

KEYWORDS

Tardive; torticollis; antipsychotic use; botulinum treatment; schizoaffective disorder

References

[1] Kaufman DM. Use of botulinum toxin injections for spasmodic torticollis of tardive dystonia. J Neuropsychiatry Clin Neurosci. 1994;6(1):50–53.

[2] Jankovic J, Brin MF. Drug therapy: therapeutic uses of botulinum toxin. N Engl J Med. 1991;324:1186–1194.

[Abstract:0241][Schizophrenia and other psychotic disorders]

Parkinsonism induced by low dose aripiprazole in combination with sertraline: a case report

Gizem Aral, Evrim Özkorumak Karagüzel, Demet Sağlam Aykut and Filiz Civil Arslan

Karadeniz Technical University School of Medicine, Department of Psychiatry, Trabzon, Turkey

E-mail address: gizem.aral@gmail.com

ABSTRACT

Drug-induced parkinsonism(DIP) is the most common movement disorder caused by drugs that affect dopamine receptors. Typical antipsychotics, also known as neuroleptics, are the most common causes of DIP. However, atypical antipsychotics, which were thought to be free

KEYWORDS

Combination; low-dose aripiprazole; pharmacotherapy; parkinsonism; sertraline

from, can also induce parkinsonism. Aripiprazole is a novel atypical antipsychotic drug that is reported to be a high-affinity D(2)-dopamine receptor partial agonist. Because of this, it has less susceptibility than typical antipsychotics for inducing parkinsonism. In the literature, only a few cases have been reported [1,2]. Sertraline is a relative selective serotonin reuptake inhibitor with some dopamine reuptake inhibitor activity, which has only rare parkinsonism side effect [3,4]. We report a patient who developed a parkinsonian syndrome while using low-dose aripiprazole in combination with sertraline.
Case presentation: A 42-year-old women with two years history of psychotic disorder referred our clinic with reduced speech volume, tremors in the hands, and slowdown in her walking. The symptoms had started 2 weeks later upon increasing sertraline dosage up to 150 mg/day with combination of aripipirazole 5mg\day by her psychiatrist. She started to walk slowly, with blank starting looks, reduced speech volüme, and shaking in the hands. Clinical examination revealed severe hypertonia in all four limbs throughout the entire range of movement, suggesting extrapyramidal rigidity. Walking was with a shortened stride and a flexed posture. Arm swing is reduced, with an intermittent resting tremor in the left hand and severe hypomimia. Lab investigations (including routine haemogram and biochemistry) were normal. She was diagnosed as drug-induced parkinsonism and biperiden was administered orally 2 mg twice daily. Four days later, she showed marked improvement on the extrapyramidal side effects (rigidity, bradykinesia, and tremor). One week after, the patient was discharged. In literature, there is one case report of parkinsonism with sertraline use 100 mg/day resolved after the drug discontinuation. The other case was 81-year-old women, with hemiparkinsonism after long-term administration of sertraline at dosage of 100 mg/day. The symptoms disappeared 3 months after withdrawal of the drug. Both these cases and many of aripiprazole-induced parkinsonism cases were old and parkinsonism resolved after the drug was discontinued. Our case is a relatively younger woman and also aripiprazole dosage was lower. However, in literature some authors suggested that both aripiprazole and SSRI (as sertraline) were safe in potential dosage for extrapyramidal side effects. In this case, low-dose aripiprazole use in combination with sertraline is reported for parkinsonism. So, we must take into account parkinsonism and other movement disorders even when prescribing low-risk drugs with low doses.

References

[1] Wickremaratchi M, Morris HR, Ali IM. Aripiprazole associated with severe exacerbation of Parkinson's disease. Mov Disord. 2006;21:1538–1539. [PubMed]
[2] Sharma A, Sorrell JH. Aripiprazole-induced Parkinsonism. Int Clin Psychopharmacol. 2006;21:127–129.
[3] Di Rocco A, Brannan T, Prikhojan A, et al. Sertraline induced parkinsonism. A case report and an in-vivo study of the effect of sertraline on dopamine metabolism. J Neural Transm. 1998;105(2):247–251.
[4] Pina Latorre MA, Modrego PJ, Rodilla F, et al. Parkinsonism and Parkinson's disease associated with long-term administration of sertraline. J Clin Pharm Ther. 2001;26(2):111–112.

[Abstract:0242][OCD]

Treatment-resistant schizo-obsessive disorder responsive to electroconvulsive therapy: a case report

Evrim Özkorumak Karagüzel, Gizem Aral and Demet Sağlam Aykut

Department of Psychiatry, Karadeniz Technical University, Trabzon, Turkey

E-mail address: gizem.aral@gmail.com

ABSTRACT
The term schizoobsessive has been to define the subgroup of schizophrenia patients who present with obsessive-compulsive symptoms/disorder (OCS). Different studies reported remarkably high co-occurrence of OCD and OCS in schizophrenia with a wide range of 10–64% for OCS and 0–31% for OCD [1]. 60% of patients show poor or no improvement in symptoms with pharmacotherapy [2].
Case presentation: A 67-year-old man with 50 years history of schizophrenia comorbid with OCD. The patient was referred to us upon a dose of haloperidol 10 mg immediate release injection by emergency service. He was internalized with the suspect of neuroleptic malignant syndrome (NMS). All features of NMS resolved on the 5th day of discontinuation of his treatment, which is fluoxetine 20 mg/day and aripiprazole 5 mg/day. Two weeks later, he showed disorganized behaviours and obsessions and compulsions were exacerbated. It included symmetry obsessions, repeated checking, picking up and collecting waste and hoarding these items. Fluoxetine dose was increased to 40 mg/day and risperidone 2 mg/day

KEYWORDS
Electroconvulsive therapy; history of neuroleptic malignant syndrome; obsessive disorder; schizophrenia; treatment resistance

was added. Disorganized behaviours were disappeared. But compulsions continued. Due to a history of failure with pharmacotherapeutic agents (including venlafaxine, risperidone, quetiapine, mirtazapine, and paroxetine) at optimal dose and response to 8 sessions of bitemporal ECT treatment, we decided to begin ECT treatment for acute symptoms. There was an immediate effect after the first two sessions leading to the short-term 50% OCS decreased. We completed 8 sessions for 2 times a week, planned maintenance ECT once in a week for one month, and OCS were decreased 40%; so we planned to continue this 2 times a month after discharge. In literature, there are few cases treated with ECT for comorbid OCD and schizophrenia [3,4]. Maletzky et al. studied the use of ECT for OCD, and commended that schizo-obsessive disorder appears to be responsive to ECT. We preferred ECT in this case with diagnosis of schizo-obsessive disorder, with the history of neuroleptic malignant syndrome who did not respond to pharmacotherapy. This case gave a good response to ECT, suggesting that ECT may be effective therapy for treatment-resistant schizo-obsessive disorder.

References

[1] Devi S, Rao NP, Badamath S, et al. Prevalence and clinical correlates of obsessive-compulsive disorder in schizophrenia. Compr Psychiatry. 2015 Jan;56:141–148.
[2] McDougle CJ, Goodman WK, Lechman JF, et al. The psychopharmacology of obsessive-compulsive disorder: implications for treatment and pathogenesis. Psychiatry Clin North Am. 1993;16:749–766. 73. Marazziti D, Catena.
[3] Lavin MR, Halligan P. ECT for comorbid obsessive-compulsive disorder and schizophrenia. American J Psychiatry. 1996;153(12):1652.
[4] Chaves MP, Crippa JA, Morais SL, et al. Electroconvulsive therapy for coexistant schizophrenia and obsessive-compulsive disorder. J Clin Psychiatry. 2005;66:542–543.

[Abstract:0243][Other]

Improvement of auditory hallucinations with rTMS: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul

E-mail address: dribrahim06@gmail.com

ABSTRACT
Auditory hallucinations are a commonly seen symptom of schizophrenia. In about one in four patients, auditory hallucinations do not benefit from antipsychotic treatment. Repetitive transcranial magnetic stimulation (rTMS) that is neuromodulation technique has been a promising option in treatment-resistant auditory hallucinations. Here, we report a patient who has had auditory hallucinations and decreased it after rTMS therapy.
Case presentation: 29-years-old, single, unemployed, male patient with schizophrenia for 11 years admitted to our patient clinic with medication-resistant auditory hallucination complaint. During the first day of illness, he used various drugs (including clozapine, risperidone, olanzapine, and amisulpride) in therapeutic doses during the effective period. There was a decrease in auditory hallucinations with the treatments but no remission, but there was improvement in the overall clinical condition. The patient had no organic systemic disease, no alcohol or substance use history. The current treatment of the patient was paliperidone palmitate 150 mg/month and quetiapine 200 mg/day. It was decided to apply rTMS by taking the signed form of the patient. This was provided for 25–30 minutes per day, at 1 Hz, left temporoparietal cortex at 100% of the resting motor threshold. TMS administered over the left TPC by figure-of-eight air-cooled coil using the Magstim Superrapid Stimulator for 7 daily sessions per week. (1500 pulses per session). This resulted in a dramatic reduction of his auditory hallucinations. He was not able to repeat it on a follow-up examination 1 month later. The auditory hallucinations of the patient we were offered benefited from the rTMS. In the literature, there are case reports that rTMS is effective on auditory hallucinations. Although the mechanism is still unclear, the most probable mechanism is the hypothesis that rTMS sent to speech recognition areas of the brain may reduce auditory evoked events. Therefore, rTMS may be a new option for drug-resistant auditory hallucinations for clinicians.

KEYWORDS
Auditory hallucinations; Magstim Superrapid Stimulator; neuromodulation; rTMS; schizophrenia

[Abstract:0245][Psychopharmacology]

First manic episode in a 77-year-old man after sertraline use: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: dribrahim06@gmail.com

ABSTRACT

Sertraline is well-tolerable and effective SSRI group antidepressant medication that is used to treat a number of psychiatric conditions, including depressive disorder, anxiety disorder, OCD, and phobic disorders. Sertraline can be safely prescribed with low side effect profile in clinical practice, including in elderly patients. Manic attacks due to the use of antidepressants can occur if there is not a frequent occurrence. However, most of these cases are seen in young and middle-aged patients.

In this article, the case involves a 77-year-old man with major depressive disorder who developed his first manic episode after taking sertraline.

Case presentation: A 77-year-old, married, male patient was admitted to our hospital emergency room with complaints of insomnia, nonsense, shouting, repetition and nervousness, all of which started last week. After the patient's neurological consultation, intracerebral mass or delirium was hospitalized with a preliminary diagnosis. The psychiatric consultation 2 days after the hospitalization was also taken to our clinic with the diagnosis of the first attack mania after the psychiatric examination. The patient had no systemic disease history and imaging and laboratory tests were normal. The patient's psychiatric history has been learned from the family who has been using sertraline 50 mg/day for the last 3 months with anxiety disorder diagnosis. The patient's Young Mania Rating Scale (YMRS) score was 44. Patient started to receive valproic acid 1000 mg/day and olanzapine 15 mg/day. In addition, the patient was given benzodiazepine as needed. After 2 weeks, the patient's complaints were partially reduced, and the YMRS score was 26. After 4 weeks, the patient complained completely, YMRS score was 6. The patient was discharged and continues to receive regular monthly checkups. The patient did not repeat the complaints. SSRIs are an antidepressant frequently prescribed by sertraline clinicians, in particular. The reason for the sertraline-induced manic episode is not fully understood. But the most likely mechanism is the hypothesis that serotonergic mechanisms play a role in the manic shift. Clinicians should be knowledgeable about the side effects of commonly used antidepressants, which will be useful in protecting against unexpected side effects.

KEYWORDS

Case report; manic switch; OCD; sertraline; SSRI

[Abstract:0247][Mood disorders]

A case of kabuki syndrome presenting with comorbid autistic spectrum disorder and bipolar disorder

Ezgi Karagöz and Neslihan Emir İnaloğlu

School of Medicine, Department of Child and Adolescent Psychiatry, Dokuz Eylül University, Izmir, Turkey

E-mail address: ezgikaragoz-56@hotmail.com

ABSTRACT

Kabuki syndrome (KS) is a rare syndrome which presents with multiple congenital anomalies and mental retardation. We are writing this report to present a case of 13-year-old patient with Kabuki Syndrome and autistic tendencies. Our aim is to explain both anomalies and neuropsychiatric symptoms and give insight for the recognition of such syndrome that might go undiagnosed and deemed rare.

Case presentation: Patient (FS) who was born in 23.12.2004 was admitted to our clinic with not being able to left alone, increased movement, harassing people sexually, rocking back and front May 2017. He was diagnosed with Kabuki syndrome when he was 5 months old. When he was started on fluoxetine in another clinic, it was resulted in increased sexual harassment and drug was discontinued. He was diagnosed with behavioural disorders, moderate mental retardation, bipolar disorder, and obsessive-compulsive disorder. He also had valproate, quetiapine, olanzapine, and aripiprazole before.

After 3 years from first admission, he still had sexual behavioural problems (touching mother's buttocks, harsh comments, tendencies to touch father's genitalia, etc.). He had stabbed his father with a knife in a temper tantrum in October, 2016. He was admitted to inpatient service in March 2017. He used quetiapine, chlorpromazine, and biperiden, resulting in rage,

KEYWORDS

Autism; bipolar affective disorder; Kabukui make-up syndrome; treatment; neuropsychological profile

speech disorders, and destructive behaviour, he discontinued biperiden 5 days later, and had a decrease in rageful behaviour.
In his outpatient visits, he was discontinued on chlorpromazine and started on diazepam. He showed signs of elevated mood, irritability, increased sexual behaviour and loss of sleep; therefore quetiapine and olanzapine doses were increased, diazepam was discontinued and he was also started on diphenhydramine. His rageful behaviour then ceased to some extent. A case of Kabuki Syndrome with ASD, MR and bipolar disorder might be a valuable contribution to current literature. In cases with bipolar disorder and ASD, it is recommended to use atypical antipsychotics and mood stabilizers. We achieved control in temper tantrums in this case with valproate, quetiapine, and biperiden.

[Abstract:0249][Psychopharmacology]

Low-dose pimozide augmentation of fluoxetine in the treatment of childhood trichotillomania

Necati Uzun

Department of Child and Adolescent Psychiatry, Elazığ Psychiatry Hospital, Elazığ, Turkey

E-mail address: necatiuzun42@gmail.com

ABSTRACT
Trichotillomania (TTM) is an impulse control disorder characterized by the repetitive tearing of hair and eyebrows. Despite the presence of various methods in the treatment of TTM, psychopharmacological therapies are one of the most commonly used ways, but treatment interventions, especially with serotonergic agents, do not always produce good outcomes. It has been shown in several studies that antipsychotic agents such as olanzapine, quetiapine, aripiprazole, risperidone, and pimozide may be useful as monotherapy or in combination with serotonergic agents in the treatment of trichotillomania. As far as we know, in the literature, there is a limited number of data on using low-dose pimozide for augmentation of selective serotonin uptake inhibitors (SSRI) in the treatment of trichotillomania in children.
Case presentation: The case presented here was a 9 year-old girl consulted our clinic with complaints of plucking her hair and eyebrows, repetitively. She had been having this problem for about four years. In particular, she was plucking the frontal and occipital regions of his head. The patient was diagnosed with trichotillomania according to the DSM-5. Clinical Global Index (CGI) score for trichotillomania was seven at the beginning of treatment. She was using fluoxetine 30 mg/day before consulted to our clinic. Another child psychiatry clinic was started fluoxetine for treating TTM one year ago. Before applying to our hospital, she was used aripiprazole 5 mg/day for two months and risperidone 2 mg/day for three months to augment fluoxetine therapy, respectively. Pimozide 1 mg/gün was started as an augmentation therapy to fluoxetine, and two weeks later trichotillomania improved slightly, and CGI score was five at that visit. Pimozide doze was increased to 2 mg/day, and one month after the first admission later, the patient's trichotillomania disappeared, and CGI score was one at that visit. Patient's trichotillomania symptoms never recurred over four months of follow-up. Some researchers suggested that antipsychotic agents may be useful as monotherapy or in combination with serotonergic agents in the treatment of trichotillomania. But in children, there is insufficient data about treating TTM with antipsychotics as monotherapy or for augmentation. In some case reports, pimozide was found beneficial to augment SSRI's activity in the treatment of adult TTM. This case report will contribute the literature about TTM treatment in children and adolescents which are resistant to SSRI's.

KEYWORDS
Augmentation; children; fluoxetine; pimozide; trichotillomania

[Abstract:0251][Sleep disorders]

Treatment of isolated cataplexy in an adolescent patient with low-dose aripiprazole

Necati Uzun

Department of Child and Adolescent Psychiatry, Elazığ Psychiatry Hospital, Elazığ, Turkey

E-mail address: necatiuzun42@gmail.com

ABSTRACT
Cataplexy is a situation of sudden and transient loss of muscle tone and mostly occurs as part of the narcolepsy. Isolated cataplexy (also known as hereditary cataplexy) is characterized by unexpected muscle tonus losses without narcolepsy and can occur as benign events in healthy individuals. Some studies suggest that hereditary cataplexy is related to HLA DQB1 alleles. In the treatment of cataplexy, symptom management with sleep hygiene practices and the use of some medication are required. Sodium oxybate, venlafaxine, and tricyclic antidepressants may be useful in the treatment of cataplexy. However, the role of antipsychotics in the treatment of cataplexy is not clear. In children and adolescents, no publication of antipsychotic efficacy has been found in the treatment of isolated cataplexy.
Case presentation: The case presented here was a 15-year-old boy consulted our clinic with complaints of sudden episodes of loss of muscle tone affecting his arms and legs in during waking hours. He described a tension-type headache, ear pain about half hour before in every episode. The patient consulted to neurology and cardiology clinics and no pathology was found. His HLA typing showed HLA DQB1*03 haplotype. The patient was diagnosed with isolated cataplexy. Aripiprazole 2.5 mg/day was started, and one month later the patient's cataplexy symptoms disappeared and had never recurred over one year of follow-up. The knowledge on the aetiology of the isolated cataplexy is not precise. One of the most significant reasons of isolated cataplexy is the hereditary transition. HLA gene family is at the forefront of hereditary cataplexy transitions among genetic studies. HLA DQB1 * 0602 haplotypes are associated with isolated cataplexy in HLA typing in isolated cataplexy cases. In addition, unlike the literature, we found HLA DQB1 * 03 haplotypes in our case. An interesting feature of our case is that preliminary symptoms such as a headache and ear pain are observed before cataplexy attacks. Information on the efficacy of antipsychotics in the treatment of cataplexy is somewhat limited. In a case of narcolepsy and schizophrenia, it was determined that antipsychotics could worsen the narcolepsy symptoms. Our case will contribute to the treatment of isolated cataplexy in the literature with the reason that in an adolescent patient, there are signs of pre-attack symptoms and treated with low dose aripiprazole treatment.

KEYWORDS
Adolescent; aripiprazole; hereditary cataplexy; isolated cataplexy; narcolepsy

[Abstract:0252][Psychopharmacology]

Allergic skin reaction with low-dose sertraline in an adolescent

Necati Uzun

Department of Child and Adolescent Psychiatry, Elazığ Psychiatry Hospital, Elazığ, Turkey

E-mail address: necatiuzun42@gmail.com

ABSTRACT
Sertraline is one of the selective serotonin reuptake inhibitors which can be used for anxiety disorders, obsessive-compulsive disorder, and depression in children and adolescents. Some side effects such as nausea, insomnia, and diarrhoea can be seen in treating individuals with sertraline commonly. However, some rare side effects like skin reactions can be seen upon using sertraline. Some individuals may be hypersensitive to sertraline. As far as we know, there is a limited number of data in the literature about low dose sertraline-induced allergic skin reactions in childhood.
Case presentation: A 14-year-old male patient was presented to our clinic for complaints of difficulty in getting to know new people, difficulty in speaking in public. Also, some physical symptoms such as trembling, sweating, palpitations, and feelings were noted before the exam in recent months. The patient was diagnosed with social anxiety disorder according to DSM-5. At the first visit, the Social Anxiety Scale (SAS) administered for measuring the levels of adolescent's social anxiety. SAS score was 15 points at the beginning. Sertraline 25 mg/day was initiated at the first visit. Two days after sertraline administration, generalized maculopapular erythema lesions were observed with swelling in the face and hands, and itching in the trunk and extremities. Drug allergy induced by sertraline in the patient was considered. The patient's sertraline treatment was stopped. Cyproheptadine was administrated after consulting paediatry clinic. The patient's testimony retracted within two weeks. Social anxiety disorder also called social phobia characterized by an intense anxiety of being judged or rejected in a social situation. The treatment of social anxiety disorder is like that of other anxiety disorders. SSRIs are commonly used in the treatment of anxiety disorders in children and adolescents. An allergic reaction is an untoward effect of sertraline. Some case reports of allergic reactions of sertraline in adults. However, there is one case report of erythema multiforme following administration low dose sertraline in child and

KEYWORDS
Adolescent; drug allergy; hypersensitivity; sertraline; social anxiety disorder

adolescents. The present case suggests that there may be individuals who are sensitive to increases in serotonin concentrations. Allergic skin reactions to sertraline in the patient may be due to high activity in the serotonergic system at the dermal and epidermal-dermal junctional area rather than a hypersensitivity to the drug molecule itself

[Abstract:0253][Psychopharmacology]

Low-dose aripiprazole-induced diurnal enuresis in a child with Tourette syndrome

Necati Uzun

Department of Child and Adolescent Psychiatry, Elazıg Psychiatry Hospital, Elazığ, Turkey

E-mail address: necatiuzun42@gmail.com

ABSTRACT

Aripiprazole (ARP) is an atypical antipsychotic with partial agonist at 5-HT1A and dopamine D2 receptors and antagonist at 5-HT2A receptors. Commonly observed adverse effects in using ARP in children and adolescents are the extrapyramidal disorder, somnolence, tremor, fatigue, nausea, akathisia, blurred vision, dizziness, and salivary hypersecretion. Besides, some authors reported that ARP-induced nocturnal enuresis in children with autistic disorder. But conversely, some authors suggested that ARP can be beneficial in the treatment of enuresis induced by antipsychotics. As far as we know this is the first reported case of ARP-induced diurnal enuresis in a child.

Case presentation: The case presented here was a 9-year-old boy consulted our clinic with complaints of eye blinking, head jerks and guttural noise. He had been having these problems for about 5 years. The patient was diagnosed with Tourette Syndrome (TS) according to the DSM-5. The Yale Global Tic Severity Scale (YGTSS) was used to measure tic severity in TS. YGTSS score was 5 and 4 for motor and vocal tics at the beginning of treatment, respectively. ARP dose was increased to 5 mg/day at second visit, and one month later TS symptoms disappeared. YGTSS was 0 for motor and vocal tics at this visit. The patient's tic symptoms never recurred over 6 months of follow-up. ARP is commonly used in the treatment of bipolar disorder, psychosis, irritability associated with autism spectrum disorder, and tic disorders for children and adolescents. Also, ARP use in the case of nocturnal enuresis is associated with antipsychotics. However, some researchers suggested that ARP can cause nocturnal enuresis in the treatment of irritability associated with autism. In the literature, there is limited inconsistencies data about the relationship with ARP and enuresis. Also, neuropharmacological mechanisms underlying the association between ARP and enuresis are currently unknown.

KEYWORDS

Aripiprazole; children; diurnal enuresis; nocturnal enuresis; Tourette Syndrome

[Abstract:0254][Psychopharmacology]

Psycotic depression after the use of varenicline: a case report

Özgen Özçelik[a], Hüseyin Kara[a] and Talya Tomar[b]

[a]Akdeniz University School of Medicine, Department of Psychiatry, Antalya, Turkey; [b]Akdeniz University School of Medicine, Antalya, Turkey

E-mail address: drozgendeu35@yahoo.com

ABSTRACT

Varenicline is a partial agonist of α4β2 nicotinic receptors what is used in smoking cessation treatment. Depressive mood, sleep disorder, suicide, agitation, aggression, psychotic and manic findings were detected in the use of Varenicline. In 2009, U.S. Food and Drug Administration (FDA) emphasized that varenicline may cause severe neuropsychiatric symptoms and exacerbations on the course of the disease in patients with schizophrenia, bipolar disorder, and major depressive disorder.

This case study aims to discuss the case that psychotic depressive mood was seen following the treatment with varenicline for 1 month after applying to the smoking cessation outpatient clinic. 56-year-old female patient, married with 3 children, is living with her family. The patient was brought to the emergency room by his son due to suicidal thoughts that started recently. It

KEYWORDS

Major depressive disorder; psychiatric signs; psychotic depression; treatment; Varenicline

was learned that the patient who was referred from the emergency room to the psychiatric outpatient clinic went to the smoking cessation clinic 1 month ago and started varenicline 0.5 mg/day. She stated that she did not want to leave the house, felt unhappy and tedious before the onset of the drug, but these complaints increased after the onset of the drug, in addition to these, uneasiness, palpitations, thoughts of death and suicide have come to her mind, and that she felt like she had a drug in her mouth and the drug will turn to a poison that would get into her blood when it melts. Depressive mood, suicidal thoughts, and paranoid delusions were detected in the patient's mental status examination, and according to DSM5 diagnostic criteria, she was diagnosed with psychotic depression. Due to this, treatment was started with sertraline 50 mg/day and aripiprazole 5 mg/day. In her control after 1 month, it was observed that the complaints decreased.
With the use of Varenicline, severe psychiatric disorders, exacerbations, or worsening of existing psychiatric disorders may occur in increasing numbers of cases. Because of these reasons, the relationship between Varenicline and psychiatric signs should be considered carefully before the onset of the drug. It should be remembered that before starting the drug a detailed mental status examination should be done to the patient and, if necessary, a psychiatric consultation would be proper. Also, patients and their families need to be informed about possible side effects.

[Abstract:0255][Eating disorders]

Anorexia nervosa induced by cannabis use in young male adult: a case report

Mutlu Muhammed Özbek[a], Mustafa Tolga Tunagür[a], Çağdaş Öykü Memiş[b], Bilge Doğan[b] and Levent Sevinçok[b]

[a]Adnan Menderes University Child and Adolescent Psychiatry, Turkey; [b]Adnan Menderes University Psychiatry, Turkey

E-mail address: mutluozbekk@hotmail.com

ABSTRACT

The compounds of cannabis, such as tetrahydrocannabinol, activate endogenous cannabinoid receptors (CB1 and CB2) in the brain. Stimulating the CB1 receptor is known to cause increased appetite and an antiemetic effect, and because of these effects, cannabinoids are used clinically. It is known that there is a high comorbidity between alcohol-substance abuse and eating disorders. In this case report, anorexia nervosa developed in a young adult male patient despite the appetite enhancing effect of cannabis is discussed.

Case presentation: Our patient is a 20-year-old male graduated from high school. He was presented to outpatient clinic with complaints of unhappiness, fatigue, anger attacks, binge eating episodes, vomiting, and weight loss. The patient received in the anamnesis: He was very overweight in middle school and primary school years and started to lose weight 6 months before he went to the military. He was informed that he used cannabis during the same period. The weight of our patient was 97 kg when he had started to use cannabis (height: 170 cm, BMI: 33.4). The post-military weight of our patient was 61 kg (height: 170 cm, BMI: 21.2). He said he continued to use cannabis in military service (nearly 3 times a week). The patient, the subject of our case, told us that he had vomited excessively in the first 3–4 months after he had started to lose weight. He also noted that he walked or sometimes ran for hours as a compensatory behaviour. It has been learned that cannabis use continues until the last 1 month. Psychoeducation was given to the patient about eating disorder. The treatment of the patient was started with 20 mg/day of fluoxetine. The comorbidity ratio of alcohol/substance abuse and eating disorder is approximately 17%. In another study, when comorbidity of illegal substance use disorder and eating disorder was evaluated, it was shown that the most commonly used substances were amphetamine and cocaine, which have appetite-diminishing effects . Cannabis has many short-term and long-term side effects. When cannabis is used, it is observed that calorie intake increases as a result of the increased consumption of snacks, such as sugary foods, biscuits, and cake. A study conducted among young people has shown that cannabis use is associated with binge-eating rather than with staying hungry, using diet products. Our patient was using cannabis for two years when he was presented to our clinic. In our case, we found that the use of cannabis was associated with anorexia nervosa. Our patient reported that he had been suffering from binge eating habits, compensatory vomiting, and exercise ritual after using cannabis during initial months of abuse. This type of weight loss is inversely related to the known effects of cannabis. Our case draws attention to the fact that anorectic patients should be questioned about cannabis use

KEYWORDS

Anorexia nervosa; binge-eating; cannabis; eating disorders; tetrahydrocannabinol

[Abstract:0265][Schizophrenia and other psychotic disorders]

Folate deficiency suggesting organicity

Abdullah Akgün, Abdullah Bolu, Taner Öznur, Cemil Çelik and Kamil Nahit Özmenler

Gulhane School of Medicine, Department of Psychiatry, Health Sciences University, Ankara, Turkey

E-mail address: akgun_61@live.com

ABSTRACT

The relationship between folate deficiency and schizophrenia has been the subject of many articles. In this study, we present a case of a brief psychotic episode that started late after folate deficiency and occurred with findings suggesting organicity, and recovered rapidly after folate treatment.

Case presentation: a 40-year-old male patient with no history of previous psychiatric diagnosis and treatment has been admitted to our clinic with symptoms showed up in last days, such as contractions, visual hallucinatory experiences, lack of communication, and disorganized behaviours. Observation of the patient in the clinic revealed that communication was closed, constantly talking to himself, hectic, weak connection to the outside world. The patient was evaluated as a psychotic episode and treatment with olanzapine 10 mg/day was initiated. Additional treatments such as lorazepam, clonazepam, and haloperidol were given occasionally for sedation and to prevent self-harm. The patient was injured by the reason that he fell on his nose. Because of the atypical nature of the symptoms, we started to examine in terms of organic aetiology. His neurological examination was normal. Folate levels were low (1.9 ng/mL) in blood tests performed on the second day of admission. B12 (439.2 pg/mL) and Ferritin (88.75 ng/mL) levels were normal. Folate supplementation was started (5 mg/day). Brain imaging methods (CT, MRI) and EEG were reported as normal. Infection markers (VDRL-RPR, Brucella IgM and IgG) were within normal limits. Folate supplementation continued. The disorganized behaviour of the patient has decreased day by day. On the fifth day of the admission, the patient's disorganized behaviour disappeared. The patient started to cooperate. Perceptual pathologies and delusions were completely resolved. The symptoms are thought to be caused by a lack of folate. Folate deficiency may be the cause of many neurological manifestations. Sometimes it can be a precipitating factor of psychiatric diseases. Folate deficiency is a fact that the clinician needs to know. We should keep in mind the lack of folate when we are confronted with psychiatric symptoms which are thought organicity. With a simple blood test, the cause can be determined and treated quickly.

KEYWORDS

Folate deficiency; organicity; psychotic

[Abstract:0267][Psychopharmacology]

Postmenopausal bleeding linked to the use of sertraline: a case report

Zehra Başar Kocagöz, Adnan Özçetin and Ahmet Ataoğlu

Duzce Universty School of Medicine, Department of Psychiatry, Duzce, Turkey

E-mail address: zehrabasarkocagoz@outlook.com

ABSTRACT

Selective serotonin reuptake inhibitors (SSRIs) that are heterogeneous in structure are commonly used antidepressant drugs in the clinic. Although there are small differences in terms of their effects, they show differences in terms of side effects. Sertraline and other SSRIs inhibit serotonin reuptake in platelets and prevent aggregation. SSRIs are particularly effective at the first stage of bleeding cascade. Haemorrhage has been reported in patients treated with SSRI. Although there are various investigations about these haemorrhages; accepted common view is that plug formation is prevented in the first phase of haemostasis, platelet aggregation is also inhibited and thus bleeding occurs. As a result, it is believed that serotonin is released into the plasma by platelets and plays a role in aggregation.

Case presentation: The patient was 52-year-old married woman. 9 months ago, the patient was presented to our outpatient clinic with complaints of feeling distress, hypochondria, and feeling of sickness especially in the morning. The first complaints began 5 days before the application. Mental status examination in the outpatient clinic when he was first presented (9 month ago) revealed that clear consciousness, mood changes and emotional anxiety, fear of sickness in thought, and diminished sleep. The patient entered the menopause period 17 years ago. After the mental status and personality traits were evaluated, sertraline 25 mg/day was started for treatment. Because the patient's complaints were partly continued at the 1st month control, sertraline dose was increased to 50 mg/day. In 2nd month of the treatment, it was learned

KEYWORDS

Platelets; postmenopausal; sertraline; SSRIs; vaginal bleeding

that the vaginal bleeding was started and continued after the drug was administered. A gynecologic examination revealed no gynecologic pathology for vaginal bleeding. No pathological findings were found in the bleeding parameters and other laboratory values were normal. The patient was followed and haemorrhage continued at 5th month; therefore it was considered bleeding may caused by sertralin and the treatment was stopped. The bleeding was decreased by the cessation of sertraline. Chronic effects of SSRIs have been reported to decrease the level of serotonin in whole blood and in platelet granules but not to alter plasma serotonin levels. It has been reported that osmotic effects of sodium can cause symptoms similar to serotonergic manifestations by altering the flow of the membrane ion, except for surface changes in erythrocytes, serotonin, or antagonists. Serotonin increases calcium ion input to endothelium, platelet, and erythrocyte cells. With calcium entry, the cells become more rigid. As a result, it is thought that erythrocytes may be more degradable with this ion input. Calcium is believed to mediate this mechanism by calmodilin and spectrin-actin and band 4.1. When these findings are evaluated, it is considered that serotonin antagonists decrease haemotocrit, increase erythrocyte rigidity, and decrease blood viscosity. However, the absence of the serotonin receptor on the surface of the erythrocyte indicates that this mechanism is realized by the indirect effect (8). We want to emphasize the uncommon side effect of SSRIs, presenting with a case of postmenopausal bleeding, starting with the use of sertraline and ending in hours with the drug cessation.

[Abstract:0269][Psychopharmacology]

Oral dyskinesia caused by risperidone and resolves with clozapine and quetiapine: a case report

Ahmet Ataoğlu, Merve Çavdar Toraman and Zehra Başar Kocagöz

Duzce Universty School of Medicine, Department of Psychiatry, Duzce, Turkey

E-mail address: yasfem@hotmail.com

ABSTRACT

Tardive dyskinesia (TD) is a prominent syndrome with involuntary hyperkinetic movements that occur due to prolonged use of antipsychotics or shortly after discontinuation of the drug. While classical antipsychotics are generally accepted as safe drugs; they can cause uncomfortable side effects such as akathisia, acute and late dystonia, parkinsonism, malignant neuroleptic syndrome and late dyskinesia. A decrease in nigrostriatal dopamine receptor activity, followed by an increase in activity known as "denervation supersensitivity" cause tardive dyskinesia.

Case presentation: 63-year-old woman presented to our clinic with behaviours that started in the mouth and keep the language moving. The patient was married, a housewife and diagnosed with schizophrenia and she has been using 50 mg/20 days risperidone depot injections for two years. The patient has self- and abusive speech, irritation, and strange behaviour. She has been followed and treated for about 40 years with the diagnosis of schizophrenia and has been followed in our clinic for the last 4 years. In the mental status examination, there was psychomotor retardation. Also, self-care diminished, emotion was shallow, thought content was poor, and speech spontaneity has decreased. There was abstract thought, judgment and insight were diminished, and there was an increase in sleep. It was considered that oro-lingual dyskinesia (OLD) due to risperidone and treatment was planned with a gradual dose increase of clozapine 25 mg/day and quetiapine 100 mg/day. The clozapine dose was increased to 175 mg/day on the 20th day of admission. The Extrapyramidal Symptom Rating Scale (ESRS) was recorded as 6 (bradykinesia: 2, dyskinetic movements: 4) at the hospital admission. On day 4 of the treatment change, there was a significant decline in the patient's OLD complaint. OLD symptoms gradually decreased and were completely resolved at the 20th day of admission, and the ESRS was recorded as 2 (bradykinesia). She was discharged with clozapine 200 mg/day and quetiapine 100 mg/day. The production of atypical antipsychotics decreased the TD incidence. Although risperidone is an atypical antipsychotic, there was a case report in the literature that OLD occurred with risperidone. Atypical antipsychotic drugs such as clozapine and quetiapine are known to be used for EPS. Navarra et al. present three cases with typical and atypical antipsychotics-triggered OLD. OLD symptoms were resolved in all three cases with quetiapine in 2 months to 4 months. In Yunxin Kwan's case report, it has been reported that TD caused by lithuril and haloperidol was completely resolved with clozapine treatment in 21 months. In our case, OLD resolved completely in 3 weeks. Synergistic use of clozapine and quetiapine may be beneficial. Because the cases presented in the literature are stretched for a longer period of time, it is intended to be presented in order to contribute to the literature.

KEYWORDS

Clozapine; oro-lingual dyskinesia; schizophrenia; quetiapine; tardive dyskinesia

[Abstract:0272][Psychopharmacology]

Unexpected complication after methylphenidate in a boy with attention-deficit/hyperactivity disorder: hiccups

Tayfun Kara[a] and İsmail Akaltun[b]

[a]Department of Child and Adolescent Psychiatry, Health Sciences University Bakirkoy, Dr. Sadi Konuk Research and Training Hospital, Istanbul, Turkey; [b]Department of Child and Adolescent Psychiatry, Gaziantep Dr. Ersin Arslan Training andResearch Hospital, Gaziantep, Turkey

E-mail address: tayfunkara@hotmail.com

ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) is a chronic condition with adverse impacts on school/work life involving symptoms of inattention and hyperactivity-impulsivity. It is the most commonly diagnosed and treated childhood onset psychiatric disorder, with a prevalence in children and adolescents of 5.9–7.9%. Immediate-release methylphenidate (MPH) (Ritalin) is the first MPH-based pharmacotherapy approved by the Food and Drug Administration (FDA) for the treatment of ADHD. Hiccups is sudden and involuntary contractions of the diaphragm and intercostal muscles. The condition is generally benign and self-limiting, but may be chronic under some circumstances. We report a case of hiccups developing following treatment in a boy started on MPH therapy with a diagnosis of ADHD.

Case presentation: A 7-year-old boy was the second of three children and was in the second year of school. He was brought by his parents to our clinic due to hyperactivity, easy boredom and irritability, academic failure, forgetfulness, and difficulty in organizing tasks and activities. ADHD was diagnosed on the basis of DSM-5 diagnostic criteria following psychiatric assessments, and IR-MPH was initiated. Two days later, the patient was brought back to our clinic by his mother. The mother stated that on the previous day, she had given the patient his medication after breakfast and sent him to school, but that the school had called 1–2 hours subsequently, and his teacher informed her that hiccups had developed, and that this condition was persisting. The hiccups stopped 1–2 hours after the mother collected the patient from school, and she did not give him the medication again. We told the mother to administer the medication when they returned home, but that the drug could be modified if hiccups recurred. The child was brought back the next day, and we were informed that hiccups had recommenced when the drug was administered, and stopped after 3–4 hours. The hiccups persisted 3–4 hours after medication administration, and this being repeated suggested that the MPH might have been the cause. MPH was therefore stopped, and atomoxetine therapy was started. The pathogenesis of hiccups is complex and has not yet been fully clarified. The neurotransmitters reported to be involved in the development of hiccups are dopamine, serotonin and GABA. Changes in their states are known to play a significant role in hiccups' development, and drugs that affect these neurotransmitters are effective in the treatment of the condition. MPH principally affects catecholaminergic activity in the prefrontal cortex and striatum. It produces this effect by increasing dopamine transmission through more than one mechanism. MPH increasing the level and effect of extracellular dopamine. In addition, MPH mediates the stimulation of the α-2 noradrenergic receptor and the dopamine D1 receptor in the cortex. Hypo-/hyperdopaminergic states are reported to play a role in the development of hiccups. It was thought that MPH could trigger hiccup by increasing dopamine. We think that the possible relationship between MPH and hiccups should be carefully monitored by physicians.

KEYWORDS

Hiccup; methylphenidate; safety; side effects; ADHD

[Abstract:0273][Mood disorders]

Cotard's syndrome: a case report

Seher Serez Öztürrk, Dudu Demiröz, Nafiye Yağlı, İkbal İnanlı and İbrahim Eren

Konya Research and Training Hospital, Beyhekim Psychiatry Clinic, Health Sciences University, Konya, Turkey

E-mail address: drdemiroz42@gmail.com

ABSTRACT

Cotard's syndrome comprises any one of a series of delusions that range from a belief that one has lost organs, blood, or body parts to insisting that one has lost one's soul or is dead. It is seen in women more frequently. Average age of onset is 52. Co-existence of psychiatric and organic diseases with Cotard's Syndrome is reported in various studies. The case of a patient is characterized by delusions of negation, immortality, and guilt as well as melancholic anxiety,

KEYWORDS

Cotard's syndrome; depression; electroconvulsive therapy (ECT); nihilistic delusions; psychotic depression

among other clinical features. In our case, Cotard's syndrome accompanied by psychotic depression will be explained.
Case presentation: The Patient is 49 years old, female, and married. The first complaints of the patient began about 10 years ago such as unhappiness, inability to work, forgetfulness, and distraction. The patient has been on treatment for depression for 10 years. Depressive symptoms increased 1.5 years ago. The patient's complaints added nihilistic delusions that the brain was completely destroyed and that the brain was replaced by poison. During this period, he received several antidepressant and antipsychotic treatment, and he had ECT treatment in hospital about 6 months ago. She had partial benefit from the treatment. Patients whose complaints have increased in the last 2 weeks have been directed to my hospital. Patient's mood was depressed and anxious. Attention is scattered, judgment of the truth is bad. Depressive themes, worthlessness, guilt, helplessness, despair, passive suicidal thought, nihilistic delusions were present in the content of thought. Patients who were diagnosed with "Cotard syndrome and psychotic depression" started treatment with clomipramine 75 mg/day, olanzapine 5 mg/day, and benzodiazepine. The patient was treated with 8 sessions of electroconvulsive therapy (ECT). The patient showed depressive symptoms and lost the psychotic sign, and was discharged from hospital with clomipramine 225 mg/day and olanzapine 5 mg/day. Cotard's syndrome is a rare case. Patients diagnosed with Cotard's Syndrome may have different psychiatric symptoms. Depression was reported in 89% of subjects; the most common nihilistic delusions concerned the body (86%) and existence (69%). Anxiety (65%) and guilt (63%) were also common, followed by hypochondriacal delusions (58%) and delusions of immortality (55). In the study evaluating the incidence of 100 case with Cotard syndrome, 3 subgroups were identified. The first group clearly includes psychotic depression features, the second subgroup is a more pure form and is likely to be associated with delusional disorders. The third subgroup is the mixed group, which includes anxiety, depression, and auditory hallucinations. There are no detailed studies in the psychopharmacologic treatment of Cotard's syndrome In drug trials, different antidepressants and antipsychotics were administered as single or combined treatment and reported to have good results. ECT is also an important treatment option in Cotard's syndrome. Especially with an underlying mood disorder, ECT was reported as a very useful technique in many case reports. In depressive disorder with psychotic features, ECT (often in combination with farmacotherapy) seems to be the most supported strategy. In our case, combined antidepressant-antipsychotic treatment and ECT treatment gave successful results.

[Abstract:0274][Psychopharmacology]

Risperidone-induced temporomandibular joint dislocation: a case report

Ayşe Erdoğan Kaya, Esra Yazıcı, Muhammed Nurullah Sezer and Çağlar Turan

Sakarya University Research and Training Hospital, Sakarya, Turkey

E-mail address: dr.ayserdogan@gmail.com

ABSTRACT
Acute dystonia is a side effect of extrapyramidal system due to D2 receptor blockade of the antipsychotics. It is a psychiatric emergency that develops dramatically during antipsychotic treatment and generally has well response to anticholinergics. Dystonias are involuntary, continuous, or spasmodic muscle contractions that cause abnormal curves and various postures. Acute dystonia may cause severe complications in some patients due to prolonged response time to treatment. One of these complications may be temporomandibular joint dislocation. Here, we report a case of acute dystonia with temporomandibular joint dislocation after risperidone treatment.
Case presentation: A 30-year-old male patient admitted to our clinic with bipolar manic episode. Positive findings in the psychiatric examination were logorrhea, irritability, mood elevation, flight of ideas, persecutions, auditory hallucinations, reference ideas, and psychomotor agitation. According to the anamnesis, he had bipolar disorder for 2 years with previous positive response to lithium, risperidone, and quetiapine treatments. Lithium and low-dose quetiapine treatment has been started for manic symptoms. Lithium increased up to 1200 mg for effective blood level. Additionally, 4 mg risperidone was administered for psychotic symptoms. Several hours after the administration of risperidone, the patient began to have contractions of the oromandibular and cervical region muscles, asymmetry on the face and neck, dysphagia, oedema, rigidity, and bradykinesia. Risperidone treatment was stopped and 5 mg biperiden HC injection was administered immediately. Bradikinesia and rigidity remitted but dystonia did not. A second injection of biperiden was administered but oromandibular region asymmetry and swallowing difficulties were still evident and prolonged to the other day. Lorazepam2.5 mg was added to the treatment but dystonia went on. The consultant of neurology and otorhinolaryngology was requested. Neurologist started botox treatment but no response was observed. After improving psychotic and manic

KEYWORDS
Temporomandibular joint; dislocation; dystonia; antipsychotics; anticholinergics

symptoms, the patient discharged with the recommendation to refer to a dentist. After the diagnosis of temporomandibular dislocation of the dentist, the patient was admitted to the oral and maxillofacial surgery department and was treated with reduction. Oromandibular dystonia may manifest itself as involuntary contraction, opening in the jaw joint or deviation, which may manifest itself as pain and temporomandibular dislocation. The highlight of our case is that the oromandibular asymmetry after the use of risperidone did not improve despite the anticholinergic agent, benzodiazepine and botox treatments inversely to the expectations that acute dystonia responds rapidly to anticholinergics. This is a rare condition. Another feature of our case is that there was no extrapyramidal side effect with risperidone in the patient's medical history. A rapid high dose initiation may be one of the leading factors of this adverse effect. If oromandibular dystonia after antipsychotic use seems to be not responding to treatment, TMJ evaluation is very important.

[Abstract:0277][Schizophrenia and other psychotic disorders]

Cavum septum pellucidum and schizophrenia: case series

Engin Sert, Yusuf Ezel Yıldırım, Pınar Çetinay Aydın, Sevilay Kunt and Tonguç Demir Berkol

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

E-mail address: dr_engin_sert@hotmail.com

ABSTRACT

Cavum septum pellucidum (CSP), a space between the two leaflets of the septi pellucidi, is thought to be a neurodevelopmental anomaly, and its presence may be consistent with neurodevelopmental theories of schizophrenia. This structure is closely linked developmentally to the limbic system, which has been implicated in the aetiology of the disorder. Magnetic resonance imaging (MRI) studies have reported a variety of brain abnormalities in association with schizophrenia. These include a higher incidence of CSP, which is consistent with a neurodevelopmental model for this disorder.

Case 1: First episode schizophrenia – 37-year-old male patient; according to the complaints of the patient himself, his neighbors changed his thoughts and prevented him from getting married. According to the patient's relative, he had suspiciousness, autism, and lack of communication. On the mental status examination of the patient: Decreased quantity of speech and poverty of thought were found. Affective expression was restricted. In the thought process, loosening of associations, referential and persecutory delusions, thought withdrawal and thought broadcasting were revealed. The patient had psychomotor retardation and avolition. There was serious impairment in the social and occupational functioning of the patient. There was no insight into his disease. Psychiatric evaluation revealed diagnosis of schizophrenia. MRI imaging of the patient has shown CSP. On the neuropsychological assessment, a mild frontal-type memory deficit was detected. The clozapine 250 mg/day dose significantly reduced the psychotic symptoms.

Case 2: Chronic Schizophrenia; 56-year-old male patient, according to the relative of the patient his complaints include talking to himself, nervousness, and scepticism. He has 13 years of disease history. A patient with poor drug compliance was admitted to our clinic due to treatment rejection. On the mental status examination of the patient, increased quantity of speech and disorganized speech were noted. Restricted affect was observed. In the thought process, loosening of associations was found. In the content of thought, persecutory delusions were detected. The patient had disorganized behaviour. There was no insight into his disease. Psychiatric evaluation revealed diagnosis of schizophrenia. MRI imaging of the patient revealed CSP. Haloperidol Decanoate 200 mg/month was started due to treatment response from haloperidol. The patient's psychotic symptoms have improved. CSP as being present if it is identified on at least one MRI slice (about 1 mm to 1.5 mm thick), and considering a CSP abnormally large if it is greater than or equal to 6 mm in size. Patients with an abnormally large CSP demonstrated poorer performance on measures of verbal learning and memory than patients with smaller CSP. Among patients, CSP length was significantly correlated with negative symptoms, verbal learning, and sentence comprehension. Late response to treatment in Case 1, switching to clozapine treatment, the presence of negative symptoms, and the impairment detected in neuropsychological tests may be associated with this condition. The severity of symptoms of our first episode schizophrenia patients, the lack of response to treatment, and the poor performance of neuropsychological tests are consistent with the information available in the literature. The significant destruction of our chronic schizophrenic cases suggests the neurodevelopmental model of CSP in the aetiology of schizophrenia as well as disease duration and treatment non-compliance.

KEYWORDS

Schizophrenia; first episode schizophrenia; cavum septum pellicidum; treatment-resistance schizophrenia; the poor performance of neuropsychological tests

[Abstract:0282][Sleep disorders]

A case of Klein Levin Syndrome treated with lithium

Erman Esnafoglu and Öznur Adıgüzel

Department of Child and Adolescent Psychiatry, School of Medicine, Ordu University, Ordu, Turkey

E-mail address: ermanesnafoglu@yahoo.com.tr

ABSTRACT

Kleine-Levin syndrome (KLS) is a rare, relapsing– remitting, debilitating sleep disorder that primarily affects adolescents. Patients with KLS experience an alternating pattern of major hypersomnia lasting 1 to a few weeks accompanied by cognitive, behavioural, and psychiatric disturbances and periods of normalcy. Common symptoms were hypersomnia (100%), cognitive changes (96%, including a specific feeling of derealization), eating disturbances (80%), hypersexuality (43%), compulsions (29%), and depressed mood (48%). As for today, the aetiology and pathophysiology of KLS are unknown. Possible triggers for KLS include head trauma and viral infections. While neuroleptics and antidepressants were of poor benefit, only lithium (but not carbamazepine or other antiepileptics) had a higher reported response rate.

Case presentation: In this case report, a 12-year-old male patient with head trauma developed KLS. Patient with head trauma and clavicle fracture following a bike accident were presented to the emergency service. The patient has not been diagnosed with any serious symptoms. After this accident, periods of 10 to 15 days of excessive sleeping, drowsiness, speech disorders, and unconsciousness have occurred. After this symptomatic interval, there was a period of 10 days without any symptoms. The patient who had 3 symptomatic attacks presented to the child psychiatric outpatient clinic. The patient's cranial MR and EEG results were normal. Apart from these symptoms, symptoms such as hypersexuality and hyperphagia have not occurred. Excessive sleep episodes were interrupted one month after the initiation of lithium treatment. In KLS, attacks start and end suddenly, which can last from a few days to several weeks. Between the episodes, the disease is fully remissionable, no sleep disorder is observed, and the patient is physically and mentally healthy. Our patient also had similar attacks. Hypersomnia episodes in KLS are basic. Among these episodes, our patient is completely healthy, and there are no complaints about sleep disorder or mental disorder. In the setting of KLS, sleep episodes are not necessarily accompanied by symptoms of hyperphagia and hypersexuality. In the treatment of KLS, valproic acid, carbamazepine and melatonin are used. Lithium treatment has been suggested to reduce the frequency of attacks or to stop attacks. Carbamazepine and lithium therapy can be used together. In our case, only lithium was used and the response was received. Response to treatment may also be regarded as a supporting finding of KLS.

Although KLS is a very rare syndrome, treatment response is very good. Especially in hypersomnia attacks seen in male patients in adolescents, KLS should be considered in differential diagnosis.

KEYWORDS

Adolescent; hypersomnia; Klein Levin syndrome; lithium treatment; sleep disorders

[Abstract:0284][Other]

Recurrent transcranial magnetic stimulation (rtms) activity in treatment-resistant obsessive-compulsive disorder: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: karagozabdulkadir@gmail.com

ABSTRACT

Obsessive-compulsive disorder (OCD) is a heterogeneous psychiatric disorder characterized by the presence of obsessions and compulsions. Very different varieties can be seen. Treatment is difficult, but recently recurrent transcranial magnetic stimulation (rTMS) has been tried in therapy. Although rTMS has been approved for depression, it is promising in the treatment of OCD. Here, we present to a 21-year-old patient with OCD for 4 years whom rTMS was administered.

Case presentation: A 21-year-old soldier, married, male, offered with symptoms of OCD cleaning obsession, too many hand washing, and long shower. Clomipramine 225 mg/day

KEYWORDS

OCD; obsessions; compulsions; rTMS

and risperidone 4 mg/day. The complaints were increasing day by day. His hands developed soap-bound dermatitis and spent 3–4 hours a day in the bathroom. He has suffered from this disease for 4 years and was treated in hospital 3 times. He had history of smoking, alcohol and no drug abuse. His laboratory studies were normal. The patient's Yale Brown Obsessive Compulsive Scale (Y-BOCS) score was 30. After the detailed examination, it was decided to apply rTMS to the patient. The patient was informed of the sign. No changes were made to the patient's current drug treatment during rTMS. TMS administered over the right dorsolateral prefrontal cortex by figure-of-eight coil using the Magstim1 Rapid2 stimulator for 5 daily sessions per week (1500 low-frequency (1 Hz) repetitive pulses in 10 trains (10 s each) with 5 s inter-train interval at 100% of the resting motor threshold) for 4 weeks. After rTMS, the patient's OCD symptoms reduced and his Y-BOCS score was 12. And not repeat again. The effect of rTMS on OCD is not fully known but it is suggested that reducing the increase of neuronal activity may be effective. In OCD treatment, large populations of randomized controlled trials are needed to validate TMS.

[Abstract:0285][Other]

Treatment with rTMS in a patient with treatment-resistant obsessive-compulsive disorder: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: dribrahim06@gmail.com

ABSTRACT

Recurrent transcranial magnetic stimulation (rTMS), a neuromodulation method, has been approved by the FDA for the treatment of resistant depression. High-frequency rTMS has been shown to increase excitability and low-frequency rTMS to reduce it. Apart from depression, rTMS is used experimentally in psychiatric disorders such as OCD and auditory hallucinations. Here, we present a 23-year-old male patient with obstructive-compulsive disorder (OCD) who is resistant to treatment.

Case presentation: A 23-year-old student, single male, presented with symptoms of OCD persistent unwanted repeated ideas about the God and due to ideas so cannot worship. Daily fluoxetine 60 mg/day and aripiprazole 5 mg/day and his complaints were the same. She has suffered from this disease for 5 years and has not had any improvement despite using various medicines. He had no history of smoking, alcohol and drug abuse. His laboratory and scanning studies were normal. The patient's Yale Brown Obsessive Compulsive Scale (Y-BOCS) score was 26. (Range of the scale: 0–40) As a result, rTMS was recommended to the patient. He gave informed consent for treatment and was included in an rTMS protocol. His current medication's dose was maintained during rTMS. TMS administered over the right dorsolateral prefrontal cortex by figure-of-eight air-cooled coil using theMagstim1 Rapid2 stimulator (The Magstim Company Ltd., Whitland, Carmanthenshire, Wales, UK) for 7 daily sessions per week (1500 low-frequency (1 Hz) repetitive pulses in 10 trains (10 s each) with 5 s inter-train interval at 100% of the resting motor threshold) for 3weeks. After rTMS, he noted that there was a great regression in patient complaints. The patient's control Y-BOCS score was 9. There was no increase in complaints on follow-up examination of the patient a month later. Recent studies show that rTMS can also be effective in OCD. Although the mechanism of action of rTMS is not fully elucidated, the most likely mechanism is that rTMS reduces the inhibitory function of cortical and subcortical neurons in OCD patients. rTMS offers a new alternative to OCD therapy for clinicians. It needs more work to be proven effective on OCD.

KEYWORDS

Magstim1 Rapid2 stimulator; obsessive-compulsive disorder; rTMS

[Abstract:0286][Other]

Deep brain stimulation (DBS) related depression: a case report

İbrahim Gündoğmuş, Abdulkadir Karagöz and Ayhan Algül

Sultan Abdulhamid Han Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: dribrahim06@gmail.com

ABSTRACT
Deep Brain Stimulation is a surgical option that has recently been administered in Parkinson's disease treatment. DBS, an effective and safe method, may cause some complications. There are reports in the literature that DBS may affect mood. Here we present a 54-year-old male patient with DBS implantation who developed depression after 2 months and was treated with escitalopram. Psychiatric disorders such as transient acute depression, anxiety, mania, and obsessive-compulsive disorder have been reported in the literature after DBS operation. But the subacute depressive disorder associated with DBS has not yet been reported. As far as we know, our case is first. In our article, possible mechanisms of DBS-related depression and future implications are discussed.

KEYWORDS
Deep Brain Stimulation (DBS); depression; escitalopram; Parkinson's disease

[Abstract:0292][Psychopharmacology]

Olanzapine pamoate injection may cause deep venous thrombosis

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT
Antipsychotic drugs are widely used in psychiatry and are associated with an increased risk of adverse effects such as venous thromboembolism. Olanzapine pamoate is a long-acting injectable form of the second-generation antipsychotic agent. It is used especially in schizophrenia patients who are nonadherent to their prescription due to various reasons. Since the introduction of this newer depot form of olanzapine, it became more commonly prescribed and nearly replaced the conventional oral agent. Deep venous thrombosis (DVT) is a severe, life-threatening condition which is somehow mostly underestimated or ignored by the psychiatrists. Although the risk of DVT due to antipsychotic drug therapy has been mentioned in various studies, the relationship with olanzapine pamoate was not referred to in the available literature. Here, a DVT after the use of olanzapine pamoate was introduced.
Case presentation: A 24-year-old male schizophrenia patient was admitted with the complaints of swollen and painful left leg. According to his past medical history, an antipsychotic olanzapine pamoate was injected two weeks ago for the first time. This LAI antipsychotic agent was administered upon his noncompliance with the previous oral treatment. Schizophrenia was diagnosed, and oral olanzapine was started one year ago. However, his denial about his diagnosis resulted in discontinuance of prescribed medication. In mental status examination, an uncooperative behaviour and increased psychomotor activity, with rare hallucinations were noted. Therefore, an alteration of the antipsychotic agent from oral form to a depot form was inevitably done. However, a week after the first dose of olanzapine pamoate injection his left leg increased in diameter, and became swollen and painful. His past medical history revealed no immobilization, restraint, or hypercoagulable medications. According to the Naranjo Adverse Drug Reaction (ADR) Probability Scale (which showed a score of 6), this adverse effect was probably induced by olanzapine pamoate. In conclusion, antipsychotic drugs are associated with increased risk of DVT. This complication may cause morbidity and mortality among people with schizophrenia who are treated for their behavioural disorders with these medications. These antipsychotic drugs, specifically olanzapine pamoate, should be used more cautiously among the patients at high risk of VTE. The patients should be informed about the risks and benefits of this medication. However, before constituting the thromboembolic risk stratification, the individual factors such as age, gender, smoking status, and the comorbidities should also be taken into consideration. Moreover, the psychiatrists should always be aware of the thromboembolic complications and side effects of these agents, and they should monitor these patients more closely. The prescription of a prophylactic antithrombotic medication such as ASA should also be considered according to the risk status of the patient upon consultation with the cardiovascular surgery department.

KEYWORDS
Long-acting; antipsychotics; olanzapine pamoate; side effect; deep venous thrombosis

[Abstract:0293][Other]

Asperger syndrome with comorbid very early-onset schizophrenia

Selçuk Dalyan[a], Esin Özatalay[a], Aslı Sürer Adanır[a] and Arif Önder[b]

[a]Department of Child and Adolescent Psychiatry, Akdeniz University, Antalya, Turkey; [b]Department of Child and Adolescent Psychiatry, Manisa Psychiatric Hospital, Manisa, Turkey

E-mail address: selcukdalyan19@gmail.com

ABSTRACT

Very early-onset schizophrenia (VEOS) is defined as onset of psychosis before age 13 years and is a rare and severe form of schizophrenia. Onset is usually after age 7 years, positive and negative symptoms are prominent, and prognosis is poor. In contrast, autism is defined by abnormal behaviour in the spheres of communication, social relatedness, and stereotyped behaviours beginning within the first 3 years of life. Asperger syndrome (AS) is a form of autism, and is defined by serious difficulties in reciprocal social interaction, fluent but pragmatically impaired speech and the presence of bizarre preoccupations and obsessions. Although autism and very early-onset schizophrenia are distinct, they have some common clinical features. Social withdrawal, communication impairment, and poor eye contact seen in autism spectrum disorders are similar to negative symptoms seen in youth with schizophrenia. Here we report a case of Asperger syndrome with VEOS, whose diagnosis was delayed because of common symptoms.

Case presentation: A 13-year-old boy with AS was presented to our outpatient clinic with auditory delusions. The boy received the diagnosis of AS at the age of 8. Since the last 3 years, his social withdrawal and communication impairment complaints have increased, and he started to complain about hearing some voices no one else could hear, but as his family associated this complaint with his AS, they did not seek help. In the last 6 months, the voices started to direct him, and became more disturbing, so the family presented him to our clinic. He got a diagnosis of AS comorbid with VEOS, risperidone 2 mg was initiated and increased to 4 mg. His positive symptoms ameliorated with risperidone treatment. Although autism and very early-onset schizophrenia are distinct disorders, they share some clinical features. Social withdrawal, communication impairment and poor eye contact seen in autism spectrum disorders are similar to negative symptoms seen in VEOS. Differential diagnosis is usually made with the age of the onset of the disease, and positive symptoms accompanying. But if VEOS is comorbid with AS, its diagnosis may be delayed because of these common symptoms. As a matter of fact, in our patient, the family did not need to apply the child until positive symptoms occurred. There are various explanations for schizophrenia-autism association. Developmental disorders per se may be risk factors for schizophrenia, and indicators of early fetal disturbance such as minor physical anomalies have been found to increase in both autism and schizophrenia. In most cases, the classification of unusual behaviour in children as prodromal or prepsychotic signs can only be done retrospectively after the manifestation of first clear psychotic symptoms. It is important to remember that some children may have both VEOS and autism spectrum disorders, in this respect.

KEYWORDS

Asperger Syndrome; autism; comorbid; symptoms; very early-onset schizophrenia

[Abstract:0294][Addiction]

A new choice for elevation: synthetic cathinone addiction

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT

In the last years, many synthetic cathinone compounds have received an increasing popularity as designer drugs of abuse, in particular among the younger population. Misuse of these synthetic cathinones popularized as "bath salt" has increased dramatically among the population since their debut in December 2010. Despite being labeled as "not for human consumption" and being marketed for different purposes such as "bath salts" or "plant food," people consume these substances to get high for their cocaine or amphetamine like effects.

KEYWORDS

Synthetic cathinones; bath salt; abuse; addiction; substance use disorder

After that, it became the most popular product among the synthetic cathinones with a street name of "Bath salt" for the last couple of years. Pharmacologically, they have been found to contain mainly mephedrone (MEPH) and methylenedioxypyrovalerone (MDPV) as the synthetic cathinone derivatives. Although there is still a lack of social and legal awareness about bath salts, numerous confirmed cases of abuse, intoxication, dependence or even death were reported to be related to the utilization of this synthetic cathinone analogue.
Case presentation: In this paper, a 22-year-old male patient who referred to the emergency department with confusion, agitation, and delirium after bath salt ingestion was reported. This case is especially important for introducing a relatively new and sporadic type of substance abuse out of United States (U.S.). In this case report, symptoms, signs, and the treatment characteristics of this new illicit drug were discussed in the light of current modalities and literature. Although these things are named as bath salts, it should be remembered that they were never intended to be put into the bath water.

[Abstract:0295][Other]

Prader–Willi Syndrome, management of hyperphagia and weight gain by methylphenidate and topiramate treatment

Erman Esnafoglu and Öznur Adıgüzel

Department of Child and Adolescent Psychiatry, School of Medicine, Ordu University, Ordu, Turkey

E-mail address: ermanesnafoglu@yahoo.com.tr

ABSTRACT
Prader–Willi syndrome (PWS) is a neurodevelopmental and neuroendocrine disorder that occurs due to the absence of expression of paternal genes at 15q11.2-q13 chromosomal region. The clinical features are variable, but typically include low birth weight, hypotonia, poor sucking and failure to thrive in infancy, onset of central obesity between 1 to 4 years of age, and poor cognition, behavioural problems, short stature, and hypogonadism. Presence of morbid obesity in about 2/3rd of the patients puts them at increased risk of several obesity-related complications, including diabetes, hypertension, obstructive sleep apnea, and non-alcoholic fatty liver disease. There are some medications such as naltrexone and bupropion, which may potentially improve satiety or help ameliorate obesity and impulsive behaviour in individuals with PWS. In this case report, we aimed to present a girl with PWS accompanied hyperphagia and obesity and we can manage hyperphagia, weight gain and obesity with usage of methylphenidate and topiramate.
Case presentation: A 10-year-old girl with a PWS diagnosis was presented here. Our patient had unstoppable eating behaviour, weight gain, and obesity. At the first visit, BMI was 38.9. In order to halt the patient's hyperphagia and weight gain, methylphenidate 40 mg and topiramate 50 mg/day were started. In the event that there was no reduction in symptoms, the treatment was reorganized as methylphenidate 60 mg/day and topiramate 100 mg/day. It has been observed that the hyperphagia is controlled, the weight loss is 5 months after 2 months, and the BMI is lowered to 35.6. Although PWS is not uncommon, these patients suffer from unstoppable eating and weight gain complaints. Stopping these symptoms that cause obesity is important in the treatment of these patients. For this reason, it should be noted that methylphenidate and topiramate treatment can be used to stop these symptoms.

KEYWORDS
Hyperphagia; methylphenidate; obesity; Prader–Willi syndrome; topiramate

[Abstract:0296][Psychopharmacology]

Resolution of hyperprolactinemia related to risperidone use by aripiprazole in an adolescent with psychosis: a case report

Şermin Bilgen Ulgar[a], Hamza Ayaydın[a] and Sema Bozbey[b]

[a]Department of Child and Adolescent Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey; [b]Luleburgaz State Hospital, Kırklareli, Turkey

E-mail address: semakurban85@hotmail.com

ABSTRACT
Risperidone is one of the commonly used antipsychotic agents in the treatment of psychosis in children and adolescents. However, it may block dopamine D2 receptors (DRD2) at anterior pituitary gland, resulting in galactorrhea, menstrual irregularity, amenorrhea, and gynecomastia. It has negative influence on drug compliance and quality of life. Here, we presented a patient with hyperprolactinemia developed during risperidone therapy for psychosis in which prolactin levels returned to normal levels with aripiprazole therapy.
Case presentation: A 15-year-old girl presented to outpatient clinic with impaired self-care, aggressive behaviours, disorganized speech and sleep disorder over 2 years. The patient was diagnosed as psychosis, and risperidone (2 mg/day) was given to the patient. During follow-up, a gradual improvement was observed in her complaints; thus, risperidone therapy (1.5 mg/day) was maintained for one year. At the end of first year, risperidone dose was up-titrated to 3 mg/day as she had inappropriate affection and self-laughing attacks. These complaints showed significant improvement after dose escalation. However, the patient presented with menstrual irregularity 5 months later. In laboratory evaluation, prolactin level was measured as 67.66 ng/ml (reference 2.8–29.2). No other biochemical or hormonal abnormality was detected in examination at gynecology department. Thus, aripiprazole (5 mg/day) was added to her treatment. Menstrual cycles became regular 2 months after initiation of aripiprazole and prolactin level was found as 17.28 ng/ml. Aripiprazole acts as partial agonist in D2 receptor and serotonin 1A (5-HT1A) receptor and as antagonist in 5-HT2A receptor. It blocks D2 receptors in hyper-dopaminergic circumstances while exert agonistic effect in hypo-dopaminergic conditions. Hyperprolactinemia occurring in response to decreased dopamine levels in anterior pituitary gland due to D2 antagonistic action of risperidone is recovered by increased dopamine level and resultant reduction in prolactin levels with agonistic effect of aripiprazole on D2 receptors. It should be kept in mind that addition of aripiprazole can be an option in the management of hyperprolactinemia in adolescents benefited from risperidone therapy.

KEYWORDS
Hyperprolactinemia; aripiprazole; risperidone; adolescent; dopamine; psychosis

[Abstract:0297][OCD]

Obsessive-compulsive disorder followed with diagnosis of tic disorder: paediatric case report

Merve Yazıcı, Çiğdem Yektaş and Enes Sarıgedik

Düzce University School of Medicine, Department of Child and Adolescent Psychiatry, Duzce, Turkey

E-mail address: merveyzc_@hotmail.com

ABSTRACT
Obsessive-compulsive disorder (OCD) is described a psychiatric disorder characterized by obsessions and/or compulsions. Epidemiological studies indicate that the paediatric population has around 2–4% of the lifetime prevalence of OCD in different cultures and populations. OCD is often accompanied by another psychiatric disorder. Common comorbid diagnoses include anxiety disorders, major depression, tic disorders, and disruptive behavioural disorders. In this article, we present a paediatric case for differential diagnosis of Tic disorder and OCD which are mostly seen as comorbid and discussed psychopharmacological interventions for both disorders.
Case presentation: A 14-year 4-month-old male patient was evaluated at our outpatient clinic with complaints of unintentional movements of hands and feet, anxious status, and nighttime urinary incontinence. It was learned that the patient's first complaints were started about two years ago with the unintentional movements of hands and feet, and also anxiety began in this period. The patient was referred to various psychiatric clinics for treatment in this period and did not use the recommended treatments regularly. In the last year, with the diagnosis of 'Tic Disorder', Risperidone 1 mg/day was started in another external centre and risperidone dose was increased to 2 mg/day and haloperidol 1 mg/day and sertraline 50 mg/day were also added. There was a partial reduction in the complaints of the patient during that period. However, the patient was directed to our outpatient clinic due to the beginning of complaints of incontinence at night, the increase of hand-foot involuntary movements and the increase of anxiety in last 3 months. The patient was evaluated with a patient-family interview and teacher forms. It was learned that he had compulsive behaviour with hand-arm movements, accompanied by control and cleaning, in order to avoid spontaneous ejaculation after dreams with sexual content. He was diagnosed with 'Obsessive-Compulsive Disorder'. It was seen that the complaint of nighttime urinary incontinence disappeared after risperidone treatment was stopped. Haloperidol treatment was also stopped. For obsessive and compulsive symptoms, aripiprazole 10 mg/day was started simultaneously and sertraline

KEYWORDS
Aripiprazole; differential diagnosis; incontinence; obsessive-compulsive disorder; tic disorder

treatment was increased to 100 mg/day. At the 6th month of clinical observation, aripiprazole 10 mg/day and sertraline 100 mg/day were easily tolerated by the patient, had no side effects, had no active OCD/tic disorder complaints, and his functionality returned to normal at school. The frequent association of OCD with clinical comorbidities is a reflection of both the diagnostic process and the differential diagnosis. In this article, we discussed the case of OCD, which is commonly both associated and misdiagnosed with tic disorder. The clinical presentation of the involvement of motor movements in both tic disorder and OCD can lead to diagnosis complexity. As in our case, patients with OCD can be followed and treated with tic disorder for a long time. With a detailed clinical interview, it should be considered that repetitive motor movements may be confronted as relaxing compulsions of an obsessive obsession with being considered as a tic disorder. In our case, SSRI, which is in the first place in OCD pharmacotherapy, has been used effectively with aripiprazole.

[Abstract:0298][Addiction]

Internet use disorder opens a brand new era for the familial incompatibility

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT

The literature primarily involved a brand new mental health problem that is named as internet addiction for the last decade after the improvements in social media as well as the development of more portable and smarter devices. Internet addiction is an uncontrollable urge for spending excessive time on the smart devices of computers, tablets or smartphones connected to the web. Upon the advances in research and the increasing demand for clinical treatment, the American Psychiatric Association (APA) has decided to include "Internet use disorder" in the appendix of the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5). Although there some studies held among the adolescents and students, no enough data available about the internet addiction among the adults or elder people. Although the web has an enormous impact on the population and provided numerous benefits to its users, it also has negative influences on people's employment and relationships. The diagnosis of internet addiction is set when an individual has lost control over the time while using the internet. This excessive usage may last long until an unwanted outcome occurs. These issues include the loss of sleep, loss of appetite and skipped meals as well as the interrupted conversations and relationships between the family members. Spending much time on the internet may also result in conflict with family members, instructors or colleagues causing educational or professional career failure. Some studies revealed that the diagnosis of internet addiction is most akin to pathological gambling. Internet addiction may also be associated with numerous comorbid states including attention-deficit and hyperactivity disorder (ADHD), social phobia, depression, and hostility.

Case presentation: We present an interesting case of internet addiction affecting both spouses referred to the outpatient clinic by the family court for family therapy. Both of them were complainant from each other for spending all the time with the smartphone messaging to the friends or attending the social media activities. The reason for their decision about divorcing was mainly because of this continuous internet addiction. The pathophysiology and the treatment modalities were discussed in the light of this frequently encountered but rarely reported cause for familial incompatibility of this era.

KEYWORDS

Internet use disorder; abuse; marriage; divorce; family

[Abstract:0299][Psychopharmacology]

Dramatic response of somatic pain to vitamin D3 supplementation in a depressive female patient: a case report

Hamza Ayaydın[a], Şermin Bilgen Ulgar[a] and Mehmet Asoğlu[b]

[a]Department of Child and Adolescent Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey; [b]Department of Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT
Depression can impair functionality in individuals. Some patient may present to psychiatrics outpatient clinics with somatic complaints. Vitamin D has an important role in brain development and function in addition to its roles in calcium homeostasis and bone development. Moreover, chronic musculoskeletal pain can be seen in 25-OH vitamin D deficiency. We aimed to present a patient who had been followed with depressive symptoms and head-neck pain and showed rapid improvement in complaints after addition of vitamin D supplementation.
Case presentation: A 32-years old woman was presented to our outpatient clinic with unhappiness, joylessness, head-neck pain, and resultant crying jag. In addition, the patient had pain and numbness at left arm and leg. In her history, it was found out that the patient presented to physical therapy and rehabilitation clinic with same complaints which appeared 6 months ago and diagnosed as fibromyalgia with normal ANA profile, RF, anti-CCP antibody, PTH, Ca, P, Mg, ALP and GGT; thus, she was prescribed duloxetine (60 mg/day). The patient reported that there was no improvement in her complaints despite 6-months of duloxetine therapy; rather, she experienced worsening in depressive symptoms due to ongoing pain complaint. No organic pathology was detected in neuroimaging and neurological examination. The patient was diagnosed as depression; thus, she was prescribed fluoxetine (20 mg/day) and mirtazapine (30 mg/day). On the control visit after one month, it was seen that the patient had persistent complaints; thus, serum 25-OH vitamin D level was measured and found as 4.4 ng/mL (<10 ng/ml, severe deficiency; 25–80 ng/ml, optimal level). The patient was prescribed 300,000 IU vitamin D3 via oral route. A dramatic improvement was observed within a week after vitamin D3 supplementation. Vitamin D has an important role in brain development and function in addition to calcium homeostasis and bone development. In clinical studies, it was shown that there are relationships between low 25-hydroxy vitamin D level (depot form in human body) and impaired cognitive function, anxiety or depression. In addition, vitamin D insufficiency is associated to musculoskeletal pain refractory to medication and neuromuscular dysfunction. While depression causes increased pain intensity, pain can enhance depressive symptoms as well. Although somatic complaints can be seen in patients presenting with depressive symptoms, it is important to perform investigations regarding aetiology before considering it as psychogenic pain. Measurement of 25-OH vitamin D level can contribute to treatment by enabling vitamin D3 supplementation in the treatment of depression and pain refractory to psychotropic agents which are frequently seen in clinical practice.

KEYWORDS
Depression; 25 hydroxy vitamin D; pain; fibromyalgia; female

[Abstract:0300][Eating disorders]

Opsomania: an unspecified feeding and eating disorder

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT
Opsomania is an excessive and uncontrollable ambition for eating only one kind of food.
Case presentation: A 53-year-old woman was referred to the psychiatry outpatient clinic by her primary care physician for the treatment of an eating disorder. The patient defined that her daily food intake has made of only cookies and cola for the last 14 years after her mother passed away. The diet consists only three small pieces of salty biscuits and a medium-sized glass of cola in the morning, for lunch and in the evening. No additional food or beverage is consumed except water with a strict compliance to this routine diet. She would rarely add an orange or a glass of milk in the evening to her diet. The patient describes neither a disgust to other foods nor a concern about her weight and shape. She defines her condition simply as an uninterruptible desire and apetite towards biscuit and cola when she is hungry. She also describes no bulumic or anorexic symptoms with no dietary restrictions. According to her social history she divorced four years ago following two years of marriage because of a spouse deception. She currently lives with her married sister and brother-in-law. She has been smoking one pack per day for the last twenty-eight years. No alcohol or illicit drug usage was reported. According to her past medical history she had a tracheal stricture which was treated with an endotracheal stent five years ago. No family history of psychiatric disorder was reported. The symptoms of shortness of breath, fatigue, lack of energy, weakness, headache, and dizziness were started five years ago. However, the symptoms of fatigue and weakness got worse for the last two months. The patient was hospitalized and the treatment was constituted multidisciplinarily. The iron depletion was initially corrected

KEYWORDS
Opsomania; uncommon; eating disorder; diagnosis; treatment

with an intravenous iron therapy, which was followed by oral iron replacement as a maintenance for the next six months. The patency of her endotracheal stent was consulted to the cardiothoracic surgery department, which has revealed no obstruction. A multivitamin supply was prescribed for her malnutrition and other probable vitamin deficiencies. The pathophysiology and the treatment modalities were discussed in the light of the limited literature of this new and weird feeding and eating disorder.

[Abstract:0301][Mood disorders]

Lithium-linked psoriasis case report

Seher Serez Öztürrk, Dudu Demiröz, Nafiye Yağlı, Sehure Azra Yaşar, İkbal İnanlı and İbrahim Eren

Health Sciences University, Konya Research and Training Hospital, Beyhekim Psychiatry Clinic, Konya, Turkey

E-mail address: drdemiroz42@gmail.com

ABSTRACT

Lithium in the treatment of bipolar disorders (BD) is the main option, there are also the effects on the immune system and many side effects of various systems. Dermatological ones are quite common among others. These are frequently acneiform rash, folliculitis, exfoliative dermatitis, maculopapular erythematous rash, dermatitis herpetiformis and psoriasis. Psoriasis is an immunologic skin disease characterized by proliferation in keratinocytes, marked changes in dermal capillary vascularity, and T lymphocyte infiltration. In psoriatic lesions predominantly of a Th1 cell-mediated inflammation and increased Th1 cell's cytokines are observed. It is emphasized that the effects of lithium immune system may be related to the development and exacerbation of psoriasis. We present a case of psoriasis which developed during lithium treatment and regressed by lithium cessation in a patient with BD.

Case presentation: 50 year-old female patient who has been followed by BD diagnosis for 16 years. The patient who has had the inpatient treatment for three times has been getting lithium treatment for approximately 16 years. Upon the appearance of plaque shaped and pearl colored lesions spread over the body 2 years ago, the drug treatment has been started by the suggestion of the dermatologist. After the medication-related liver enzyme levels has risen, the oral medication was given up and phototherapy was suggested. While the patient was taking lithium 600 mg/day, aripiprazole 30 mg/day upon the increasing complaints of the patient, she has been hospitalized with the prediagnosis of manic episode. The lithium 900 mg/day and aripiprazole 30 mg/day treatment were carried on. Since there were psoriatic plaques spread on her body and scalp, she has been consulted with dermatology. Tropical treatment suggested by the dermatology has been administered and the patient could not benefit from the treatment. It was thought that the patient had lithium-linked psoriasis. Lithium has beet cut off gradually. The patient started to take valporic acid as a mood stabilizer; 15 days after the lithium was cut off, it has been observed that the psoriactic plaques were decreased. After her complaints decreased, the patient was discharged from the hospital with valproic acid 1000 mg/day, aripiprazole 30 mg/day. It has been observed 1 and a half months later that the psoriatic plaques have disappeared completely. Besides the inflammation of dermatologic lesions which are present on the lithium treatment, it is possible that new lesions can form at the patients which have had no skin rash incidents. It has been showed that lithium has decreased the cyclic adenozinmonophosphat(cAMP) activity and this causes neutrophilic infiltration. It has been detected that there were decreased cAMP levels on the psoriatic skin as well and it has been stated that this may be important on regulation of epidermal proliferation. In the literature, the cases that reveal after the use of lithium are a few. In our case, psoriasis revealed in a patient who has no dermatological illness known before, and with the cutting of lithium the psoriatic plaques disappeared completely; the patients who use lithium should be examined in a proper way while considering the dermatological lesions.

KEYWORDS

Bipolar disorders (BD); dermatological lesions; lithium; psoriasis; manic episode

[Abstract:0302][Other]

A case of Capgras syndrome and olanzapine-induced obsessive-compulsive symptoms

Betül Uyar Ekmen[a], Hasan Akçalı[b] and Cuma Taş[c]

[a]Department of Psychiatry, State Hospital of Osmaniye, Osmaniye, Turkey; [b]Department of Psychiatry, State Hospital of Kozluk, Batman, Turkey; [c]Department of Psychiatry, State Hospital of Bingöl, Bingöl, Turkey

E-mail address: betuluyar@hotmail.com

ABSTRACT
Capgras syndrome is characterized by rare and persistent delusional misidentification disorders. The patient believes that their close relatives are not really themselves, but are replaced by identical individuals. Usually, it exists with schizophrenia and organic psychosis. Treatment of Capgras syndrome is the treatment of existing psychosis. Atypical antipsychotics such as clozapine, risperidone, quetiapine, and olanzapine for treatment may trigger obsessive-compulsive symptoms in patients.
In this article, a case of Capgras syndrome, which caused obsessive-compulsive symptoms during olanzapine treatment, is mentioned.
Case presentation: A 35-year-old female patient who had been diagnosed with schizophrenia for six years believed that her mother, father, and elder sister had changed with their counterparts. Therefore, the patient was diagnosed with Capgras syndrome. Treatment compliance for three months was not good, and there was an increase in symptoms. She was benefitted from olanzapine before, and we have learned that she has a sister with schizophrenia who was benefitted from olanzapine. The patient had previously benefitted from olanzapine than olanzapine + fluoxetine treatment was started to the patient. Psychotic symptoms were partially alleviated with olanzapine, but obsessive-compulsive symptoms developed. The fluoxetine dose was increased. In this way, the obsessive-compulsive symptoms of the patient were regressed. Our patient had a diagnosis of schizophrenia with Capgras syndrome. Since our patient had benefitted from olanzapine before, olanzapine was started again. For significant negative and depressive symptoms, we started fluoxetine. The patient benefited from olanzapine, but olanzapine triggered obsessive-compulsive symptoms in the patient. Studies are supporting this in the literature. Since the patient has benefited from olanzapine, it has not been cut off; fluoxetine dose has been increased. Increased doses of fluoxetine have also relieved the patient's obsessive-compulsive symptoms.
Obsessive-compulsive symptoms occurred with olanzapine reported in 2 cases, but olanzapine was not discontinued because the patient's psychotic symptoms decreased with olanzapine. Instead, fluoxetine in one case and clomipramine in the other case have been added to the olanzapine treatment. Patients benefited from these treatments. Capgras syndrome is characterized by rare and persistent delusional misidentification disorders. The patient believes that their close relatives are not really themselves, but are replaced by identical individuals. Treatment of Capgras syndrome is the treatment of existing psychosis. Atypical antipsychotics such as clozapine, risperidone, olanzapine, and quetiapine for treatment may trigger obsessive-compulsive symptoms in patients. If the patient's psychotic symptoms benefit from the current treatment, instead of discontinuing the existing antipsychotic drug, another group of drugs effective for obsessive-compulsive symptoms such as serotonin reuptake inhibitor or clomipramine may be added.

KEYWORDS
Atypical antipsychotics; Capgras Syndrome; obsessive-compulsive symptoms; olanzapine; psychosis

[Abstract:0304][Mood disorders]

An unusual bipolar disorder relapse in a nonagenarian patient

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT
Bipolar disorder (BD) is a mood disorder that is defined by episodes of mania, hypomania, and major depression. BD is usually encountered in the young adults. Although the BD is rarely seen in elder patients, it still constitutes 8 to 10% of all psychiatric admissions among the patients in advanced age. The definition of geriatric BD is used for the patients older than fifty. The knowledge about the characteristics of BD among elderly is insufficient, and the prevalence is 7–25% of all bipolar patients. The BD affects approximately 0.1% of the population over the age of sixty-five. However, the number of geriatric BD patients are expected to increase due to progressive ageing of the world population through the forthcoming consecutive decades. In this paper, an unusual bipolar disorder relapse seen in a nonagenarian was reported. To our knowledge, this is the first reported BD relapse case seen in a nonagenarian.
Case presentation: A 96-year-old male patient admitted to the psychiatry outpatient clinic with increased energy, anger, uninterrupted speech that present most of the day and reduced need for sleep, and thoughts of the family are going to be harmed for the last 10 days. According to information taken from his family, these complaints were present for three weeks. It is gotten worse for the past 10 days. He was hospitalized due to unruly behaviour, persecutory delusions, and functional disability. Quetiapine was started at 12.5 mg once a day as a treatment and increased gradually up to 50 mg per day in two divided doses. The symptoms declined after this

KEYWORDS
Bipolar disorder; unusual; relapse; nonagenarian; treatment

treatment in 3 weeks. And no side effects were observed. Then, lithuril 300 mg per day was started as a prophylactic treatment due to his past well response and preventing cognitive decline (no episode since 1994 to cut off Lithuril 6 months ago). Lithuril might also prevent further episodes and also cognitive decline. Late-life bipolar disorder, mainly LOB disorder seems to be a definite asset from BD in the younger population. Currently, vascular changes in the brain associated with the late-life bipolar disorder are suggested for etiopathogenesis. If this 'vascular mania hypothesis' is valid after that prophylactic cardiovascular tactics might be efficient. The other important point is: lithium might prohibit any more impairment in cognition, which is cognitive deterioration associated with the late-life bipolar disorder.

[Abstract:0306][Psychosomatic Medicine and Liaison Psychiatry]

Capgras syndrome due to hypothyroidism

Serhat Tunc[a] and Hamit Serdar Basbug[b]

[a]Department of Psychiatry, School of Medicine, Kafkas University, Kars, Turkey; [b]Department of Cardiovascular Surgery, School of Medicine, Kafkas University, Kars, Turkey

E-mail address: drserhattunc@gmail.com

ABSTRACT

Capgras syndrome (CS) is characterized by the delusional belief that the person's acquaintances have been replaced by an imposter. Its primary characteristic is the transient, recurrent, or persistent delusional thought that his/her parents, partner, etc., have been substituted by same-looking 'fake' persons. Although they were firstly reported as rare conditions, the later investigations foreseen its frequency more. One-year prevalence of Capgras syndrome is reported as 2.5% in acute psychiatric inpatients. Capgras Syndrome due to general medical disorder may develop in 25–40%. These disorders include endocrine disorders, infections, head trauma, brain tumors, delirium, dementia, lithium intoxication, epilepsy, hepatic encephalopathy, Parkinson's disease, nephrotic syndrome, and migraine. The most commonly reported endocrinological disorders include hypothyroidism, thyroid tumors, pseudohypoparathyroidism, pituitary tumors, diabetes, and hypoglycaemia. In this paper, a fascinating presentation of CS triggered by Hashimoto thyroiditis in schizophrenia patient was reported.

Case presentation: A 32-year-old man was brought to the psychiatry outpatient clinic with his mother and sisters upon punching his mother one hour ago. He told that he did not punch his mother he just hit his mother's imposter. He thought that his mother was replaced by an imposter. He was looking his mother as a foreign person for two weeks. He told them "She is not my mother." He has talked and laughed with himself, thought that he was harmed by other people and he did not leave home due to thinking people were hurting and watching him, and did not take a bath for a month. He diagnosed with schizophrenia eight years ago. He was hospitalized two times. He used intramuscular risperidone depot form of risperidone (Consta®) 37.5 mg per/two weeks and quetiapine 100 mg/day for three years. Levothyroxine sodium 0.05 mg/day was started and increased gradually up to 0.1 mg/day by endocrinology consultation. Risperidone 3 mg per/day treatment was started orally and increased gradually up to 6 mg/per day. Consta® 37.5 mg IM depot treatment and quetiapine 100 mg per/day was continued. He responded well to treatment. His Capgras-related delusions were improved and gained slight insight within two weeks. His TSH level was found reasonable with clinical improvement. His PANSS point was 30 at discharge (Positive symptoms: 5, negative symptoms: 7, and general psychopathology: 18). Although CS is usually noticed in the condition of psychiatric disease, it may be related to many neuropsychiatric or organic and neurological diseases. These include dementia, head trauma, epilepsy, cerebrovascular disease, neurodegenerative disease, most commonly Lewy body disease, and multiple sclerosis. In this case report, an uncommon endocrinologic aetiology and the treatment of CS was presented in the light of available literature.

KEYWORDS

Capgras syndrome; Hashimoto thyroiditis; psychosis; schizophrenia; treatment

[Abstract:0313][Psychopharmacology]

Oculogyric crisis (acute dystonia) in child patient induced by aripiprazole use

Cansu Mercan Işık, Belde Demirci, Seda Aybüke Sarı and Ayla Uzun Çiçek

School of Medicine, Department of Child and Adolescent Psychiatry, Cumhuriyet University, Sivas, Turkey

E-mail address: dr.cansumercan@gmail.com

ABSTRACT
Atypical antipsychotics are used for treatments of behaviour disorders, diffused developmental disorder, mental retardation in childhood, stereotypic behaviours, nervousness, hyperactivity, aggression, and self-destructive behaviours. Aripiprazole is an antipsychotic medicine which has partial agonistic effect on dopamine D2 receptor and serotonin 1A receptor; and described as "dopaminergic system stabilizer." It is said that it does not cause extrapyramidal adverse effects by decreasing dopaminergic activity in the nigrostriatal pathway because of its partial agnostic effect. In this article the case of Oculogyric Crisis (Acute Dystonia) induced by Aripiprazole use of an 11 years old female case. This case is important since child patient samples take place in literature rarely.
Case presentation: A 11-year-old female case was presented to our clinic for the reasons such as self-destructive behaviours and burst of anger. When the patient was 3, she was diagnosed with low mental retardation; when she was 6, she was diagnosed with ADHD. It is learnt that her ADHD treatment was started with Methylphenidate 18 mg/day and Methylphenidate 36 mg/day has been used since last year for the patient has been taking special education support for 8 years. A few months ago, Risperidone 0.5 mg was added to Methylphenidate treatment because of self-destructive behaviours and burst of anger at epicentre. However, on the 5th day of treatment, the patient was presented to the emergency department with involuntary muscle contractions on her body. After the injection of Biperiden 1×5 mg IM at the emergency department, the contractions relieved approximately within 2 hours. The Risperidone treatment was given up and 2.5 mg Aripiprazole was preferred to be used by the patient who presented to our child and adolescent psychiatry clinic after the increase of her complaints. On the 3rd day of use of Aripiprazole 2.5 mg, the patient was presented to the emergency department with the complaint of upper visual fixation. Any positive finding could't be detected in neurologic and psychiatric examinations. After the evaluation of conversion disorder, tardive dystonia, and encephalopathy, she was diagnosed with oculogyric crisis (acute dystonia). After the injection of Biperiden 1×5 mg IM, the oculogyric symptoms of the patient regressed within 2 hours. It causes acute dystonia by blocking dopamine D2 receptors in caudate, putamen, and globus pallidum of antipsychotic drugs. In 90% of acute dystonia cases it emerges on the first days of medication or together with increasing the dose. The number of reported cases is relatively low in literature because the risks of developing extrapyramidal adverse effect of the antipsychotic drugs (which are the partial agonists of the D2 receptors like Aripiprazole) are lower than the other typical antipsychotics. The reported cases are mostly related to adult patients. Our case is crucial as she is one of the rare cases reported to literature in paediatric age group. Additionally, mental retardation children have a higher risk of developing side effects due to psychotropic drugs than their healthy counterparts. For the patients with mental retardation, psychotropic drugs should be taken in lower doses comparing to normal-mental-level patients. It should be careful when using antipsychotics in children and adults and it should be kept in mind that atypical antipsychotics may lead to side effects such as acute dystonia even at low doses, especially if risk factors are present.

KEYWORDS
Acute dystonia; aripiprazole; atypical antipsychotic; child; oculogyric crisis

[Abstract:0317][ADHD]

Methylphenidate-induced Raynaud's phenomenon

Ezgi Eynalli, Ozge Metin, Perihan Cam Ray, Aysegul Yolga Tahiroglu and Gonca Gul Celik

Department of Child and Adolescent Psychiatry, School of Medicine, Cukurova University, Adana, Turkey

E-mail address: dr.eeynalli@gmail.com

ABSTRACT
Stimulants, such as methylphenidate (MPH), are used as the first-line treatment for children with ADHD. The most common side effects of psychostimulants are lack of appetite, weight loss, insomnia, headaches, stomachaches, and irritability. In the literature, there are a limited number of reports on the association between Raynaud's phenomenon (RP) and stimulant treatment. RP is a peripheral vasculopathy characterized by recurrent reversible ischemia attacks of the extremities which are triggered by cold or emotional stress. Some of the mechanisms contributing to the pathogenesis of RP include increased blood viscosity and vascular tone. Herein, we will describe a 12-year-old boy with ADHD who experienced RP after 10 mg immediate release-MPH but not during atomoxetine treatment.
Case presentation: A 12-year-old boy presented to our clinic with the complaints of hyperactivity, learning difficulties, oppositional and compulsive behaviours. He diagnosed with ADHD, intellectual disability and PANDAS. Before starting long-acting methylphenidate

KEYWORDS
Atomoxetine; attention-deficit/hyperactivity disorder; child; methylphenidate; Raynaud's phenomenon

treatment, immediate release MPH was administered in our clinic to observe any possible side effect. After taking 10 mg MPH, coldness and blue-purple color in his fingers were observed. These symptoms passed after about 4 hours. In the clinical follow-up, atomoxetine treatment was started and well-tolerated without RP. In the present case, the development of RP following MPH treatment and complete resolution after its effect disappeared is suggestive of a causal effect. The microvascular impairment plays a role in the pathogenesis of RP. The increased vascular tone may be related to increased sympathetic activation. MPH blocks the transport of both dopamine and norepinephrine and affects both the dopaminergic and noradrenergic systems. Central stimulation is responsible for the peripheral release of catecholamines leading to increased vascular tone. Such a release would lead to manifestation or aggravation of signs and symptoms of RS. Several case reports showed the presence of association between RP and stimulant treatment. In a retrospective case-control study that examined the relationship between stimulant treatment and RP, a significant association has been found. Atomoxetine, a selective norepinephrine reuptake inhibitor, was excluded from this study because it was not considered as a central nervous system stimulant. However, the case of dose-dependent RP following the use of atomoxetine on a girl has recently been described. In contrary, RP has not been observed during atomoxetine treatment in our case. The differences on pharmacologic mechanism between two drugs may be responsible for this finding. Drug-induced RP mostly goes unrecognized because of the limited knowledge and benign nature of this side effect. Further studies are needed to examine the incidence and possible pathophysiology of RP in related to ADHD treatments, including atomoxetine. Physicians treating ADHD and prescribing psychostimulants should be aware of this rare symptom.

[Abstract:0318][Psychosomatic Medicine and Liaison Psychiatry]

Schizophrenia and cancer

Semra Ulusoy Kaymak[a], Tuğçe Akçaer[b], Görkem Karakaş Uğurlu[b], Serdar Süleyman Can[b], Murat İlhan Atagün[b] and Ali Çayköylü[b]

[a]Ankara Ataturk Research and Training and Training Hospital, Psychiatry Clinic, Turkey; [b]School of Medicine, Psychiatry Department, Ankara Yildirim Beyazit University, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT

The relationship between schizophrenia and cancer is inconsistent. Cancer prevalence of schizophrenia patients seems to be lower although there are a high number of risk factors that may predispose to cancer, such as high prevalence of smoking, alcoholism, sedentary life, unhealthy diet, and low and inefficient access to health care systems [1]. When interpreting the reasons of lower incidence rates of cancer in patients with schizophrenia, it is useful to consider the following reasons: Firstly, patients with schizophrenia may not be aware of their physical symptoms and they may have limited access to diagnostic and treatment services for physical complaints. This may be associated with missing cancer diagnosis in this population. Most cancers are diagnosed in patients older than 60 years in general population. Schizophrenia is more common in young adults and has shortened life expectancy (approximately 15–25 years) because of overall higher mortality rates. Behavioural risk factors such as cognitive impairments, and disorganized thinking of patients may be another reason which contribute to initial presentation occurring at a later stage of the disease or refusal of medical treatment. Attitudes of medical staff are another issue. Psychiatric symptoms that be kept in the forefront hampers the holistic evaluation.

Case presentation: 50-year-old, homeless man presented to emergency room with the swelling of his left leg and scrotal oedema. His white blood cell count was 32.52 K/Ul, haemoglobin was 8.6 g/dL, and platelet level was 84 K/Ul. Bilateral inguinal lymphadenopathy and oedema in scrotum and left leg were determined on physical examination. Cerebral atrophy with enlargement of cortical sulci and non-specific gliosis in right periventricular region were detected in MRI. After admitting to hematology inpatient clinic, he refused all diagnostic procedures and treatments. On psychiatric consultation, the patient was restless, has poor eye contact, slowed speech, blunted affect, persecutory and referential and persecutory delusions, disorganized speech, poor insight, and social withdrawal. After the psychiatric consultation he was transferred to psychiatry clinic. He was diagnosed with schizophrenia according to DSM-5 treated with aripiprazole 15 mg/day. The dosage of aripiprazole gradually increased to 30 mg/day. After 10 days in psychiatric ward, patient accepted to take treatments and diagnostic procedures suggested by hematology department. Diagnosis of mantle cell lymphoma of patient was made by fine needle

KEYWORDS

Schizophrenia; cancer; comorbidity; consultation; liasion

aspiration biopsy in conjunction with immunocytochemistry and cytokinetic studies. Hematologist planned to chemotherapy protocol for mantle cell lymphoma. Psychotic symptoms relieved after aripiprazole 30 mg/day treatment. Then the patient was placed in the nursing home by the social service workers. It is clear that the patient's cognitive deficits or disorganized thinking, delusions can create some difficulties in patients with schizophrenia and cancer. A close collaboration between the oncology department and the mental health care professionals is essential in the care of schizophrenia and cancer patients. It is important to increase access to diagnostic and treatment services in patients with schizophrenia.

Reference

[1] Leucht S, Burkard T, Henderson J, et al. Physical illness and schizophrenia: a review of the literature. Acta Psychiatr Scand. 2007;116:317–333.

[Abstract:0322][Psychopharmacology]

Visual an auditory hallucination with sertraline: a case report

Elif Merve Kurt[a], İbrahim Özkan Göncüoğlu[b] and İsmail Ak[a]

[a]Department of Psychiatry, Karabuk University School of Medicine, Karabuk, Turkey; [b]Karabuk Research and Training Hospital, Department of Psychiatry, Karabuk, Turkey

E-mail address: emk1989_6@hotmail.com

ABSTRACT

Sertraline is a transient serotonin reuptake inhibitor and is frequently used in psychiatric disorders such as depression and anxiety disorders. We will discuss about visual and auditory hallucinations resulting in the use of high dose sertraline for 4 days in this case.

Case presentation: 17-year-old, single, high school student, female patient presented to another psychiatry clinic two weeks ago due to depressive complaints. Sertraline treatment with a dosage of 50 mg is started to the patient who shows no psychotic symptoms. Despite the fact that the dosage is specified as 50 mg, the patient used it as 150 mg instead, during 4 days, with the rush of getting healed as soon as possible. However, she is faced with visual and auditory hallucinations afterwards. The patient jumped down from the balcony because of the hallucinations. She only made this because of what she saw and because of the voices that motivated her. She did not describe any suicidal thoughts. There was no psychiatric history within her family. She neither had a history of a manic or psychotic attacks, nor a history of addictive drugs. No organic pathology was found in her brain MRI. Olanzapine 5 mg treatment was started for the patient. She did not mention any kind of delusions or hallucinations after a week when she came back for the check up. There are two distinct features that distinguish sertralin from other SSRIs, which are inhibition of dopamine transporter (DAT) and weak antagonist effect on the Sigma-1 receptor. In this case, overactivation of the mesolimbic dopaminergic pathway may have induced visual and auditory hallucinations due to the inhibitory effect of sertraline on the dopamine transporter. The other factor that may have caused those hallucinations is that sertraline binds to sigma receptors at high levels, modulating hippocampal excitatory neurotransmission and inducing psychotic symptoms. Psychotic symptoms are uncommon side effects of SSRIs. Visual and auditory hallucinations are also these rare side effects. As with our case due to sertraline DAT inhibition and antagonist effects on weak sigma 1 receptors, high dosing at the beginning of the treatment may cause visual and auditory hallucinations. We think that it is necessary to inform patients in this regard at the beginning of treatment.

KEYWORDS

Dopamine; hallucinations; sertraline; sigma-1; visual

[Abstract:0324][Addiction]

Intravenous abuse and misuse of drugs which are recommended for medication: a case report

Merve Tsakir Chasan, Lut Tamam, Soner Çakmak and Mehmet Emin Demirkol

Department of Psychiatry, School of Medicine, Çukurova University, Adana, Turkey

E-mail address: mervecakir616@gmail.com

ABSTRACT
The use of medicines outside medical indications, and especially the use of medicines on their own initiative or on the advice of unauthorized persons in situations where the psychiatrist does not need it is called 'Drug Abuse'. It is a physician's recommendation and misuse of the medical indication is also called 'Misuse of Medicine'. In our article, abuse and misuse of the Buprenorphine + Naloxone combination and Mirtazapine recommended for the treatment of opioid addiction will be discussed in the light of current literature.
Case presentation: The patient is 28 years old, high school drop out, single, male presented to our clinic complaining of desire for substance abstinence, reluctance, malaise, and insomnia. From the clinical history, it is evident that he has been using cannabis and heroin intravenously or inhaling almost everyday since he was 15. He has fought with his superiors during his military service and stayed in prison for six months. He was presented with the request of quitting substance to AMATEM (Alcohol and Drug Addiction Treatment and Research Center). He has been using Buprenorphine + Naloxone combination intravenously repeatedly. He has relaxed with the help of intravenous Buprenorphine + Naloxone and felt euphoria and did not use heroin in that period. After an argument with his friend in the military service and he used heroin intravenously and escaped military service. He has used Mirtazapine intravenously, which is recommended by a psychiatrist to whom he consulted for desire of substance abstinence, irritability, and insomnia, and he did not feel relief; so he stopped trying. In the psychological examination of the case, observed associations were regular, the emotional state was mildly depressed; the perception, memory and orientation were natural. Antidepressant and antipsychotic medication was recommended with the preliminary diagnosis of 'substance use disorder' in the case. Individual psychotherapy administered. It has been learned that the patient who does not come to the regular outpatient clinic visits is in prison for another criminal case. Mirtazapine is a tetracyclic antidepressant. In the literature, there is no evidence that mirtazapine has been used for treatment abuse, or misuse. The case is characterized by abuse of mirtazapine intravenously. In addition, the case reported that the intravenous combination of Bupranorphine + Naloxone combination has almost similar efficacy with the opioid and he used it repeatedly. A previous study showed that some patients who switched from Buprenorphine to Buprenorphine + Naloxone combination were using drugs recommended by intravenous route, and euphoria was not satisfactory. Some studies have shown that although the Buprenorphine + Naloxone combination is much more effective when withdrawn from the nasal cavity, it has been shown that patient is comfortable with intravenous use and preferred this route of use. Physicians working in mental health and other areas should be aware that the proposed medicines may be used for abuse or misapplication and they have to question the use of medicines especially in individuals with substance use disorder history. It is important because of possible misuse or abuse of medication and to prevent related complications.

KEYWORDS
Addiction; drug abuse; drug misuse; intravenous buprenorphine + naloxone combination; intravenous mirtazapine

[Abstract:0328][Mood disorders]

Manic episodes with psychotic features triggered by the use of slimming pills containing sibutramine

Erdem Örnek, Ayşe Sakallı Kani and Volkan Topçuoğlu

Marmara University Pendik Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: erdem.ornek@yahoo.com

ABSTRACT
Sibutramine is a serotonin, norepinephrine and lesser extent of a dopamine reuptake inhibitor used in the treatment of obesity. Insomnia, nausea, dry mouth, constipation are the side effects that are commonly reported with sibutramine. Also, cardiac and neuropsychiatric side effects (including psychosis, panic attacks, depression and suicidal tendencies, delirious state, amnesia, and hypomanic or manic episodes) have been reported in literature. Sibutramine, as an antiobesity drug was approved in the U.S.A. in 1997 and in the European Union in 1999, but removed from all markets in the European Union because of cardiovascular complications. Despite being banned by the Ministry of Health, the sale of these products continues by dot com companies and herbalists. In this report we present a case of 44-year-old female who has recurrent manic episodes with psychotic features that is precipitated by sibutramine, without previous psychiatric history. There were 2 manic episodes with psychotic features that have occurred first in 2014 following the use of slimming pill for 1.5 months of period, and, in 2015 with the use of same slimming pills for a 1-week period. With this report we aim to present our case comparing with literature and raise the awareness of probable adverse effects of over the counter products especially which are claimed to include herbal content.

KEYWORDS
Mania; psychotic features; sibutramine; side effects; slimming pills

[Abstract:0335][Neuroscience: Neuroimaging-Genetics-Biomarkers]

Arachnoid cysts associated with schizophrenia

Serdar Süleyman Can, Fatma Şahin, Ceren Çamur and Sümeyye İslamoğlu

School of Medicine, Psychiatry Department, Ankara Yıldırım Beyazıt University, Ankara, Turkey

E-mail address: drsereyim@hotmail.com

ABSTRACT

Arachnoid cysts are benign intracranial lesions that are seen due to inflammatory, congenital, or traumatic causes. It is seen rarely in the group of intra-arachnoidal space-occupying lesions and represents about 1% of these lesions. They are seen more frequently in men and on the left side. In most of the cases, they do not cause clinical symptoms, and are diagnosed incidentally during radiological imaging. In symptomatic cases, the clinical symptoms may vary from mild to severe in time. They even may vary in a way that will disappear spontaneously. There have not been enough studies showing arachnoid cysts' association with psychiatric disorders.

Case presentation: 25 year-old male patient, being followed up for 3 years with the diagnosis of schizophrenia, was presented to our clinic with complaints such as talking to himself, damaging the equipment at his house, and having thoughts of being followed and harmed. In 2014, during his period of military service, patient suffering from similar complaints were started on risperidone 3 mg/day and his complaints were relieved. After he quit taking his medication,8 months ago, the complaints reoccurred. BPRS, SAPS, SANS scores were respectively 61, 64, and 42 at his hospitalization to our service. Patient's medication was rearranged as risperidone 4 mg/day and in his follow ups, transition to the depot injections was planned. He underwent Cranial MRI scanning to exclude the organic pathologies. On the MRI result, a 3 cm arachnoid cyst at the localization of left sylvan sulcus was detected. The patient was consulted to the Neurosurgery Department with his clinical manifestation and Cranial MRI scans. Immediate neurosurgical intervention was not thought and outpatient clinic control 6 months later from now with cranial MRI scans was suggested. In conclusion, it is difficult to be certain whether arachnoid cyst is just incidentally detected on a psychotic process or responsible for an organic psychotic disorder. As a result, we believe that our case could be a guide on this process while there has been not enough studies showing association of psychotic disorders with arachnoid cysts.

KEYWORDS

Arachnoid cysts; case; intracranial; lesion; schizophrenia

[Abstract:0338][ADHD]

Extended release methylphenidate treatment of primer enuresis nocturna in an adolescent with attention-deficit hyperactivity disorder

Rukiye Çolak Sivri

Department of Child and Adolescent Psychiatry, Ankara Research and Training Hospital, Ankara, Turkey

E-mail address: drrukiyecolaksivri@gmail.com

ABSTRACT

Enuresis is defined as the failure of urethral sphincter control involuntary. The term primary enuresis is used to describe those individuals who have never achieved continance [1]. The prevalence of enuresis is %15–20 in the child population but it is a self limited disorder with a substantial rate of spontaneous remission. Enuresis nocturna (EN) can cause loss of self-esteem and other psychological disorder and as the age progresses, the problem becomes more stressful. Attention Deficit Hyperactivity Disorder (ADHD) is a common heterogenous condition that impairs academic, social, and family function. An epidemiologic study shows that the most common comorbidity of ADHD is enuresis [2]. Children with ADHD had a 2.7 times higher incidence of enuresis than general population. ADHD and enuresis comorbidity studies show that ethiopathogenesis is associated with generalized developmental delay in maturation [3]. We report a case after initiating a treatment of extended release methylphenidate (ER-MPH) for ADHD that cessation of enuresis which wasn't reported in the first visit by the 17-year-old adolescent boy.

Case presentation: C. was a 17 year-old male adolescent who was brought to our outpatient clinic by his parents due to carelessness, forgetfulness, unable to concentrate and work for exams. He was hyperactive since his primary school ages, and he showed a significant decline in academic performance, especially in recent years. As a result of clinical evaluation

KEYWORDS

ADHD; adolescent; enuresis nocturna; extended release form; methylphenidate

and the information obtained from family, he was diagnosed with ADHD combined subtype according to the criteria of the DSM-5 (American Psychiatric Association 2013). No additional psychiatric illness was detected. He was started on ER-MPH (Medikinet Retard ®) and the dosage was adjusted to 20 mg/day. At 1-month follow up, his carelessness and forgetfulness symptoms were decreased and he had experienced significant improvement in academic performance. There was not any side effects. He also reported that he did not talk about the problem of urinary incontinence in the first visit despite being asked. He has never achieved continance before. He has always avoided certain social situations, like overnight camps and slumber parties. He reported that enuresis ceased rapidly during the first week of treatment and no more seen again for a month. In conclusion, this report suggest that clinician should be aware that the ER-MPH can cease enuresis in an adolescent. The precise mechanism of how ER-MPH stops enuresis remains to be elucidated. A high sleep arousal threshold was one of the hypothesis of enuresis nocturna. Stimulants decreasing sleep arousal threshold that results have their effects on enuresis. ER-MPH treatment can be alteratively used enuresis, especially in the presence of ADHD. And also clinicians should be aware under reported enuresis problems assessing adolescent for reasons such as stigmatization.

[Abstract:0340][Psychopharmacology]

Case report: effects of osmotic-release oral system and modified-release methylphenidate agents on enuresis and encopresis in a child with ADHD

Enes Sarıgedik and Nihal Yurteri Çetin

Duzce University School of Medicine, Department of Child and Adolescent Psychiatry, Duzce, Turkey

E-mail address: enessarig@outlook.com

ABSTRACT

Enuresis and encopresis can be comorbid to Attention-deficit/hyperactivity disorder (ADHD) with a percentage as high as 17–19.1% and 8–9.0% respectively. Drugs which contain methylphenidate and atomoxetine are reported to be effective in treating comorbid enuresis and encopresis. A case of a 6 years 10 months old boy is presented in this paper, who was diagnosed with ADHD, enuresis and encopresis all at once and experienced a decline of frequency in enuresis and encopresis episodes during modified-release methylphenidate treatment, and when switched to osmotic-release oral system methylphenidate the frequency of enuresis and encopresis increased again, and when the treatment was switched back to modified-release methylphenidate treatment, frequency of enuresis and encopresis is decreased back and ultimately disappeared.

Case presentation: No organic pathology was identified during paediatric assessment of the child and his psychomotor development was found to be normal according to his age. Modified-release methylphenidate treatment was used to treat ADHD and behavioural approach was used to treat enuresis and encopresis. After medical treatment was started, there was a significant decline in the frequency of enuresis and encopresis episodes, but due to limited improvement in ADHD symptoms the treatment was switched to osmotic-release oral system methylphenidate. There was a notable increase in the frequency of enuresis and encopresis episodes. And after the treatment was switched back to modified-release methylphenidate, the enuresis and encopresis frequency decreased again and eventually disappeared. No similar case was found to be reported in the literature. Yet there are studies which states that cases whose encopresis cannot be reduced with immediate-release methylphenidate can benefit, even be cured with osmotic-release oral system methylphenidate. In conclusion, it should be noted that treatment response to different acting methylphenidate agents can differ between individuals.

KEYWORDS

Attention-deficit/hyperactivity disorder; encopresis; enuresis; modified-release methylphenidate; osmotic-release oral system methylphenidate

[Abstract:0343][Psychopharmacology]

Amenorrhea induced by sertraline treatment in an adolescent girl

Merve Sertdemir and Ömer Faruk Akça

Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey

E-mail address: drcuramerve@gmail.com

ABSTRACT
Amenorrhea may be seen in patients who use psychiatric medication, especially as a side effect of antipsychotic medications. This is often associated with hyperprolactinemia due to blocking of the dopamine 2 receptors on the tuberoinfundibular pathway. There are a few cases in literature reporting SSRI-induced amenorrhea; however, the underlying causes are mostly associated with hyperprolactinemia. We present a case (an adolescent girl) of secondary amenorrhea induced by sertraline treatment which might be related to FSH decrease.
Case presentation: A 17-year-old girl was admitted to our clinic with the complaints of fear of death in crowded places. She could not attend school lessons and exams, and she did not want to leave the home because of that fear. She had panic attacks with palpitation, sweating, chest discomfort 3–4 times in a week. The patient stated that these complaints had begun 2 years ago and sertraline 75 mg/day of treatment had been offered with a diagnosis of panic disorder diagnosis by the psychiatrist she referred to. Her symptoms had improved with her treatment at that time, but amenorrhea had developed as side effect of the drug despite she had previously had regular a menstrual cycle. In the gynecology clinic in which she had been referred to, blood tests showed 109.5 ng/mL of the Follicule-Stimulating Hormone (FSH). Her prolactin level and ultrasonography evaluation had been normal. When medication had been terminated, the patient's menstruation cycle had regained, but symptoms of panic disorder had resumed. We prescribed 50 mg/d sertraline with a diagnosis of panic disorder for the patient after a detailed psychiatric examination. Because the previous FSH elevation may have been related to various different causes and she had previously benefitted from sertraline treatment, the same medication was started to the patient. Panic disorder symptoms decreased within 6 weeks of treatment; however, the amenorrhea recurred. Her serum FSH levels was found to be elevated up to 68 ng/ml and prolactine levels were normal according to the blood tests. The patient's sertraline treatment was switched to the citalopram 20 mg/day and the patient began to having regular a menstrual cycle with a normal FSH level. In the literature there are a few cases of hyperprolactinemia and amenorrhea associated with selective serotonin reuptake inhibitors (SSRIs). Most of these reports are associated with hyperprolactinemia, which might be related to the relationship between serotonergic and dopaminergic activities. As far as we know, no other case about SSRI-induced amenorrhea without prolactinemia has been previously reported in literature. We hypothesize that the mechanism could be related to the regulation of the GnRH by serotonin via GABAergic pathways. Further studies are needed on this topic.

KEYWORDS
Adolescent; amenorrhea; follicle-stimulating hormone; sertraline; side effect

[Abstract:0344][Anxiety disorders]

Exacerbation of panic symptoms with benzodiazepines in a patient with panic disorder and general anxiety disorder

Doğa Sevinçok[a], Mutlu Muhammed Özbek[b], Çağdaş Öykü Memiş[c], Bilge Doğan[c] and Levent Sevinçok[c]

[a]Dr. Behcet Uz Children Research and Training Hospital, Department of Child and Adolescent Psychiatry, Izmir, Turkey; [b]Department of Child and Adolescent Psychiatry, Adnan Menderes University, Manisa, Turkey; [c]Department of Psychiatry, Adnan Menderes University, Manisa, Turkey

E-mail address: dsevincok@hotmail.com

ABSTRACT
Benzodiazepines (BDZ) are primarily used in the treatment of anxiety disorders, muscle spasms, seizures, and insomnia. Inhibitory action of BDZ through gamma-aminobutyric acid (GABA) type A chloride channels results in relaxation, and decrease in anxiety. Nearly 1% of patients are estimated to have unusual experiences with BDZ. Although BDZ are generally safe and effective drugs to reduce anxiety in appropriate doses, they may occasionally produce aggression or agitation particularly in patients with previous histories of hostile and aggressive behaviours. In children and adolescents, impulsive behaviours may worsen with disinhibition effects of BDZ. Panic attacks may occur with several drugs such as serotonin reuptake inhibitors, mefloquine, isotretinoin, rimonabant, and corticosteroids. The mechanisms of these paradoxical reactions are not well understood. BDZ may lead to violent or agitated behaviours by cortical inhibition, and altering serotonin transmission in the central nervous system (CNS). Here, we present a case of panic disorder and generalized anxiety disorder who had panic attacks after almost every BDZ administrations.
Case presentation: 37-year-old woman admitted with shortness of breath, intense anxiety, trembling, and fear of death which first started 10 years ago following a violent fight with her husband. She reported that her symptoms increased immediately after lorazepam which was administered during her first attack. Over time, the number and severity of panic attacks increased and the anxiety caused an impairment in her life. During her frequent emergency department visits, her panic symptoms increased at times when BDZ treatment was

KEYWORDS
Benzodiazepin; generalized anxiety disorder; panic attacks; panic disorder; paradoxical reactions

administered. Her husband began to warn emergency service staff not to apply any BDZ for her panic attacks. The patient reported that antidepressant drugs did not improve her panic and anxiety symptoms. After 1 mg/per os lorazepam was administrated during her last panic attack, her anxiety symptoms worsened and a severe agitation occurred. Her medical examination did not reveal any pathology related to palpitation and shortness of breath. The patient was started a 10 mg/d of escitalopram. Next day, she was discharged with her own request. In approximately 1% of the population, administration of a BDZ elicits a paradoxical reaction characterized by increased talkativeness, excitement, and anxiety. The most significant risk factors for developing an atypical response to BDZ are age, genetic predisposition, higher BDZ doses, and psychiatric or personality disorders. In our patient, BDZ administration caused an increased anxiety and irritability. None of the risk factors above are valid in our patient except of current psychiatric disorder. Previous reports suggested some possible mechanisms explaining the paradoxical response to BDZ. These mechanisms include altered cholinergic, and serotonin transmission, suppression of CNS function, and compensatory responses to BDZ. One proposed cause of paradoxical responses to BDZ is multiple allelic forms of GABA receptors. These mechanisms may explain the exacerbation of panic symptoms after BDZ use in our patient. According to our knowledge, despite various reports for paradoxical reactions, there is limited data regarding that benzodiazepines acutely worsen panic, and anxiety symptoms. Further clinical studies are required to explain the mechanism of paradoxical reactions induced by BDZ.

[Abstract:0345][OCD]

In a case with learning problems, is obsessive-compulsive disorder confused with early-onset schizophrenia? A case report

Emre Ürer, Gökçen İlçioğlu Ekici and Birim Günay Kılıç

Department of Child and Adolescent Psychiatry, Ankara University School of Medicine, Ankara, Turkey

E-mail address: emreurer@yahoo.com

ABSTRACT

OCD and schizophrenia are known to be among the oldest psychiatric disorders. Despite the fact that the onset of both disorders is usually in adolescence and childhood, the number of studies and case reports evaluating psychotic symptoms association with OCD in this age group is quite few. In the child and adolescent age group, family should be taken up comprehensively; where appropriate, parents should be consulted in adult psychiatry clinics for diagnostic evaluation. Detection and treatment of other comorbidities in children and adolescents with OCD with psychotic symptoms is of great importance in ensuring the well being of the patient. Learning disabilities is a serious problem with about 5–10% of children with academic failure. Children with learning disabilities may experience psychiatric comorbidities in clinical samples at rates as high as 60%.The most frequent comorbid diagnoses are attention-deficit/hyperactivity disorder and depression, anxiety disorders, obsessive-compulsive disorder, low self-esteem and suicidal behaviours are frequently encountered, especially in cases of stigmatization or peer violence. OCD is a psychiatric disorder with a lifetime prevalence of about 2–3% which affects recurrent obsessions and/or compulsions, progressive, periodic changes and social and daily functions of the individual. Early onset of more severe symptoms (psychotic symptoms) were associated with poor prognosis. In this case report, a differential diagnosis was made with early-onset schizophrenia in a case of learning disabilities and OCD

Case presentation: A 13-year-old male patient was admitted to our hospital with his mother, father, elder sister with complaints of not attending school, be obsessive, unable to use his hands. Neonatal and neurodevelopment story were normal. In addition, he had number counting compulsion, paranoid thoughts and starting to stand up, eating, toilet seating and other self-care skills began to fulfil the family. It was noticed that the physical evaluation of the patient was based on the age of the patient, that it was appropriate to the socioeconomic level and gender of the dress, that self care was good and he was worried. The intelligence clinically gave a borderline, in WISC-R test battery the total intelligence score was 65. Laboratory tests were normal. The family were informed about OCD and early-onset schizophrenia. The patient is told that the diagnosis of the diagnosis is clear. When clomipramine treatment was initiated but no response was obtained, treatment with risperidone and sertraline was continued, cognitive behavioural therapy was administered simultaneously. Parents were directed to adult psychiatry for diagnostic evaluation.

Studies show that obsessive-compulsive symptoms are present in 7.8–46% of schizophrenic patients. The most common obsession is contamination in children and adolescents with obsessive-compulsive disorder is transmission. Obsession, symmetry order obsessions, aggression, sexual, and religious obsessions are other common obsessions. Obsessive thoughts

KEYWORDS

Learning disabilities; obsessive-compulsive disorder (OCD); early-onset schizophrenia; psychotic symptoms; family assessment

and compulsive behaviours related to counting are more frequent in OCD patients with psychotic symptoms than in patients with obsessive-compulsive disorder alone. It is known that obsessions and compulsions in schizophrenia are usually absurd and stereotypical and that obsessive thoughts are self consistent. In obsessive-compulsive disorder, obsessions are known to be foreign to the self and accompanied by significant anxiety as well as in our patients. Assessment of emotional, drug therapy and psychotherapeutic interventions in patients with psychotic features is important to ensure that the differential diagnosis is accurate. The family should be treated as a whole and, if necessary, parents should be directed to adult psychiatry

[Abstract:0346][Autism]

Autism spectrum disorder in a child of mother with schizophrenia who received antipsychotic drugs during pregnancy

Keziban Turgut[a] and Ömer Faruk Akça[b]

[a]Department of Psychiatry, Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey; [b]Department of Child and Adolescent Psychiatry, Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey

E-mail address: dromerakca@gmail.com

ABSTRACT

Autism Spectrum Disorder (ASD) is a developmental disorder defined by impaired social interaction, communication, and behaviour. There are many factors related to aetiology of autism such as genetic and neurobiological factors. Previous studies in this field reported elevated frequency of psychiatric disorders among parents of children with ASD and suggested that there may be an association between parent's psychiatric disorders and children's diagnosis of ASD. Also there are many studies investigated the effect of maternal antidepressant use during pregnancy on the development of ASD. Here we present a case of ASD with maternal antipsychotic use for ongoing psychotic symptoms during pregnancy.

Case presentation: A 33-month-old boy admitted to child and adolescent psychiatry outpatient clinic with complaints of delayed speech and aggressive behaviours. He was born out of 40 weeks pregnancy by caesarean section delivery without any perinatal complications. Birth weight was 2750 gram. He was breastfeeded for 18 months. There was no history of any seizures, fever, and any medical illness. His physical and motor development was normal for age. But there was a delay at language development. Parents reported significant diminished social interaction (poor eye contact, no attempt to interact with non-familiar people), communication difficulties (only speaking few words, not responding to his name) and restricted patterns of behaviours (not playful with other children of his age, playing with toys in a different way, rocking, twirling). He hits and bites his parents to express his feelings or needs. In mental status examination, eye contact was restricted, twirling was present and there was no verbal communication. By the history and mental status examination findings, a diagnosis of ASD was made to the patient according to DSM-5. In family history, his mother was 36 years old and she had been following with schizophrenia for 16 years. Before pregnancy, her symptoms were in remission under amisülpirid 200 mg/day and haloperidol 5 mg/day treatment. During pregnancy and in the postnatal period, this treatment was continued and only mild fluctuations were seen in her psychotic symptoms. Although there are many studies investigating the relationship between the ASD and maternal antidepressant use, there were no reports related to association of ASD with maternal antipsychotic use. In this case, we suppose that use of antipsychotics during pregnancy might have a role in the development of autism.

KEYWORDS

Autism spectrum disorder; aetiology; maternal antipsychotic use; schizophrenia; side effect

[Abstract:0348][Psychopharmacology]

Side effect of methylphenidate in children with Williams syndrome: systemic hypertension

Ezgi Eynalli[a], Perihan Cam Ray[a], Aysegul Yolga Tahiroglu[a], Gonca Gul Celik[a], Canan Kuygun Karci[b], Ozge Metin[a] and Ayse Avci[a]

[a]Department of Child and Adolescent Psychiatry, School of Medicine, Cukurova University, Adana, Turkey; [b]Department of Child and Adolescent Psychiatry, Adana Ekrem Tok Psychiatry Hospital, Adana, Turkey

E-mail address: dr.eeynalli@gmail.com

ABSTRACT
Williams syndrome (WS) caused by deletion at the chromosome 7q11.23 is a complex genetic condition characterized by cardiovascular disorders, mental retardation, friendly personality, dysmorphic face, and body features. The most common psychiatric disorders found in WS are attention-deficit/hyperactivity disorder (ADHD), specific phobia, and generalized anxiety disorder. Approximately 64% of individuals with WS meet criteria for ADHD and there have been studies on effectiveness of stimulants in WS. It has been reported that methylphenidate (MPH) is the first choice for ADHD treatment in WS, and common side effects are appetite reduction irritability, sleep problems, and headache. Increasing heart rate and high blood pressure have been reported during MPH treatment but not seen commonly. In this report, we presented a 6-year-old girl with WS who experienced high blood pressure after taking the long-acting MPH.
Case presentation: A 6-year-old girl was referred to our outpatient clinic with complaints of hyperactivity, learning difficulties, muscle weakness and inattention. According to her family, he had developmental delay. She has been using 5 mg/d aripiprazole for behavioural problems and also 300 mg/d valproic acid for epilepsy. Aripiprazole treatment was stopped because she did not see any benefit. She was referred to genetic outpatient clinic because of her dysmorphic appearance and developmental delay and she was diagnosed with WS. According to her psychiatric assessment, she was diagnosed with ADHD and mental retardation-mild type. After the evaluation of paediatric nephrology and paediatric cardiology clinics 10 mg/d long-acting MPH was started. After 3 hours from the first dose, systolic blood pressure increased to 200 mm/Hg and diastolic blood pressure increased to 100 mm/Hg. Then, she was monitored in the intensive care unit and discharged after she recovered. ADHD are often seen in individuals with WS. It has been observed that MPH is often well tolerated in individuals with WS. But in our case, after the first dose of 10 mg long-acting MPH, intensive care was required for a life-threatening high blood pressure. Improvement of symptoms after termination of drug effect supports drug-related side effect in this case. The mechanisms explaining the relationship between psychostimulants and raised blood pressure is incompletely understood. Similarly, the etiopathogenesis underlying the WS vasculopathy is not yet understood. Further study is needed for enlightening this adverse effect. When physicians prescribe psychostimulants in children with WS, regular electrocardiography and blood pressure monitorisation is important because psychostimulants may raise heart rate and blood pressure.

KEYWORDS
Attention-deficit/hyperactivity disorder; hypertension; methylphenidate; side effect; Williams syndrome

[Abstract:0350][Mood disorders]

Huntington's disease associated with bipolar disorder: a case report

Mustafa Çağrı Yıldız, İbrahim Taş, Recep Başaran, İsmet Esra Çiçek, Azra Sehure Yaşar, Osman Ak and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT
Huntington's disease (HD) is an inherited disease and an autosomal dominant disorder, that causes the progressive breakdown (degeneration) of nerve cells in the brain. HD has a broad impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders. Most people with HD develop signs and symptoms in their 30s or 40s. Medical diagnosis of the onset of HD can be made following the appearance of physical symptoms specific to the disease. Genetic testing can be used to confirm a physical diagnosis if there is no family history of HD. The most common psychiatric disorder associated with HD is depression. Mania can also associated with HD which can cause elevated mood, overactivity, impulsive behaviour, and inflated self-esteem. Also, weight loss is common in people with Huntington's disease, especially as the disease progresses.
Case presentation: The patient was male, married, and 50 years old. He was presented to outpatient clinic of psychiatry with his wife and his complaints were aggression, visual hallucinations, impaired attention and executive function, irritability, insomnia, choreiform movements, pressured speech, and grandiose plans. His first complaints had started almost 10 years ago and presented to psychiatrist but his medical adherence were low and he rejected to use drugs. Some problems easily seen in interview like impairments involuntary movements, difficulty organizing, prioritizing or focusing on tasks, impaired gait, posture and balance, lack of impulse control that can result in outbursts, acting without thinking and seriously weight loss. He was consulted to neurology and diagnosed as a HD. Olanzapine 5 mg/day was ordered and augment to 15 mg/day. With this treatment, patient's affective

KEYWORDS
Bipolar disorder; chorea; dementia; Huntington's disease; mania

symptoms were regressed and he was discharged from hospital. Psychiatric changes have appeared before the usual onset of HD. The affective disorders may be present 20 years prior to the onset of chorea and dementia in HD. Life expectancy in HD is generally around 20 years following the onset of visible symptoms. Clinical trials of new experimental treatments are underway and planned in HD. Compounds that have failed to prevent or slow progression of HD. This case shows that patients of HD can present with symptoms of either depression or mania. Hence cases such as ours emphasize the need for the psychiatrists to be aware of the psychological symptoms presenting with organic brain disease.

[Abstract:0353][Schizophrenia and other psychotic disorders]

Combination of neuro-Behçet disease and psychosis

İbrahim Taş, Mustafa Çağrı Yıldız, Recep Başaran, İsmet Esra Çiçek, Saliha Çalışır, Ali Baran Tanrıkulu and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT

Behçet's disease is recognized as a disease that cause inflammatory perivasculitis, inflammation of the tissue around a blood or lymph vessel. Behçet's disease with neurological involvement, neuro-Behçet's disease (NBD), involves central nervous system damage in 5–50% of cases. In parenchymal neuro-Behçet's disease, cerebral hemispheric involvement may result in encephalopathy, hemiparesis, hemisensoryloss, seizures, and mental changes, including cognitive dysfunction and psychosis. Non-parenchymal NBD targets vascular structures; the symptoms arise in the same area. The main clinical characteristic is the cerebral venous thrombosis. Stroke-like symptoms such as confusion, weakness, and dizziness may be monitored. The combination of neuro-behçet disease and psychosis frequency is lower in literature. In this report we presented a case about combination of neuro-behçet disease and delusional disorders. **Case presentation**: The patient was 47 years old, male, married, had some complaint like suspiciousness, irritability, aggression, sleep disturbances, and auditory hallucinations. These symptoms were increased almost one months and disturbed him so he presented to psychiatric outpatient clinic. At 2006, because of blurred vision, oral aphthous ulcers, and genital ulcers, he has gone to doctor and diagnosed as a Behcet disease. Six months ago, the patient committed suicide because of auditory hallucinations and after this event he stayed almost 2 months at intensive care unit. When he discharged from intensive care unit, he couldn't walk. After that the patient had some complaints like introversion, aggression, unhappiness, and unwillingness. Because of these complaints, he was presented to psychiatrist. Doctor prescribed him sertralin 50 mg/day. However, the patient did not visit doctor regularly and discontinued medication but complaints continued. There was no specific psychiatric disease in family history. 100 mg/day quetiapine and 0.5 mg/day risperidone were ordered to patient and dose of risperidone was increased to 3 mg/day with clinical follow-up. Psychotic symptoms are regressed with this medication and the disease is in remission now. The information about combination of neuro-behçet disease and delusional disorders are obtained from some case reports in literature. Psychiatric problems are mostly seen in Behcet disease; the reason for this situation is not clear. Some kinds of proimflammatuar cytokines like IL-1 beta, IL-8 and TNF alfa may influence the activity of neuroendocrine system, which increase the predisposition of psychiatric disease.

The patients whose diagnosis is Behcet disease have important psychiatric problems. Also, neuro-Behcet disease treatment is very important to prevent the complications of the disease. Otherwise these patients must be examined by psychiatrist during clinical follow-up and must be treated for psychiatric disease.

KEYWORDS

Central nervous system; cognitive dysfunction; delusional disorders; neuro-behçet disease; Psychosis

[Abstract:0354][Mood disorders]

Pramipexole augmentation in treatment-resistant bipolar depression: a case report

Recep Başaran, İbrahim Taş, Mustafa Çağrı Yıldız, İsmet Esra Çiçek, Ali Baran Tanrıkulu, Osman Ak and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT
Bipolar II disorder is a bipolar spectrum disorder characterized by at least one episode of hypomania and at least one episode of major depression. Diagnosis for bipolar II disorder requires that the individual must never have experienced a full manic episode. Bipolar II is notoriously difficult to diagnose. Patients usually seek help when they are in a depressed state. Treatment typically includes three things: the treatment of acute hypomania, the treatment of acute depression, and the prevention of the relapse of either hypomania or depression. The main goal is to make sure that patients do not harm themselves.
Case presentation: The patient is 52-year-old female with bipolar II disorder diagnosed 17 years ago. The patient was hospitalized because of depressive episode. For the last six months, the patient was receiving lithium 900 mg/day quetiapine 600 mg/day and risperidone 4 mg/day. The patient was severely depressed and developed parkinsonism 10 days ago from the last hospitalization. Risperidone was stopped; biperiden was added to treatment. Depressive and parkinsonian symptoms did not improve with this therapy. ECT was administered for suicidal ideation. Biperiden was stopped; pramipexole and rasagiline were added to treatment. The addition of pramipexole stabilized both the patient's depressive and parkinsonian symptoms. We present a case of bipolar depression in which the patient responded significantly to addition with pramipexole, without any side effects, after failure of adjunctive repetitive ECT. Patients with bipolar disorder experience depressive episodes three times more often than manic and hypomanic episodes despite a wide range of various drugs, a significant proportion of depressed bipolar patients fail to respond to the treatment strategies. Currently available international treatment guidelines for bipolar depression indicate compounds targeting the dopaminergic system as useful augmentative strategies, in case of poor response. In particular, dopamine agonists (i.e. pramipexole) have received increasing interest for their potential antidepressant effects in bipolar depression.
This case report suggests that pramipexole may be an effective and safe medication for treating treatment-resistant bipolar depression.

KEYWORDS
Antidepressant; bipolar disorder; dopaminergic system; pramipexole; treatment resistant

References

[1] Buskist W, Davis SF, eds. 21st century psychology: a reference handbook. ThousandOaks (CA): Sage; 2008, p. 290. ISBN 978-1-4129-4968-2.

[2] Muller-Oerlinghausen B, Berghofer A, Bauer M. Bipolar disorder. Lancet. 2002;359(9302):241–247.

[Abstract:0356][Psychosomatic Medicine and Liaison Psychiatry]

Electroconvulsive therapy in pseudocholinesterase deficiency: a case report

Mustafa Çağrı Yıldız, İbrahim Taş, Recep Başaran, Şenay Yıldız Bozdoğan, Osman Ak, Yasemin Gökçenoğlu and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: dr.yildizmcagri@gmail.com

ABSTRACT
Pseudocholinesterase deficiency is an inherited blood plasma enzyme abnormality in which the body's production of butyrylcholinesterase is impaired. People who have this abnormality may be sensitive to certain anaesthetic drugs, including the muscle relaxants succinylcholine and mivacurium as well as other ester local anaesthetics. Electroconvulsive therapy (ECT), formerly known as electroshock therapy, and often referred to as shock treatment, is a psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric disorders. The side effects in the brain and the general physical risks of ECT are similar to those of brief general anaesthesia. ECT was administered in conditions where there is a need for rapid, definitive response because of the severity of a psychiatric or medical condition. We present the case of a patient with previously undiagnosed pseudocholinesterase deficiency who experienced the need for prolonged mechanic ventilation after administration propofol and succinylcholine.
Case presentation: The patient is female, married, and 32 years old. She was presented to outpatient clinic of psychiatry and complaints were insomnia, irritability, aggression, visual and auditory hallucinations, low self care, and suicidal ideation. Olanzapine 10 mg/day and risperidone 2 mg/day were ordered but her complaints are not regressed and ECT was administered for suicidal ideation. In ECT, she needed prolonged mechanic ventilation, and because of this situation we have taken blood sample to measure blood level of pseudocholinesterase enzyme and result is 0.19 U/L. With this result we detected the

KEYWORDS
Electroconvulsive therapy; enzyme abnormality; prolonged mechanic ventilation; pseudocholinesterase deficiency; succinylcholine

pseudocholinesterase enzyme deficiency and in next ECT we administered rocuronium to patient for preventing apnea. After the detection of PCHE deficiency (PCHE level: 0.19 U/L), we performed the modified ECT with rocuronium. Response to treatment was good and we completed 9 ECT sessions without complication. Screening for PCHE levels in the pre-ECT assessments is efficacious in order to decrease the complications of the ECT procedure.

[Abstract:0357][Psychosomatic Medicine and Liaison Psychiatry]

Factitious schizophrenia: a case report

Ali Baran Tanrıkulu, Azra Yaşar, Tuba Şerife Elmas, Ali Metehan Çalışkan and İbrahim Eren

Konya Research and Training Hospital, Department of Psychiatry, University of Health Science, Konya, Turkey

E-mail address: barantanrikulu9@gmail.com

ABSTRACT

Factitious disorder refers to the psychiatric condition in which patients deliberately produce or falsify symptoms and signs of illness for the purpose of assuming the sick role. DSM-5 describe two presentation of disease 1: 1) Factitious Disorder Imposed on Self (Munchausen's Syndrome); 2) Factitious Disorder Imposed on Another (Munchausen by proxy). It may present as feigned physical and psychological symptoms. A case of factitious psychological symptoms suggestive of psychosis is reported.

Case presentation: A 20-year-old, unmarried female student studying at a university. She was admitted to the hospital following complaints such as auditory hallucination, self harming, feeling a monster in her chest and talking to someone who is copy of her, for 2 months. Her self explanation was very well. She had been mocked by her family about her symptoms. But when she had started to harm herself, the family became alert and took her to a hospital. Since her early teens, the patient was found to become anxious and has anger outbursts over minor issues at home. At the age of 17 years, she had visited a psychiatrist and was being treated for depression and anger with citalopram with bad compliance. She was willing to explain her complaints. She mentioned about a friend of her who has been treated for schizophrenia. And she has read books and made online search about schizophrenia. She asserted that she has psychiatric problem, especially schizophrenia. She described the psychotic symptoms and in fact provided details on these phenomena. She described suicide thoughts in regular intervals for 2 months. She described depressive symptoms derived from her relationship with family. She was started with duloxetine for depressive symptoms.

She was seen 3 times in a week when she scratch her body and crying in ward. She could remember what she's done. Within 2–3 days of admission, her auditory hallucination diminished and her insight was intact towards hallucination. When some complaints disappeared the new ones became appear. Her manner was very assertive about her diagnosis. She wanted a diagnosis insistently. She was very reactive to us as long as we did not talk about diagnosis. She was very enthusiastic about talking about her signs. In later interviews she was assertive about schizophrenia even if not schizophrenia she has to a psychiatric disorder. Her psychotic symptoms were changing. Her expectation from treatment was to get a diagnosis and get rid of symptoms. She was confronted with her diagnosis in a mild and emphatic way for protect to therapeutic relationship. Then she requested releasing from hospital and following outpatient clinic. She was released with duloxetine 30 mg. The feigned psychosis is usually suspected by the nursing staff and junior medical staff, but experienced clinicians are reluctant to consider it. In case of unusual, puzzling clinical manifestation, the presence of symptoms or behaviours when the patient is being observed, swiftly occurrence or disappearance of symptoms, being eager to explain signs, talking about symptoms exaggeratedly clinician must be suspicious about feigned psychosis, factitious disorder.

KEYWORDS

Factitious schizophrenia; feigned psychosis; Factitious Disorder; Munchausen's Syndrome; puzzling clinical manifestation

[Abstract:0358][Psychopharmacology]

Activation syndrome related to atomoxetine use: a case report

Sümeyra Elif Kaplan and Çiğdem Yektaş

Duzce University School of Medicine, Department of Child and Adolescent Psychiatry, Duzce, Turkey

E-mail address: dr.s.elifkaplan@gmail.com

ABSTRACT
Activation syndrome has been defined as hyperemotional arousal and behavioural activation symptom clusters including irritability, aggression, restlessness, anxiety, emotional lability, impulsivity, insomnia, akathisia, and mania/hypomania. Studies have shown that behavioural activation may be possible after antidepressant use in patients with mood disorder, especially those with unipolar depression. Atomoxetine is a non-stimulant drug indicated for attention-deficit and hyperactivity disorder, which selectively inhibits noradrenaline transporter and reduces noradrenalin reuptake in central nervous system. In this article, we present a 8-year-old male patient with activation syndrome after dose increasement during atomoxetine treatment.
Case presentation: The patient who has been followed by paediatric endocrinology outpatient clinic due to short stature was also diagnosed with Attentional Deficit Hyperactivity Disorder (ADHD) at our outpatient clinic and was prescribed moderate methylphenidate (MPH) for ADHD symptoms. In his follow-up visits, it was understood that there was a partial response to MPH and numbness in his hands in the presence of information from the family interview and the teacher, therefore short-acting methylphenidate treatment was started. Because of excessive loss of appetite after the drug change, MPH treatment was stopped. Initial doses of atomoxetine were prescribed as 0.5 mg/kg/day and increased to 1.2 mg/kg/day in 2 weeks. After 1 month, atomoxetine doses was increased to 1.4 mg/kg/day due to partial clinical response. After 1 week of dose increase, aggression, outburst of anger, sticking pen to his friends, licking floors and his friends, irritability, aggression, oppositional behaviours, restlessness, impulsivity, and hyperactivity symptoms that previously not reported have been observed. Atomoxetine treatment was stopped immediately. Symptoms disappeared within 2 days after the cessation of the treatment of atomoxetine. As a result, various mechanisms for pathophysiology of activation syndrome have been studied. From these, it is known that the noradrenergic system may be effective. Activation syndrome triggered by atomoxetine has not been established in the literature. In this case it has been thought that activation syndrome may occurred because of noradrenalin increase after atomoxetine use. It should be noted that clinicians should pay attention about the possibility of activation syndrome after 2–3 weeks of atomoxetine use or drug change.

KEYWORDS
Activation syndrome; atomoxetine; attentional deficit hyperactivity disorder; behavioural activation; noradrenalin

[Abstract:0359][Dementia syndromes]

Is a psychotic exacerbation or frontotemporal dementia?

Hazal Muhsinoglu[a], Alper Zıblak[b] and Ayşe Nur İnci Kenar[b]

[a]School of Medicine, Department of Child and Adolescent Psychiatry, Pamukkale University, Denizli, Turkey; [b]School of Medicine, Department of Psychiatry, Pamukkale University, Denizli, Turkey

E-mail address: hazall14@hotmail.com

ABSTRACT
Frontotemporal dementia (FTD) is the second most common cause of early-onset dementia and accounts for approximately 13% of all dementia. Typical onset age is 45–60 years, more common in men. They are misdiagnosed more often than late-onset dementias, mostly with neuropsychiatric charts. Unable to perform daily activities, decrease in self-care, decrease in human relations, and change of eating habits are frequently encountered in clinical appearance. In this article, we present a male frontotemporal dementia with psychiatric symptoms such as behaviour, personality, and affect changes, which began years after the diagnosis of schizophrenia.
Case presentation: The first complaints of a 39-year-old male, single, primary school graduate presented to psychiatric outpatient clinic for the first time after completing military service 15 years ago, complaining of scepticism, loss of self-care, Cranial magnetic resonance (MR) imaging of the patient who had partial benefit from antipsychotic treatments on the complaints of insomnia for the last 3 months, increase in demand for money, accumulation of garbage, consumption of 10 packages of cigarettes a day, increase in sexual activity, decrease in communication, and marked atrophy in the temporal lobes. With these findings, frontotemporal dementia was diagnosed as a diagnosis of the present psychotic disorder of the patient. In FTD cases, different psychiatric symptoms can be seen related to the affected neuroanatomical regions. Personality and behavioural changes in frontal region involvement, apathy and psychotic manifestations; when the temporal region is affected, emotional blunting, distance between interpersonal relationships, and hypomania-like behaviours may be seen in the frontal plane. Neglect of self-care, accumulation of strange things, changes in eating habits can be seen. Disinhibition can be diagnosed as FTD cases, late-onset

KEYWORDS
Frontotemporal dementia; schizophrenia; neurodegenerative diseases; psychotic exacerbation; comorbidity

schizophrenia or atypical psychosis due to inappropriate social behaviour, repetitive compulsion-like behaviours, absence of internal appearance. Psychotic symptoms occur in 13–14% of FTD patients. Emotional blunting, impaired judgment, loss of consciousness, decreased self-care, and impaired social functioning are among the negative statements of schizophrenia and are also seen in FTD. The relationship between FTD and schizophrenia has been investigated because of familial comorbidity and similarity of neuroanatomical regions. On the other hand, FTD patients may miss psychotic symptoms and later add FTD to patients with psychotic disorders. In our case, behavioural changes (socially inappropriate behaviours, childlike behaviour, accumulation of strange things, lack of empathy, hyperorality) and persistence of these symptoms that did not occur in the last 3 months of previous psychotic exacerbations have caused the suspicion that the present schizophrenia frontotemporal dementia may have been added.
It is still not possible to explain the relationship between schizophrenia and FTD. However, in the presence of late-onset psychotic symptoms, FTD should be considered in differential diagnosis. The separator may be a contributor to diagnostic imaging, especially functional brain imaging. Neurodegenerative diseases should be kept in mind both as differential diagnosis and comorbidity if symptoms such as schizophrenia and similar psychotic disorder are diagnosed and personality and behavioural changes and cognitive dysfunctions that have not been seen before in the clinical course of the patient are revealed.

[Abstract:0360][Psychopharmacology]

Single-dose oral prednisolone treatment on acute onset–severe obsessive-compulsive symptoms in PANDAS: a case report

Cantekin Can[a], Perihan Cam Ray[a], Gonca Gul Celik[a], Aysegul Yolga Tahiroglu[a], Ozge Metin[a], Canan Kuygun Karci[b] and Ayse Avci[a]

[a]Department of Child and Adolescent Psychiatry, Cukurova University School of Medicine, Adana; [b]Department of Child and Adolescent Psychiatry, Dr Ekrem Tok Mental Health and Diseases Hospital, Adana

E-mail address: cantekincan89@hotmail.com

ABSTRACT

Paediatric autoimmune neuropsychiatric disorder associated with streptococcal infection (PANDAS), known subset of paediatric acute-onset neuropsychiatric syndrome (PANS), is characterized by the sudden-onset of OCD and/or tic symptoms in childhood, following a group A-betahaemolytic streptococcal infections. Though the certain pathophysiology of PANDAS is yet unknown, recent studies point out that the inflammatory processes may contribute to the pathophysiology. Therefore, the first-line evidence-based OCD therapies such as selective serotonin reuptake inhibitors, cognitive behaviour therapy may be insufficient in these cases. In PANDAS patients, it is stated that treatment of underlying inflammatory processes and infections may be decreased psychiatric symptoms. In our case, we report a 15-years-old boy with PANDAS whose OCD symptoms decreased significantly after single-dose oral methyl-prednisolone.

Case presentation: A 15-years-old boy admitted to our outpatient clinic with complaints of feeling necessary to touch whatever around him, washing his hands more than 50 times, disgusting from his sputum, vomiting after swallowing 7–8 times per day, erasing and writing the same letters 3–4 times in lessons, avoiding to solve the third and eighth questions in exams, hoarding leaves from trees, worrying about parents' health conditions. Symptoms had begun suddenly one month ago and similar OCD symptoms, such as necessary to touch, cleaning, and separation anxiety, had a relapsing-remitting course when he was in primary school. He was extremely distressed by these symptoms, so he refused to go to school. He had lost 10 kilograms in one month. In laboratory examination, antistreptolysin-O (ASO) was 736 IU/mL. He was diagnosed as 'PANDAS OCD'. Aripiprazole was started 2.5 mg/day; and behavioural interventions such as motivation and gradual exposure homework were given. Because he had allergy to penicillin-G, Azithromycin was started using 500 mg/day three doses and then 500 mg/per week. By the fourth week of medication, he said that he hasn't seen any benefits; also he was feeling worse than first. So, we recommended single-dose oral methyl-prednisolone 20 mg. 10 days after taking oral methyl-prednisolone, we observed that OCD symptoms were markedly improved. He began going to school every day and the most important point to notice that the patient began to feel healthy as before. As it's thought that autoimmunity has an important role in PANDAS, immunosuppression may be an important part in treatment of these cases. Many case reports and some studies shown that treatment with corticosteroids, antibiotics, nonsteroidal anti-inflammatory drugs and intravenous immunoglobulin are useful for psychiatric symptoms of PANDAS. It's known that duration between symptoms and treatment is crucial

KEYWORDS

PANDAS; PANS; OCD; corticosteroids; treatment

for an autoimmune disorder. Corticosteroids may help to protect the brain cells from early autoimmune damages, immediately. In our case, single-dose methyl-prednisolone decreased the symptoms significantly. So, it's considered that early corticosteroid treatment may have benefits in PANDAS, probably protecting the brain from acute inflammation. This result needs to be replicated with large clinical studies.

[Abstract:0361][Psychopharmacology]

Atomoxetine-induced Raynaud's phenomenon: a case report

Ipek Percinel Yazici and Kemal Utku Yazici

Firat University School of Medicine, Department of Child and Adolescent Psychiatry, Elazig, Turkey

E-mail address: ipek.pr@hotmail.com

ABSTRACT

Atomoxetine is a selective norepinephrine reuptake inhibitor used in the treatment of attention-deficit/hyperactivity disorder (ADHD). Cardiac murmur, hypertension, and heart rhythm changes can occur rarely. Raynaud's phenomenon is a vasospastic condition characterized by pallor, cyanosis, and redness at the extremities of the body triggered by cold and emotional stress factors. In this article, it is aimed to present a girl with ADHD who developed Raynaud's phenomenon during atomoxetine treatment.

Case presentation: A nine-year-old girl was presented to our outpatient clinic with her mother with the complaints of attention problems, unable to concentrate on her lessons, not listening to her teacher in the class, forgetfulness, difficulty in completing daily assignments, impatience, and inability to wait her turn. She was evaluated by a psychiatrist in another centre and was diagnosed with ADHD and 18 mg/day of OROS-methylphenidate was started two years ago. It was learned that the family stopped using the drug because of the apparent weight loss. Complaints continue increasing each year, the case was presented to us this year with her teacher's insistence. As a result of all the clinical evaluations done by us, the case was diagnosed with ADHD. The previous drug story was taken into account and atomoxetine started at 10 mg/day (approximately 0.47 mg/kg/day). No side effects were described in the controls performed with two weeks interval and the drug dose was increased in a dose-controlled manner first to 18 mg/day (0.85 mg/kg/day) and then to 25 mg/day (1.19 mg/kg/day). On the third day after increasing the dose to 25 mg/day, the case was presented to us with the complaints of coldness, paleness, and cyanosis on the tips of the hands and toes. The complaints started about an hour after taking the drug, when she was exposed to the cold or when she was excited, and when the triggering did not continue, she recovered after a few hours. The case was thought to have Raynaud's phenomenon. No underlying organic disease was detected in the organic examinations. The case received 6 points from the Naranjo Adverse Drug Reaction Probability Scale. It was thought that the hallucinations of the case could 'probably' be associated with atomoxetine and it was discontinued. After atomoxetine was discontinued, the complaints of the patient were completely resolved and did not repeat in the controls performed with one-week interval. Her family did not want to continue to the drug treatment. The drug-free follow-up continues in our clinic. Although the aetiology of Raynaud's phenomenon is still not fully understood, it is thought to be related to changes in vascular activity. Noradrenergic activation by the use of atomoxetine may have caused prolonged vasospasm by stimulating noradrenergic receptors with peripheral effect. As far as we can see, our case is the second child in the literature reporting similar side effects. There is a need for studies on the subject. It is important for clinicians to be cautious about Raynaud's phenomenon, a rare side effect of using atomoxetine, which stimulates noradrenergic activity.

KEYWORDS

ADHD; atomoxetine; child; norepinephrine; Raynaud's phenomenon

[Abstract:0364][Schizophrenia and other psychotic disorders]

Does schizotaxia have implications in difficult-to-treat patients with schizophrenia?

Evrim Özkorumak Karagüzel, Gamze Kutlu and Gizem Aral

Karadeniz Technical University School of Medicine, Department of Psychiatry, Trabzon, Turkey

E-mail address: evrimozkorumak@yahoo.com

ABSTRACT
Paul Meehl used the term "schizotaxia" to describe the genetic predisposition to schizophrenia in 1962. Nowadays, schizotaxia describes abnormalities in affect, cognition, and social functioning so schizotaxia is not merely a theoretical construct, it may be a clinically consequential condition. Because families are often involved in treatment programs for patients with schizophrenia, it is likely that many schizotaxic patients participate in the treatment of their relative with schizophrenia. In this case report, we discussed the role of a schizotaxic family member in the treatment of a case of schizophrenia.
Case presentation: 25 years old woman with positive psychotic symptoms was internalized to the clinic. She has high volume speech sometimes screaming in the clinic. The sleep was very short and had self-destructive behaviours. Also, psychomotor agitation was striking. She had difficulty in caring for herself, so her mother started to be with her in the clinic. But after her mother escorting her, the drug adherence and psychomotor agitations were increased. The mother could not obey the rules of the clinic and instructions of the treatment team. She had a low level of interactions with the treatment team and usually tries to manage her daughter according to her conception. The patient got worse despite the optimal pharmacological treatment. Due to the role of schizotaxia in family intervention, the mother was psychoeducated repeatedly about her daughter's disease and the interventions. After that intervention, the mother was more compatible with the treatment settle. The patient is still being followed in the clinic with improvement in the symptoms. Psychoeducational family intervention includes learning facts about the disorder, and method of coping with their relative's illness is an important part of the schizophrenia treatment in case of schizotaxic relatives. In this case, this may be compromised due to impairments of schizotaxia of the mother. It was not misinterpreted by the treatment team as indicating resistance on the part of the mother, rather some skills for intervention for her daughter was taught. Then the mother engaged in the treatment of her daughter and the patient's clinical condition improves together with pharmacotherapy and family intervention. Participation in family interventions is an important issue in the treatment of patients with schizophrenia. So, schizotaxia must be kept in mind in case of difficulty to treat patients with schizophrenia.

KEYWORDS
Schizophrenia; schizotaxia; treatment; family intervention; treatment resistance

[Abstract:0365][Psychosomatic Medicine and Liaison Psychiatry]

Somatoform pain disorder and self-medication in an adolescent: a case report

Çağlar Soykan[a], Cansu Pınar Şen[b], Mehmet Fatih Ceylan[b], Selma Tural Hesapçıoğlu[b] and Özden Şükran Öneri[b]

[a]Department of Psychiatry, Ankara Yildirim Beyazit University, Ankara, Turkey; [b]Department of Child and Adolescent Psychiatry, Ankara Yildirim Beyazit University, Ankara, Turkey

E-mail address: ozdenuneri@yahoo.com

ABSTRACT
Adolescents may present with recurrent medically unexplained somatic symptoms; the most common being a complaint of pain. Underlying psychiatric conditions such as depressive disorder, anxiety disorder, or somatoform disorder may be associated with these somatic symptoms. Self-medication is defined as the inappropriate use of drugs without a physician's advice in order to treat self-diagnosed health problems. Several studies showed that the prevalence of self-medication in adolescence population ranges from 2% to 95%, high prevalence rate may lead to abuse, misuse, or overuse of drugs. We present a case of an adolescent boy with complaints of severe pain and multidrug misuse.
Case presentation: Our patient was 15-year-old, male, youngest, and only male child of four children in his family. His mother and his sister had a history of severe pain complaints associated with rheumatoid arthritis. He presented to our clinic with complaints of severe pain in the lower back region and extremities with multidrug usage against physician's advice. He had maintained well until 13 years of age when he started to complain of moderate to severe pain daily, which caused his absence from school for 2 years. He was taken to various healthcare institutions where he was examined for his symptoms by methods including MRI scans, EMG, EEG, laboratory evaluation and no pathologic findings were found. He was referred to a psychiatry outpatient clinic and he received fluoxetine treatment with the diagnosis of anxiety disorder. His complaints of pain persisted and he started investigating psychotropic drugs and analgesics to relieve his pain. He used many drugs (amitriptyline, pregabalin, gabapentin, memantine, sertraline, duloxetine, imipramine, venlafaxine, lamotrigine, aripiprazole, quetiapine, paroxetine, lorazepam, olanzapine, mirtazapine, risperidone, bupropion, haloperidol, etc.) in two years' period without any physician's advice or control. In our clinic, the case was hospitalized and his multidrug self-medication was stopped. The primary intervention strategies used during the admission were

KEYWORDS
Pain; disorder; psychosomatic; self; medication

psychoeducation, rehabilitation modelling, and behavioural techniques. Escitalopram 10 mg/day and quetiapine 25 mg/day were started because of his intensive anxiety symptoms. During his hospitalization, it was observed that even though he complained of severe pain, he could be easily engaged in other topics or activities. Improving his functionality and building a therapeutic alliance were aimed. He was assured that genuineness of his pain was believed. He was encouraged to continue with his normal activities despite the pain, the importance of focusing attention and distraction in pain perception was told. His efforts were appreciated by the treating team. During a follow-up, he reported his pain symptoms as reduced. Diagnosis of somatoform pain disorder was kept. Our case reveals the importance of psychiatric examination in medically unexplained symptoms. Delay in the diagnosis of somatoform disorders may extend adolescent's disability. Focusing on reducing functional disability, interventions to improve physical and psychosocial functioning in everyday activities are key aspects of the treatment. Self-medication may cause dangerous drug interactions, incorrect dosage, incorrect administration, adverse reactions, incorrect self-diagnosis, masking of another disease, and risk of misusing drugs as seen in our patient. Clinicians should be aware of the links between factors promoting self-medication and somatoform pain disorders.

[Abstract:0366][Psychopharmacology]

Mirtazapine-induced periorbital oedema in a child patient: a case report

Abdullah Karataş, Hatice Altun and Umut Karaaslan

Department of Child and Adolescent Psychiatry, Kahramanmaras Sutcu Imam University, Kahramanmaras, Turkey

E-mail address: darkstone78@gmail.com

ABSTRACT

Mirtazapine is a noradrenergic and specific serotonergic antidepressant with a special psychopharmacological mechanism. It enhances noradrenergic transmission through the central α2-adrenoceptor blockade and is a 5-HT2 and 5-HT3 receptor antagonist. Moreover, it increases serotoninergic message via the 5-HT1A receptor. Depending on the histamine 1 (H1) receptor antagonism, sedation, increased sleep and appetite occur. Mirtazapine has side effects such as increased sleep and appetite, sedation, fatigue, hypotension, constipation, dry mouth; however, impairment of liver function and bone marrow suppression depend on granulocytopenia and gastrointestinal symptoms. In the literature periorbital oedema has been reported after the use of mianserin from antidepressants. In addition, peripheral oedema following mirtazapine, phenelzine, isocarboxazid, escitalopram, sertraline use has been reported. According to our knowledge, there is no case report or study regarding mirtazapine-related periorbital oedema. Here, we present a paediatric patient with periorbital oedema following mirtazapine use).

Case presentation: A 13-year-old, male patient presented to the clinic with complaints of crying, fear, anxiety, dizziness, nausea, loss of appetite, and insomnia. There was no previous physical and psychiatric disease history. Psychiatric examination of the case revealed anxiety disorder according to DSM-5. Mirtazapine was started at 7.5 mg/day due to the patient's symptoms such as insomnia, nausea, and loss of appetite. The mirtazapine dose was gradually adjusted to 30 mg/day. The patient who was clearly benefiting from the treatment was invited to the monthly follow-up control. After increasing the dose of mirtazapine, the patient complained of swelling around both eyes. In the paediatric clinical examinations, no organic pathology which could explain periorbital oedema was detected. The drug was discontinued due to the possible side effects due to mirtazapine, and follow-up without medication was recommended. One week after the medication was discontinued, the patient's periorbital oedema resolved. One month later, mirtazapine was discontinued. Fluoxetine was started to be given as 10 mg/day due to the recurrence of anxiety symptoms. Fluoxetine 20 mg/day was continued to be used in patients with marked improvement in their complaints, due to no side effects with fluoxetine and benefit from treatment. In this case, periorbital oedema appeared simultaneously with increasing doses of mirtazapine. Systemic diseases that explain the condition are excluded. There is no medication that could cause oedema. The patient did not develop oedema while using fluoxetine alone for anxiety complaints. Oedema has contracted after cessation of mirtazapine treatment. These findings suggest that periorbital oedema may be due to mirtazapine. There are three reports in the literature of peripheral oedema due to mirtazapine in adult patients. In one of the three cases of oedema due to mirtazapine, oedema was reduced after cessation of mirtazapine treatment. Lahdelma et al. have reported that peripheral oedema is regressed by increasing the dose of mirtazapine in the two cases reported. It is important that clinicians pay attention to these side effects in patients receiving mirtazapine. There is a need for more extensive work to explain the mechanism and frequency of this side effect.

KEYWORDS

Antidepressant; mirtazapine; periorbital oedema; side effect; child patient

[Abstract:0367][Schizophrenia and other psychotic disorders]

Case report: a 16-year-old early onset schizophrenia case with extremely sensitive response to treatment side effects

Nurdan Kasar and Nihal Yurteri Çetin

Düzce University Child and Adolescent Psychiatry, Düzce, Turkey

E-mail address: nurdankasar@hotmail.com

ABSTRACT

Schizophrenia, a heterogeneous clinical syndrome, causes significant disturbances in behavioural, emotional, and cognitive functions. Onset prior to age 18 is called early-onset schizophrenia (EOS), and onset prior to 13 is called very early-onset schizophrenia. Cases with EOS are reported to have more slowly progressive onset and worse clinical outcome.

Case presentation: Here, we describe the case of a 16-year 2-month-old male adolescent with EOS, with a history of mild mental retardation, who presented with social withdrawal, regression in self-care skills, and functional disability. These symptoms started 5 years ago and increased year by year.

We performed a preliminary workup, including routine laboratory examination which was normal. The patient received a comprehensive medical workup including brain MRI and CT, EEG, metabolic screen tests by paediatric neurology. It was learned that he was admitted to our hospital with the same symptoms 2 years ago but the family did not continue to child and adolescent psychiatric follow-up. He had no family history of psychiatric diseases. On the initial evaluation, his affect was flat. He did not make eye contact, did not respond to calling his name and what was asked. It observed that he could only said 'mother' and 'shot the door'. The patient was first administered risperidone 2×0.5 mg/day. After initiation of risperidone treatment, akathisia and sialorrhea appeared and the treatment was switched to quetiapine 2×50 mg/day. When quetiapine dose was increased to 2×100 mg/day, significant enuresis and encopresis were detected. Then, the treatment was returned back to the dose of 2×50 mg/day quetiapine. Then enuresis and encopresis were not detected. The treatment was continued with 2×50 mg/day quetiapine for 15 days. Quetiapine dose was increased to 2×100 mg/day with an extremely slow dose increment and any side effects have not been detected yet. Treatment guidelines for EOS are mostly based on the adult literature. Antipsychotic drugs should be started at low dose and titrated slowly. It is known that psychotropic drugs should be used at lower doses in patients with mental retardation than those with normal intelligence due to sensitivity to side effects. In children and adolescents, additional research is needed to better assess the prevalence of EOS and the response to antipsychotic treatments.

KEYWORDS

Early-onset schizophrenia; akathisia; encopresis; enuresis; sialorrhea

[Abstract:0371][Stress and related situations]

Diagnosis and differential diagnosis in Dissociative Identity Disorder: a case report

Nilfer Şahin and Damla Balkan

Department of Child and Adolescent Psychiatry, Muğla Sıtkı Koçman University School of Medicine, Muğla, Turkey

E-mail address: nilfersahin@hotmail.com

ABSTRACT

Dissociation is defined as the impairment or alteration in the complementary functions of consciousness, memory, and identity. Dissociative Identity Disorder is 1% in the community and 5% in the inpatient psychiatric services. Although it is not uncommon, it is difficult to diagnose unless the symptoms specifically queried. Studies have shown that patients have an average of 7 years between psychiatric admission and diagnosis. It is indicated that the patients had four different diagnoses at this time, such as affective disorder, personality disorder, anxiety disorder, and schizophrenia. In this case report, a 15-year-old male with dissociative identity disorder who admitted to our outpatient clinic with psychotic findings will be discussed.

Case presentation: A 15-year-old male patient admitted to the external centre 3 months ago with complaints of hallucination symptoms, such as seeing blood on the floor and seeing dead bodies for a few hours, and depersonalization symptoms such as monitoring his body from the outside. As a result of evaluations made by paediatric neurology and child psychiatry, no organic pathology was found and sertraline and risperidone treatment were started.

KEYWORDS

Alter personality; diagnosis; differential diagnosis; dissociative identity disorder; childhood trauma

According to the information received from the patient, it was learned that he has lived in Muğla for about 6 years and said that he felt very lonely here, that he was unhappy for this reason, he wanted to return to his hometown. After he moved to Muğla, about 4 years ago, his grandfather, who loved and supported him most, died. He said he was very sorry for the death of his grandfather. After the death of his grandfather, one day, a man came in while he was sitting with his brother at their father's workplace, and he said "If I see you here again, I will kill your father." He has not been able to get away from the effect of this event for a long time, he was very afraid. He did not tell another traumatic event. He said that he heard too much sound in his head, he could not understand some of them, and the ones he understood were "go from here, come to freedom." When he was asked whether he heard a voice other than these voices, he talked about the presence of Ismail – a 20-year-old, strong, medical student who helped him – and Necati – a 24 years old, who works in the industry, and has the ability to control the lights. Along with these two, he also mentioned Ali, who prevented him from committing suicide by taking medication. He said that they live together with all alter personalities. According to DSM-5, the diagnosis of the patient was considered as Dissociative Identity Disorder. Weekly negotiations were planned with an agreement with the alter personalities. His pharmacologic treatment continued in the same way. As a result, this disease, which is more common than expected, especially starting in childhood and largely affected by childhood experiences, should be kept in mind by all health workers who are interested in children and adolescents.

[Abstract:0375][Psychosomatic Medicine and Liaison Psychiatry]

Couvade syndrome: a rare case report

Aslıhan Okan İbiloğlu and Abdullah Atli

Dicle School of Medicine, Department of Psychiatry, Dicle University, Diyarbakir, Turkey

E-mail address: aslihanokan@gmail.com

ABSTRACT

Couvade syndrome, also called sympathetic pregnancy, or "pregnant dad syndrome," is a situation, where the father experiences somatic and/or psychiatric symptoms during his wife's pregnancy. Various similar symptoms in epidemiologic studies have been described in the husbands of pregnant women with an incidence of between 11% and 65%.

Onset is generally during the third gestational month. Both men and women may be experienced second-trimester decreases in emotional symptoms and third-trimester increases in negative emotional symptoms. This changes may be occurred in sexual habits of cases in 87.67%, whereas fear and anxiety symptoms in 36.98% of cases. Symptoms of husband generally resolve with childbirth.

The aim of the conducted case report was to analyse the Couvade Syndrome. We examined the couvade symptoms and association with the male empathy in our case.

Case presentation: Mr XX a 32-year-old men was referred to our outpatient psychiatry department with the complaints of weight gain, gastritic symptoms, food cravings, nausea and vomiting, palpitation, insomnia, anxiety, irritability, and headache, for around 5 months. The patient and patient's family are not having any psychiatric disorders. His wife was getting treated for infertility, since about to 4 years. But, approximately 5 months ago, his wife visited her obstetrician who after doing the relevant physical and biochemical examinations, subsequently confirmed that she was pregnant. The most common of symptoms are changes in appetite, nausea, insomnia, and weight gain. On the other hand, somatic symptoms can include the gastritic symptoms, food cravings, nausea and vomiting, increased or decreased appetite, diarrhoea, toothache, headache, itch, muscle tremors, abdominal bloating, pseudocyesis, nosebleed, or other pains. With the exception of nausea, physical symptoms were less frequent in the husband with pregnant wives than in those without pregnant wives. The frequency of couvade symptoms in husbands is generally associated with empathy. In other words, a husband who is emotionally susceptible or prone to distress may physiologically experience the pregnancy of their wives. According to many studies in the literature, husbands generally feel ambiguous about the future in their new role as a father and also are afraid of the family man responsibility, especially for the baby. Couvade syndrome is not a recognized medical condition. Its source is a matter of debate. Also, it does not appear in the nosology of the Diagnostic Statistical Manual of Mental Disorders: DSM-5ersion 5 (American Psychiatric Association 2013). Nevertheless, early comments tended to medicalize it as a psychosomatic disorder. In our opinion, this situation should be followed by many heterogeneous samples to assess the relationship between socio-demographic factors and the syndrome. As a result, further research is needed to confirm these findings and to determine the implications of these symptoms for the marital relationship.

KEYWORDS

Couvade syndrome; sympathetic pregnancy; pregnant dad syndrome; pseudopregnancy; husband

[Abstract:0376][Mood disorders]

Electroconvulsive therapy in a pregnant bipolar affective disorder patient: a case report

Rabia Erdogan, Esra Yazici, Tugba Mutu, Ozlem Akcay Ciner, Ali Savas Cilli and Atila Erol

Department of Psychiatry, Sakarya University School of Medicine Research and Training Hospital, Sakarya, Turkey

E-mail address: erdogan_rabia@hotmail.com

ABSTRACT

There is an increased risk of relapse in mood disorders during pregnancy. The lack of medications also increases relapse risk significantly. The drugs that pass through the placenta can lead to foetal teratogenicity, toxicity, perinatal syndromes, and withdrawal syndromes in the foetus. Mothers and infants are at increased risk for both diseases and medications. For this reason, we need to evaluate the benefit/risk ratio when treatment is planned. Besides psychopharmacological drugs, ECT is also known as a fast, reliable, and effective treatment option in pregnancy but "how many numbers of sessions is safe" is not clear. In this case report, the use of ECT up to 26 sessions and antipsychotics in a patient with bipolar disorder who have had manic episodes twice during pregnancy will be discussed.

Case presentation: A 22-year-old female patient was admitted to our clinic with complaints of much and loud speaking, irritability, excitation, and deprivation in need of sleep. The patient was pregnant for 11 weeks. The patient had the anamnesis of well response to quetiapine, olanzapine, and valproic as it previously for 6 years but she stopped using her medication for a few months. Her previous medication except valproic as it was administered by titration but although olanzapine was used up to 20 mg/day with quetiapine up to 400 mg/day, no significant improvement was observed in her symptoms so ECT was planned at the 24th day of hospitalization. Consultations of Obstetrics and Gynecology and Anesthesia Clinics and family consent were obtained. Thirteen sessions of ECT were administered to the patient every other day. The patient's manic symptoms improved and she was externalized with olanzapine 20 mg/day. One month after externalization, the patient presented to the hospital again for similar complaints with incomplete adherence to medication. Olanzapine up to 20 mg/day was gradually administered and quetiapine was added up to 400 mg/day but still sometimes haloperidol 10 mg injections were needed because of her intensive excitations so ECT was planned again. The patient was administered 13 sessions ECT every other day again. During all this period, the patient was consulted to Obstetrics and Gynecology Clinic before and after every ECT sessions and no pathology was detected. The patient was externalized as 28-week-old pregnant by recommending Community Counselling Centre control. The patient had a spontaneous vaginal delivery at the 38th week of gestation and gave birth a 2600-g baby girl with a 1-minute Apgar score of 9 and a 5-minute Apgar score of 10. ECT has been reported as a rapid, safe, and effective treatment option in the treatment of bipolar affective disorder, in APA treatment guidelines. This case provides data of high dosage of antipsychotics and several sessions of ECT in pregnant women with healthy birth to the literature. Treatment of major psychiatric problems such as schizophrenia and bipolar disorder during pregnancy is very difficult. This case shows that several sessions of ECT can be safely administered in pregnancy as a treatment option when benefit/risk assessment is done.

KEYWORDS

Pregnancy; electroconvulsive therapy; bipolar affective disorder; olanzapine; quetipine

[Abstract:0378][Neuroscience: Neuroimaging-Genetics-Biomarkers]

Frontal lobe syndrome: a case report

Esra Porgalı Zayman, Cengiz Darılmaz, İsmail Reyhani and Rıfat Karlıdağ

Department of Psychiatry, Inonu University, Malatya, Turkey

E-mail address: cengizdarilmaz@gmail.com

ABSTRACT

This case is presented in order to facilitate the differential diagnosis of a patient's (previously diagnosed with bipolar affective disorder, schizophrenia, and personality disorder) frontal lobe syndrome resulting from frontocarvaryal hypertrophy and frontal lobe pressure.

Case presentation: A 32-year-old female patient presented to psychiatry department with the complaints of auditory, olfactory, and visual hallucinations, persecution delusions, increase in

KEYWORDS

Diagnosis; frontal lobe syndrome; psychiatric disorders; bipolar affective disorder; schizophrenia

sexual desire, increased level of energy. The patient was hospitalized. In patient's medical history, it was learned that the patient's complaints started 7 years ago and the patient was hospitalized before in other clinics with bipolar affective disorder, personality disorder, and schizophrenia. Although the patient's complaints were partially diminished, auditory, olfactory, and visual hallucinations continued. During the examination, the patient had hallucinations of auditory (in an imperative tone), atypical visual (little crooked people and objects), and olfactory. The patients' biochemical and hematological values, thyroid function tests, folic acid level, and ECG were in normal limits. The neuropsychological test implemented on the patient revealed simple and complex attention deficits, partial impairment in executive functions (verbal fluency and countdowns), impairment in abstraction, impairment in planning, mild impairment in visual–spatial perception, and secondary impairment in memory. Brain MR imaging of the patient was reported as "frontocarvaryal hypertrophy and consequently, both frontal lobes were slightly flattened." Frontal lobe syndrome (FLS) is a clinical tablature showing itself with personality and behavioural changes resulting from pre-frontal cortex's (PFC) getting damaged by various causes. Psychiatric symptoms may change according to the area where PFC is damaged and it causes these cases to be considered as psychotic disorders and mood disorders. The patients' impulsive behaviour, inappropriate sexual behaviour, increased sexual desire, atypical auditory and visual hallucinations, and insomnia led us to diagnose bipolar disorder, schizophrenia, and personality disorders in the outpatient clinic. However, after the interviews with patients and their relatives, we learned that complaints of the patient are persistent, there was no evidence to suggest any psychiatric disorder before the symptoms began, behavioural changes did not match the pre-disease personality pattern. Evaluating these and NPT results, brain MR results, and neurological evaluation, the patient was diagnosed with FLS. A large number of psychiatric disorders exist that can interfere with FLS; and with a carefully taken medical history and some details that can be detected in a psychiatric examination can be a great help in diagnosing the FLS.

[Abstract:0381][Autism]

Clonidine use in the treatment of irritability and aggression in adolescents with autism spectrum disorder: three cases

Kübra Yıldırım[a], Yunus Emre Dönmez[b], Serdar Karatoprak[a] and Özlem Özcan[a]

[a]Department of Child and Adolescent Psychiatry, Inonu University Malatya, Turkey; [b]Department of Child and Adolescent Psychiatry, Malatya Research and Training Hospital, Malatya, Turkey

E-mail address: kubracanpolat@gmail.com

ABSTRACT

Children and adolescents with autism spectrum disorder (ASD) can show aggressive and problematical behaviours to themselves or individuals around them due to symptoms of irritability and aggression. Several pharmacological treatments are used for behavioural problems in these patients. In this report, our experiences with clonidine therapy, which is an α2-adrenergic receptor agonist, in three adolescent ASD cases with irritability and aggression complaints will be shared in line with the literature.

Case presentation:

Case 1: 15-year-old female patient was being followed for 10 years by our clinic with a diagnosis of ASD and mild mental retardation. A great number of antipsychotic drugs such as risperidone, haloperidol, olanzapine, quetiapine, aripiprazole, and zuclopenthixol had been tried in the treatment of the patient who had complaints of irritability and aggression in outpatient clinic follow-ups. Clonidine 112.5 µg tb was added in the treatment of the patient who did not benefit from the treatment. The patient's treatment was reorganized as olanzapine, quetiapine, and clonidine. Clonidine dose was increased to 150 µg. Regression was observed in the patient's complaints and her sleep became regular. When sedation occurred with the increase in dose, the treatment was ended since the family did not want to continue the treatment.

Case 2: 15-year-old male patient who had been followed up with a diagnosis of ASD in an outer centre referred to our clinic with complaints of irritability, aggression, and restlessness. It was learned that the patient had received various antipsychotic therapies for his complaints; however, since he did not benefit from these therapies, clonidine tb. was added in his treatment. At the moment of his referral to our outpatient clinic, he was using clonidine 150 µg, aripiprazole, olanzapine, and fluvoxamine. The patient's clonidine dose was increased to 225 µg. The patient's irritability decreased and no treatment-induced adverse effect was observed.

KEYWORDS

Autism spectrum disorder; adolescents; clonidine; irritability; aggression

Case 3: 15-year-old male patient was being followed for 11 years by our clinic with a diagnosis of ASD and mild mental retardation. A great number of antipsychotic drugs such as risperidone, haloperidol, olanzapine, quetiapine, aripiprazole, zuclopenthixol, chlorpromazine and benzodiazepines, melatonin, and sodium valproate had been tried in the treatment of the patient who had complaints of irritability, aggression, and sleep disorder in outpatient clinic follow-ups. Clonidine 150 µg tb was added in the treatment of the patient who did not benefit from the treatment. The patient's treatment was reorganized as olanzapine, quetiapine, and clonidine. Clonidine dose was increased to 350 µg. The patient's irritability decreased significantly and no therapy-induced adverse effect was observed. Symptoms of irritability and aggression are frequent comorbid of ASD. Second-generation antipsychotics are primarily preferred in the pharmacological treatment of irritability in children and adolescents. There are studies in the literature which showed that clonidine is also effective in the treatment of irritability and aggression. In the cases we followed, clonidine therapy was found to decrease irritability and no treatment-induced adverse effect was observed except for only one case. As in our cases, clonidine is effective and safe in symptoms of treatment-resistant irritability and aggression in ASD.

[Abstract:0384][Schizophrenia and other psychotic disorders]

Acute psychosis followed by one dose of pseudoephedrine hydrochloride

Ozlem Akcay Ciner, Esra Yazici and Ali Savas Cilli

Department of Psychiatry, Sakarya University School of Medicine Research and Training Hospital – Psychiatry Sakarya, Sakarya, Turkey

E-mail address: ozlmakcay@gmail.com

ABSTRACT

Pseudoephedrine hydrochloride is an upper respiratory decongestant commonly used in vasomotor and allergic rhinitis and colds. It is a sympathomimetic amine and has properties similar to other stimulants amphetamine [1].

Case presentation: 24-year-old housewife, primary school graduate, married, and living with her husband and two children had no previous psychiatric story. Followed by a single dose of ibuprofen (200 mg) + pseudoephedrine hydrochloride (30 mg) orally, she started complaints in the morning such as not recognizing her children, seeing the mouse and telling them that there were people at home. When she was brought to the emergency service, her orientation was normal. She was sleepy, had difficulty in maintaining attention, and has no perception pathology. Cranial CT, haemogram, and electrolyte levels were normal. Three days after, patient re-entered with complaints such as not to sleep, self-continuous conversations about irrelevant-disconnected things, saying that she was dead in the grave, tightly closing her mouth to not eat, decrease in self-care. She phrases like "do not throw my children into the fire," mentioned that she was on tv. Sexual desire increase was also reported. After hospitalization she entered the examination room with her bare feet and spoke while her eyes were closed. She was conscious, oriented, and cooperated. She talked a bit quickly. She had difficulty concentrating, irritability, tangential speech, and persuasion and reference delusions. Perception pathology was not detected. The abstract thought was corrupted. Medical histories: no smoking, alcohol, or substance abuse. Her sister has a history of conversion disorder. Cranial Magnetic Resonance (MRI) did not reveal any cerebral pathology. Thyroid functions, vitamin levels, complete blood count, baseline biochemical values, calcium (Ca) and phosphorus (P) values, and neurological examination were normal. Psychometric evaluation was consistent with pseudoephedrine-induced psychosis. IQ 71 (Kent EGY test) was reported. Haloperidol (10 mg) and biperiden (2 mg) injection im were performed to control irritability and excitation. The patient had significant sedation in the morning observation and decided to follow up without medication. After 24 h, haloperidol 5 mg/day was administered orally and the patient was discharged with the treatment of haloperidol 5 mg after 9 days of inpatient treatment. On the 10th day after discharge, she had no psychotic symptoms. Biperiden 2 mg/day tablets were added to the treatment for EPS. Olanzapine 5 mg/day started and planned to reduce and discontinue haloperidol. There was no psychotic and EPS symptom in controls. Pseudoephedrine may cause schizophrenia-like psychosis and mania, psychotic states and visual and auditory hallucinations were also reported, especially after intravenous abuse [2]. The psycho-pathway mechanism of pseudoephedrine is thought to be the release of catecholamine, noradrenaline, and dopamine from the anterior synaptic nerve terminals, similar to amphetamines. The use of pseudoephedrine, a widely used drug, should be kept in mind when excluding general medical conditions and drug/substance use, especially in acute psychosis patients who are urgent.

KEYWORDS

Acute psychosis; drug-induced psychosis; haloperidol; olanzapine; pseudoephedrine hydrochloride

References

[1] Acute psychosis following intravenous abuse of pseudoephedrine: a casereport.

[2] Postpartum psychosis induced by bromocriptine and pseudoephedrine, Acute psychosis following intravenous abuse of pseudoephedrine: a case report.

[Abstract:0385][Mood disorders]

First manic episode in advanced age dementia: a case report

Dudu Demiröz, Ali Hakan Öztürk, Seher Serez Öztürk, Hilal Seven, İkbal İnanlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Health Sciences University, Konya, Turkey

E-mail address: drsevenhilal@hotmail.com

ABSTRACT

The onset of bipolar disorder after 50 years old is recognized as late-onset bipolar affective disorder. There are some differences between early and late-onset bipolar disorder in terms of aetiology, epidemiology, phenomenology, prognosis, comorbid diseases, and treatment. Some researchers reported that early onset is associated with poor prognosis and late onset is more associated with psychotic symptoms and may require long-term hospitalization. Comorbidity of neurologic diseases such as dementia and stroke is common in the late-onset disorder. In this case, we want to discuss a patient diagnosed with dementia who developed a manic episode at the advanced age.

Case presentation: 57-year-old female, housewife patient was diagnosed with Alzheimer's disease 3 years ago and has been had a treatment with Rivastigmine patch 10 cm/day, Memantine 20 mg/day, and Sertraline 50 mg/day. There were no further complaints except for forgetfulness and difficulties of life because of poor memory. The patient's relatives took her to our clinic because of some symptoms noticed in the last 10 days such as delusions of persecution, suspiciousness, irritability, psychomotor agitation, screaming, talkativeness, self-mutilation, harming others, insomnia, and increased appetite. The patient was immediately hospitalized for further evaluation. Mini Mental Test score was 15. Hyperintensity of some lesions was seen in periventricular and subcortical white matter in cranial MR imaging. Sertraline was immediately stopped and olanzapine 5 mg/day was added to the treatment and then increased to 10 mg/day. Anti-dementia drugs were continued. At the end of 4 weeks of inpatient treatment, symptoms of manic episode decreased. After being discharged from hospital, the patient has been euthymic without psychotic symptoms in outpatient clinic evaluations. In our case, we accepted this situation as a manic episode superimposed on dementia because of late onset, meeting the criteria of manic episode, comorbidity of dementia, and accompanying psychotic features. Akiskal considered a manic episode superimposed on dementia as Bipolar Type 6. Sertraline treatment may be confusing but the patient has never developed a manic or hypomanic episode for 3 years. It is reported that manic episode is more associated with hyperintensity in fronto-temporal regions, parietal regions, basal ganglia. In our case, hyperintensity of some lesions was seen in periventricular and subcortical white matter in Cranial MR. Elderly onset mania must evaluated comprehensively in terms of comorbid neurologic diseases. New- and late-onset manic episode must be evaluated comprehensively with a detailed history of the disease, neurologic examination, and neuroimaging.

KEYWORDS

Bipolar Type 6; dementia; late-onset manic episode; manic episode; psychotic mania

[Abstract:0388][Mental retardation]

Propranolol medication for aggressive behaviour in an adolescent with intellectual disability

Hamza Ayaydın[a], Şermin Bilgen Ulgar[b] and Sema Bozbey[b]

[a]Department of Child and Adolescent Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey; [b]Lüleburgaz State Hospital, Kırklareli, Turkey

E-mail address: semakurban85@hotmail.com

ABSTRACT
Intellectual disability (ID) is defined as a limitation in adaptation to daily life and in cognitive functions beginning before the age of 18. Accompanying aggression and self-harming behaviours are common. Aggression toward the patient himself or others is the main cause of presentation for psychiatric treatment among subjects with ID. Aggression in subjects with ID can severely impact on individuals' social adaptation and education and on the quality of life of caregivers. Various agents are used as antiaggressive drugs, including lithium, anticonvulsants, and antipsychotics, although data regarding the effectiveness of these are limited. Propranolol is a non-selective β-blocker antihypertensive agent shown in the literature to be effective in the treatment of aggression. This report describes the successful management with propranolol of aggressive and destructive behaviours in an adolescent with severe ID.
Case presentation: A 17-year-old male patient with severe ID presented to our outpatient clinic, accompanied by his parents, due to "aggressive behaviour, self-harming and hitting people around him" with little or no provocation over the previous 2 years. He had been started on haloperidol 10 mg/day, risperidone 4 mg/day, clonazepam 4 mg/day, valproic acid 1000 mg/day, carbamazepine 400 mg/day, chlorpromazine 200 mg/day, aripiprazole 30 mg/day, quetiapine 600 mg/day, methylphenidate 27 mg/day, sertraline 50 mg/day, and biperiden 6 mg/day for his existing symptoms at an external centre but had failed to benefit from treatment. Significant impairment had occurred in social adaptation since the onset of the aggression, and he had been unable to attend special education for the preceding year. Numerous scratches were present on the parents' hands and arms and bites on the patient's own hands and fingers. No evidence was found of mood disorder or psychosis that might account for his aggressive state. Most of the medication was discontinued (with gradual dose reduction) and propranolol 120 mg/day was added (with gradual incrementation and the dose divided into three) to haloperidol 10 mg/day, biperiden 6 mg/day, and chlorpromazine 200 mg/day and significant improvement was observed in the patient's symptoms in 3–4 weeks. Our patient was unable to continue his education during the period of aggression and his father was unable to go to work regularly. Propranolol is a β-adrenergic antagonist agent capable of use in various medical conditions. It has also been used in the treatment of aggression in various neuropsychiatric conditions, including schizophrenia, dementia, and ID. The effect mechanism is uncertain. However, its effects are thought to be associated with central β-adrenergic blockage, effects on the sympathetic nervous system, or serotonergic blockage. In our case, significant improvement in aggression was determined with propranolol even at a daily dose of 120 mg, and no marked side effects were observed. In conclusion, this case report was intended to increase awareness on the part of clinicians that propranolol may be effective in adolescents with ID and aggression refractory to multidrug therapy.

KEYWORDS
Intellectual disability; aggression; propranolol; adolescent; β-adrenergic blockage

[Abstract:0390][Autism]

Risperidone-induced alopecia in a child with autism spectrum disorder

Hamza Ayaydın[a], Şermin Bilgen Ulgar[a] and Sema Bozbey[b]

[a]Department of Child and Adolescent Psychiatry, School of Medicine, Harran University, Şanlıurfa, Turkey; [b]Lüleburgaz State Hospital, Kırklareli, Turkey

E-mail address: semakurban85@hotmail.com

ABSTRACT
Risperidone appears to be effective in associated behavioural problems with autism spectrum disorders (ASD), including aggression, irritability, and self-injurious behaviour. Alopecia involves the loss of some or all of the hair from the head and/or other parts of the body. Drug-induced alopecia is a side effect characterized by generalized hair loss which is reversible when the medication is discontinued. In the literature, there are cases in which antipsychotic-induced alopecia has been reported. In this report, we present a rare alopecia case with autism spectrum disorder, which developed after the onset of risperidone treatment and resolved after cessation of the medication.
Case presentation: A 4-year-old female was referred to our outpatient clinic for her aggressiveness, self-injurious behaviours, stereotypies, and hyperactivity. She was diagnosed with ASD due to her severe impairment in social–emotional reciprocity and language development and repetitive behaviours. Because of her repetitive behaviours and behavioural problems, risperidone was initiated at 0.25 mg/day and then the dose was increased to 0.75 mg/day. Four weeks after starting risperidone 0.75 mg daily, her family reported a diffuse and nonscarring hair loss and there was no hair loss complaint before risperidone use. The investigations to detect possible medical causes (complete blood count,

KEYWORDS
Risperidone; autism; child; alopecia; psychotropic

blood urea, creatinine, aspartate aminotransferase, alanine aminotransferase, free T4- and thyroid-stimulating hormone, serum iron, and ferritin) were within normal ranges and no additional dermatological disease was found that could induce alopecia. For this reason, we decided to switch to aripiprazole. During this period, there was a decrease in the alopecia and no increase in the behavioural symptoms of the patient. We report a female patient with ASD developing alopecia following risperidone use. Although it is not known how the psychotropic medicines induce this effect at a molecular level, antipsychotic medicines appear to act by inducing premature telogen or resting phase that cause hair loss. However, the use of risperidone has become widely common in treating behavioural problems associated with ASD, thus, this case report indicates that the need to monitor the possibility of alopecia precipitated by risperidone is increasingly important.

[Abstract:0391][Schizophrenia and other psychotic disorders]

Very early-onset schizophrenia with intensities at bilateral lateral ventricle posterior horns: a case report

Cansu Pınar Şen[a], Çağlar Soykan[b], Selma Tural Hesapçıoğlu[a], Mehmet Fatih Ceylan[a] and Özden Şükran Üneri[a]

[a]Department of Child and Adolescent Psychiatry, Yildirim Beyazit University, Ankara, Turkey; [b]Department of Psychiatry, Yildirim Beyazit University, Ankara, Turkey

E-mail address: ozdenuneri@yahoo.com

ABSTRACT

Schizophrenia that started before the age of 18 is defined as "early-onset schizophrenia" (EOS); if it started before the age of 13 it is called "childhood-onset or very early-onset schizophrenia" (COS). COS is rare and there are limited numbers of cases in the literature.

Case presentation: Our patient was 10-year-old, female, referred to our clinic with visual and auditory hallucinations, psychomotor agitation, and hostility. Her complaints started two years ago acutely. She has no family history of psychiatric disorders. She was referred to paediatric neurology clinic and hospitalized for further investigations. The only finding in her evaluations was T2 and flair intensities in adjacent to the bilateral lateral ventricle posterior horns in her cranial magnetic resonance imaging (MRI). She discharged from child neurology clinic with no neurological diagnosis and consulted to our child and adolescent psychiatry clinic. Reference and persecution delusions, such as her teacher do not want the patient to succeed, her friends want to harm her, strangers want to kill her, they are following her, have begun to emerge. She reported that she sees four different girls in her room for two years, they have different characters, and these girls are saying bad words to the patient. The patient was becoming anxious when she hallucinated. She had no history of adverse childhood experiences. In her mental status examination, she was conscious, orientated, and cooperated. She had difficulty in maintaining the conversation, distractibility, and inability to sustain attention. She hospitalized and risperidone was initiated and increased to 3 mg/day. Schizophrenia is a heterogeneous, multifactorial disease. Genetic and environmental factors play a role in its aetiologies. The neurodevelopmental model is the best model that describes the development of schizophrenia. Another important factor in aetiology is neuroanatomical changes. Among the most common structural brain deficits in schizophrenic adults are increased lateral ventricular volumes and reductions in hippocampus, thalamus, and frontal lobe volumes. Similar neuroanatomical changes and limbic structures are thought to play an important role in the aetiology of EOS. In COS, cortical abnormalities are more serious. Our case is a COS and she has no history of psychosis in her family. It is thought that intensities in adjacent to the bilateral lateral ventricle posterior horns in her cranial MRI may play an important role in the aetiology of COS in our case.

KEYWORDS

Childhood; early; onset; schizophrenia; very

[Abstract:0399][Anxiety disorders]

Fluoxetine-induced enuresis nocturna in a 7-year-old boy

Aslı Sürer Adanır, Perihan Turhan Gürbüz, Aybike Erdem and Esin Özatalay

Department of Child and Adolescent Psychiatry, Akdeniz University School of Medicine, Antalya, Turkey

E-mail address: perihan.turhan@hotmail.com

ABSTRACT
Selective serotonin reuptake inhibitors (SSRIs) are used as first-line treatment for anxiety disorders and depression in children and adolescents. Although SRRIs are used for the treatment of enuresis, at the same time enuresis is one of the side effects of these drugs. To our knowledge, there are only nine cases of SSRI-induced enuresis, four of them are children, in the literature. As far as we know, there are no enuresis cases induced with fluoxetine. Here, we report a case of enuresis nocturna which resolved after discontinuation of medication and started after reusing.
Case presentation: AS, a 7-year and 6-month-old boy, was referred to our outpatient unit for his anger and fears. He was diagnosed with General Anxiety Disorder (GAD) and started on 10 mg/day fluoxetine. During his 4 months follow-up, his family reported that he experienced nocturnal enuresis with the frequency of 3–4 times a week while he was taking his medicine. Due to his parents' concern, the patient did not take his medicine regularly. During these four months, they stopped giving their son his medicine four times and unknown time and reported that with cessation of the drug, his enuresis has subsided rapidly each time. Also on every occasion that fluoxetine was initiated, he developed nocturnal enuresis again. He and his family had no history of enuresis. Serotonin has an important role in bladder control with central and peripheral mechanisms. Although the mechanism of the antienuretic effect of SSRIs is enlightened, the mechanism of enuretic effect has not been elucidated. There are contradictory findings of whether this side effect is due to the central nervous system or receptors on the bladder muscles. It is reported that serotonin potentiates cholinergic neuromuscular transmission in isolated human detrusor muscle indirectly. Activation of 5HT-4 receptors modulates cholinergic/purinergic transmission in the urinary bladder. It is suggested that the enuresis occurs with the activation of neuronal 5HT-4 receptors in the detrusor muscle. In a study, it was found that patients who were treated for gastrointestinal motor disturbance with 5 HT-4 agonists (e.g. cisapride) developed micturition with increased frequency and it supports these previous findings. Therefore, SSRIs may interact with 5HT-4 receptors through serotonin reuptake blockage and this can be the same mechanism in the presence of enuresis. Researchers should consider this side effect of SSRIs as a possible cause for new-onset enuresis. Since SSRIs are increasingly prescribed in paediatric population, clinical trials are needed to evaluate the side effect of SSRIs in this respect.

KEYWORDS
Fluoxetine; SSRI; side effect; enuresis nocturna; children

[Abstract:0411][Psychopharmacology]

Atonic seizure developed during clozapine use and treated successfully by valproic acid in a patient with schizophrenia: a case report

Hamza Ayaydın[a], Şermin Bilgen Ulgar[a] and Mehmet Asoğlu[b]

[a]Department of Child and Adolescent Psychiatry, Harran University School of Medicine, Sanliurfa, Turkey; [b]Department of Psychiatry, Harran University School of Medicine, Sanliurfa, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT
Although schizophrenia is a psychiatric disorder which may disrupt the functionality of both patients and their caregivers, it may be refractory despite treatment with multiple antipsychotic therapies. Clozapine is a potent antipsychotic agent that is used in the treatment of psychotic disorders when other antipsychotic agents failed. Although clozapine use is associated with adverse effects such as sedation, hypotension, hyper-salivation, and less frequently agranulocytosis, it may also cause EEG abnormalities and epileptic seizures. Here, we discussed a woman with schizophrenia in whom atonic seizure was developed during clozapine treatment and treated successfully with valproic acid.
Case presentation: A 21-year-old woman was presented to the outpatient clinic with unhappiness, insomnia, meaningless speech, crying, and laughing without reason over 7 months. The patient had auditory–visual hallucinations, disorganized speech, and behaviour; thus, she admitted to the ward with the initial diagnosis of schizophrenia. No abnormality was detected in the biochemical test, neuroimaging studies, and neurological examination. The patient was prescribed haloperidol (20 mg/day), quetiapine (800 mg/day), and olanzapine (20 mg/day); however, no improvement was observed in complaints; thus, clozapine was started to the patient. Clozapine dose was escalated to 400 mg/day within 2 months. After a week, the patient experienced recurrent drops due to acute weakness in her legs which lasted a few minutes. No abnormal finding was detected in neurological examination, EEG, and brain MR imaging. Thus, it was considered as clozapine-related atonic

KEYWORDS
Clozapine; valproic acid; drug-induced seizures; atonic seizures; psychosis

seizures and clozapine dose was tapered. However, clozapine dose was re-escalated up to 400 mg/day due to worsening of complaints. Valproic acid (1000 mg/day) was added to the therapy for atonic seizures. Drop episodes were resolved one week after initiation of valproic acid. In addition to blockade in dopamine receptors, clozapine also affects a number of receptors including those in norepinephrine, histamine, acetylcholine, and serotonin systems. Myoclonic and atonic seizures can develop with clozapine use. This may be explained by the reversal of the inhibitory effect of GABA on 35S-*t*-butyl-bicyclophosphorothionate (35-TBPS) by clozapine. In our patient, drop attacks developed by increased clozapine dose were clinically considered as atonic seizure despite lack of epileptic discharges on EEG and dramatic response to valproic acid positively contributed treatment process and compliance in the patient. Atonic seizures should be considered in patients who experienced acute syncope or drop attacks during clozapine therapy and atonic seizures, which are a potential risk for tonic-clonic seizures, should be treated by the anticonvulsant agent such as valproic acid. Atonic seizure should be kept in mind in patients who experienced syncope or drop attacks during clozapine use, even in the absence of EEG abnormality and appropriate antiepileptic agent should be started when it is contraindicated to taper clozapine dose.

[Abstract:0413][Mood disorders]

Psychotic mania after intra-vehicle traffic accident in an adolescent patient

Cansu Pınar Şen, Mehmet Fatih Ceylan and Selma Tural Hesapçıoğlu

Department of Child and Adolescent Psychiatry, Yildirim Beyazit University, Ankara, Turkey

E-mail address: fatihceylan80@yahoo.com

ABSTRACT

Psychiatric disorders are common consequences of traumatic brain injury (TBI). Secondary manic episode after TBI rarely reported in children. Here, we report this 16-year-old patient with bipolar affective disorder following traumatic brain injury.

Case presentation: A 16-year-old male patient underwent an in-car traffic accident about a month before he apply to our clinic with the complaints of insomnia, increase in speech, aggression, irritability, increase in religious activities, seeing the devil, and scepticism which were present in the last two weeks. In brain imaging studies of the patient, he had a subarachnoid haemorrhage, lesions between corpus callosum and the two lateral ventricles. The patient was admitted to the inpatient clinic with bipolar disorder psychotic mania diagnosis. Olanzapine 10 mg/day treatment was initiated for mood swings and psychotic symptoms. Due to the continuation of the patient's complaints, olanzapine was gradually advanced to 25 mg/day and valproic acid 1250 mg/day drug treatment was added. He was discharged after 40 days with recovery. In our patient, there was a lesion between the corpus callosum and the two lateral ventricles. Existing lesions were adjacent to the limbic system, which was effective in regulating the emotional state of the brain. This may have been effective in the development of mania. It has been suggested that the primary risk factors for the rarely seen secondary mania are TBI, epilepsy, and subcortical atrophy (increased ventricular-to-brain ratio).

KEYWORDS

Adolescent; mania; paediatric bipolar disorder; TBI; traumatic brain injury

[Abstract:0414][Schizophrenia and other psychotic disorders]

Bilateral temporomandibular joint dislocation in treatment-resistant schizophrenia patient

Emine Tuğçe Akçaer[a], Görkem Karakaş Uğurlu[a], Mustafa Uğurlu[b], Semra Ulusoy Kaymak[b], Serdar Süleyman Can[a] and Ali Çayköylü[a]

[a]Department of Psychiatry, Yildirim Beyazit University, Ankara, Turkey; [b]Department of Psychiatry, Ankara Ataturk Research and Training Hospital, Ankara, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT
Extrapyramidal symptoms are common side effects of antipsychotic medications. The extrapyramidal side effects include acute dystonia, dyskinesia, Parkinsonism, and tardive dyskinesia. Dystonia-like oculogyric crisis, deviation of eyes, difficulty in speaking, and grimace of face cause sustained muscle contractions, repetitive twisting movements. The mechanism of these side effects is a blockade of dopamine receptors in basal ganglia which leads to an excess of cholinergic output in striatum. Drug-induced dystonia is a secondary dystonia. The drugs with a high potency of D2 receptor blockade are most likely to produce acute dystonic reactions. Individual susceptibility is an important risk factor for the development of acute dystonia. For example, young males who are naive to antipsychotic drugs are more susceptible to the development of acute dystonia. Because in older patients have diminished a number of dopamine D2 receptors. Oromandibular dystonia is a most common presentation of dystonia. It is a focal dystonia and can be presented like forceful contractions of face, jaw, tongue. In a severe form of oromandibular dystonia, the mechanical energy can cause bilateral temporomandibular joint dislocation.
Case presentation: A 40-year-old female patient was admitted to the psychiatry ward with auditory and visual hallucinations, delusion of persecution, complaints of suspiciousness, and decreased self care for 6 months. Because of her symptoms that were resolved after monthly paliperidone injection treatment in her last psychiatric hospitalization, she was put on treatments with paliperidone injection and lorazepam 3 mg/day. After 1 month, the second injection of paliperidone palmitate (150 mg/one month) is done. After two weeks, there was no improvement in her psychotic symptoms and 5 mg/day haloperidol treatment was added to her paliperidone palmitate injection. Within 2 days, the patient had pain in the bilateral pre-auricular region and complaints with the inability to close her mouth. Upon examination, the patient had oromandibular dystonia, rigidity in her arms, and parkinsonian symptoms. The patient's vital signs and systemic examinations were normal. Haloperidol was stopped immediately, and 5 mg biperiden intramuscular injection and diazepam 10 mg/day were given. Patient symptoms were remained, on the same day ear–nose–throat specialist consultation was arranged and bilateral anterior temporomandibular dislocation was diagnosed. After that, under local anaesthesia dislocation was reduced. Then patient treatment was changed with clozapine treatment. Extrapyramidal system side effects and psychotic symptoms of patient were resolved. TMJ dislocation is rare side effects of antipsychotic medication but it produces serious functional disability and considerable fear for patients and caregivers. Clinicians should be aware of this complication for comprehensive treatment of patients.

KEYWORDS
Acute; dystonia; treatment resistant; temporomandibular joint dislocation; schizophrenia

[Abstract:0416][ADHD]

Suicide attempt after atomoxetine use in a patient with autism

Özlem Doğan and Özlem Özcan

Department of Child and Adolescent Psychiatry, Inonu UniversitySchool of Medicine, Malatya, Turkey

E-mail address: ozlemdogan444@hotmail.com

ABSTRACT
Studies which examine the frequency of ASD and ADHD comorbidity have found ADHD comorbidity in 28–83% of ASDs. In the ASD group, ATX has been reported to have moderate effects in decreasing ADHD symptoms, decrease irritability, stereotype, and social withdrawal; it has also been reported to have tolerable side effects, cause more progress in the long-term use, and have decreased adverse effects in time. Risk of suicidality with ATX has been reported in Europe since 2004 and in America since 2005. There is a warning label of suicide risk in the U.S.A. for Strattera. In the literature, studies conducted with suicidal risk and self-harm in typically developing, it has been associated with increases in suicidal risk, and comorbid situations such as depression and antisocial behaviour. In individuals with neurodevelopmental disorder, ADHD is more frequent when compared with typically developing. Although there is a wide literature on the efficacy of ATX on typically developing children and adolescents, there are few studies on individuals with neurodevelopmental disorder.
Case presentation: A 12-year-old male patient had been followed since he was 2 years old with a diagnosis of autism and diagnosis of ADHD for 6 years old. For his irritability, treatment was initiated with risperidone and haloperidol. Since these drugs caused increases in cholesterol and triglyceride, the drugs were discontinued. Later, olanzapine 5 mg was used in case of need; however, due to elevated liver enzymes in liver function tests, it was discontinued. When the patient was referred again with complaints of taking off clothes, banging doors, and extreme irritability, he was started aripiprazole 5 mg/g; due to the continuation of irritability and burst

KEYWORDS
ADHD; atomoxetine; autism; self-mutilation; suicide attempt.

of anger in follow-ups, aripiprazole dose was increased to 10 mg/g gradually, risperidone 1.5 mg/g was added, atomoxetine 50 mg/g was added for the ADHD treatment. In this period, the parents were divorced and the patient's mother moved. During this period, there was an increase in bursts of anger, self-destructive behaviours, attempts for self-destruction with a knife, and upon his attempt to throw himself out from the window. He was treated in the paediatric psychiatry service. Strattera was cut down on and completely discontinued; in follow-ups decrease was observed in his self-destructive behaviours; however, his bursts of anger were continuing. In the follow-ups, a partial decrease in bursts of rage continued and no self-destructive behaviour was observed. As far as we know, this case is the only autism case reported in the literature that started to have suicidal and self-destructive behaviours after atomoxetine. The patient's self-destructive behaviours and suicidal thoughts started after Strattera and decreased after the drug was stopped; however, this situation can also be associated with the presence of domestic stressor, depression which may have developed with stress in the autistic patient caused by changes in routines due to moving or previous comorbid behaviour problems of the patient. We think that the close follow-up of self-mutilative and suicidal considerations in ASD patients with atomoxetine use as authors and the work to be done in this regard will have beneficial results.

[Abstract:0417][Motor disorders]

Late diagnosis and complicated clinical appearance: frontotemporal dementia

Görkem Karakaş Uğurlu[a], Emine Tuğçe Akçaer[a], Serdar Süleyman Can[a], Semra Ulusoy Kaymak[b], Tahir Kurtuluş Yoldaş[c] and Ali Çayköylü[a]

[a]School of Medicine, Department of Psychiatry, Yıldırım Beyazıt University, Ankara, Turkey; [b]Atatürk Research and Training Hospital, Department of Psychiatry, Ankara, Turkey; [c]Ankara Research and Training Hospital, Department of Neurology, Ankara, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT

Frontotemporal dementia is a clinically heterogeneous syndrome which is characterized by atrophy in the frontal lobe and temporal lobe of the brain with sparing the occipital lobe and parietal lobe. It has three different clinical subtypes; behavioural variant frontotemporal dementia is clinically presented with marked behavioural changes such as dis-inhibition, apathy, semantic dementia is characterized by progressive loss of knowledge about words and objects and progressive non-fluent aphasia is clinically characterized by loss of grammar and speech production errors which is known apraxia of the speech. Also, frontotemporal lobar degeneration is frequently associated with movement and neuromuscular disorder.

Case presentation: 42-year-old female patient without previous psychiatric history, 4 years before. In 2013 she began to show symptoms of personality changes and uninhibited behaviour such as impulsivity, irritability, lack of interest in the daily activities, and verbal aggressiveness to her family. In 2015 due to worsening of her symptoms, she had several administrations to the emergency department. But she did not undergo any psychiatric consultation. One year before, she became disengaged from her prior activities like home jobs. Because of her physical and verbal aggressiveness to her children, her children were placed to orphan's home by social workers. One month before, in July 2017, the loss of balance, dysarthria and gait abnormality, poor self-care (she did not care about her personal hygiene and she wore clothing), and loss of weight (88 Lbs in 2 months) were added to her prior symptoms. After these symptoms, she admitted to our emergency department and consulted to neurology and psychiatry departments. Computerized tomography of the patient showed diffuse frontal and temporal atrophy. Other neurological and laboratory examination excluded any cerebrovascular disease or encephalitis. Her psychiatric examination was difficult because of dysarthria. But the patient had irritability and psychomotor agitation. Neurological examination revealed that dysarthria, protrusion of lips, abnormal involuntary perioral movements, bilateral dystonia in her arms and chorea-like movements in her arms and her left legs, saccadic suppression, general bradykinesia, ataxia in trunk and extremities. In the left temporal lobe, high-voltage, fast rhythmic activity was recorded in her electroencephalography record. Her MRI of the brain showed diffuse atrophy of frontal lobe and temporal lobe. Because of her weight loss (88 Lbs for 2 months) in a short period of time, several malignancies were excluded by laboratory examination, mammography, endoscopy, colonoscopy, and ultrasonography. Vasculitis, acanthocytosis, and Huntington disorder (by genetic tests) were also excluded. This syndrome was defined as corticobasal syndrome with frontotemporal lobar degeneration and the patient was put on treatment with olanzapine 10 mg/day. There is a need for a multidisciplinary approach for the patients diagnosed with frontotemporal lobar degeneration. Frontotemporal dementia is difficult to recognize because the symptoms associated with FTD are seen as a result of natural ageing, memory problems are not clearly evident and it is early onset compared to

KEYWORDS

Frontotemporal dementia; corticobasal symptoms; treatment resistant; psychotic; dysarthria

other dementias. For this reason, as in this case, the diagnosis is delayed and the symptoms become complicated. Health professionals should remember the diagnosis of FTD in patients over 40 years of age with behavioural and personality changes.

[Abstract:0418][Schizophrenia and other psychotic disorders]

Riluzole augmentation in treatment-resistant schizoaffective disorder with comorbid obsessive-compulsive disorder: a case study

Mustafa Tolga Tunagür[a], Nuran Bilgen[b] and Vesile Altınyazar[b]

[a]Department of Child and Adolescent Psychiatry, Adnan Menderes University, Aydın, Turkey; [b]Department of Psychiatry, Adnan Menderes University, Aydın, Turkey

E-mail address: mustafatolgatunagur@gmail.com

ABSTRACT

The negative symptoms are resistant to current antipsychotic treatments and affect the quality of life and functioning in patients with schizophrenia spectrum disorders. There are several new studies focusing on glutamate modulation in order to relieve these resistant symptoms. As a glutamatergic modulator, riluzole is a promising candidate for the treatment of neurodegenerative and psychiatric disorders. We report a case of riluzole augmentation in treatment-resistant schizoaffective (CAD) with comorbid obsessive-compulsive disorder (OCD). **Case presentation**: A 28-year-old male with CAD diagnosed 5 years ago. He had alcohol and substance (cannabis, ecstasy) abuse history before CAD began and also his three relatives were suffered from schizophrenia. He was admitted to our clinic with auditory and visual hallucinogenic experiences, paranoid and bizarre delusions, poor thought content, lack of insight, increased libido, aggression, irritability, insomnia, and grandiosity. He had a blunted affected and reported auditory and visual hallucinations in the form of being called by a girl he saw on the wall. His paranoid delusions were to be poisoned by some people. There were obsessions related to contamination and compulsions in the form of frequent and longtime hand washing, cleaning, and bathing for a long time. His diagnose was changed from schizophrenia to CAD because of recurrent mood episodes (depressive and manic) and continuing psychotic symptoms beyond mood episodes in history. A diagnosis of OCD fulfilling all criteria was also relevant apart from schizophrenia. His physical examination and laboratory tests (including magnetic resonance imaging of the brain and electroencephalogram) were normal. In history, he has no response to several antipsychotic treatments including risperidone, olanzapine, haloperidol, flupentixol, and quetiapine. A partial clinical response was received to clozapine and amisulpride combination and 21-time electroconvulsive therapy but he discontinued his medication after being discharged and developed similar symptoms. The patient was incompatible with all treatments, including depot medications. Riluzole was initiated and maintained at a dose of 50 mg twice a day in addition to the current treatment (clozapine, risperidone, and lithium). The scores of the Scale for the Assessment of Positive Symptoms (SAPS) and Negative Symptoms (SANS) decreased from 34 to 3, 52 to 0, respectively, after one month. Significant reductions in obsessive and manic symptoms were also observed. During his 6-month follow-up, his compliance with medication improved considerably and his well-being maintained. Moderately elevated liver enzyme levels from the side effects seen with riluzole were also occurred in our case and returned to normal levels within 2 weeks. In our case, the prominent improvement was observed with riluzole augmentation in negative, positive, manic, and obsessive-compulsive symptoms, which were resistant to other pharmacotherapies. Riluzole may be a safe and effective medication for the treatment of both negative-positive and mood symptoms in patients with chronic psychosis. These findings should be further examined in patients with CAD and schizophrenia.

KEYWORDS

Mania; obsessive-compulsive disorder; riluzole; schizoaffective disorder; schizophrenia

[Abstract:0419][Schizophrenia and other psychotic disorders]

A case of psychosis developed after a pontine ischemia

Mustafa Tolga Tunagür[a], Muhammed Mutlu Özbek[a], Çağdaş Öykü Memiş[b], Bilge Doğan[b] and Levent Sevinçok[b]

[a]Department of Child and Adolescent Psychiatry, Adnan Menderes University, Aydın, Turkey; [b]Department of Psychiatry, Adnan Menderes University, Aydın, Turkey

E-mail address: mustafatolgatunagur@gmail.com

ABSTRACT
Hallucinations and delusions are most prominent symptoms of psychosis. Mood and anxiety disorders, apathy, less often psychosis are seen after a stroke. Especially after lesions on the right temporoparietal and temporoparietooccipital complexes, and subcortical deep structures, psychosis have been reported. Here, we report a case of acute psychosis with auditory hallucinations and paranoid delusions which started after an ischemic pontine lesion. **Case presentation**: A 66-year-old female patient in the post-stroke period was admitted to our clinic because of a suicide attempt. She reported that some auditory hallucinations emerged two months after the stroke, and she attempted to suicide to get rid of these voices. The patient had no previous history of any psychiatric disorder, or suicidal behaviour. Her physical examination was normal. The neurological examination revealed a mild weakness (4/5) on the right arm and leg with a psychomotor retardation. She also had a depressive mood. She reported auditory hallucinations in the form of voices belonging to two persons who commanded, commented, insulted, and swearing. She said that they would hurt herself and her children. She had paranoid delusions to be followed by these people and to be killed by them. Her rutin blood examination, chest x-ray, and electrocardiogram were normal. Risperidone was initiated at 1 mg/day and increased to 3 mg/day. We also administrated 50–100 mg/day of sertraline for her depression. The scores of the Scale for the Assessment of Positive Symptoms (SAPS) and Negative Symptoms (SANS) decreased from 40 to 8 and from 22 to 0, respectively. Three months later, she was admitted to our clinic second time because of the increased auditory hallucinations. Risperidone was discontinued and haloperidol was started at 0.5 mg/day, and increased to 5 mg/day. The frequency and intensity of the voices declined in the second week, and totally disappeared in the fourth week. Although depression, anxiety, and mania were frequently reported after a stroke, acute psychotic episodes are very rare in the literature. Different psychotic states are seen according to the location of the lesions, but temporoparietooccipital lesions have a higher risk of developing psychosis. There are previous case reports of psychosis and auditory hallucinations after pontine lesions. Acute psychosis cases characterized by paranoid delusions, visual, auditory, tactile hallucinations associated with central pontin myelinosis were also reported. The relationship between the lesion characteristics and psychosis remains unclear. We suggested that the pontine infarction in our patient was related to the development of acute psychosis. Rostral brainstem dopaminergic and cholinergic neurons and mesopontine projections may be involved in the development of psychosis. In conclusion, a better understanding of the psychiatric symptoms associated with focal lesions in the central nervous system may provide important clues in understanding the organic causes of psychiatric disorders.

KEYWORDS
Auditory hallucination; ischemia; paranoid delusions; pontine; psychosis

[Abstract:0420][Psychopharmacology]

Acute idiosyncratic fluoxetine-induced liver injury

Görkem Karakaş Uğurlu[a], Fatma Şahin[a], Emine Tuğçe Akçaer[a], Semra Ulusoy Kaymak[b] and Ali Çayköylü[a]

[a]Department of Psychiatry, Yıldırım Beyazıt University School of Medicine, Ankara, Turkey; [b]Atatürk Research and Training Hospital, Department of Psychiatry, Ankara, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT
Antidepressants are usually used in the management of depression, anxiety disorders, and other psychiatric illnesses. Antidepressants used at therapeutic dose intervals cause various adverse drug reactions such as hepatotoxicity. Although information on antidepressant-induced liver injury is rare, 0.5–23% of patients treated with antidepressants may develop asymptomatic elevation of serum aminotransferase levels. Fluoxetine, fluvoxamine, citalopram, paroxetine, mirtazapine, and venlafaxine are associated with reversible liver injury upon ceasing of the agent. Fluoxetine is an antidepressant, one of the first of the class of selective serotonin reuptake inhibitors (SSRIs) introduced into clinical use. Liver test abnormality has rarely been reported in patients using fluoxetine (less than 1%), and elevations are usually modest and usually does not require dose changes or cutting. It was found that 0.5% of the aminotransferase value of patients treated with fluoxetine was three times more than the normal value. Here, we describe a patient with elevated liver function test after fluoxetine treatment.
Case presentation: A 49-year-old female patient was presented with depressed mood, anhedonia, feelings of guilt, suicidal thought, insomnia, and diminished appetite. Hamilton Depression Rating Scale (HDRS) score was 27. The patient was diagnosed with major depressive disorder and put on treatment with sertraline 50 mg/day. Patient's depressive

KEYWORDS
Fluoxetine; side effects; hepatic injury; acute; antidepressants

symptoms remained after 4 weeks with 50 mg/day treatment (HDRS was changed from 27 to 24). Sertraline treatment was stopped after that fluoxetine treatment was started for depressive symptoms. The patient developed marked liver enzyme elevations four days after starting fluoxetine (20 mg daily). She had no history of liver disease or asymptomatic elevation of a marked liver enzyme before fluoxetine treatment. At the beginning of fluoxetine treatment, her liver function tests were in the normal range (AST: 25 U/L, ALT: 28 U/L, ALP: 121 U/L, GGT: 104 U/L). There was no pathological finding in his physical examination. Laboratory testing showed modest elevations in serum aminotransferase levels (ALT: 220 U/L; AST: 104 U/L), alkaline phosphatase (227 U/L) and gamma-glutamyl transpeptidase levels (611 U/L). Tests for hepatitis A, B, and C, EBV, HSV were negative as were autoantibodies. Abdominal ultrasound, MRCP showed no evidence of biliary obstruction or any other pathology. Fluoxetine was stopped, and liver function tests began to improve quickly. In the following 29 days, laboratory tests were normal except for GGT. There are studies which showed fluoxetine-related hepatic injury but in this case, the liver function tests elevations were reported just few days after fluoxetine treatment had started. Although SSRIs are some of the most commonly used prescription medications worldwide, reports of clinically apparent hepatic injury during their use are not common. When patients develop clinically apparent liver injury from an SSRI, there is not enough information whether another member of this group can be substituted for the treatment. Because of these reasons, along with careful monitoring of liver function, it is perhaps prudent if the use of SSRI treatment is considered necessary for the antidepressant therapy.

[Abstract:0425][Schizophrenia and other psychotic disorders]

A rare case report of folie impossée

Aslıhan Okan İbiloğlu and Abdullah Atli

Department of Psychiatry, Dicle University School of Medicine, Diyarbakir, Turkey

E-mail address: aslihanokan@gmail.com

ABSTRACT

In the literature, shared psychotic disorder has also been referred to as folie à deux, shared imposed psychosis and infectious insanity. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), shared psychotic disorder was removed, as a separate disease entity and was included in the section on other specified schizophrenic spectrum disorders. According to the DSM-5, in the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder. There are four types of folie a deux: (1) Folie impose'e; (2) folic simultane'e; (3) folie communique'e; and (4) folie induite. Folie impose'e is the most common form of folie a deux, in which the primary case is typically dominant and forceful. The secondary case is usually dependent and highly suggestible. Other risk factors include female gender, mental retardation, suggestibility, passivity passive personality traits, histrionic personality traits, and suspiciousness, in the secondary patient. We report here, a case of folie à deux in a married couple, in which the delusions in the husband, the primary person, were caused by Behçet's disease. In our example of organic psychotic disorder leading to shared psychosis, the wife adopted her husband's delusions through folie impossée, a category of folie à deux that occurs when the secondary person is otherwise mentally sound.

Case presentation: The patient is female, 33-year-old, married, a housewife, lives with her husband. According to her sister, primary care doctor referred the patient to our psychiatry department for acute psychosis. As a result, our patient was forcefully brought to the hospital by her sisters. Her husband also came with his wife, and not leaving each other's side, even for a minute, in the mental status examination. At the time of mental status examination, our patient was very agitated, uncooperative, and unkempt. The patient had no past psychiatric, medical, or surgical disorders. There was no family history of any psychiatric or medical disorders. The patient refused to take any medication and left secretly from the hospital with her husband. The delusions of a person with psychosis are transferred to a healthy person who is mentally sound. Generally, both cases are intimately associated, also delusions of the recipient dissolved after the separation. The mental status examination of affected persons would be significant for the delusional thinking, lack of insight, poor attention or concentration. Many studies of separate cases have shown that delusional ideas are rarely transmitted to a healthy subject from their partner. On the other hand, a person with passive personality traits may have a genetic predisposition to psychotic disorder and, as a result, may develop this disorder.

KEYWORDS

Shared psychotic disorder; delusional disorder; folie impossée; folie a deux; rare case report

[Abstract:0427][Anxiety disorders]

Anxiety disorders accompanying eating refusal: case report

Ebru Ulu, Esra Demirci and Sevgi Özmen

Department of Child and Adolescent Psychiatry, Erciyes University School of Medicine, Kayseri, Turkey

E-mail address: dr.yaman91@gmail.com

ABSTRACT

It is reported that 15–35% of young children have nutritional problems. Nutritional disorders are biopsychosocial problems arising from physiological, psychological, and social factors. Sociodemographic characteristics of the parents, psychiatric disorders and symptoms in the child and parent, characteristics of the child's mood, mother–child interaction and attachment are frequently evaluated in the researches on aetiology of these disorders. The underlying pathology in some of the patients who refuse to eat may be due to the child's anxiety disorder. Anxiety disorders are common psychopathologies of childhood. Children can present with a variety of symptoms or behaviours that may signify an anxiety disorder: avoidance, somatic symptoms, sleep problems, poor school performance, explosiveness, and eating problems.

Case presentation: A 5-year-old male patient was brought by his parents with complaints of sister jealousy and eating refusal to the policlinic. He was generally an anxious child. Even though his brother was jealous, his parents did not worry even the simple things he worried about her. He always warns his parents about the possibility of harm to her. He reported that he had vomited due to an infection two months ago. After that day, every meal time will be spent worrying about taking food out of the mouth, eating food, and avoiding the fear of vomiting has begun. About two months ago, the patient's grandfather was sick and was taken to the hospital and died after the heart attack. After this, he began to worry that he would die if he vomited. Moreover, it was learned that the patient had social phobic features such as anxiety in friend's relations, limited participation in class activities. When the patient started his kindergarten this year, he experienced about one week of separation and the situation improved with the attitude of the family. He was also often worried that his parents would get sick. His psychiatric examination showed that he developed an age appropriate, his general mood was anxious. The resume did not have a feature in the family history. From the results of the examinations and evaluations, the patients were evaluated as comorbid anxiety disorders accompanying eating refusal. Five-milligram fluoxetine treatment was started and recommendations were given to the family. Posttraumatic feeding disorder (PTFD), emetophobia, anxiety disorders, and attachment disorders should be considered in the differential diagnosis of patients who refuse to eat in childhood. PTFD is characterized by food refusal after traumatic events to oropharynx or esophagus. Emetophobia is also called nausea and vomiting phobia or specific vomiting phobia. In attachment disorders, the child cannot become individualized and may turn the perception of personal inadequacy into wrong attitudes about eating behaviour. In this case, anxiety-related eating rejection was accompanied by social phobia and separation and other anxiety findings. In this case report, psychiatric emotional care and detailed interview with the patient resulted in a differential diagnosis of eating rejection. Although the case is different from the others, we can see various anxiety disorders together at the same time although the patient is 5 years old.

KEYWORDS

Anxiety; eating; rejection; social; phobia

[Abstract:0428][Psychopharmacology]

Clozapine-induced retrograde ejaculation: a case report

Abdullah Bolu, Abdullah Akgün, Taner Öznur and Cemil Çelik

Gulhane School of Medicine, Department of Psychiatry, Health Sciences University, Ankara, Turkey

E-mail address: akgun_61@live.com

ABSTRACT

Retrograde ejaculation (RE) associated with antipsychotic use has been reported in the literature. However, RE due to the use of clozapine is very rare. In the following case, clozapine-induced RE will be reported.

Case presentation: Mr M., 31-year-old, single patient. The patient has been following up and treating with a diagnosis of schizophrenia for about 5 years. Admission to the clinic has been made due to the somatic delusions, grandiose delusions, and persecution delusions that develop on the deterioration of medication compatibility. It is understood that olanzapine treatment was given at the first episode, medication partial benefit was reported, but the drug compliance deteriorated after a while from the discharge. It was understood that the patient was not able to gain insight into the disease chart, and the drug compatibility was poor. In the

KEYWORDS

Case; clozapine; ejaculation; induced; retrograde

last admission, the patient was treated with clozapine 25 mg/day and the dose was gradually increased. Weekly CBC was followed, no abnormality was detected. On the 20th day of hospitalization, clozapine dosage was increased to 200 mg/day. The patient did not report any complaints other than fatigue until he reached this dosage, and the patient began to describe the urological problems 3 days after the 200 mg/day dosage. The blood prolactin level was within normal limits. The patient could not give sperm for the examination, but sperm was seen in the urine sample after orgasm. No pathology was detected in the patient's urinary system. It was evaluated that the symptoms described by the patient were compatible with RE. In a patient who had never had such a symptom before, RE could be developed due to the use of clozapine. Because the patient was seriously disturbed by the present symptoms and lack of insight into his/her illness, treatment with clozapine treatment should be gradually reduced and replaced with paliperidone. Clozapine dose was reduced to 150 mg/day, paliperidone oral 6 mg/day treatment was added. After 4 days, clozapine was reduced to 100 mg/day and paliperidone was increased to 9 mg/day. During the follow-up period, the symptoms of the patient disappeared, and it was learned that sperm started to come after orgasm. RE associated with atypical antipsychotic use is less reported than RE with typical antipsychotic use. In particular, RE cases associated with risperidone are frequently encountered in the literature. However, the number of REs due to clozapine is very limited. Sometimes in psychiatric practice, patients' urological complaints can be a part of their delusions, but sometimes they can be a realistic complaint. With this case, we aimed to warn physicians about the RE side effect of clozapine.

[Abstract:0436][Psychopharmacology]

A case with Asperger's disorder and comorbid schizophrenia responded to clozapine

Ümit Haluk Yeşilkaya, Ozge Sahmelikoglu Onur and Omer Akay

Department of Psychiatry, Bakirkoy Prof. Mazhar Osman Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Istanbul, Turkey

E-mail address: halukyesilkaya@gmail.com

ABSTRACT

It is suggested that the frequency of schizophrenia and other psychotic disorders is high in cases with Asperger's disorder (AD) and in their families. On the other hand, information regarding management of schizophrenia in cases with AD is limited. In this presentation, a 21-year-old case with AD and comorbid schizophrenia is reported. Her psychotic symptoms did not respond to sodium valproate, risperidone, melatonin, quetiapine, olanzapine, lamotrigine, aripiprazole, and clomipramine.

Case presentation: A 21-year-old female, with a history of AD and has been using haloperidol 15 mg/day biperiden 4 mg/day, oxcarbazepine 300 mg/day, chlorpromazine 600 mg/day for 4 months, had symptoms of irritability, compulsions of checking, increased amount of speech, and agitation. These symptoms had begun 2 weeks ago. She had been diagnosed with AD 11 years ago, hospitalized for seven times since then and advised to take sodium valproate, risperidone, melatonin, quetiapine, olanzapine, lamotrigine, aripiprazole, and clomipramine. Her lab work-up was unremarkable, including urine toxicology. In her psychiatric examination, puerile attitude, perseveration, compulsions of checking, and auditory hallucinations were noted. The patient met DSM-5 criteria for schizophrenia and AD was followed by treatment including haloperidol 20 mg/day, biperiden 10 mg/day, and chlorpromazine 400 mg/day. Despite seven sessions of ECT, the symptoms of the patient continued. The treatment was changed to clozapine 25 mg/day and the dose was gradually increased to 125 mg/day. Within 10 days, her symptoms were totally improved and she was discharged from the hospital with the treatment of clozapine 125 mg/day. Based on this case, it might be suggested that patient's genetic analysis should be assessed cautiously, especially there is a history of blood relationship between parents. Increased awareness might be essential to identify DiGeorge Syndrome as a differential diagnosis of psychotic symptoms with bipolar disorder clinic presentation.

KEYWORDS

Asperger; clozapine; comorbid; responded; schizophrenia

[Abstract:0439][OCD]

Psychosurgery-indicated treatment-refractory obsessive-compulsive disorder: an overview through a case illustration

Yasin Hasan Balcioglu and Fatih Oncu

Bakirkoy Prof. Mazhar Osman Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Forensic Psychiatry Unit, Istanbul, Turkey

E-mail address: yhasanbalcioglu@gmail.com

ABSTRACT

Symptom trajectories and clinical courses of obsessive-compulsive disorder (OCD) highly vary. The continuous and waxed pattern of the disorder leads substantially diminished the quality of life and increased caregiver burden. Therefore, a prompt and influential approach to the management of OCD is crucial. Treatment algorithms are well defined for the disorder; however, OCD is one of the most challenging psychiatric entities to treat. The combination of psychopharmaceuticals and psychotherapies is the gold standard intervention; nevertheless, sufficient improvement in OCD could not be achieved in a considerable number of patients despite a conventional approach is employed. Treatment-resistant and treatment-refractory OCD are the terms commonly used for the patients with a severe prognosis and inadequate response to the OCD treatment. Such patients are considered as candidates for more invasive alternatives such as electroconvulsive therapy (ECT), transcranial magnetic resonance, deep brain stimulation (DBS), and conventional psychosurgery. This case illustration presents a treatment-refractory OCD patient who was indicated psychosurgical intervention as a last resort.

Case presentation: Our patient was a 42-year-old man and admitted to our outpatient clinic with a compulsory treatment order following an arson. He had a 14-year history of OCD that had documented treatment-refractory. After first being diagnosed with OCD, multiple regimens of serotonin reuptake inhibitors such as paroxetine, fluoxetine, and clomipramine had been tried over 7 years. Treatment did not succeed any visible improvement over years; moreover, the symptoms had worsened. His functionality had rapidly deteriorated. Risperidone, haloperidol, and cognitive behavioural therapy were introduced as augmentation. Nonetheless, hospitalization was required three years ago and nine sessions of ECT were administered with the diagnosis of treatment-refractory OCD. However, the symptoms were yet to be improved. The patient was offered a referral to neurosurgery for psychosurgery; however, he did not consent to undergo the surgery and was discharged with an SSRI combined antipsychotic medication. In his current psychiatric interview, obsessions and compulsions still existed with a slight improvement of functionality. He was hospitalized and planned a referral for psychosurgery again. The serious hazards of unresponsiveness to standard therapies in OCD include severe ongoing loss of psychosocial and occupational functioning and the significant risk of suicide. Invasive techniques are well known for pharmacological non-responsiveness of OCD for long years. Psychosurgical approaches aim to utilize specific neuroanatomical structures on which have strong scientific arguments regarding their associations with the severe prognosis of OCD. The cortico-striato-pallido-thalamo-cortical loop, the circuit of Papez, and the basolateral circuit are the three main neural circuitries which are recognized as having roles in the pathogenesis of OCD; therefore, invasive interventions target the structures of these networks. As far as the regarding literature suggests, because of the unfavourable outcomes of the conventional surgery, DBS has generated new interest as a non-destructive and reversible neuromodulatory technique. Invasive techniques should be employed reasonably and immediately in the presence of an unresponsiveness to standard therapies as an adjunct to, rather than a substitution of, pharmacological and psychological strategies.

KEYWORDS

Anterior cingulate cortex; capsula interna; obsessive-compulsive disorder; psychosurgery; treatment-refractory

[Abstract:0443][Psychopharmacology]

Mydriasis associated with atomoxetine treatment

Çiğdem Toklu Yalvaç[a], Ümit Işık[a] and Erol Erkan[b]

[a]Department of Child and Adolescent Psychiatry, Yozgat City Hospital, Yozgat, Turkey; [b]Department of Ophthalmology, Yozgat City Hospital, Yozgat, Turkey

E-mail address: crsumt@gmail.com

ABSTRACT

Atomoxetine is the first non-stimulant medication for the treatment of attention-deficit/hyperactivity disorder (ADHD). Atomoxetine is generally safe and well tolerated for the treatment of ADHD in the paediatric population. Headaches, upper abdominal pain, decreased appetite, vomiting, nausea, irritability, dizziness, and somnolence are among the most common side effects. In addition to these common side effects, it has been reported that the use of atomoxetine can be associated with an increased risk of mydriasis (Alhatem and Decker 2008; Bahali et al. 2014). Herein, we report a case of mydriasis associated with atomoxetine in a child with ADHD and dyslexia.

KEYWORDS

ADHD; Atomoxetine; Dyslexia; Mydriasis; Side Effect

Case presentation: A 13-year-old boy, who had no significant medical history, presented with ADHD and dyslexia. The patient was started on 25 mg of atomoxetine orally once daily for 7 days. The dose was then increased gradually to 60 mg orally once daily. After three weeks of atomoxetine treatment pupil dilatation was noticed by him and his mother. The patient denied any blurred vision, headaches, nausea, vomiting, or pain in his eyes. The patient was notified about his dilated pupils as being a possible side effect of atomoxetine. The patient was consulted to the ophthalmology department two days after atomoxetine cessation for differential diagnosis and detecting possible effects of atomoxetine on visual functions. In his ophthalmologic examination, his visual acuity was 20/20 in both eyes without any correction. Direct and indirect light reflexes were normal. His intraocular pressures were both within the normal range. Other than mydriasis in his both eyes biomicroscopic and fundus examination revealed normal signs bilaterally. Pupil sizes were measured using a millimeter ruler while the patient was fixating on a distant, non-accommodative target. Under scotopic, mesopic, and photopic conditions, his pupil sizes of his right and left eye were 8.1 mm and 8.2 mm; 6.6 mm and 7 mm; 3 mm and 3.8 mm, respectively. Atomoxetine was stopped, and mydriasis resolved within five days. Atomoxetine is a highly selective and potent inhibitor of the presynaptic noradrenaline transporter, acting both centrally and peripherally. Atomoxetine increases both norepinephrine (NE) and dopamine (DA) levels, especially in the prefrontal cortex. Atomoxetine also increases the effect of norepinephrine in various regions (Dadashova and Silverstone 2012). Mydriasis results when stimulation of the sympathetic nerves excites the radial fibres of the iris causing dilation of the pupils. An increase in NE caused by NE reuptake transporter inhibition has been shown to induce mydriasis in healthy volunteers. It is possible that atomoxetine may induce mydriasis via indirect a-1 adrenoceptor activation, mediated in turn via NE reuptake inhibitor effects (Dadashova and Silverstone 2012; Yu and Koss 2003). The clinical importance of mydriasis in patients using atomoxetine increases in the presence of shallow anterior chamber or angle abnormalities predisposing to acute angle closure. Acute angle closure glaucoma is an ophthalmic emergency and can cause blindness if left untreated. Although it is uncommon, clinicians should be aware of the possibility of atomoxetine-induced acute angle closure due to devastating outcomes.

[Abstract:0451][Autism]

High-functioning autism or Asperger's disorder follow-up period: detailed retrospective evaluation and novel status determination of a case and prospective guidance

Mehmet Hamdi Örüm[a], Tezan Bildik[b], Mahmut Zabit Kara[c], Helin Yılmaz[b], Hasan Akın Tahıllıoğlu[b] and Aysun Kalenderoğlu[a]

[a]Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey; [b]Department of Child and Adolescent Psychiatry, Ege University School of Medicine, Izmir, Turkey; [c]Department of Child and Adolescent Psychiatry, Adiyaman Research and Training Hospital, Adiyaman, Turkey

E-mail address: mhorum@hotmail.com

ABSTRACT

The main characteristic of high-functioning autism or Asperger's disorder (HFA/AD) is severe and sustained impairment in social interaction as well as the development of restricted, repetitive patterns of behaviour, interests, and activities. Pharmacotherapy helps to alleviate some symptoms and signs of autism and autistic spectrum disorders. However, the main problem with these patients is the incompatibility of the drug with various reasons.

Case presentation: In this article, a case with the diagnosis of HFA/AD followed in the same clinic for more than 10 years had been transferred. The files are being examined retrospectively, discussing the difficulties encountered during the diagnosis in the presence of varying symptoms during the follow-up, and presenting results from 12-weeks prospective follow-up in the context of various tests. When the retrospective and prospective follow-up of the patient is observed, antidepressant treatment was effective in our patient with the additional diagnosis of major depression and anxiety disorder, and antipsychotic use was found to be effective in relieving psychotic symptoms. The therapeutic relationship established with the patient was thought to have contributed significantly to treatment compliance. It was emphasized that solving the parental problem of resistance to treatment increased the functioning of the patient. It should not be forgotten that in the monitoring process, additional mental illnesses may occur, especially during adolescence, and that early recognition and treatment of these disorders is important in improving the patient's social cohesion and functioning.

KEYWORDS

Asperger disorder; adolescent; high functioning autism; psychopathology; scale

[Abstract:0452][Schizophrenia and other psychotic disorders]

Hyponatremia associated with repeated use of sodium valproate

Mehmet Hamdi Örüm[a], Aysun Kalenderoğlu[a], Oğuzhan Bekir Eğilmez[a], Murat Eren Özen[b] and Yaşar Kapıcı[a]

[a]Department of Psychiatry, Adiyaman University School of Medicine, Adiyaman, Turkey; [b]Psychiatry Clinic, Private Adana Hospital, Adana, Turkey

E-mail address: mhorum@hotmail.com

ABSTRACT

Sodium valproate is one of the medications used in the treatment of schizoaffective disorder, bipolar disorder, and epilepsy. Tremor, drowsiness, Reye-like syndrome, hepatic failure, thrombocytopenia, and pancreatitis are the most frequent side effects of this medication. Hyponatremia is another serious side effect which has also been previously associated with the use of carbamazepine, oxcarbazepine, clozapine, and selective serotonin reuptake inhibitors (SSRIs). Here, we report the case of a patient with hyponatremia associated with sodium valproate.

Case presentation: Mr Y. was 30 years old. He was being followed-up at a psychiatry outpatient clinic for 10 years, with a diagnosis of schizophrenia. He was using 6 mg/day of risperidone for 3 years. His psychotic symptoms were not taken under control with this treatment, and the parents stated the agitation, threatening behaviour, and talking to himself. He was started on clozapine 25 mg/day, and it was titrated up to 800 mg/day for control of positive symptoms of psychosis. Sodium valproate was added to the treatment to prevent possible epileptic seizures. Upon titration of the sodium valproate to 1500 mg/day, the sodium level was found to be 125 mmol/L, the potassium level 4.1 mmol/L, and the chloride level 96 mmol/L. The newly developed hyponatremia was attributed to sodium valproate or clozapine as there were no obvious underlying disorders to cause the hyponatremia. These two drugs were stopped. Hyponatremia ceased 10 days after his sodium valproate and clozapine intake was stopped. However, after 2 months of being discharged, he presented to the emergency service with similar complaints. It was learned that sodium valproate 1000 mg/day started spontaneously due to the fact that the patient was the first drug to heal itself. Clozapine was restarted because hyponatremia was thought to be due to sodium valproate. This case report suggests that physicians should be aware that sodium valproate may induce a SIADH-like syndrome with hyponatremia with a high morbidity and mortality. Further systemic research should be conducted with respect to anticonvulsant-associated hyponatremia to provide a greater understanding of both its prevalence and aetiology.

KEYWORDS

Clozapine; male; hyponatremia; psychiatry; sodium valproate

[Abstract:0453][Psychopharmacology]

Escitalopram-induced hyponatremia: a case report

Murat Eren Özen[a], Mehmet Hamdi Örüm[b] and Aysun Kalenderoğlu[b]

[a]Psychiatry Clinic, Private Adana Hospital, Adana, Turkey; [b]Department of Psychiatry, School of Medicine, Adiyaman University, Adiyaman, Turkey

E-mail address: mhorum@hotmail.com

ABSTRACT

Hyponatremia due to Selective Serotonin Reuptake Inhibitors (SSRIs) has previously been reported in association with drugs such as paroxetine, fluoxetine, and sertraline. An SSRI, escitalopram-associated hyponatremia, has also been reported in patients who use more than one medication, but this leads to confusion in terms of aetiology. There is not enough data available about young people has escitalopram-induced hyponatremia.

Case presentation: This case report describes a case of hyponatremia in a 44-year-old male patient who developed secondary to escitalopram in a short time. The hyponatremia chart improved with the withdrawal of escitalopram, but it reappeared when the patient started taking it again at his own will. The relative absence of multiple medical conditions and not being used with other medications that are at high risk for hyponatremia makes this escitalopram–hyponatremia relationship more explicit.

KEYWORDS

Escitalopram; hyponatremia; male; selective; serotonin reuptake inhibitors

[Abstract:0455][Autism]

Differential diagnosis of psychotic process in adult autistic spectrum disorders: case series

Murat Eren Özen[a], Ümit Kılıçoğlu[b], Mehmet Hamdi Örüm[c], Aysun Kalenderoğlu[c] and Murad Atmaca[d]

[a]Psychiatry Clinic, Private Adana Hospital, Adana, Turkey; [b]Psychologist, Private Adana Hospital, Adana, Turkey; [c]Department of Psychiatry, School of Medicine, Adiyaman University, Adiyaman, Turkey; [d]Department of Psychiatry, School of Medicine, Firat University, Elazig, Turkey

E-mail address: mhorum@hotmail.com

ABSTRACT

Schizophrenia is a psychiatric disorder that usually begins at an early age when significant disturbances are seen in feelings, thoughts, and behaviour, where the patient is distracted from the facts and has problems in interpersonal relationships, often closing in. Autism is a disorder that prevents brain development, which causes limited and repetitive behaviour that damages social interaction and communication. Although the differences between schizophrenia and autism have been revealed at the theoretical level, especially in high-functioning autism, inability to be diagnosed at an early age, the similarity of symptoms has led to the confusion of these two disease symptoms in later life. In adulthood, the bizarre speech in autism patients, strong and irrevocable beliefs, can be confused with disorganized speech and delusions in schizophrenic patients.

Case presentation: In this presentation, three cases with a differentiating diagnosis of autism and schizophrenia were reported. Their ages are 23, 24, and 30. All of them are males. When differentiating between the two diseases, it is emphasized that the more commonly held thinking is based on a logical basis.

KEYWORDS

Adult autistic spectrum disorder; Asperger; autism; differential diagnosis; schizophrenia

[Abstract:0458][Mood disorders]

Possible hiccup-inducing mechanism of aripiprazole: a case report

Murat Eren Özen[a], Mehmet Hamdi Örüm[b] and Aysun Kalenderoğlu[b]

[a]Psychiatry Clinic, Private Adana Hospital, Adana, Turkey; [b]Department of Psychiatry, School of Medicine, Adiyaman University, Adiyaman, Turkey

E-mail address: mhorum@hotmail.com

ABSTRACT

Hiccup is an involuntary, intermittent, spasmodic contraction of the diaphragm and inspiratory muscles resulting in sudden inspiration and ending with abrupt closure of the glottis, followed by a peculiar sound. Although the exact underlying pathophysiology of hiccups is poorly understood, multiple causes, including gastric distension or gastroesophageal reflux, drugs, lesions, or infections of the central nervous system, and irritation of the phrenic or vagus nerves, have been attributed to the aetiology of hiccups. This is the case of a depressed patient with hiccups induced by aripiprazole.

Case presentation: A 45-year-old single and illiterate woman with a well-balanced premorbid personality who has suffered from multiple depressive episodes from the ages of her 20s. She was not given any class of antipsychotics or mood stabilizers. Venlafaxine was administered and we planned to gradually increase her dose by 150 mg/day until her second visit. For her sleep problem, a 100 mg dosage of trazodone was prescribed. Her second visit revealed some improvement, but not enough, and she continued to experience sleeping problems. With the idea of accelerating improvement, 5 mg of aripiprazole was added to treatment at the night. Within 6 h of taking aripiprazole, the patient started having continuous hiccups. After omitting aripiprazole from her prescription regimen, the hiccups stopped in approximately 66 h. Upon the second administration of aripiprazole, the hiccups recurred within 6 h. The literature suggests that aripiprazole-associated hiccups may be related to the sequence in which antipsychotics are trialed. When a patient's treatment switch to an antipsychotic with a D2 partial agonist, from an antipsychotic with the potent D2 blockade and subsequent D2 receptor upregulation, may result in hiccups. In this case, the patient was antipsychotic naive prior to the initiation of aripiprazole, and the absence of antipsychotic sequence. Hiccups reported by authors resolve approximately in 72 h after aripiprazole's discontinuation and are associated with nearly 3-day half-life of the drug, which is 66 h in this case. Here, we can suggest that hiccups in some patients may be a result of underlying pathology and the process used to treat it, as well as the duration of illness, treatment resistance, and past drug combinations used.

KEYWORDS

Antipsychotic; aripiprazole; female; hiccup; psychiatry

[Abstract:0462][Schizophrenia and other psychotic disorders]

Coconut oil as a nutritional supplementation in the treatment of schizoaffective disorder: case series

Vesile Altınyazar[a], Gulgaz Karimova[a] and Mustafa Tolga Tunagür[b]

[a]School of Medicine, Department of Psychiatry, Adnan Menderes University, Aydin, Turkey; [b]School of Medicine, Department of Child and Adolescent Psychiatry, Adnan Menderes University, Aydin, Turkey

E-mail address: mustafatolgatunagur@gmail.com

ABSTRACT

Coconut, *Cocos nucifera* L., is a tree grown to provide a large number of products, mostly grown for nutrition and medical values. Coconut oil is derived from the coconut fruit and comprises medium-chain fatty acids (MCFA). And also coconut is rich in dietary fibre, vitamins, and minerals. MCFA are easily absorbed and metabolized by the liver, and can be converted to ketones as an important alternative energy source in the brain which may be beneficial to people developing or already with memory impairment, as in Alzheimer's disease (AD). In addition, phenolic compounds and hormones (cytokinins) in coconut can help prevent amyloid-peptide aggregation, which potentially inhibits an important step in the pathogenesis of AD. And also coconut oil has been shown in animal studies to have antistress and antioxidant activity. Another area where coconut oil treatment is being tried is drug-resistant epilepsy as a part of the ketogenic diet. Pretreatment with the extract of *C. nucifera* was caused significant protection against pentylenetetrazole-induced convulsions in experimental animals. It was found to increase the brain serotonin and GABA level in mice as responsible for antiepileptic activity. The evidence supports the concept that coconut may be beneficial in the treatment of obesity, dyslipidaemia, elevated LDL, insulin resistance, hypertension, cardiovascular disease, and type 2 diabetes as well as epilepsy and Alzheimer's disease.

Case presentation: We initially recommended coconut oil as a nutritional supplementation to current treatment in a 42-year-old woman who has been treated since the age of 16 due to epilepsy and schizoaffective disorder, and has widespread tardive dystonia in her body. She has only partial benefit from antiepileptic treatment although many antiepileptic drugs were tried. From the first month after the use of the patient's coconut oil (3×5 ml), epileptic seizures decreased in one month and also other benefits were observed on tardive dystonic contractions and positive and negative symptoms even though there was no antipsychotic treatment change. And then we also recommended another three patients who were treated for schizoaffective disorder and who had partial benefit from psychotropic therapy, and all of them showed significant improvement, especially in negative symptoms. Coconut oil is thought to be potentially useful in the treatment of psychotic disorders and further research is needed in this respect.

KEYWORDS

Schizoaffective disorder; treatment resistance; negative symptoms; coconut oil; nutritional supplementation

[Abstract:0463][PTSD]

Using quetiapine as enhancing drug in a PTSD and depression patient undergone sexual abuse: a case report

Asiye Arıcı, Hatice Altun and Feyza Hatice Sevgen

Department of Child and Adolescent Psychiatry, Kahramanmaras Sutcu Imam University School of Medicine, Kahramanmaras, Turkey

E-mail address: asiyearici@hotmail.com

ABSTRACT

Post-traumatic stress disorder (PTSD) is the leading psychopathologic result in children and adolescents who became sexual abuse (SA) victims. It occurs in 21–50% of the victims. PTSD is a clinical condition characterized with the symptoms as follows: avoiding trauma reminders, insomnia, flashbacks, having apathy to the environment, reduced affective varieties, negative mood regarding the traumatic experiences, irritability, failure to pay attention, and sudden bursts of anger. A variety of psych pharmaceuticals including anti-depressants and anti-psychotics are being used in the treatment of PTSD. In this case report, a patient with PTSD and depression as a result of sexual abuse was treated with both fluoxetine and quetiapine presented. With this regime, a high rate of remission was achieved in the patient.

KEYWORDS

Adolescent; child; depression; flashback; quetiapine; PTSD

Case presentation: A 14-year old female was presented to the clinic as a judicial case. As an SA victim from a relative in the form of penetration a year ago, she had crying, extreme uneasiness, remembrance of the incident continuously, relieving the incident, avoiding situations that can remind the incident, extreme aggressiveness, insomnia, becoming withdrawn, unhappiness-unable to feel joy, and discontinuing the school. She was being treated for the lack of growth hormone for 8 years. In her family history, she had a mother who was raped by a cousin when she was 14 years old. In her psychiatric evaluation, she was diagnosed with PTSD and major depression according to DSM-5. She was prescribed fluoxetine 20 mg 1*1 daily. In the first month of medical treatment, her sleep and appetite was restored, her being withdrawn, and her mood was improved but because her aggression, anxiety, self-blaming, the feeling of something bad was about to happen, having flashback, having self-mutilative behaviours such as hair pulling and hitting herself while having flashbacks was aggravated, fluoxetine treatment was reorganized as 20 mg 2*1 as 40 mg daily. In the third month of treatment because of her self-blame, anxiety, bursts of anger, willingness to die, intense flashbacks, inability to sleep undisturbed, quetiapine 50 mg 1*1 daily was added to her medical treatment. In control evaluations, the dosage of quetiapine was raised progressively to 400 mg daily because of the persistence of her symptoms. In the second month of her treatment with fluoxetine 40 mg daily and quetiapine 400 mg daily, her depressive symptoms were measured to lessen significantly according to the CGI-GI scale. Her bursts of anger, self-mutilating behaviour, avoidance, over anxiety, and relieving the incident symptoms also lessened significantly according to the CGI-GI scale. Her medical treatment is still ongoing. Although selective serotonin reuptake inhibitors (SSRI) are being used primarily in the treatment of PTSD, there are accumulating data that second-generation anti-psychotic drugs such as clozapine, olanzapine, risperidone, and quetiapine can be used as monotherapy or supportive therapy agents. The use of quetiapine in a wide range of dosage (25–400 mg/daily) in children/adolescents showed to be able to decrease the symptoms of PTSD. In this case, 2 months of daily 400 mg doses of quetiapine reduced the symptoms of PTSD and depression significantly. Quetiapine should be kept in mind when treating children, because of its safeness in side effects of EPS, raising the levels of prolactin, and messing the lipid panel. There is need for prospective cohort studies regarding the usage of quetiapine in PTSD patients.

[Abstract:0464][Psychopharmacology]

Clozapine-linked side effects and management of side effects in treatment-resistant adolescent schizophrenia: five cases

Zehra Alğan and Özlem Özcan

Department of Child and Adolescent Psychiatry, Inonu University, Malatya, Turkey

E-mail address: drzehraalgan@hotmail.com

ABSTRACT

Schizophrenia is a heterogeneous clinical syndrome involving disruption in cognitive, behavioural, and emotional areas progressing with occupational functional difficulties. When the disorder begins before the age of 18 years, it is defined as the early-onset schizophrenia and if it begins before the age of 13 years it is defined as very early-onset schizophrenia. This presentation shares the medication side effects and management of these side effects in psychosis cases treated with clozapine in the in-patient ward of İnönü University School of Medicine, Pediatric and Adolescent Mental Health and Diseases Department from 2016 to 2017. **Case presentation**: We included five cases (two males, three females) monitored in our inpatient unit for psychotic disorders. Of the five cases, two had early-onset schizophrenia and three had very early-onset schizophrenia diagnosis. Diagnoses were made in clinical interviews based on DSM-5. The mean age of cases was 14.3 years. For treatment, all patients began on 25 mg/day clozapine. Mean of 265 mg/day dose was used. Monitoring durations varied from 4 to 10 weeks. During monitoring, two cases developed the obsessive-compulsive disorder. One patient responded to imipramine treatment, while the complaints of the other patient regressed after reducing their dose. One case developed enuresis nocturna and recovered during monitoring. Two cases developed gastroesophageal reflux which responded to pantoprazole treatment. All cases had sedation observed from the first week. In four of the five cases, hypersalivation developed and responded to tropicamide treatment. During the patients' hospital stay weight was monitored and a mean increase of 0.6 kg per week was observed. One case had an increase in liver function tests assessed as hepatotoxicity, which responded to a reduction in clozapine dose. None of the patients developed agranulocytosis, neutropenia, or epileptic seizures. Early-onset schizophrenia is a tableau including the disrupted functioning of the child and family along with

KEYWORDS

Child; clozapine; medication; schizophrenia; side effects

developmental and social difficulties. Clozapine is frequently indicated for early-onset schizophrenia after the failure of two antipsychotic treatments. Studies lasting from 12 weeks to 9 years have shown significant clinical improvement in children and adolescents with clozapine. Additionally, clozapine is associated with metabolic, neurologic, and hematologic medication reactions. Sedation is especially observed in the first weeks of treatment, as in our cases. Although the obsessive-compulsive disorder side effect of clozapine has not been sufficiently investigated in adolescents, it occurred in 40% of our cases. Weight gain is one of the common side effects of clozapine. The findings related to weight gain in our cases comply with the literature. Although there are data on the efficacy of clozapine in the treatment of treatment-resistant psychosis among adolescents, this population has a greater tendency to experience side effects compared to adults. There are not enough academic studies on this topic. In spite of our low case number, we believe that this study will contribute to the literature.

[Abstract:0473][Mood disorders]

The use of steroid induces manic attack: a case report

Fadime Dalboy, Mehmet Ak and Faruk Uğuz

Department of Psychiatry, Necmettin Erbakan University Meram School of Medicine, Konya, Turkey

E-mail address: fdmdlby@gmail.com

ABSTRACT

Corticosteroids are used in the treatment of many diseases especially autoimmune and hematological diseases. Corticosteroids have different psychiatric side effects. These include mania, hypomania, depression, mixed episode, anxiety, panic attacks, delirium, suicidal thoughts etc. Psychotic symptoms can accompany many times. In this case report, after steroid use, the development of manic attack in the patient who has a Behcet's disease is presented.

Case presentation: 53 years old female patient; was diagnosed with posterior uveitis due to Behcet's disease in the 2008 year. After steroid treatment started for the uveit attack. One week after the drug had started, some symptoms developed in the patient. Insomnia, hyperactivity, increase in the amount of speech, persecution delusions, etc. The relatives of the patient presented to the psychiatric clinic with these complaints 2 weeks later. Psychiatrist interrupts medication considering steroid-induced manic episode. The patient had begun lithium therapy. The symptoms of the patient passed within 2 weeks after the drug (steroid) had been discontinued. The patient used lithium therapy regularly for 3 years. The patient had no psychiatric complaints until 2016. In 2016, the patient who had a uveitis incident started treatment with steroids (prednisolone 25 mg). Ten days after steroid treatment, some manic symptoms began: Such as a decrease in the amount of sleep, an increase in the amount of speech, hyperactivity, persecution delusions ("they will rape, attack me," etc.). The patient was admitted to the psychiatric clinic with a diagnosis of a manic episode. Brain MR was withdrawn in terms of exclusion of neuro-Behcet syndrome diagnosis and consulted with neurology. Neuro-Behcet diagnosis had been excluded by neurologist. The patient was counselled to the relevant clinics and the steroid treatment was cut down. The patient was treated with lithium 3*1, olanzapine 10 mg 2*1. One week after the medication was stopped, the patient's complaints quickly disappeared. Manic symptoms disappeared. Corticosteroids can cause many psychiatric symptoms. Psychiatric side effects due to steroid use are reported as 5.7% independent of dose for cortisol. The risk of psychiatric side effect increases as dose increases. Studies indicate that mania and hypomania are more frequent in the early period of steroid treatment and depression is more frequent in the long period. Therefore, caution should be exercised when risk factors (drugs that alter cytochrome enzyme activity, hypoalbuminemia, rheumatic disorders such as SLE, family history, female gender, pre-morbid personality traits) present in patients who have started high-dose steroid therapy.

KEYWORDS

Manic attack; steroid; Behcet's disease; uveit attack; Neuro-Behcet

[Abstract:0474][Schizophrenia and other psychotic disorders]

An update of treatment and aetiology of Catatonia based on an adolescent case

Kübra Kılınç, Fatih Hilmi Çetin and Serhat Türkoğlu

Department of Child and Adolescent Psychiatry, School of Medicine, Selcuk University, Konya, Turkey

E-mail address: kubradurmus_1991@hotmail.com

ABSTRACT
Catatonia is a motor dysregulation syndrome with main symptoms and signs such as mutism, posturing, stupor, motor rigidity, hyperalertness, refusal to eat or drink, and hypokinesis. While previously defined as a subtype of catatonia schizophrenia, in DSM-5, it was included as a separate category in the section "schizophrenia spectrum and other psychotic disorders." In this case report, it is aimed to discuss the aetiology and treatment methods through a case which entered the catatonia tabulation rapidly.
Case presentation: A 15-year-old male patient was brought to the outpatient clinic by his father and uncle. He had not eaten anything – drunk and he had never talked nearly for four days. He lived in a village. His family engaged in animal husbandry and he was a shepherd. He had left form the high school in the first grade. He was very scared and wet after a heavy rain 3 days ago. His complaints also started after. There was no trait to the value of the resume and family history. He had no substance use. He was reluctant to interview and disinterested in the environment. He did not answer the questions asked, he did not have an eye contact. His emotional involvement was flat. Waxy flexibility and posture reception were partially present. Paediatric neurology consultation was made for the exclusion of organic aetiology and patient was admitted to the service. There were no abnormalities in blood tests, neurological examination, brain MR and EEG. Dramatic improvement was observed following oral treatment with 2.5 mg lorazepam. It is diagnosed in the presence of at least three of the 12 markers, including the motor and psychic indicia described in DSM-5. Indications are: stupor, catalepsy, waxy elasticity, mutism, negativism, posture, parenthood, stereotyping, agitation, facial wrinkles, echolalia, and echopraxia. Although it is a relatively rare condition in the range of 0.7–17% of all psychiatric conditions in adolescents, its mortality is higher than others. Catatonia can accompany in many different psychiatric illnesses and somatic diseases. A minority of catatonic patients suffers from schizophrenia (30%), while a majority has a bipolar disorder (43%). In up to 25% of cases, catatonia is related to general medical or neurologic conditions. The treatment of catatonia in children and adolescents should follow the same principles as in adults. Firstly, great care should be taken to avoid complications. Although a number of pharmacological agents have been tried successfully in catatonia, rarely, if ever, the effect is as immediate and dramatic as seen with benzodiazepines. If benzodiazepines fail (inadequate or transient response, excessive sedation), ECT should be started without delay. The general notion to discontinue neuroleptics because of their inefficacy and their potential of aggravating the catatonic symptoms. Zolpidem, a positive allosteric modulator of GABA-A receptors, seems to be a safe and effective treatment alternative. Because of its *N*-methyl-D-aspartic acid antagonist properties, amantadine and its derivative memantine have been tried in catatonia.

KEYWORDS
Adolescent; catatonia; aetiology; lorazepam; treatment

[Abstract:0475][Impulse control disorders]

Self-harm behaviour, get blood from self with injector: a case report

Kübra Kılınç, Fatih Hilmi Çetin and Serhat Türkoğlu

Department of Child and Adolescent Psychiatry, School of Medicine, Selcuk University, Konya, Turkey

E-mail address: kubradurmus_1991@hotmail.com

ABSTRACT
The deliberate self-harm behaviour which defined as attempting to own body resulting in tissue damage without conscious desire of people to die is a major public health problem worldwide. The causes of deliberate self-harm, risk factors, the relationship between mental disorders and treatment strategies are not fully known. Deliberate self-harm must be distinguished from suicidal behaviour.
It has been reported that the incidence is 1% in the community and this rate can be up to 12% in the adolescent and young adult age group. Self-harm behaviour can be classified as neurotic (nail eating, excessive epilation, unnecessary plastic surgery attempts), religious (self-whipping), ceremonial (circumcision), psychotic (genital self-injury, amputation), organic brain disease traditional (nail cutting, hair cutting). The aetiology of self-harming behaviour and a phenomenon that takes blood from itself, a rare form of behaviour, is discussed in this article.
Case presentation: A 14-year-old girl was brought to the outpatient clinic with her mother because of lying and self-harm (cut wrists). She lives with her mother and two sisters. Her parents have been living separately for about 5 years. She was a high-school first-grade student. They sometimes get together to her father but she thinks her father is irrelevant. She had no substance use. Sertraline 50 mg of therapy has been started, interviews planned. In a follow-up, it is understood that she told her teachers that she had a disease and she

KEYWORDS
Adolescent; get blood; psychodynamic; self-harm; trauma

should get blood from self regularly. She was getting 5 cc of blood from self five times a day. She had read on the internet before. If she continued this for 17 days, she was thinking she would die without notice. Nobody would know why she died. After the mother and her friends learned the situation, she gets blood from self, sprayed her face, took her own photo, and sent it to her friend. Due to self-mutilative behaviours, there were emergency service applications. 0.5 mg of risperidone was added to the treatment. She was regreted because of the lie and the attempt she made. Relationships with her father were assessed and efforts were made to obtain support from the father for the therapy process. Until today, psychodynamic, biological, and psychosocial factors have been investigated among the causes of self-harm behaviour. Endogenous opiates due to addiction and pain; serotonin due to aggression and impulsive nature; Due to its compulsive nature, work on dopamine is intensified. Numerous studies of self-injurious adolescents and adults have shown a relationship between behaviours of self-harm behaviour and childhood traumas. In the psychodynamic approach, it is considered as the feeling of self-protection against the difficulties of life. It is also very clear that there is a need for a large number of large-scale studies on the causes of self-harm behaviour, the investigation of risk factors, and the development of interventions for self-harm behaviour.

[Abstract:0477][Psychopharmacology]

Remission of nocturnal enurezis after methlyphenidate treatment in a boy with 9 years of age

Tayfun Kara and Semra Yılmaz

Department of Child and Adolescent Psychiatry, Health Sciences University, Bakirkoy Dr. Sadi Konuk Research and Training Hospital, Istanbul, Turkey

E-mail address: tayfunkara@hotmail.com

ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) is the most frequently seen childhood neuropsychiatric disorder. Methylphenidate (MPH) is a first-line drug in the pharmacological treatment of ADHD. Enuresis is defined as urinary incontinence at least twice a week for 3 months after 5 years of age without organic causes. It is termed as nocturnal enuresis (NE) if it occurs only during night-time sleep. NE has an important clinical and psychological burden and leads social, psychological, and emotional distress which reduces the quality of life. Enuresis is reported to co-exist in up to 30% of children with ADHD. Here, we report a case who showed a significant improvement in NE with MPH which was given for the ADHD treatment.

Case presentation: A 9-year-old boy was brought to the outpatient clinic by his parents with the complaints of overactivity, difficulty in organizing tasks, losing items, impulsive behaviours, low school success, and night-time bed wetting. Night-time bed wetting was noticed which was present since very early ages with a frequency of almost every night. The patient was consulted with the paediatric urology clinic and organicity was excluded. The patient was diagnosed with ADHD and NE on the basis of DSM-5 diagnostic criteria. For ADHD treatment, long-acting MPH with a dose of 0.5 mg/kg was started. At his first month visit, improvement was noticed both in ADHD symptoms and in NE complaints. When the MPH dose was increased to 1 mg/kg, together with the ADHD symptoms NE complaints ceased. The family stated that they had to cessate the MPH medication one week ago, because they had gone a holiday outside the city and forgotten to bring the medication with them. The patient was experiencing bed wetting in almost every night for the last one week in which no MPH was taken. After restarting the MPH treatment, both ADHD and NE complaints ceased again. MPH leads the blockage of dopamine and norepinephrine reuptake and so indirectly causes an increase in extracellular dopamine and norepinephrine levels. Dopamine may mediate the alertness effect of MPH in the central nervous system. Dopaminergic cell groups send descending projections to the spinal motor neurons and play a neuro-regulatory role in various spinal functions including motor control. It is suggested that dopaminergic drugs may influence the micturition physiology not only in the CNS, but at the peripheral level as well and the dopaminergic effect may contribute to the smooth muscle tonus of the lower urinary tract. The enhancement of therapeutic dopamine function through these dopaminergic effects of MPH has been thought to play a role in the treatment of enuresis. A noradrenergic effect on the bladder may lead to relaxation in the detrusor muscle and subsequent decrement in the bladder contractility and this eventually causes an increase in bladder capacity. Besides, this effect may cause sphincter contraction and a decrease in the rate of urinary incontinence. In conclusion, MPH can be considered as an alternative treatment in NE cases that do not respond to traditional medical treatment in children with/without ADHD.

KEYWORDS

Attention-deficit hyperactivity; children; nocturnal enuresis; treatment; enuresis

[Abstract:0478][Stress and related situations]

Gardner–Diamond Syndrome: a rare case of psychogenic purpura

Aslıhan Okan İbiloğlu[a], İbrahim İbiloğlu[b] and Mustafa Özkan[a]

[a]Dicle University School of Medicine, Department of Psychiatry, Diyarbakir, Turkey; [b]Dicle University School of Medicine, Department of Pathology, Diyarbakir, Turkey

E-mail address: aslihanokan@gmail.com

ABSTRACT

Gardner–Diamond Syndrome (GDS), also referred to as psychogenic purpura or painful bruising syndrome, autoerythrocyte sensitization, is a rare and poorly understood clinical presentation of unexplained painful ecchymotic lesions. These lesions occur mostly on the extremities, trunk, or the face. It is known that diagnosis of the GDS requires the presence of purpura or bleeding in a patient with normal PT, aPTT, complete blood cell count, as well as other causes of bleeding with psychiatric conditions must be eliminated as possible causes of the similar clinical findings. The first publication concerning psychogenic purpura was by Gardner and Diamond in 1955. Generally, an underlying psychiatric disease or a triggering psychological stress is of important diagnostic value. Psychiatric disorders that have been associated with GDS include depression, anxiety disorder, dissociative disorder, and multiple personality disorder, as well as histrionic, dependent, or borderline personality disorder.

Case presentation: A 37-year-old male referred with recurrent episodes of painful ecchymotic bruising over the back aspect of trunk and shoulder. These episodes were substantially precipitated by emotional stress related to the marital relationship. Interestingly, these lesions did not recur for 6 months after the cause of his emotional stress was relieved. Other clinical examination was unremarkable. Also, in all investigations any organic disorder was not detected. As shown in disease episodes of our patient are associated with painful ecchymotic lesions; although all systemic tests of the coagulation system are normal. On the other hand, the diagnosis of our patient was confirmed by induction of similar lesions by intradermal injection of the patient's own washed red blood cells. But, this autoerythrocyte sensitization test (0.1 ml intradermal injection of washed autologous erythrocytes) is unreliable and generally not useful. This test should be made in non-reachable, hands skin areas for preventing factitious wounds. The skin (punch) biopsy has never been conclusive and is considered an unreliable method for the diagnosis of GDS. However, our patient's biopsy result has revealed extravascular erythrocytes in the dermis, oedema, and nonspecific lymphohistiocytic infiltration around the blood vessels. As a result, based on the above-mentioned findings of our patient, a final diagnosis of GDS was made. Treatment of our patient has been started on 25 mg/day and then the dose has been escalated to 50 mg/day. The following weeks of his treatment, all lesions of the patient were returned to normal. GDS may be confused with many disorders especially with dermatologic symptoms, including the idiopathic thrombocytopenic purpura, Henoch-Schonlein purpura, von Willebrand disease, dermatitis artefacta, cellulitis, as well as psychiatric disorders such as Munchausen's syndrome and even malingering. Therefore, GDS should be considered in the differential diagnosis of purpura, especially in patients with psychiatric problems. In patient's treatment, selective serotonin reuptake inhibitors (SSRI) exert their effect through antihistaminic, anticholinergic, and serotonin blocking properties, these features of SSRI may have led to substantial improvement in patient symptoms.

KEYWORDS

Gardner–Diamond syndrome; psychogenic purpura; painful bruising syndrome; autoerythrocyte sensitization; stress

[Abstract:0479][Other]

An 8-year-old paediatric patient who attempted suicide and possible risk factors: a case report

Osman Bertizlioğlu, Hatice Altun and Ece Merve Yazar

Department of Child and Adolescent Psychiatry, Sutcu Imam University School of Medicine, Kahramanmaras, Turkey

E-mail address: dr.osmanbrtz@outlook.com

ABSTRACT

Suicide is placed on the top cause of death for the youth in many countries. It is reported that the life-long prevalence of suicide attempts in adolescents is between 3.5% and 11%. With regard to community mental health, it is critical to address suicide as a case and identify its causes starting from early ages. Suicide as a behaviour is a complex symptom affected by the existence of psychiatric disorders, insufficient social support, and sociocultural issues.

KEYWORDS

Suicide; child; adolescent; PTSD; depression

Suicide rates increase with the adolescence period; and it is most commonly observed in children and adolescences between ages of 15 and 19. It is stated that the suicide rate is very low for ages below 10. Here, risk factors relating to the suicide behaviour of an 8-year-old paediatric patient, who attempted suicide at a very early age, are presented.
Case presentation: An 8-year-old girl patient is going to the second grade. The patient, who was sexually abused by an old man about a year ago, was presented to our clinic with complaints of unwillingness to go to school, increasing nervousness, difficulty to fall asleep, and dreadfully waking up with frequent dreams, decreasing school performance, unwillingness to interact with her older brother and her father, avoidance behaviour, frequently recalling the incident, unwillingness to talk about the incident, introversion, sudden irritation, and inertia. It was learned that the patient was threatened by the family of the abuser; the abuser was released by the court; the patient had to change her home and school due to threats; and there were domestic problems. The patient, who did not have any peculiarities in her autobiography, was diagnosed with post-traumatic stress disorder (PTSD) and depression based on DSM-5 after conducting a psychological examination. Sertraline 25 mg and lorazepame 0.5 mg were prescribed. Eleven days after the initial interview, it was learned that the patient was taken into the intensive care unit after taking medicine in a suicide attempt by locking herself in the bathroom of their home as she encountered the abuser after leaving the school. Medical and individual treatments intended for patient's symptoms of PTSD and depression were continued after the intensive care. Suicide is a circumstance that surfaces because of hopelessness, despair, and burnout caused by intense stress. It is a known fact that drug addiction, chronical medical disorders, negative familial conditions, and psychiatric disorders increase the risk of suicide. Sexual, physical, and psychological abuse during the childhood, and parental neglect are also among factors increasing the risk of suicide. In this case, risk factors, which are considered to be causes of patient's suicide behaviour, are sexual abuse, PTSD, and depression that developed from sexual abuse, insufficient psychosocial support by the family, the family and the patient being threatened with death by the abuser and the family being forced to move to another city after that incident, the abuser being released by the court, degenerating communication within the family, the patient having problems in adapting to changes in school and the neighborhood, and ideas of despair and hopelessness. It is argued that suicide can be observed even before adolescence as it happened in this case; it is necessary to pay attention to a detailed psychiatric examination of the patient if there are risk factors; and it is important to provide psychosocial support for both child and family after the incident of abusing.

[Abstract:0480][Mood disorders]

Severe urticaria induced with sertraline use: a case report

Ahmet Özercan, Ayşe Sakallı Kani and Mehmet Kemal Kuşçu

Marmara University Pendik Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: ahmet.ozercan@gmail.com

ABSTRACT
Allergic cutaneous reactions including urticaria, erythema multiforme, and Steven Johnson syndrome are side effects that can be life-threatening and require urgent evaluation. However, serotonin-selective reuptake inhibitors (SSRIs) are safe medications, adverse cutaneous reactions may also occur as a side effect of SSRIs. In this presentation, we would like to report a patient who had severe urticaria induced with sertraline treatment.
Case presentation: A 55-year-old, male, inpatient treatment, was diagnosed with major depressive disorder. Depressive mood, loss of interest and enjoyment in usual activities, reduced energy, and decreased activity were noted in his psychiatric examination. For his depressive symptoms, sertraline 50 mg/day treatment was started and sertraline dose was increased up to 100 mg/day after 3 weeks. After 2 days of sertraline dose increase, erythematous maculopapular rashes were formed in the patient. A dermatology consultation was requested and after the consultation of the dermatology, the patient was diagnosed with urticaria and antihistaminic treatment (desloratadine) was started. During this period, the patient's rashes continued and antihistaminic treatment was increased the full dose. In the re-evaluation of the patient after one week period, there was no recovery in patient's lesions with antihistaminic treatment therefore rashes were thought to be due to sertraline and the drug was reduced to 50 mg dose firstly and then discontinued.
After discontinuation of sertraline, venlafaxine treatment was initiated subsequently. Under the venlafaxine treatment, existing rashes disappeared and no more allergic cutaneous reactions were observed on the 6 months follow-up period. In conclusion, due to allergic skin lesions being one of the side effects seen in the use of SSRIs, clinicians need to be alert in this regard and keep this side effect in mind during treatment.

KEYWORDS
Depression; psychiatric symptoms; sertraline; side effect; urticaria

[Abstract:0481][Neuroscience: Neuroimaging-Genetics-Biomarkers]

Prion disease emerging with depressive symptoms: a case report

Muhammet Akbolat[a], Ayşe Sakallı Kani[a], Volkan Topçuoğlu[a], Gazanfer Ekinci[b] and İpek Midi[c]

[a]Marmara University Pendik Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey; [b]Marmara University Pendik Research and Training Hospital, Department of Radiology, Istanbul, Turkey; [c]Marmara University Pendik Research and Training Hospital, Department of Neurology, Istanbul, Turkey

E-mail address: muhammetakbolat@gmail.com

ABSTRACT

Prion is a rare neurodegenerative disease which often starts in the age of sixties. Patients may complain of fatigue, drowsiness, anxiety, and depression. Mental deceleration and strange behaviours occur during the course of the disease and cognitive impairment and neurological findings emerge very soon. In this report, we present a case of prion disease emerging with depressive symptoms.

Case presentation: Ms T a 58-year-old woman admitted to our outpatient unit with the complaints of depressed mood, malaise, drowsiness, reduction in the speed and amount of speech, and crying attacks that began after a social stressor. After a few weeks, her relatives noticed strange behaviours, a decrease in her personal care, retardation in her movements, a disorganized speech, with perseveration, and abnormal movements in her muscles. During the appliance, she had been taking duloxetine 60 mg/day and escitalopram 5 mg/day for one month. After examination, the patient was referred to our inpatient unit for differential diagnosis and treatment. All of the patient's medications were stopped. After three days of her admission, catatonic symptoms occurred including abnormal gestures, waxy flexibility, and stupor. There was no abnormality in routine blood tests, except for increased CRP. Cranial MRI and EEG were performed. The patient was consulted to neurology and radiology departments. Slow spike wave discharge was observed in the EEG. Radiology evaluated the MR result in favour of prion (Creutzfeld Jakob). Neurology was also diagnosed in the patient with prion based on the clinical course, cranial MR and EEG results. The patient was transferred to the neurology clinic. This case was presented as a reminder that neurodegenerative diseases should be found in the differential diagnosis of psychiatric diseases.

KEYWORDS

Catatonic symptoms; depressed mood; neurodegenerative disease; prion; retardation

[Abstract:0486][Psychopharmacology]

Lithium therapy-induced acne: a case report

Berrin Ünal, Deniz Altunova, Ali Metehan Çalışkan, Tuba Şerife Elmas and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

E-mail address: denizaltunova@hotmail.com

ABSTRACT

Lithium is a major drug used in the treatment of the bipolar and schizoaffective disorder. Dermatologic side effects are quite common in lithium therapy. The most common side effects are acneiform rash, folliculitis, maculopapular rash, and psoriasis. We present a case of a patient diagnosed with schizoaffective disorder with common nodular acne after lithium use.

Case presentation: The present case concerned a 40-year-old man, who was unemployed and diagnosed with schizoaffective disorder at age 30. He was admitted to the psychiatric ward of the clinic because of increased level of energy, decreased need for sleep, increased libido, and increased verbal output with a disorganized thought process. The manic symptoms lasted for 4 weeks with lithium 1200 mg/day (0.88 mEq/L), olanzapine 10 mg/day and paliperidone palmitate (75 mg eq) treatment. At 3-months post-hospitalization, he came to us with severe acne lesions. The laboratory values for haemogram, metabolic panel, and levels of sex hormones were normal. Because of acne, lithium was stopped and valproate was added, at 750 mg/day, and increased to 1500 mg/day. In his 2-month follow-up visit, the lesions had improved considerably. Dermatological side effects such as acne, psoriasis, skin rashes, and rarely hair loss have also been reported with lithium use. When the patient had a dermatologic side effect of lithium, we planned to stop lithium and switch to another mood stabilizer valproate. We did not prefer to use isotretinoin because of psychiatric side effects. The lesions are improved with the treatment. Lithium-related cutaneous adverse effects can be distressing to patients and may affect medication compliance. If the skin lesions are moderate to severe, switching from lithium to another mood stabilizer may be necessary.

KEYWORDS

Lithium; valproate; side effects; acne; schizoaffective disorder

[Abstract:0487][Addiction]

Methylphenydate and 4-fluoromethylphenydate abuse: a case report

Fadime Dalboy, Fatih Mücahit Harmankaya, Mehmet Ak and Adem Aydın

Department of Psychiatry, Meram School of Medicine, Necmettin Erbakan University, Konya, Turkey

E-mail address: fdmdlby@gmail.com

ABSTRACT

Methylphenidate is an agent that acts on dopaminergic pathways in the central nervous system. Amphetamine and methylphenidate are used as the first choice in the treatment of attention-deficit and hyperactivity disorder. The abuse of methylphenidate is becoming a growing problem day by day. The study in the U.S.A., the annual average of the abusive usage methylphenidate was reported to be 4%. The non-medical/illegal usages of methylphenidate have caused addiction, negative reactions, and medical complications. In this case report, a case of admission is mentioned due to methylphenidate abuse in Necmettin Erbakan University, Meram School of Medicine, Department of Psychiatry.

Case presentation: A 22-year-old male patient was admitted to a psychiatric clinic without any known psychiatric disorder other than a shyness personality trait. When the patient was 18 years old, he received a cold medicine with pseudoephedrine, and after having taken the medicine, he liked the stimulant effect that this medicine would reveal and provided. As a result of this, he began to use this medicine for 1–2 years without a prescription. Meanwhile, the patient's brother was prescribed a methylphenidate drug for ADHD by a psychiatric doctor. The patient took 2–3 doses of this drug to try. After taking medicine, he said "I was the best time of my life for a couple of hours," he began to misuse methylphenidate in order to regain that effect. During periods when methylphenidate is available, he has used this drug in a variety of ways at high doses (150–200 mg per day, anal, and nasal). He claimed that when I took the medicine in different ways, it affects me farther and faster. So, he began to examine ways to obtain it from the internet when it was limited in a prescriptive way. He began to sell 4-floromethylfenidat abroad on the internet. The drug was sent in cargo between the book and the newspaper in powder form. He took it in an anal or nazal way. Aggressive behaviours were developed when the family prevented him from taking the drug. After two years abusive usage of the metilfinidant, the patient was taken to the hospital by his family and hospitalized for treatment. He was in anhedonia, anxious mood after the mental condition examination. The patient started to receive paroxetine 20 mg/day and quetiapine 200 mg/day. On day 3 of the admission, when the patient was found to have stored 4-fluoromethylphenydate in a rectangle with a pouch wrapped around the rectal canal, he was discharged at the request of his family and himself.

Methylphenidate is a commonly prescribed medicine in patients with narcolepsy and attention-deficit/hyperactivity disorder (ADHD), although it has an abuse potential. ADHD develops social symptoms as well as clinical symptoms in patients, but abuse is increasing day by day. The prescription of methylphenidate by an unindexed physician leads to increased medical complications arising from misuse of methylphenidate due to increased illegal trade.

KEYWORDS

ADHD; methylphenydate; 4-fluoromethylphenydate; addiction; drug abuse

[Abstract:0488][Addiction]

Pregabalin abuse in a patient with bipolar disorder: a case report

Ali Metehan Çalışkan, Berrin Ünal, Deniz Altunova, Ebru Çiftçi and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

E-mail address: denizaltunova@hotmail.com

ABSTRACT

Pregabalin is a GABA analogue approved by the United States Food and Drug Administration for the treatment of neuropathic pain, fibromyalgia, and epilepsy. Off-label uses include generalized anxiety disorder, social anxiety disorder, bipolar disorder, insomnia, and chronic pain. Pregabalin has been abused by euphoric, analgesic, and anxiolytic effects (1). Its potential for abuse has become apparent day by day.

Case presentation: A patient, a 37-year-old man, who was diagnosed with bipolar disorder and with a history of illicit drug use, was admitted to the psychiatric ward of the clinic, a year ago. The patient reported a history of 3,4-methylenedioxymethamphetamine (MDMA) and synthetic

KEYWORDS

Pregabalin; abuse potential; addiction; withdrawal; bipolar disorder

cannabinoid use for 10 years. His urine toxicology was positive for MDMA and synthetic cannabinoid. He improved clinically with lithium 1200 mg/day and olanzapine 20 mg/day treatment and was discharged on day 35. Six months after discharge, he took some pregabalin tablets from his friends and experienced euphoric feelings. In the following months, the use of pregabalin dose increased up to 1000 mg per day. The patient reported that he had experienced severe withdrawal symptoms including severe tension, trembling, sweating, and anxiety when he tried to stop using pregabalin. He admitted to the psychiatric ward of the clinic and his withdrawal symptoms were controlled by gabapentin 1200 mg/day. Gabapentin was gradually reduced and stopped. He was discharged with lithium 1200 mg/day and olanzapine 20 mg/day treatment. Some authors have already published data about cases with tolerance, withdrawal symptoms, and dependence for pregabalin. It might have a potential for abuse. Our patient had a history of severe withdrawal symptoms including severe tension, trembling, sweating, and anxiety when he tried to stop using pregabalin. Pregabalin abuse increases continuously. It might have a potential for abuse. Physicians should be aware of the substantial potential of pregabalin for abuse and addiction.

[Abstract:0489][Schizophrenia and other psychotic disorders]

Schizophrenia with cavum septum pellucidum et vergae association: a case report

Deniz Altunova, Berrin Ünal, Ali Metehan Çalışkan, Nafiye Yağlı and İbrahim Eren

Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey

E-mail address: denizaltunova@hotmail.com

ABSTRACT

Psychotic symptoms and disorders can be seen in brain structural anomalies. The septum pellucidum, which forms the medial wall of the lateral ventricles, is a thin layer of two laminates. If the two leaflets of septum pellucidum are not completely joined, it is called cavum vergae and this is considered to be the most severe form of an anomaly among the septum pellucidum developmental anomalies (1). The association of cavum septum pellucidum (CSP) with schizophrenia is thought to be neurodevelopmental. Several magnetic resonance imaging studies have found a prevalence of large CSP in schizophrenic patients higher than normal individuals. It is suggested that a common developmental anomaly in the other midline structures and connections of the large "cavum vergae" may be indicative and may lead to psychotic statements for this reason. In this case, we aimed to present a case in which schizophrenia is diagnosed and has a variation of the septum pellucidum et vergae.

Case presentation: 39-year-old male patient, primary school graduate, unmarried, farmer. The disease began in the form of nervousness speech enhancement, erotomanic delusions about 10 years ago and the patient has not been a doctor's application in those years. The patient was hospitalized for 2 weeks due to visual hallucinations, persecution delusions, self-mutilative behaviours, restlessness in another psychiatric clinic 2 months ago and he was discharged with aripiprazole 30 mg/day, quetiapine 300 mg/day, paliperidone palmitate (75 mg eq). The patient was admitted to our clinic after exhibiting psychomotor agitation, visual hallucinations, and persecution delusions. In the psychiatric examination, poor self-care, irritable affect, psychomotor agitation, persecution delusions, and auditory illusions were noted. His concentration, attention span, and memory were considerably impaired. The physical examination result and laboratory values for haemogram, liver and kidney function tests, prolactin, thyroid hormones, electrolyte, and EEG were normal. Treatment was settled as quetiapine 300 mg/day, paliperidone palmitate (150 mg eq), and lorazepam 3 mg/day. In the brain MRI, cavum septum pellucidum et vergae variation was detected. The patient was consulted to the neurosurgery. With the recommendation of the brain surgeon, the clinically improved patient was discharged to the neurosurgery department for hospitalization.

There was no direct relationship between schizophrenia and CSP presence or large CSP in the studies performed. However, it is observed that large CSP is associated with symptoms such as severe thought disorders in schizophrenia patients, increased risk of suicide, and loss in cognitive domains such as intellectual function, verbal learning, and memory. The case we have is generally compatible with the literature information. In these patients, care must be taken in terms of situations that may require surgical intervention, such as hydrocephalus, and the necessary imaging and consultations should be performed as soon as possible.

KEYWORDS

Cavum septum pellucidum; schizophrenia; magnetic resonance imaging scan; neuroimaging; self mutilating behaviour

[Abstract:0491][Stress and related situations]

Dissociative disorder after childhood trauma: a case report

Merve Çavdar Toraman, Ahmet Ataoğlu, Zehra Başar Kocagöz, Neslihan Yazar and Busra Bahar Ataoğlu

Department of Psychiatry, Duzce Universty School of Medicine, Duzce, Turkey

E-mail address: yasfem@hotmail.com

ABSTRACT

In dissociative disorders (DD), deterioration of functions of sensing, memory, identity, or environment is seen. Behaviour in DD may be remembered but rather perceived as behaviour of someone else. DD can be seen in a wide spectrum ranging from simple situations such as dreaming, forgetting, and distraction in everyday life to dissociative identity impairment. In the aetiology of DD, the experiences of childhood such as emotional, physical, and sexual abuse play an important role.

Case presentation: 33 years old, married, housewife. She was evaluated at the emergency department with the complaints of hearing his father to call her who died, seeing the image of his mother and father, intermittently looking at the empty wall, plucking his knife, and squeezing his throat. In the first evaluation, it was observed that the patient did not respond to the verbal warnings and the patient reacted in a painless stimulus leaping manner. The examination revealed that mood was depressive, affective was anxious, dissociative amnesia at the memory examination, judgment, and insight was reduced. The patient had been presented to our clinic in 2014 with the complaints of hearing voices, harming himself, disappearing for a while, providing financial gain through prostitution, returning home, and remembering nothing about this turn. She was followed up in our clinic with a preliminary diagnosis of dissociative amnesia and dissociative fugue. In the history of the patient, it was learned that she grew up in a chaotic family environment, at the age of 13 he had childhood abuse and neglect stories, and at the age of 13, he was married with religious marriage. After being married for 3 months, he fell into the hands of the prostitute; she married again at 17 years old and divorced after 3 years. She fell into the hands of the prostitution again. She was hospitalized for follow-up on 25.12.2017 with the preliminary diagnosis of the mixed dissociative disorder. The treatment was started as olanzapine 10 mg/day and escitalopram 20 mg/day. The development of acute dissociative amnesia is caused by conflicting thought content that includes feelings of disappointment, hopelessness, embarrassment, and guilt experienced by the patient. The relationship between childhood abuse and neglect and dissociation has been shown in both retrospective and prospective studies. The escapes of our patient whom we regard as dissociative fugue; we think that this is a protective mechanism used to reduce the feelings of guilt, embarrassment, and anxiety because of she has not family supporting, turning to prostitution to make living. With this, we think that it is a defense chosen by the use of dissociative amnesia instead of the coping mechanisms that have not yet developed with other traumatic events that we have experienced according to both socio-cultural environment and familial teachings. It is necessary to keep in mind that DD can be seen after childhood trauma (CT). In our case, mixed dissociative (dissociative amnesia, fugue) symptoms, which we thought to have developed with CT, was presented in order to draw attention to CT and child brides by examining the dynamics of the case.

KEYWORDS

Amnesia; childhood trauma; dissociative disorders; fugue; prostitution

[Abstract:0494][Mood disorders]

Chronic mania: a case report

Neşe Yorguner Küpeli[a], Necati Serkut Bulut[b] and Kaan Kora[c]

[a]Psychiatry Department, Marmara University Pendik Research and Training Hospital, Istanbul, Turkey; [b]Psychiatry Department, Sakarya University Research and Training Hospital, Sakarya, Turkey; [c]MD, Psychiatrist, Istanbul, Turkey

E-mail address: neseyorguner@yahoo.com

ABSTRACT

Chronic mania is defined as the presence of manic symptoms for at least two years without remission, and is significantly less frequent than chronic depression. The estimated prevalence is around 6–12% among all bipolar disorders. Here, we present a case of chronic mania, despite the use of several medications and ECT trials, who has been exhibiting uninterrupted symptoms of mania for nearly 8 years.

KEYWORDS

Bipolar; disorder; chronic; mania; treatment; resistant

Case presentation: Mr M. is a 33-year-old single man who has graduated from high school. Eight years ago, the patient was brought to our clinic by his family with symptoms of psychotic mania presenting for the last two months. He was taking valproate (2000 mg/day) and risperidone (6 mg/day), and ECT was administered a few weeks before. Despite the medications and ECT, the manic symptoms, including delusions, persisted. The patient who had no insight was hospitalized and detailed evaluation revealed that his psychiatric history began at age 17 with talkativeness, pressured speech, insomnia, increased libido, and grandiose delusions. From the first manic episode until the mentioned admission, he had two depressive and four manic episodes with repetitive hospitalizations. The inter-episodic periods were reported to be symptom-free. His premorbid personality was defined as calm, introverted, and disciplined. Medical work-up were normal, there were no alcohol/substance use disorder or a history of significant psychiatric/neurological illness in his family. His mental status examination revealed euphoric mood, increased psychomotor activity, pressured speech, insomnia, flight of ideas, and grandiose delusions. Since the previous episodes were remitted with lithium and zuclopenthixol, these two were added to his ongoing medication. However, for the following eight years including the hospitalization period, it has been observed while the vegetative symptoms remitted, remaining symptoms including euphoric mood, grandiosity, pressured speech, and lack of insight persisted despite multiple re-hospitalizations, the use of pharmaceutical combinations of mood stabilizers with antipsychotic agents including clozapine, as well as numerous ECT trials. Young mania scores were determined as 39-22-36-18-26 in subsequent evaluations. Moreover, there has been no improvement in the patient's social and occupational functioning ever since. In the current classification systems, the duration of a manic episode is defined as at least 7 days, while epidemiological studies indicate that, if not treated, the episode usually lasts no more than 6 months. However, the duration may be more prolonged and even become chronic in some cases (3), so that a patient with chronic mania lasting for up to 48 years has been reported in the literature (4). However, the factors related to the chronicity have not been clearly identified. A study comparing the clinical features of patients with acute and chronic mania suggested that underlying hyperthymic temperament and recurrent manic episodes were important determinants of chronicity. Our case is an example of the chronic treatment-resistant mania. Unlike the chronic depression, which is a well-established clinical entity, chronic mania is a relatively less known and rarely diagnosed condition. Further studies and case reports are needed to elucidate the neurobiological basis of chronic mania and to determine factors contributing to chronicity.

[Abstract:0498][Schizophrenia and other psychotic disorders]

A tardive dyskinesia case benefiting from aripiprazole treatment

Cihad Yükselir[a] and Serkan Zincir[b]

[a]Balikesir Atatürk City Hospital, Balikesir, Turkey; [b]Eskişehir Yunus Emre State Hospital, Eskisehir, Turkey

E-mail address: dr.c.yukselir@gmail.com

ABSTRACT

Tardive dyskinesia is a clinical situation characterized by involuntary movements resulting in the long-term antipsychotic use. It makes treatment difficult and causes the daily function of the patient get worse.

Case presentation: Fifty-four-year-old male patient was brought to the psychiatric service by his family as a result of talking no one, closing himself in his room, and especially involuntary movements around the neck, chin, and mouth. According to his story, he was diagnosed with schizophrenia and given antipsychotic treatment about 20 years ago. He was partly benefited from various antipsychotic treatments in the process. Complaints were repeated with an increase in positive symptoms due to the fact that treatment is not used regularly. He was using zuclopenthixol depot 200 mg/month. There were involuntary movements especially at his lips, neck, and chin for 6 months. In his psychiatric examination, he had decreased interest about his surroundings, less attention to dress, unlimited sociability, decreased speech and voice, he had slow thinking, difficulty understanding, poor concentration, poor memory, and difficulty expressing thoughts, his objective and subjective judgments were distorted, he had affective flattening. He was diagnosed with schizophrenia and tardive dyskinesia due to antipsychotic use according to DSM-5 diagnostic criteria. His antipsychotic treatment was stopped and started oral clonazepam 2.5 mg/day. At the end of the first week, aripiprazole 15 mg/day treatment was added. Clonazepem treatment was stopped at the end of the second week. In the sixth week of treatment, a significant decrease was observed in the patient's involuntary movements. Involuntary Movement Scale (AIMS) score decreased 21 to 9. In the second month of treatment, reduction in negative symptoms was determined. PANSS Negative score decreased from 30 to 21. Treatment was changed to aripiprazole long-acting injection. The patient's monthly follow-up showed that

KEYWORDS

Antipsychotic; aripiprazole; dopamine D2 receptors; schizophrenia; tardive dyskinesia

negative symptoms and involuntary movements diminished and remission with treatment. Tardive Dyskinesia is a hyperkinetic movement disorder that often occurs during long-term antipsychotics treatment or shortly after treatment. The blockade of dopamine D2 receptors because of long-term use of antipsychotics has been suggested to cause hypersensitivity to dopamine receptors. Stopping antipsychotics which in use, short-term benzodiazepine treatment and using atypical antipsychotic treatment are among the treatment modalities. Because of the partial agonist effect on dopamine D2 receptors and reducing negative symptoms, aripiprazole treatment is a preferable option.

[Abstract:0505][Autism]

Autism Spectrum Disorder (ASD) in two siblings

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT

Autism Spectrum Disorder (ASD) is a neurobiologic disorder arising from genetic, familial, and environmental factors and affecting social relations, communication skills, interests, and behaviour of the individual in an unfavourable way. Mild modifications of social and communicational deficits of ASD have been observed in 25% of first-degree relatives of individuals with ASD and ASD risk is 50 to 100 fold increased compared with the normal population especially in the siblings. We believe that our case is noteworthy in that both siblings are diagnosed with ASD.

Case presentation: A five-year-four-month-old male patient was presented to our outpatient clinic for renewing his special education report. It was learned that he had been followed for ASD for the last 2 years. His family history revealed that his 8-year-old elder sister was also followed with the diagnosis of ASD and she also received special education. His sister was born as a premature baby weighing 940 g and remained in the incubator for a few months. Psychiatric assessment of the male case revealed that he could not speak, had very limited eye contact, and kept turning the object in his hand forward and backward. A child with ASD has a high probability of having distant or close relatives with ASD or ASD-like disorders. Although birth history and presence of risk factors in the elder sister are among other factors that can be associated with ASD, this does not change the fact that familial factors have an important place in ASD aetiology. Our case is noteworthy in showing the familial tendency in the aetiology of ASD.

KEYWORDS

Autism; disorder; familial; factors; spectrum

[Abstract:0506][Anxiety disorders]

A case with seperation anxiety and alopecia areata

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT

Separation anxiety disorder is developmentally inappropriate and excessive anxiety or fear of separating from the people one is attached to. Symptoms should last at least 6 months. This anxiety frequently manifests itself in children as fear of getting lost and never reuniting with parents again. Alopecia areata (AA) is a dermatosis characterized by hair losses with clearly defined borders. The skin in the hair loss areas has a normal appearance. This disease develops without gender or age predilection and it should be noted that 20% of cases are children. Stress and especially events such as mourning, separation, and accidents can sometimes trigger the disease. Studies have reported that negative life events are seen at a high rate before the hair loss. This case was deemed worthy of presentation because it is a case of alopecia areata starting immediately after separating from the mother.

KEYWORDS

Alopecia; areata; anxiety; disorder; separation

Case presentation: A 7-year-old male patient. Approximately 7 months ago, his brother was diagnosed with Type 1 diabetes mellitus. During that period, his mother stayed 10 days at the hospital with his brother. During the same period, the best friend of the patient moved to another city. Hair loss started in our case following these events and soon it turned into total hair loss. The patient presented to dermatology and was diagnosed to have total alopecia areata and treatment was started. History obtained from the mother revealed that, simultaneously with the hair loss, the patient had symptoms such as fear of separating from his mother, following his mother like a shadow, desire to sleep with his mother at night, and feeling excessive anxiety in the absence of his mother. Medical therapy was started on the patient who did not receive any psychiatric support for 7 months and behavioural assignments were given. Although genetic factors, infections, and autoimmune factors play roles in the etiopathogenesis of AA, it cannot be denied that psychological factors are precipitating factors. Our case can provide guidance for comprehending the relationship of AA with stressful events. Our case was deemed worthy of presentation because of its emphasis on the psychological aspect of AA.

[Abstract:0507][Specific learning disabilities]

Concomitance of autism spectrum disorder and dyslexia in a case

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder starting in the first years of life manifesting itself with delayed or deviated social interaction and communication and involving repetitive-limited-extraordinary behaviour/interests. Environmental and immunologic factors are thought to play a role in the etiopathogenesis together with hereditary factors. Dyslexia (learning difficulty) can be defined as the inability to gain the academic skills expected from one while having a normal or above normal intelligence. In dyslexia, there are disruptions in the fusiform gyrus, temporoparietal cortex, and inferior frontal gyrus and their functional connections and associated white matter pathways in the brain, but cerebellar deficits can also exist. Amygdala, frontal and temporal cortices, and cerebellum are the regions with most reported anomalies in ASD. Both disorders are developmental brain disorders. In fact, both diseases have been placed under the headline of neurodevelopmental disorders in DSM-5. We deemed our case worthy of presentation because common neuroanatomic structures were affected and both disorders are developmental.

Case presentation: 5-year-3-month-old case followed with the diagnosis of ASD underwent a psychiatric assessment and it was noted that he turned toward voices, had limited eye contact, just started forming sentences including three words, had stereotypies like turning around himself and head nodding, and was hyperactive. According to the history obtained from his family, he wrote numbers backward, and especially confused the letters b and d, wore his shoes on the wrong feet, could not hold a pencil and had difficulties synthesizing, arriving at conclusions, and making interpretations. Following clinical evaluation, the diagnosis of dyslexia accompanying ASD was considered. The presence of both ASD and dyslexia in our case is noteworthy. Affected brain regions suggested a common etiopathogenesis and can provide guidance for further studies in this field. It has been proven once again in our case that the affected brain region and presence of common neuroanatomic regions with dyslexia are very important in ASD.

KEYWORDS

Autism; disorder; dyslexia; etiopathogenesis; spectrum

[Abstract:0508][Psychosomatic Medicine and Liaison Psychiatry]

Somatic symptom disorder in a case

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT
Somatic symptom disorder involves annoying, chronic somatic symptoms, and associated non-functional thoughts, emotions, and/or behaviours. The symptoms should last at least 6 months. The most frequently reported symptoms are headache, feeling of a lump in the throat, and abdominal pain. Usually, an association can be found between the onset of somatic symptom and the time psychosocial stressor is involved in one's life. Conditions such as depression and anxiety are frequently present in the families of children with somatization symptoms. Our case is noteworthy because of its rarely seen somatic symptoms and its familial psychiatric burden.
Case presentation: An 8-year-old girl was presented to our outpatient clinic because she was afraid of eating. She thought foods would get stuck in her throat and cause her to choke. Her symptoms started 1.5 years ago after she got intoxicated from spoilt milk and stayed 2 days at the hospital and she developed behaviours such as refusing solid and liquid foods, feeling full after taking a bite from all the foods, and leaving the food. She lost 5 kg in 1.5 years and medical therapy was started. Her family history revealed that her father, grandmother, and mother had panic disorders and received drug treatment. Our case who presented with a different clinical picture of somatic symptom disorder emphasizes that psychiatric diseases generally interact with each other even though they are diseases classified under different headlines and that familial transmission is important. Our case is important because it supports the dominant role of familial factors in the aetiology of somatic symptom disorder.

KEYWORDS
Anxiety; diseases; psychiatric; somatic; symptoms

[Abstract:0509][OCD]

Fluoxetine treatment of a case of skin picking disorder and obsessive-compulsive disorder

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT
Obsessive-compulsive disorder (OCD) is a psychiatric disorder, characterized by obsession and/or compulsions. Obsessions or fixations are repetitive and annoying thoughts, impulses, or images that spontaneously enter consciousness and the individual knows that they are nonsense or wrong. Compulsions are motor or mental activities that are usually performed within certain rules in order to prevent an obsession. OCD has been removed from the headline of anxiety disorders with DSM-5 and has been classified under the headline of Obsessive-Compulsive and Related Disorders. Skin picking disorder is also placed under this heading. Skin picking disorder is the presence of repetitive skin picking behaviours resulting in skin lesions and repetitive interventions to decrease-stop these behaviours. The most frequently used practices thought to be most effective in the treatment of skin picking disorder are cognitive behavioural techniques. However, there are cases reporting that antipsychotics can also be useful. Few studies have supported that selective serotonin reuptake inhibitors (SSRI) are effective. In addition to being a case of concomitant skin picking and OCD, our case is also noteworthy for benefiting from SSRI therapy.
Case presentation: A 12-year-old male patient was presented to our outpatient clinic with symptoms of obsessions with staying long in the bathroom, shampooing his hair strictly three times, washing his body four times with foam, washing his hands uncountably many times during the day, alongside picking his skin on the fingers and lips of 5-year duration. His family stated that he mostly picked his skin when he was under stress, used a cream because it hurt, was sorry about its obnoxious appearance, and cried for hours. He had his obsessions for approximately 5 years, and skin picking was present for 1 year. His family history revealed that he was the eldest of four siblings, his siblings were healthy, and his father and grandfather were followed and treated because of OCD. Behavioural recommendations were given to the patient with these symptoms. Fluoxetine 20 mg/day was started as a medical therapy. Fluoxetine therapy was titrated stepwise up to 60 mg/day during the control visits. The case was followed for approximately 8 months. In his last control, his skin picking and obsessions were decreased to almost none. We believe that treating our case of concomitant skin picking and OCD with SSRI can throw light on the future studies. Introduction of skin picking disorder without a dermatologic problem into a separate diagnosis category in DSM-5 and its treatment with fluoxetine can accelerate studies on this subject.

KEYWORDS
OCD; fluoxetine; picking; skin; treatment

[Abstract:0510][Tic disorders]

Tic disorder in a case with Familial Mediterranean Fever (FMF)

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT

Familial Mediterranean Fever (FMF) is an autosomal recessive disorder caused by mutations in the MEFV gene. This gene has been mapped on chromosome 16p13.3 and encodes a protein (pyrin) found in granulocytes. Although aetiology of FMF is not fully known, in addition to MEFV gene mutations, presence of some regulatory genes and unclear environmental factors are in dispute. In addition, the immune system also plays an important role in the aetiology. There are an increasing number of studies reporting the association of genetic changes disrupting the production and secretion of interleukin-1 with autoinflammatory diseases like FMF. FMF is characterized by periodic abdominal pain, fever, and joint pain. Tic disorder is characterized by sudden, quick, repeated, irregular movements, and vocal outbursts. Tic disorder is thought to be polygenic and multifactorial. Alongside genetic factors, the importance of association of immunologic factors with neuropsychiatric disorders like tic disorder has increased recently. Our case was deemed worthy of presentation because it can contribute to the common etiopathogenesis underlying FMF and tic disorder.

Case presentation: A Eight-year-old girl was presented to our outpatient clinic because of tics in the form of shrugging her neck and shoulders and clearing her throat. The symptoms of the patient had a duration of approximately two months. History obtained from her family revealed that she had repeated abdominal pain and fever for five years, was diagnosed with FMF by a paediatrician when she was four years old, and her diagnosis was confirmed with a genetic analysis. Her elder sister also had similar episodes of fever and abdominal pain and her mother was followed because of obsessive-compulsive disorder. Pathogenesis of both diseases has not been fully clarified yet. Starting from a common etiopathogenesis, our case is noteworthy for giving more importance to the genetic and immunologic aspects of both FMF and tic disorder. Concomitance of these two diseases with very different clinical appearances as seen in our case is important for suggesting a common etiopathogenesis.

KEYWORDS

Disorder; familial; fever; mediterranean; tics

[Abstract:0511][Psychopharmacology]

Fluoxetine-related hair loss: a case report

Dilşad Yıldız Miniksar[a] and Pelin Çon Bayhan[b]

[a]Malatya Research and Training Hospital, Department of Child and Adolescent Psychiatry, Malatya, Turkey; [b]Samsun Psychiatry Hospital, Departmant of Child and Adolescent Psychiatry, Samsun, Turkey

E-mail address: dr_dilsad1984@hotmail.com

ABSTRACT

Fluoxetine is a specific and potent serotonin reuptake inhibitor (SSRI). Main adverse effects seen in children and adolescents during fluoxetine use are sleeplessness, sedation, gastrointestinal adverse effects (nausea, diarrhoea, abdominal pain), loss of appetite, change in weight, sexual dysfunction, and behavioural activation. Drug-induced alopecia is a frequently seen adverse effect of psychotropic drugs. Alopecia is rare with use of selective serotonin reuptake inhibitors which have an increasing popularity. Therefore, we aimed to present a case of diffuse hair loss which is a rare and at the same time an undesired adverse effect of fluoxetine therapy causing drug incompliance.

Case presentation: An eleven-year-old girl was brought to our outpatient clinic after a stressor she experienced approximately two weeks ago and had symptoms of reliving the events, hypervigilance all the time, startling, inability to pay attention and concentrate. The diagnosis of acute stress disorder was considered and she was started on fluoxetine 20 mg/day. When the patient came to a control visit one month later, she had benefited from the treatment but her hair fell out in clumps. There was no pathology in her biochemical and hormonal work up that would explain this condition and fluoxetine-induced alopecia was considered. Her drug was stopped. It was noted in her monthly visits that her hair loss stopped completely. Literature search has revealed few cases of hair loss and alopecia with SSRIs. It

KEYWORDS

Hair; loss; fluoxetine; serotonin; treatment

has been shown that human skin produces serotonin, transforms this into melatonin and melatonin in turn affects hair growth cycle. Thus, serotonin balance in the skin is thought to influence the balance between hair growth and loss. Although the mechanism of drug-induced alopecia is not fully known, we believe that the balance of serotonin–melatonin–hair growth cycle can be important regarding the hair loss in our case.

[Abstract:0513][Tic disorders]

A case with late onset, isolated motor and vocal tics: Wilson's disease (WD)

Faruk Pirinççioğlu[a], İsmail Karka[b], Meltem Göbelek[a], Öznur Akıl[a], Sümeyra Güngören[b] and Mehmet Asoğlu[a]

[a]Department of Psychiatry, Harran University, Sanliurfa, Turkey; [b]Department of Child and Adolescent Psychiatry, Harran University, Sanliurfa, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT

Wilson's disease (WD) is an autosomal recessive disorder that usually occurs in advanced childhood or adolescence, hepatic, neurological, psychiatric findings, or a combination of these. Tic disorders are a group of neuropsychiatric disorders. It is characterized by short and fast motor movements or sound extractions. Tics typically appear between the ages of 5 and 6, and tend to reach their most severe when they are between the ages of 10 and 12.

In this article, we presented a case with late onset, isolated motor and vocal tics (Tourette-like syndrome), and WH diagnosis.

Case presentation: A.B. 38 years old, married, female patient. She complained to our policlinic about complaints of restlessness, repetition eye blinking, and quick speech. About two years ago, it was stated that the patient with no complaints and complete functioning was getting worse and unable to do his own care. During the interview, it was observed that she had repeated eye blinking, nose pulling, throat clearing, and lip bending behaviours. It was also found that recall questions asked (echolalia) and the simple movements made by me were displayed in the same way (echopraxia). No pathology was detected in blood tests (biochemistry, haemogram, TSH, B12, folate, ferritin, and ceruloplasmin). Copper was measured as 532.2 mcg/day (15–70 mcg/day) in 24 h urine. The neurological examination was completely normal. WD was pre-diagnosed with gastroenterology Liver biopsy was performed at the external centre, biopsy was evaluated in favour of WD. WD typically begins with a presymptomatic period, during which copper accumulation in the liver causes subclinical hepatitis, followed by cirrhosis and neuropsychiatric symptoms. Psychiatric manifestations may precede hepatic or neurological symptoms. The patient had planned drug treatment for his tics for 2 years and despite the treatments the patient's functioning and self-care deteriorated. The main treatment should be the treatment of the disease leading to tic disorder. WD is a disease that can be prevented by treatment, early diagnosis is affected positively by disease progression and treatment response. In summary, neurology consultation and screening of copper metabolism are of vital importance in differential diagnosis in acute or acutely developing psychiatric conditions. There were reports of isolated neuropsychiatric findings then followed by WD diagnose cases. However, in the literature, it is the first case report to be presented with isolated motor and vocal tics after WD.

KEYWORDS

Wilson's disease; tics disorders; Tourette-like syndrome; neuropsychiatric disorders; motor and vocal tics

[Abstract:0516][Motor disorders]

Neuroacanthocytosis: a case report

Deniz Deniz Özturan[a], Zeynep Bebek Yılmaz[b], Derya Deniz Kürekçi[b] and Aykut Özturan[c]

[a]Samsun Mental Health and Diseases Hospital, Samsun, Turkey; [b]Samsun Gazi Hospital, Samsun, Turkey; [c]Samsun Asarcık Hospital, Samsun, Turkey

E-mail address: dr_zeynepbebek@hotmail.com

ABSTRACT

Neuroacanthocytosis is a slowly progressive and rare neurodegenerative group of disease that is accompanied by involuntary movements such as chorea, tic, dystonia, orofacial dyskinesia, and with neuropsychiatric symptoms such as epileptic seizure and depression.

Case presentation: CC, 36 years old, right-handed, male. The patient checked in to our emergency service complaining about the involuntary movements in his arms and shoulders,

KEYWORDS

Neuroacanthocytosis; orofacial dyskinesia; tics; neuropsychiatric disorders; acanthocytosis

the difficulty in his chewing something and the spasms through his neck. From the medical history told by himself and his near of kin, it was learned that his first complaints started as twitching of his chin; so he had difficulty in eating food and therefore he checked into the department of neurology. The patient, whose neurological examination and brain MRI was evaluated as normal, was directed to the department of psychiatry as his complaints were thought to be psychological. Approximately being followed-up for three years with tic disorder diagnosis, the patient took drugs such as Escitalopram, Risperidon, and Sertraline and there was a partial remission in his complaints. For the last one week, when the chin muscle spasms of the patient increased much more in addition to the fact that his involuntary arm and shoulder movements arose, the patient checked into our emergency service. At the time he came to our clinic, his extrapyramidal symptoms were apparent. He could not even sit properly; he was involuntarily moving his arms and shoulders and having involuntary spasms around his mouth. His affect expressed anxiety. He was having difficulty in speaking (because of the dystonia around his chin). Any psychotic symptom or perception deficiency was not determined.
There is no abnormality in his routine haemogram and biochemistry tests. In the peripheral smear, 4% of acanthocyctes was found. Through the neurological examination, having a score of 30 in the mini mental test, the patient had a dysarthric speech, the motions of his bulbus oculi depended on his will to all directions and his eyes' pupils were isocoric. His pupillary light reflex was bilaterally normal. Other cranial neuro-examinations were normal and motor system examination was absolute. His deep tendon reflex was hypoactive in four extremities and his plantar reflex was bilaterally flexor. The cerebellar examination could not be evaluated because of his involuntary movements. In his sensory examination, there was a glove/sock-like sensation – hypoesthesia – moreover, the sensory of the position was normal while the vibration perception was lower in all the extremities. In his extrapyramidal system examination, there was an oromandibular dyskinesia of him. His brain magnetic resonance imaging (MRI) was normal. His motor and sensory nerve conduction studies in his double-sided upper and lower extremities were stated as normal in EMG. Neuroacanthocytosis and the accompanying psychiatric symptoms negatively affect the life quality of the patient and his family. It should not be forgotten that the patient and his near of kin be informed about the upcoming psychiatric symptoms and the psychiatrists do the essential examination before diagnosing. With a simple method like the peripheral smear, the diagnosis can be got quickly and their treatments begin.

[Abstract:0517][Psychopharmacology]

Aripiprazole-induced stuttering in an 8 year-old boy with ADHD

Mihriban Ünay, Aslı Sürer Adanır and Esin Özatalay

Department of Child and Adolescent Psychiatry, Akdeniz University, Antalya, Turkey

E-mail address: mihriban_ay@hotmail.com (M. Ünay)

ABSTRACT
Stuttering is defined as a disturbance in the normal fluency and pattern of speech in which a person tends to repeat sounds and syllables or whose speech includes sound prolongations and broken words. Two types of stuttering have been described: iatrogenic and developmental. Iatrogenic stuttering is caused by drugs, as a side effect, generally in patients who have a developmental disorder or have a family history of stuttering. Stuttering associated with antipsychotics is a rarely encountered side effect. A number of studies have indicated that stuttering may occur as a side effect of antipsychotic drugs, such as chlorpromazine, trifluoperazine, fluphenazine, levomepromazine, olanzapine, risperidone, and clozapine. We found only two case reports of aripiprazole-induced stuttering. However, there are also case reports of the use of aripiprazole in the treatment of stuttering in the literature. Here, we present a case of exacerbation of stuttering in an ADHD patient which is thought to be related to a relatively lower dosage of aripiprazole.
Case presentation: An 8-year-old boy was presented to our clinic with the complaints of lack of concentration, overactivity and getting bored easily, bothering his classmates during lectures, difficulty in completing his homework and tasks, and stuttering. His symptoms started at pre-school period and increased by the time, especially during school time. The boy was the second of the three siblings with a non-specific past medical history but family history revealed that father had ADHD and stuttering. After a comprehensive psychiatric and psychometric evaluation, a diagnosis of ADHD combined-type was diagnosed according to DSM-5 criteria and 18 mg/day oros-methylphenidate (LA-MPH) was prescribed. Two days later, the patient was presented to our clinic with a complaint of widespread body rash and the drug was discontinued because of drug intolerance. 10 mg/day atomoxetine was initiated for the first week and increased to 25 mg/day during the second week by considering his body weight (21 kg). Despite the use of atomoxetine, the impulsivity symptoms persisted, so aripiprazole 2 mg/day was added to the treatment. After 10 days of aripiprazole usage, the family presented the boy again and reported a severe exacerbation of

KEYWORDS
ADHD; antipsychotic; aripiprazole; child; stuttering

his stuttering. The increase in stuttering was attributed to aripiprazole and he showed recovery after the cessation of the drug. Aripiprazole is an atypical antipsychotic with a distinct way of action from all currently available antipsychotic drugs. It acts on both postsynaptic dopamine D2 receptors and presynaptic autoreceptors, and is considered as a partial dopaminergic agonist. Although stuttering is mentioned as a rare side effect of antipsychotics, the possible mechanisms causing the occurrence of stuttering in this situation are not known. Analogous to the production of extrapyramidal side effects, dopamine/acetylcholine balance may be relevant to the suppression or aggravation of stuttering in susceptible persons. This hypothesis is relevant to the observation that neuroleptics have been reported to both provoke and suppress stuttering.
In this case, aripiprazole treatment resulted in exacerbation of stuttering and discontinuation of aripiprazole abolished that effect. We believe that exacerbation of stuttering was triggered by aripiprazole.

[Abstract:0523][Mood disorders]

The first episode mania in a patient with arachnoid cyst: a case report

Hasan Mervan Aytaç and Nazan Aydın

Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Research and Training Hospital, Istanbul, Turkey

E-mail address: mervan176@hotmail.com

ABSTRACT
Arachnoid cysts, which exist in approximately 1% of the population, are congenital malformations originated from the arachnoid layer. Arachnoid cysts can occur at any location in the cranium but typically in the middle cranial fossa, cerebellopontine corner, supracollicular region, sella, suprasella areas, and vermis. They have been also reported frequently in psychiatric patients. In this article, we present a 35-year-old male patient with arachnoid cyst who had manic findings for a week and no history of the disease.
Case presentation: The patient who has never presented to the outpatient psychiatry clinic before, has been very angry, and aggressive for a week. The less need for sleep, loss of appetite, rapid speech, increased psychomotor activity, and self-confidence also present. The patient has doubts and references ideas that he believed his family say things about him behind and do something his back. While he was planning to attack his family members, he was brought to an emergency psychiatric service by his son. It was diagnosed as a first episode manic attack. When the anamnesis was taken from the patient, it was learned that he has been had a headache for a long time and the pain was not relieved without using analgesics. Then the patient was counselled to the neurology emergency clinic to exclude organicity in terms of neurological diseases. Diffusion magnetic resonance imaging (MRI) and computed tomography (CT) of the brain were administered to the patient at the neurology emergency clinic. CT showed the arachnoid cyst that located in the right temporal region of the brain. After all of this procedural process, the patient was admitted to the inpatient male service and Young Mania Rating Scale (YMRS) was calculated as a 27. Valproic acid 1500 mg/day and quetiapine 800 mg/day were started as a treatment for the patient. On the seventh day of treatment, the patient's complaints had decreased, the blood valproic acid level was measured as 70 µg/ml. YMRS was calculated as 3. Since the patient was sleeping regularly and the anger attacks and reference ideas were disappeared, it was planned to be discharged of the patient from the hospital. The clinical presentation of arachnoid cyst is rarely accompanied by mental disorders, and the most cases are asymptomatic and randomly diagnosed. It is difficult to determine whether the arachnoid cyst lesion is completely responsible for the general psychiatric condition of the patient. Imaging is very important for mental disorders which have acute onset, atypical symptoms, no family history. There is a need for more comprehensive researches about the investigation of neuropsychiatric disorders accompanying brain structural disorders.

KEYWORDS
Arachnoid cyst; psychiatry; bipolar; manic; psychotic

[Abstract:0525][OCD]

Obsessive-compulsive disorder after an acute left medical cerebral artery infarct in which basal ganglia is preserved

İsmail Karka, Faruk Pirinççioğlu, Öznur Akıl, Meltem Göbelek and Mehmet Asoğlu

Department of Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT
Obsessive-compulsive disorder (OCD) is a mental disorder which is characterized by obsessions and/or compulsions. OCD typically begins in the childhood or adolescence period and it is a chronic disorder with a chronic course. Obsessive-compulsive disorder that occurs during old ages is generally seen as case presentations which allied to an emphasis on cerebrovascular events. Pathologies in the frontotemporal, cingulate cortex, and especially basal ganglia are the cause of OCD. We will discuss an OCD case and its treatment that develops following an acute left medial cerebral artery infarct in which basal ganglia is preserved.
Case presentation: A 67-year-old male patient was brought to our psychiatric outpatient clinic with a complaint of irritability and bizarre behaviour by his relatives. According to the information that received from patient's relatives, it has been learned that patient had a stroke 25 days ago. He has taken into intensive care for 10 days with the diagnosis of ischemic stroke consistent with left MCA on the diffusional MR imaging and it was learned from the epicrisis notes that he was discharged from the hospital. It was stated that patient was trying to order the coverlets, trying to keep the bottles on the table at the same level and number, and he was repeating that room was dirty and it had to be cleaned. During the interview, it was seen that the patient was going to the sink constantly to try to wash his hands. Sertraline 50 mg and olanzapine 5 mg for his agitation had been initiated for the treatment. Through content could not be evaluated clearly and Y-BOCS could not be implemented due to patient's Wernicke aphasia. According to the information that was received from patient's relatives at the one week after the interview, it was stated that one-third of the symptoms of OCD was reduced. Although OCD aetiology is heterogeneous, increased activation was seen in the frontal lobes, basal ganglia (esp. caudate), and cingulum of people who have taken OCD diagnosis. Multiple case presentations describe new OCD that occurs after neurological lesions affecting CSTC circuits (e.g. Ischemic stroke, traumatic brain injury). Selective Serotonin Reuptake Inhibitors and cognitive behavioural psychotherapy (CBT) are the primary treatment for OCD. However, there is no sufficient information on how to determine the pathogenesis of secondary OCD symptoms as a result of organic brain lesions. It has been seen that serotonergic agents and cognitive behavioural therapies have a benefit on the level of case presentations. In our case, as there was Wernicke aphasia, cognitive behavioural therapy which was not considered appropriate. Serotonergic sertraline 50 mg and olanzapine 5 mg were initiated and it has been seen that patient regressed the symptoms of OCD. As a result of our literature review, we have observed two OCD cases that occur after left cerebral artery infarction in which basal ganglia was affected. Therefore, this case is the first case in the literature as OCD that developed after left MCA infarction in which basal ganglia is not involved.

KEYWORDS
Obsessive-compulsive symptoms; brain infarction; middle cerebral artery infarct; basal ganglia; Selective Serotonin Reuptake Inhibitors

[Abstract:0529][Psychotherapies]

The impact of story writing on dynamic psychotherapy

Can Tuncer, Volkan Seneger, Burcu Bakar Kahraman, Selma Hilal Avcı and Hasan Turan Karatepe

Department of Psychiatry, Istanbul Medeniyet University, Istanbul, Turkey

E-mail address: senegervolkan@hotmail.com

ABSTRACT
Demonstrating the development of patient's therapeutic alliance, transference, countertransference, and positive outcome during dynamic psychotherapy sessions by utilizing her story-writing skills.
Case presentation: A single female patient in her forties who never married and lives with her parents. For years, she has been complaining about her neck contracting and slanting left. About 20 years ago, she got medical help because of similar complaints. Over the years, in neurology clinics, she has been getting medication and psychotherapy elsewhere. The patient had been curious about writing since childhood and had been intensely writing stories and poems. She stated that following a year of cognitive behavioural therapy did not provide any relief in her symptoms. After understanding her ability to write stories in the psychiatric narrative of the patient, we found out that dynamic psychotherapy we have administered has strengthened both the therapeutic relationship in the patient and demonstrated a clear improvement in the patient's present complaints with transference and countertransference with a written story. Patient's attachment, trust, and safe environment problems and related pathological defense mechanisms were evaluated in the context of the patient's stories. The patient was tentatively diagnosed with conversion disorder and was very eager to come to therapy sessions on a regular basis. Her motivation to come every session and share her stories during sessions allowed us to discuss the patient's childhood and especially her relationship with her mother in a way that provided emotional insight and awareness.

KEYWORDS
Conversion; disorder; dynamic; psychotherapy; story; writing

[Abstract:0532][Schizophrenia and other psychotic disorders]

Treatment of catatonia in adolescent with lorazepam: a case report

Ali Metehan Çalışkan[a], Mehmet Arslan[b], Ebru Çiftçi[a], İkbal İnanlı[a] and İbrahim Eren[a]

[a]Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Department of Psychiatry, Babaeski State Hospital, Kırklareli, Turkey

E-mail address: drmehmetarslan@hotmail.com

ABSTRACT

Catatonia is a syndrome of motor dysregulation that includes excessive motoric activity, stereotypical movements, extreme negativism or mutism, echolalia or echopraxia, and other involuntary movements (1). Catatonia has been associated with a wide variety of psychiatric, medical, neurological, substance-related, endocrine, infectious, and metabolic conditions. Benzodiazepines and electroconvulsive therapy are considered first-line treatments.

Case presentation: The patient is a 17-year-old male with no previously documented psychiatric history. He was admitted to our outpatient unit due to persecution delusions, poor appetite, insomnia, and auditory and visual hallucinations. Olanzapine 5 mg/day was prescribed to manage psychotic symptoms. Three days after starting olanzapine the patient became suddenly stiff showing catatonic symptoms. The features of his catatonic episode were mutism, stupor, immobility and an extreme level of rigidity, waxy flexibility, posturing, including the psychological pillow. Upon physical examination, upper and lower extremities were hyperreflexic. The results of full blood count, biochemistry, thyroid function tests, and B12 vitamin level tests were normal. Brain imaging including CT scan, magnetic resonance imaging (MRI) scan, and electroencephalography (EEG) was all normal. According to DSM-5 criteria, catatonia was diagnosed and lorazepam 2 mg/day was prescribed. Within two hours, his flexed posture improved significantly and he became more verbally interactive and lucid. The patient completely recovered from catatonia in three days. Olanzapine was titrated up to 10 mg for psychotic symptoms. Lorazepam was continued at the current dose. On the 20th day of hospitalization, he was discharged home on olanzapine 10 mg/day and lorazepam 1 mg/day and with a scheduled follow-up psychiatry appointment. There was no recurrence of catatonia during 3 months of follow-up. Our patient experienced a first episode of catatonia and psychosis. Lorazepam rapidly relieved our patient's catatonic symptoms. In conclusion, lorazepam is a reasonable initial choice in the treatment of catatonia.

KEYWORDS

Catatonia; benzodiazepines; lorazepam; olanzapine; adolescent

[Abstract:0533][Psychopharmacology]

Mirtazapine-induced priapism: a case report

Ali Metehan Çalışkan[a], Mehmet Arslan[b], Sıla Çalışkan[c], Yusuf Çokünlü[a] and İbrahim Eren[a]

[a]Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Department of Psychiatry, Babaeski State Hospital, Kırklareli, Turkey; [c]Department of Psychiatry, Beyhekim State Hospital, Konya, Turkey

E-mail address: drmehmetarslan@hotmail.com

ABSTRACT

Priapism is a prolonged stimulation with painful, persistent penile erection without sexual stimulation or arousal. Drug-induced priapism is associated with antidepressants, antipsychotics, mood stabilizers, anticoagulants, and antihypertensive agents. We present a case with repeated priapism associated with mirtazapine use.

Case presentation: The case is a 23-year-old male with no previously documented psychiatric history. The patient was admitted to our outpatient unit due to depressed mood, anhedonia, poor appetite, insomnia, feelings of hopelessness, and helplessness. The patient met the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, for a diagnosis of Major Depressive Disorder. Mirtazapine 30 mg/day was prescribed to manage depressive symptoms. Two days later, he presented to the emergency services with the complaints of continuous penile erection and pain of 16 h duration. The urology service was consulted, and the patient's priapism resolved completely within a few hours after intracavernosal washing. Laboratory tests were performed, including a complete blood count, a basic metabolic profile, and a coagulation study. All the results were within normal limits. Medical history was negative for blood dyscrasias, tumors, spinal cord injury, trauma, and substance abuse. Mirtazapine was stopped, and the patient was switched to 10 mg per

KEYWORDS

Priapism; mirtazapine; depression; antidepressant; side effect

day of escitalopram. The priapism had not returned when he was seen in follow-up a month later. Priapism may occur at any time during the treatment course of psychotropic medications. Clinicians who prescribe mirtazapine should be aware of the possibility of the rare complication of priapism in their patients.

[Abstract:0534][Mood disorders]

Synthetic cannabinoid-induced manic episode in patient with previously unknown bipolar disorder

Ali Metehan Çalışkan[a], Mehmet Arslan[b], Sıla Çalışkan[c], İkbal İnanlı[a] and İbrahim Eren[a]

[a]Department of Psychiatry, Konya Research and Training Hospital, Konya, Turkey; [b]Department of Psychiatry, Babaeski State Hospital, Kırklareli, Turkey; [c]Department of Psychiatry, Beyhekim State Hospital, Konya, Turkey

E-mail address: drmehmetarslan@hotmail.com

ABSTRACT

Synthetic cannabinoids are becoming a large public health concern due to their increasing use, unpredictable toxicity, and abuse potential. The most common symptoms in cases reported with synthetic cannabis use are agitation, angry, paranoia and reference delusions, disorientation, seizure, and nausea. We report a patient with the previously undiagnosed bipolar disorder who experienced a manic episode after smoking a synthetic cannabinoid.

Case presentation: MY is a 23-year-old male with no previously documented psychiatric history. The patient admitted to our psychiatry inpatient clinic due to increased level of energy, grandiosity, decreased need for sleep, pressure of speech, irritability, excessive speech, physical and verbal aggression, distractibility, and auditory hallucinations. Each of these symptoms occurred within 24 h of smoking synthetic cannabinoid. The patient had no previous history of synthetic cannabinoid use. There was a history of bipolar disorder in the family. The results of full blood count, biochemistry, thyroid function tests, and B12 vitamin level tests were normal. His urine toxicology was positive for synthetic cannabinoid and negative urine toxicology for stimulants, cocaine, opiates, benzodiazepines, and cannabinoid. The patient was diagnosed with Substance-induced Bipolar Disorder according to DSM 5 (American Psychiatric Association 2013), olanzapine treatment was started 10 mg/day and dosage was increased to 20 mg/day. The patient's symptoms gradually improved within three weeks and the patient was discharged with 20 mg/day olanzapine. Here, we describe a case of manic episode induced by within 24 h of smoking synthetic cannabinoid. In conclusion, increasing use of synthetic cannabinoid, clinical psychiatrists should keep in mind substance use history of cases of the rapid onset manic episode.

KEYWORDS

Synthetic cannabinoid; substance use disorder; bipolar disorder; acute mania; olanzapine

[Abstract:0535][Psychopharmacology]

Tardive akathisia with clozapine: a case report

Dudu Demiröz, Zeynep Yücehan, Nafiye Yağlı, Seher Serez Öztrük, Hatice Yardım Özayhan and İbrahim Eren

Konya Research and Training Hospital, Beyhekim Psyciatry Clinic, Health Sciences University, Konya, Turkey

E-mail address: drdemiroz42@gmail.com

ABSTRACT

Akathisia is a movement disorder characterized by involuntary movements that cause restlessness and distress. Antiemetic, antidepressant, antiepileptic, anticholinergic, sympathomimetic and antiparkinsonian drugs, calcium channel blockers, lithium and especially antipsychotic drugs can cause movement disorders. Tardive akathisia (TA) is a late-onset movement disorder. In our case, olanzapine treatment of tardive akathisia caused by clozapine is described.

Case presentation: 32 years old, male patient. The first complaints of the patient started 10 years ago in the form of nervousness, aggression, auditory hallucinations, self-talk, reference

KEYWORDS

Akathisia; Barnes Akathisia Scale; Clozapine; Risperidon; Tardive akathisia

delusions, suspicion, persecution delusions, closing in. The patient used oral risperidone for varying doses and he was benefited from the treatment with risperidone. Three years ago, depot risperidone treatment (50 mg/14 days) was started when the patient did not use the treatment regularly. Approximately 1 year ago, after exacerbation of positive symptoms, nervousness, aggression, clozapine was added to treatment. Clozapine was increased to 300 mg/day. The patient's complaints of restlessness, inability to stay still, and urgent need to move have been started for 3–4 months. The patient who had an increase in complaints was admitted to our clinic after the policlinic application. BARS (Barnes Akathisia Scale) score was 13. The current situation of the patient was thought to be tardive akathisia due to clozapine. Clozapine was gradually reduced and discontinued. Olanzapine treatment was started and the dose was increased to 20 mg/day. The patient's akathisia table declined. BARS: 3. The patient was discharged with olanzapine 20 mg/day, depot risperidone 50 mg/14 days. In the pathophysiology of tardive akathisia due to antipsychotic drugs, firstly, dopaminergic mechanisms are notable. Almost all antipsychotics (in this study, clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole) were reported to cause akathisia in a recent review of 77 studies and surveys. The patient was taking antipsychotic treatment for 10 years. Oral risperidone was used in the first 7 years of treatment, depot risperidone was used in the last 3 years, and clozapine treatment was added for the last 1 year. Another point to be considered in the differential diagnosis in relation to our case is the development of akathisia due to the used risperidone. Because, in the literature, there are case reports of akathisia caused by risperidone. After our patient's clozapine treatment was discontinued and olanzapine was switched on, with the recovery of the akathisia, we decided that akathisia was not associated with risperidone. Although there are reports in the literature that clozapine improves TA, our case had akathisia findings of 6–7 months after clozapine started. So, we think that the current state of our patient is tardive akathisia due to clozapine. Secondary movement disorders due to antipsychotic use constitute a large part of the extrapyramidal disorders seen in clinical practice. The ideal approach is to prevent these disorders from developing. This can be achieved with antipsychotic drugs which are used only when there is a definitive indication and at the most effective doses. In addition, patients using antipsychotic medication should be evaluated regularly for abnormal involuntary movements using rating scales.

[Abstract:0536][Mood disorders]

ECT application in an adolescent case

Yakup Doğan[a], Canem Kavurma[a], Arif Önder[a], Öznur Bilaç[a] and Aslı Sürer Adanır[b]

[a]Manisa Mental Health Hospital Department of Child and Adolescent Psychiatry, Manisa, Turkey; [b]Department of Child and Adolescent Psychiatry, Akdeniz University, Antalya, Turkey

E-mail address: drykpdgn@gmail.com

ABSTRACT

Electroconvulsive Therapy (ECT) is an effective treatment method for the treatment of mental illnesses. Studies on the use of ECT in adolescents began in the 1980s and were found to be more effective than psychopharmacology alone in the appropriate patients.

Case presentation: MG, 15-year-old male patient. He was referred to our clinic with psychotic depression because of unhappiness, lack of enjoyment of life, aggression, somatic complaints, fear, resistant suicidal thoughts after the second hospitalization in three months in a university hospital. In the examination, his mood was depressed and his affect was restricted. The amount of speech was reduced; he was giving short answers to questions. Psychomotor activity was decreased. In the content of his thought, there were delusions of harm from his family. He was diagnosed with major depression with psychotic features and he was hospitalized. Venlafaxine and aripiprazole therapy were started to the patient who did not benefit from fluoxetine 60 mg/day, alprazolam 2 mg/day, sertraline 150 mg/day, risperidone 1 mg/day, aripiprazole 10 mg/day and 13 sessions of transcranial magnetic stimulation (TMS). ECT was started after neurology and anaesthesia approval for suicidal thoughts and delusions in the patient who did not benefit from the treatment with 225 mg venlafaxine and 20 mg aripiprazole for one month. Bifrontal bilateral application started with 40% electric dose. In every application, it increased by 20% and reached 160%. The Beck depression scale score, which was 32 before ECT, dropped to 16 after repeated ECT applications. Side effects were not described except for headache during ECT. The CGI-SI score administered during the hospitalization period decreased from 6 to 3. The CGI-GI score was 2. The patient was continued to be treated with 225 mg/day of venlafaxine, whose suicidal thoughts and delusions receded, and was discharged with partial recovery.

Although ECT has been shown to be effective and reliable in clinical conditions such as major depression, bipolar disorder, and schizophrenia in adolescents, concerns about possible adverse

KEYWORDS

Adolescent; depression; electroconvulsive therapy; psychopharmacology; psychotic

effects on the developing brain, lack of experience, negative perceptions of families about ECT made its use very rare when compared to adults in Western societies. In the handbook of American Academy of Child and Adolescent Psychiatry, it is written that after evaluating diagnosis, severity of symptoms, and pharmacotherapy response criteria, ECT can be used in appropriate patients. These three criteria are: (1) Presence of a disease with ECT indications (major depression, mania, schizophrenia, etc.), (2) the symptoms of the disease are permanent and restrictive, and (3) continuing symptoms after using two different psychotropic treatments. It has been observed that our case meets the criteria of diagnosis, symptom severity, and psychopharmacologic nonresponse. ECT treatment is with significant benefit and low-grade side effect compliant with the literature. ECT is a treatment with effective and low side effect profile in treatment-resistant cases. When there is a resistance, ECT treatment should be evaluated among the options and administered in the treatment of adolescents patients.

[Abstract:0539][OCD]

Mid-life crisis with obsessive and psychotic features

Serdar Süleyman Can, Ali Çayköylü, Özlem Karakaya and Gökçen Turan

Ankara Yıldırım Beyazıt University, School of Medicine, Psychiatry Department, Ankara, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT

Schizophrenia and obsessive-compulsive disorder are defined as different disorders but clinical manifestations could go hand in hand. Clinical course may overlap or change from one to the other.

Case presentation: A 31-year-old female patient presented with complaints of obsessions to some words, referential delusions such as thinking that when words which she gets irritated by being said, they would have said for her and aggressiveness to people saying those words. The patient, diagnosed with Bipolar Affective Disorder at her previous administration to another clinic, 11 sessions of electroconvulsive therapy had been administrated but there had been no long-term remission of her symptoms. At that time, she had the medication as lithium 1200 mg/day, risperidone 4 mg/day, biperiden 2 mg/day, clonazepam 1 mg/day. When her history had been reviewed, it was realized that first complaints were obsessions for words referring time, getting older, and referential delusions had been added in time. Having benefitted from lithium treatment, medication had been continued at the same dosage. Clonazepam dosage was increased to 2 mg/day while she had symptoms of anxiety and irritability. Risperidone treatment was stopped because of the lack of treatment response. Trifluoperazine treatment was started and increased to 10 mg/day. Fluoxetine 20 mg/day was started as antiobsessional treatment. Consequently, when the anamnesis was examined in detail, it was first noticed that obsessive-compulsive disorder was started and then the psychotic content was added to the progression of her disease. As a result, learning the initial period of the disease in a patient with psychotic symptoms will guide us in the treatment.

KEYWORDS

Case; diagnosis; mid-life; obsession; psychosis

[Abstract:0540][Motor disorders]

The efficacy of methylphenidate treatment in an adolescent patient with essential tremor

Necati Uzun[a] and Burak Elbeyli Ahmet[b]

[a]Department of Child and Adolescent Psychiatry, Elazığ Psychiatry Hospital, Elazığ, Turkey; [b]Department of Neurology, Necmettin Erbakan University, Meram School of Medicine, Konya, Turkey

E-mail address: necatiuzun42@gmail.com

ABSTRACT

Essential tremor is a syndrome which characterized by postural or kinetic tremor, usually affecting the hands and forearms. The underlying cause of essential tremor is unknown. Epidemiological studies indicate that up to 5% of the adults have essential tremor, and 5–

KEYWORDS

ADHD; adolescent; essential tremor; methylphenidate; propnalolol

30% of adults with essential tremor report tremor onset during childhood. However, no prospective studies targeted specifically to children about essential tremor. Some factors such as emotional stress, fatigue, hunger, caffeinated drinks, and smoking cigarettes can be worsening the severity of essential tremor. Also, some drugs such as lithium, antidepressants, antipsychotics, and methylphenidate can exacerbate tremor. Propranolol and primidone usually can be beneficial in the treatment of essential tremor.
Case presentation: A 17-year-old boy consulted neurology clinic with complaints of hand tremor. In neurological examination, no pathology was obtained except tremor in both hands. Magnetic resonance imaging (MRI) was performed to the patient and MRI revealed no pathology. There was no problem in biochemical and hormone tests. The patient was diagnosed essential tremor and propranolol 60 mg/day was started. After one month, at the second visit propranolol was elevated to 120 mg/day because of continuation of the essential tremor. Meanwhile, the patient who had been followed up and treated with attention-deficit/hyperactivity disorder (ADHD) diagnosis in the last year, consulted again to the child and adolescent psychiatry clinic for ADHD treatment. Methylphenidate 27 mg/day treatment for ADHD treatment was initiated who has been used before for the treatment of ADHD. Essential tremor completely disappeared after one week after the patient started treatment with methylphenidate 27 mg/day. At this time, the patient stopped the treatment of propranolol by himself and essential tremor symptoms never recurred over 2 months of follow-up. Propranolol is frequently used in the treatment of essential tremor. Patients who do not benefit from treatment with propranolol may benefit from agents such as benzodiazepines, botulinum toxin, and gabapentin. However, antidepressants, antipsychotics, and stimulants used in psychiatric disorders often increase the severity of essential tremor. A recent study suggested that striatal dopamine transporter abnormalities can be seen in the patients with essential tremor. Our case has shown that methylphenidate may be useful in essential tremor treatment differently from the current literature. This may be related to striatal dopamine transporter abnormalities that occur in essential tremor cases. Future studies investigating the stimulants and essential tremor will improve our knowledge of this topic.

[Abstract:0542][Psychopharmacology]

Lamotrigine-induced Stevens-Johnson Syndrome

Hüseyin Kara[a], Özgen Özçelik[a], Mehmet Murat Balcı[a], Mehmet Murat Kuloğlu[a] and Talya Tomar[b]

[a]Department of Psychiatry, Akdeniz University, Antalya, Turkey; [b]Medical School, Akdeniz University, Antalya, Turkey

E-mail address: kayfen_huseyin@hotmail.com

ABSTRACT
Lamotrigine is an antiepileptic used for treating epilepsy. Recently, this drug has started being used for mood stabilization in psychiatric patients. Lamotrigine is associated with hypersensitivity reactions, which are most commonly characterized by skin rash. Cutaneous side effects of this drug are mostly maculopapular eruptions that have been seen in 10% of patients. The most troublesome side effect of lamotrigine is an allergic rash which makes it necessary to withdraw the drug.
In this study, we report a patient diagnosed with bipolar disorder and borderline syndrome, and who had received lamotrigine but developed generalized skin rash at the second week of treatment and the drug was stopped.
Case presentation: 20-year-old, female, single. She was hospitalized to the psychiatry service with pre-diagnosis of bipolar disorder and borderline syndrome. She was using olanzapine tablet 10 mg/day and lamotrigine tablet 50 mg/day for a week as a treatment that began at another centre. After the patient's examination, lamotrigine dosage was increased to 100 mg. One week later, she had rash and itching on her face and arms and swelling on her face and lips. The patient was evaluated as acute angioedema, urticaria by the dermatology department. Lamotrigine was suspected to be the culprit and was discontinued immediately. Intravenous prednisone 40 mg was given to the patient and desloratadine tablet 5 mg/day was started. On the following day, extensive erythematous papules, plaques, vesicles, and crust impetigo in the malar and frontal areas of the face and erythematous papulovesicular lesions in the trunk and limbs including palmar and plantar regions were observed. A culture of pus was done from the lesions on her face and *Corynebacterium tuberculostearicum* proliferated. Elevation of liver function (ALT: 121, AST: 92) was observed in the routine laboratory tests of the patient. The patient who was referred to the dermatology department again was diagnosed with the Stevens-Johnson syndrome (SJS). On the 18th day of her hospitalization, the patient was discharged upon her and her relatives' requests. Two days

KEYWORDS
Drug reaction; lamotrigine; Stevens-Johnson syndrome; side effects; skin rash

after discharge, crusted lesions on her body, macerations on her hands and toes, haemorrhagic crusts in her mouth, erosions in the oral mucosa were seen in the dermatological control. Conjunctiva, nasal mucosa, and genital mucosa were normal. Methylprednisolone tablet 32 mg/day and for the lips mupirocin 2% pomade were given to the patient. One month later, at the patient's control, it was found that the lesions completely disappeared except the erythematous macules on her face and pustular lesions on them.
SJS is an immunecomplex-mediated hypersensitivity complex that typically involves the skin and the mucous membranes. SJS is a serious systemic disorder with the potential for severe morbidity and even death. The risk of developing SJS with lamotrigine is rare and relatively predictable during the first few weeks of its use; clinicians prescribing this medication should, however, be aware of this high-risk condition. It is mentioned that these side effects can be reduced by starting the treatment with lamotrigine at a low dose or making the dose increasement slow.

[Abstract:0546][Psychopharmacology]

Low-dose ariripiprazole use in hyperprolactinemia caused by paliperidone palmitate: a case report

Neslihan Yazar, Ahmet Ataoğlu, Adnan Özçetin, Safiye Bahar Ölmez, Zehra Başar Kocagöz and Merve Çavdar

Duzce Universty School of Medicine, Department of Psychiatry, Duzce, Turkey

E-mail address: nyazar91@gmail.com

ABSTRACT
One of the side effects of the antipsychotic drugs is hyperprolactinemia. Clinically, hyperprolactinemia is the plasma prolactin level above 18 ng/ml in males and 30 ng/ml in females. The most obvious symptoms of hyperprolactinemia caused by antipsychotics, breast tenderness, galactorrhea, menstrual irregularity, decreased libido, and decreased bone mineral density. The side effects of hyperprolactinemia of antipsychotics are often dose dependent. Atypical antipsychotics such as clozapine, olanzapine, quetiapine, aripiprazole, and ziprasidone do not significantly increase the prolactin level, while risperidone and amisulpride may increase prolactin levels in atypical antipsychotics. In this case report, we present a case whose hyperprolactinemia (based on paliperidone palmitate treatment) was treated with aripiprazole.
Case presentation: A 48-year-old male, single, living with his family, began to receive treatment for the diagnosis of Schizophrenia based on his strange behaviours that started after the military service. His complaints were social withdrawal, increased interest in scientific matters, and hallucinations. He admitted to the psychiatric clinic 2 years ago because of his poor treatment compliance. His current treatment was paliperidone palmitate 75 mg per month and he is in a remission period when we saw him in our outpatients' clinic. In his routine blood tests for control examination, haemogram and biochemical evaluation were seen as normal but his prolactin level was 75 ng/ml in the hormone evaluation. Then we add 5 mg per day aripiprazole in his treatment due to decrease in his hyperprolactinemia. His control prolactin level was observed at 30 ng/ml in the control tests after a month. Paliperidone treatment continued because the patient's compliance with treatment was low. But also we increased the aripiprazole dosage in his follow-up. The long-lasted aripirazole treatment can be a better option for this patient than long-lasting paliperidone palmitate. Risperidone is known to cause more hyperprolactinemia than other atypical antipsychotics due to its high affinity to 5-HT2 receptors and D2 receptors compared to other atypical antipsychotics. There are different studies regarding the side effect of hyperprolactinemia of paliperidone, which is an active 9-OH metabolite of risperidone. There are studies that suggest that 9-hydroxy metabolite plays a predominant role in the release of risperidone into prolactin release and increased side effects of hyperprolactinemia in the use of paliperidone. When hyperprolactinemia is detected by antipsychotic use; treatment options reduce the antipsychotic dose, to pass to another antipsychotic without affecting the prolactin level, to add a partial dopamine agonist. Low-dose aripiprazole therapy is successfully administered in hyperprolactinemia due to other antipsychotics. Especially male schizophrenic patients with negative symptoms cannot express the clinical effects of hyperprolactinemia (like loss of libido). The patient may be exposed to long-term side effects of hyperprolactinemia. Therefore, it is recommended that patients taking antipsychotics should be followed closely for the side effect. In our case, there was a decrease in prolactin levels after the addition of low dose aripiprazole to hyperprolactinemia, which is similar to risperidone but is different in terms of hyperprolactinemia in the use of paliperidone palmitate. Our case was considered worthy to be presented for this reason.

KEYWORDS
Antipsychotics; aripiprazole; hyperprolactinemia; paliperidone palmitate; risperidone

[Abstract:0547][Other]

A dissociative identity disorder case of bilateral pseudocortical blindness, left pseudohemiparesis and speech disorder and the therapy administered

Mehmet Asoğlu, Meltem Göbelek, Öznur Akıl, Faruk Pirinççioğlu and İsmail Karka

Department of Psychiatry, School of Medicine, Harran University, Sanliurfa, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT

Dissociative disorders are defined as a loss of motor and/or sensory functions, which point a neurologic or another organic disease due to psychological conflict or requirement. Dissociative identity disorder (DID) is a psychiatric disease, which has attracted most of the attention among other dissociative disorders and which is associated with memory and identity disorders. In this case presentation, a dissociative identity disorder of a 20-year-old patient, which developed after severe headache and fainting and presented with bilateral pseudocortical vision loss, left pseudohemiparesis, and speech disorder, is discussed together with the therapy administered.

Case presentation: Mr T is a 20-year-old male patient. He presented to the psychiatric clinic for the first time with his relatives upon complaints of bilateral total vision loss, speech difficulty, loss of strength on the left side of the body and inability to walk. Complaints of the patient started 30 hours ago, while he was at a training course with a severe headache. He suddenly fainted on the way to the hospital for severe headache. No organic pathology was found as a result of all investigations at the emergency department of our hospital and then the patient was referred to the psychiatry clinic. As the patient who presented to our psychiatric outpatient clinic had difficulty in speech, he tried to express himself in sign language. As a result of the detailed mental status examination, the patient was thought to be dissociative. Hypnotherapy was administered to the patient for almost 1 h. During the therapy, it was observed that the patient was dominated by an alter identity. We found out via the alter identity that the patient had a car accident resulting in material damage 1 month ago with his two cousins. It was understood that 1 alter identity has developed in the patient as a result of this event almost 1 month ago. The real identity of the patient was integrated with the alter identity developed 1 month ago by use of hypnotherapy. Vision loss of the patient fully recovered, his speech was normal and fluent, and he was able to walk. His last memory was having a severe headache at the training course and getting into a car with his friends to go to the hospital. The patient described a full 30-h anamnesis during the whole process, including the hypnotherapy we administered. It was decided to follow the patient without prescribing any medicine, since the symptoms of the patient recovered. DID, which is a chronic and poly-symptomatic disease, in general may clinically present with various symptoms. DID is one of the diseases with very well-understood aetiology and treatment among the psychiatric diseases. Treatment is only psychotherapy and the prognosis is good with appropriate psychotherapy. This case presentation aims to highlight that dissociative identity disorder may be confused with several other psychiatric diseases and in case of failing to make the right diagnosis and apply the necessary psychotherapy; the patients may suffer without any treatment for a long period of time.

KEYWORDS

Anamnesis; dissociative disorders; dissociative identity disorder; hypnotherapy; psychotherapy

[Abstract:0551][Disruptive behavior disorders]

Risperidone treatment for behavioural disturbances in identical twins with pseudohypoaldosteronism type 1

Evrim Aktepe, Pınar Aydoğan Avşar and Yakup Erdoğan

Department of Child and Adolescent Psychiatry, Suleyman Demirel University, Isparta, Turkey

E-mail address: dr_pinaraydogan@hotmail.com

ABSTRACT

Pseudohypoaldosteronism type 1 (PHA1) is a condition characterized by problems regulating the amount of sodium in the body. There are two types of PHA1 distinguished by the severity of disease, the genes involved and how they are inherited. Autosomal dominant PHA1 caused by mutations in the NR3C2 gene, characterized by excessive sodium loss from the kidneys. This form of the condition is relatively mild and often improves in early childhood. The other type,

KEYWORDS

Genetic syndromes; mental retardation; NR3C2 gene deletion; pseudohypoaldosteronism type 1; risperidone

autosomal recessive PHA1, caused by mutations in the SCNN1A and SCNN1B genes, characterized by sodium loss from the kidneys and other organs. This type is more severe. In autosomal dominant PHA1, the clinical spectrum may vary from asymptomatic patients diagnosable only by elevated aldosterone levels to patients with salt-losing nephropathy, usually presents with failure to thrive, vomiting, and dehydration in early infancy. Developmental delay, mental retardation, head, eye, extremity, and congenital heart anomalies are widely seen.
Case presentation: In this case report, we present 5 years old identical male twins with pseudohypoaldosteronism type 1 autosomal dominant form who was presented to our clinic with complaints such as aggression, harming other and themselves, no reaction to pain and hyperactivity. Because of the dysmorphic phenotype detected at birth, genetic research was done and NR3C2 gene deletion was found on the 4th chromosome. They had serious developmental retardation; held up head at age 1, sat with support at age 2, started crawling at age 3, and started walking at age 4. They both have small atrial septal defects. Also one of the twins had a frontal bone surgery when he was 4 months old because of the protrusion. When they were presented to the clinic, verbal communication could not be established, they were able to spoke only three words. In physical examination, they had low nasal bridge, triangular face, large ears, and small lips. They were very hyperactive and it was very difficult for their parents to keep them under control. One of them had a history of falling from balcony and the other one had burnt himself with boiling water. Although they were on special education for 3 years they could not receive commands and had no toilet education. Risperidone is an atypical antipsychotic which has FDA approval for treatment of irritability associated with autism, including symptoms of aggression, self-injury, and temper tantrums after 5 years of age. Because of uncontrollable behavioural disturbances of twins, risperidone treatment was started at low dosage (0.25 mg/day) due to the congenital heart condition. During control visit, parents noted a prominent reduction in hyperactivity and aggression complaints. Also learned from the teacher's form that they were more compatible in special education and more eager to receive commands. In conclusion, mental retardation, behavioural disturbances such as hyperactivity, aggression, and developmental delay are very common in children with genetic syndromes. Special education is very important for them to gain academic, functional and life skills to live independently. Antipsychotic treatments such as risperidone may lower behavioural disturbances, and improve compliance with education and progression.

[Abstract:0552][Psychopharmacology]

Aripiprazole-induced psychogenic polydipsia in a child with conduct disorder

Tayfun Kara[a] and İsmail Akaltun[b]

[a]Department of Child and Adolescent Psychiatry, Gaziantep Dr. Ersin Arslan Training andResearch Hospital, Gaziantep, Turkey; [b]Department of Child and Adolescent Psychiatry, Health Sciences University Bakirkoy, Dr. Sadi Konuk Research and Training Hospital, Istanbul, Turkey

E-mail address: drmahirx@hotmail.com

ABSTRACT
Conduct disorder is one of the most commonly encountered difficulties in the mental health of children. Aggressive behaviour toward other people, animals, or property, deceitfulness, stealing, or other severe forms of rule-breaking are one of the main characteristics of this disorder. Antipsychotic agents are used to control disruptive behaviours in clinical conditions in which aggression constitutes a basic component. Irregularity of dopaminergic activity plays a role in aggression, and most antipsychotic agents antagonize that activity. Psychogenic polydipsia is a condition characterized by excessive intake of water independent of a feeling of thirst and antidiuretic hormone and that can result in severe clinical complications if not treated. We describe a case of psychogenic polydipsia developing following atypical antipsychotic (aripiprazole) use during treatment of a child diagnosed with conduct disorder.
Case presentation: An 11-year-old child was brought to our clinic by his family. He was brought to our clinic due to truancy, frequent fighting, mistreating animals, and taking money and objects from the home and friends without permission. Conduct disorder was diagnosed following interviews and assessments and based on DSM-5 diagnostic criteria. The patient was started on aripiprazole 5 mg and advised to attend follow-up 2 weeks subsequently. When the patient was brought to follow-up 2 weeks later, we learned that excessive water drinking behaviour had begun 2–3 days after starting the medication, that this had worsened and he was now drinking 40–50 glasses of water a day. The endocrinology department was consulted following these new symptoms. Psychogenic polydipsia was suspected following assessments at the paediatric endocrinology department and the water deprivation test. We formed a strong opinion that the psychogenic polydipsia might be associated with aripiprazole. Aripiprazole was discontinued, and the patient was invited to a further check-up. On the arrival, we learned that the patient's behavioural problems were persisting but that the excessive water drinking

KEYWORDS
Psychogenic polydipsia; aripirazole; safety; side effects; antipsychotic

had resolved. It has been suggested that psychogenic polydipsia has a multifactorial aetiology. The dopaminergic, cholinergic and histaminergic systems and the hippocampus are believed to be involved in the aetiology (5,6). Aripiprazole exhibits a partial agonist effect on dopamine D2 receptors. Thirst and water drinking are controlled by the lateral hypothalamus. Dopamine acts as an important neurotransmitter or neuroregulator in this region. Animal studies have shown an association between increased dopaminergic activity and polydipsia. Some publications have suggested that polydipsia may be caused by inappropriate antidiuretic release syndrome developing in association with antiepileptic, psychotropic or anticholinergic drug use. In our case, too, psychogenic polydipsia developed independently of antidiuretic hormone but after use of the atypical antipsychotic aripiprazole. Some studies have reported that dopamine hypersensitivity may be involved in the development of polydipsia. We think that this condition may be associated with an increase in dopamine or dopamine sensitivity with aripiprazole use. Aripiprazole may have caused psychogenic polydipsia through dopamine hypersensitivity or by causing a relative increase in dopamine levels. We think that physicians should be aware of polydipsia, capable of causing severe complications, as a potential side effect.

[Abstract:0553][Mood disorders]

Administration of ketamine infusion in unipolar depression

Öznur Akıl, Meltem Göbelek, İsmail Karka, Faruk Pirinççioğlu, Özlem Beğinoğlu and Mehmet Asoğlu

Department of Psychiatry, Harran University, Sanlıurfa, Turkey

E-mail address: canbolatoznur@gmail.com

ABSTRACT

Ketamine is known as *N*-methyl-D-aspartate glutamate receptor antagonist and can be effective in the treatment of depression. Recent studies have shown that ketamine causes rapid but temporary favourable antidepressant effects in treatment resistance. We would like to report a case who had been admitted to the hospital due to a depressive episode with the symptoms of loss of appetite, sleeping, and speaking problems, and was later diagnosed with obsessive-compulsive disorder after the administration of ketamine infusion.

Case presentation: We report a college-educated 25-year-old male who was doing his compulsory military service in Izmir at the time of depressive symptoms. He was admitted to the hospital with the complaint of the 10 weight loss and worsening of the symptoms such as loss of appetite, feeling of the sadness, tearfulness, and loss of interest. Two years ago, he had also been hospitalized with the diagnosis of depression and successfully treated with Venlafaxine and Mirtazapine for 6 months.

Physical examination did not reveal anything remarkable. The patient was not cooperative during the mental health evaluation. He refused to speak and did not make any eye contact. He was in a depressive and sad mood. Her routine laboratory work revealed low free thyroid hormone levels and hence he was referred to Endocrinology and Metabolism Clinic. He was diagnosed with a pituitary tumor-hemangioma – after magnetic resonance imaging. First, electroconvulsive therapy (ECT) was planned due to the fact that the patient had been refusing to eat and drink. But ECT was found to be risky after the consultation of the patient with the Department of Neurosurgery. The informed consent was obtained from the relatives of the patient for the administration of intravenous ketamine. Under the conditions of intensive care unit, intravenous ketamine was given with a single dose of 0.5 mg/kg over 40 min. There was no side effect reported right after the treatment within 24 h. He started to eat and talk the day after the treatment. When he was asked about his symptoms and he talked about the reason why he stopped eating. He reported that when he ate, his relatives became sick so he stopped eating. He was diagnosed with obsessive-compulsive disorder. Aripiprazole 20 mg/day, Venlafaxine 75 mg/day, Mirtazapine 30 mg/day were added to the treatment regimen. The patient was discharged with a partial remission at the 47th day of the admission with improvements of the symptoms. Ketamine has been demonstrated to play a rapid beneficial role in the treatment of depression but there is still limited information about the dose–response relationship or the most suitable administration way. Therefore, future studies are recommended in order to test the efficacy of ketamine when compared with other active comparators such as electroconvulsive therapy or antidepressant–antipsychotic drugs combinations. In terms of effective treatment, more studies are needed on ketamine dosage, administration method, and frequency.

KEYWORDS

Ketamine; unipolar depression; obsessive-compulsive disorder; treatment resistance; efficacy

[Abstract:0554][OCD]

Intersection of faith and symptoms in obsessive-compulsive disorder

Can Tuncer, Burcu Bakar Kahraman, Volkan Seneger and Rümeysa Yeni Elbay

Department of Psychiatry, Istanbul Medeniyet University, Istanbul, Turkey

E-mail address: senegervolkan@hotmail.com

ABSTRACT

Obsessive-compulsive disorder (OCD) is culture free and has prevalence more or less up to 2% throughout the world. Cultural features, especially faith of a patient, may determine the content of obsessions and compulsions. It is important to differentiate faith-related obsessions and compulsions from delusions. Therefore, the aim of this case report is to highlight the clinical skills required to make it possible so appropriate diagnosis and management of patient would be achieved.

Case presentation: The patient was 50 years old, married with two children. About two years ago, she said she was "possessed" by "non-Muslim Jinns" telling her to say "blasphemous things." She said she was silencing "these voices coming from inside" by reading Surahs from Quran. Her life became miserable and her daily functions were deteriorated. She has been suffering from "anxiety and fear" since her marriage as she said. She was given antipsychotic medications for the last 3 months and they did not provide any relief. We prescribed escitalopram together with a small dosage of quetiapine and there was a significant improvement in her clinical picture. When there is a clear distinction between obsession, compulsion, and delusion on the basis of the patient's understanding of the cause of her illness it enables to reach the diagnosis of OCD without further complications. The role of cultural issues in the context of OCD should always be a prerequisite in assessment, differential diagnosis, and management of this disorder.

KEYWORDS

Faith; OCD; differential diagnosis

[Abstract:0555][Psychopharmacology]

Phagophobia successfully treated with low-dose aripiprazole in an adolescent: a case report

Rukiye Çolak Sivri[a], Hayriye Hızarcıoğlu Gülşen[b] and Arzu Yılmaz[c]

[a]Department of Child and Adolescent Psychiatry, Ankara Research and Training Hospital, Ankara, Turkey; [b]Department of Pediatric Gastroenterology, Ankara Research and Training Hospital, Ankara, Turkey; [c]Department of Pediatric Neurology, Ankara Research and Training Hospital, Ankara, Turkey

E-mail address: drrukiyecolaksivri@gmail.com

ABSTRACT

Phagophobia is a condition characterized by avoidance of swallowing foods, intense fear of choking while eating solid food in the absence of phsysiological and anatomical abnormalities. Patients often have an intense fear experience by swallowing food or drinks. Phagophobia effects may include a significiant weight loss and malnutrition results of avoidance of eating. It may severe enough to be life-threatening. Phagophobic patients usually show panic symptoms such as breathing difficulties, muscle tension, tremor, flushing during meals, and commonly refuse eating solid food or avoidance these conditions. Phagophobia was mentioned in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) in the new diagnostic category of avoidant/restrictive food intake disorder (ARFID). Literature about phagophobia is sparse and there is no specific treatment modality for this life-threatening conditions. We present a case of phagophobia in a 15-year-old female adolescent after she witnessed his father's choking while eating chicken.

Case presentation: A 15-year-old female adolescent was consulted due to the lack of solid food intake for 10 month from the paediatric neurology clinic. She lost 13 kg of weight within a span of 10 months. Her Body Mass İndex (BMI) 14.2, BMI persantile <3 p and she was amenorrheic for two months. All clinical examination and laboratory tests were within normal limits. Endoscopic evaluation could not be made because of refusing invasive evaluation. In the first visit, the patient was alert and oriented. She stated that she did not like to eat. There was no preoccupation with body image and weight. In the second examination she reported that she witnessed his father's choking while eating chicken. A piece of chicken stuck his troat she and her family rushed him to emergency service. After this accident, she started to have

KEYWORDS

Adolescent; eating disorder; fluoxetine; aripiprazole; phagophobia

fear eating chicken and then it was spread to all solid food which leads to significant weight loss. She was started on fluoxetine 10 mg/day and gradually increased 20 mg/day. And also behaviour therapy session scheduled weekly. After six-session combination medication and behaviour therapy she still couldn't eat solid food. Aripiprazole 2.5 mg/day was added to the patient. After two weeks, she started to eat some solid food and it was increased number of type of solid foods and her anxiety during meals was decreased slowly. She rapidly gained weight and started to menstruate for a month. Phagophobia is a rare condition and no proven effective treatment described the life-threatening illness. The use of aripiprazole in eating disorders has been investigated more in Anorexia Nervosa. To our knowledge, this is the first case that treated phagophobia with aripiprazole. Aripiprazole is a partial agonist of dopamine D2 receptor (D2) and serotonin 1A receptor (5-HT1A) and antagonist of serotonin 2A receptor (5-HT2A). 5 HT1A receptor agonism may help resolve anxiety symptoms. And also D2 reseptor agonism may facilitate behavioural change in the context of psychotherapy. On the other hand presented case is lack of insight into the illness seriousness and aripiprazole treatment may mitigate this problem.

[Abstract:0558][Anxiety disorders]

Efficacy of cognitive-behavioural therapy in the trypophobia in the an adolescent case

Yasemin İmrek, Mesut Sari, Büşra Pala and Yusuf Öztürk

Department of Child and Adolescent Psychiatry, Abant Izzet Baysal University, Bolu, Turkey

E-mail address: yasemin_akkus@hotmail.com

ABSTRACT

Specific phobias have been defined as "marked fear or anxiety about a specific object or situation" in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and are classified as anxiety disorders. A specific phobia is reliably bound to a particular object or situation (the phobic stimulus) and occurs when individuals engage the phobic stimulus in thought or action. Trypophobia is the disgust response or unpleasant feelings and often somatic responses induced by observing a cluster of concave objects (holes) or objects reminiscent of clusters of holes. In this case, a 17-year-old adolescent girl, whose chief complaints included the inability to look hole object, avoidance, intense anxiety lasting for five years is presented.

Case presentation: A 17-year-old female high school junior presented to our outpatient department with a complaint of "inability to look hole objects, intense fear and avoidence when looking hole objects." It was learned from the history that the inability to look hole objects began 5 years ago after she saw small holes in the rotten chocolate. Thereafter, she did not look the hole objects, drawing, picture and when she saw the hole object, she felt intense anxiety including shortness of breath, palpitation, and avoided this situation and cried. When she looked the hole object, drawing and picture, she thought her body would be a hole and the holes would swallow herself. Her complaints have begun to increase and have also occurred in the school in the last 1 year. She did not listen to lessons and when she saw the "hole and familiar word" in the exam, she did not continue the exam. She also cried and ran away from home when her mothers prepared the village bread in the breakfast because the inside of the village bread is perforated. She did not also look spider because its legs would wrap around herself. When she saw a spider and looked drawing, a picture of spider, she escaped from the situation. First, psychoeducation about the tri-part model of emotion, distorted thinking, and behaviour related to trypophobia was carried out. The relationship between emotional thoughts and behaviours of the case was formulated. Then, relaxation strategies including calm beating and progressive muscle relaxation were done. Finally, imaginal exposure was done as was seen the hole object to the case in the computers. She was anxious initially, and then her anxiety decreased. SCARED, CGI-S scores were 13 (subthreshold anxiety symptoms) and 2 (borderline mentally ill) after the first month follow-up. Interviews with the case are continuing. Trypophobia more commonly experienced disgust compared to fear in response to clusters of holes, a significantly larger percentage of individuals fulfilled the DSM-5 criteria for specific phobia. Despite the great degree of psychological distress and impairment experienced as a result of trypophobia, the majority of individuals (89.2%) had never sought treatment specifically for trypophobia. Of those who did receive treatment, 50% found it to be helpful. In the tryphobia treatment, cognitive behavioural treatment may be useful to a similiar effect others anxiety disorders.

KEYWORDS

Trypophobia; anxiety; adolescent; cognitive; behavioural therapy

[Abstract:0559][Mood disorders]

Quetiapine and fluoxetine combination treatment-induced hypomania in the psychotic depression

Güler Göl, Mehmet Akif Cansız, Uğur Savcı and Yusuf Öztürk

Department of Child and Adolescent Psychiatry, Abant Izzet Baysal University, Bolu, Turkey

E-mail address: golguler@gmail.com

ABSTRACT

Paediatric bipolar disorder (BD) is a mental disorder affecting about 2% of youth under the age of 18. About 20–40% depressed youth develop BD. Those with a high risk of developing BD seem to have more psychotic depression, family history of depression, and pharmacologically induced mania or hypomania. In this case, a 14-year-old adolescent girl, whose chief complaints included hopelessness, anhedonia, loss of appetite, continuous crying, and auditory hallucination giving orders to die, is presented.

Case presentation: A 14-year-old female high school junior was presented to our outpatient department with a complaint of hopelessness, anhedonia, loss of appetite, continuous crying, and auditory hallucination giving orders to die. It was learned from the history depressive symptoms such as hopelessness, anhedonia, and loss of appetite for three months. Auditory hallucination giving orders to die was added, saying to commit suicide in two weeks. She was hurting herself in the form of a boot, was hitting head with her hands as she did not hear the sounds. It was impaired academic functioning for this year because she distracted and did not concentrate the lessons. There was no peer relationship both home and school because she did not want to make friends with anyone. History, mental status examination, and psychometric tests supported the diagnosis of "psychotic depression" according to DSM-5 criteria. The case was followed up with weekly controls and extended-release quetiapine was started as increased gradually. The last dose of extended-release quetiapine increased to 400 mg/day. There was a decline in psychotic symptoms one month after extended-release quetiapine 400 mg/day treatment and PANSS score was 30 (positive = 7, negative = 7, general = 16). Fluoxetine was added the extended-release quetiapine because of depressive symptoms. However, the case used the fluoxetine irregularly. In the third week after the fluoxetine and extended-release quetiapine medication, she committed to suicide with 10 × 400 mg quetiapine. In the third day after the suicide attempt when she was evaluated in our outpatient clinic, it was observed that she was very energetic, had elevated mood, decreased the need for sleep, and increased talkative. The case was evaluated Young Mania Rating Scale (YMRS). YMRS score was 16. As she was assessed as a hippomania episode, fluoxetine was stopped and quetiapine 600 mg/day was continued as a mood stabilizer. In the follow-up after a week, the hypomanic symptoms were decreased and YMRS score was 6. The case is still being followed. The literature reports mania/hypomania cases associated with atypical antipsychotics and antidepressant effects in addition to its antipsychotic effects. When the literature review was evaluated, manic switch cases with quetiapine were found. Quetiapine has a low rate of 5HT2A/D2 binding rate, but its affinity for receptors 5HT2A is higher compared to D2 receptors at lower doses and it is considered to play a role in the development of mania/hypomania. If extended-release quetiapine and fluoxetine medication are considered in the treatment of psychotic depression, clinician should be careful in terms of hypomania.

KEYWORDS

Quetiapine; fluoxetine; psychotic depression; induced; hypomania

[Abstract:0560][ADHD]

First dose-induced angioedema due to phosphatidylserine – a complementary ADHD treatment

Berna Gündüz Çıtır, Hatice Aksu and Sema Çam Salihoğlu

Department of Child and Adolescent Psychiatry, Adnan Menderes University, Aydın, Turkey

E-mail address: bernagndz@hotmail.com

ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD), characterized by attention problems, hyperactivity, and impulsivity, is a common paediatric psychiatric disorder. Multimodal treatment approaches including psychosocial and medical interventions are used in the treatment of ADHD. Complementary treatment is a nonmedical choice of other treatment options. Rare allergic reactions due to stimulants and complementary treatments have been

KEYWORDS

ADHD; allergic reaction; phosphatidylserine; complementary treatment; case report

reported. Here, we present a case with the diagnosis of ADHD suffered from an angioedema, an unexpected adverse effect, due to monotherapy of phosphatidylserine use.
Case presentation: Our case is a 6-year-old boy who was brought to our outpatient clinic with complaints of hyperactivity, paying less attention to the lessons, and fights with his friends. He has no developmental delays. There was no child psychiatric application before. The parents and his teacher filled out the scales; "Disruptive Behavior Disorders Screening and Evaluation Scale" and "Conners Parent Rating Scale." After psychiatric and psychometric assessment, the diagnosis of ADHD was considered. Stimulant was recommended but his parents did not approve a medication. Therefore, phosphatidylserine was offered. The parents gave consent on the use of a herbal drug. Phosphatidylserine (150 mg/day) was started together with the psychosocial interventions. Unfortunately, the parents reported that their child had experienced some side effects even with a single dose use of phosphatidylserine. Parents had noticed swelling on the lips and face of the child and they brought him to an emergency unit as quick as possible. Angioedema was resolved after a pheniramine maleate injection. The phosphatidylserine use was stopped after that single dose. In spite of the inadequate efficacy, fish oil, herbal-based treatments, and trace elements are commonly used in the treatment of ADHD when the parents are unreluctant to the use of stimulants. However, adverse effects of these alternative treatments have been reported. In our case, phosphatidylserine use led to an allergic reaction. As far as we know, we have not come across a similar case with phosphatidylserine. Clinicians should be careful for unexpected side effects even prescribing herbal alternative treatments.

[Abstract:0561][Psychopharmacology]

A case of ecchymosis associated with sertraline

Nurhak Çağatay Birer[a], Güler Özkula[a] and Ercan Altınörs[b]

[a]School of Medicine, Department of Psychiatry, Başkent University, Ankara, Turkey; [b]School of Medicine, Department of Psychiatry, Osmangazi University, Tokat, Turkey

E-mail address: nurhak1979@hotmail.com

ABSTRACT
Selective serotonin reuptake inhibitors (SSRI) are commonly used in psychiatric disorders. Hematological side effects associated with SSRI use are seldom and their aetiology still remains unclear. The aim of the present case was to report ecchymotic lesion developing after sertraline use and to discuss its development in view of similar cases in the literature.
Case presentation: A 41-year-old female patient referred to our outpatient clinic with complaints of anhedonia and irritability. Two months after the onset of treatment, she presented again with ecchymotic lesions the largest of which was at the size of 5 × 5 cm on her lower limbs. Although hematological side effects are usually reported with fluoxetine and paroxetine in the literature, haematological side effect that can occur with sertraline should also be borne in mind. Ecchymosis can be observed even if factors that can lead to bleeding are ruled out. It is our suggestion that clinicians should also take this side effect into account when following up their patients.

KEYWORDS
Ecchymosis; hematology; sertraline; side effect; SSRI

[Abstract:0562][Psychopharmacology]

Trifluoperazine abuse with an unusual dose: a case report

Fatih Baz and Mesut Yıldız

School of Medicine, Department of Psychiatry, Marmara University, Istanbul, Turkey

E-mail address: bazfatih@gmail.com

ABSTRACT
Trifluoperazine is a typical antipsychotic drug used for the treatment of schizophrenia and other psychotic conditions. It is also effective and commonly prescribed for non-psychotic anxiety. Although antipsychotics are not considered to have abuse potential, there are a number of case reports demonstrated that it is not a rare phenomenon. In this article, we present a case of trifluoperazine abuse in a non-psychotic patient.
Case presentation: A 50-year-old male, his first admission to psychiatry clinic was 21 years ago. After an admission to a cardiologist, with complaints of palpitation, chest pain, high blood

KEYWORDS
Abuse; addiction; antipsychotics; panic disorder; trifluoperazine

pressure, shortness of breath, and fear of having a heart attack. The patient was diagnosed as panic disorder and was accepted to inpatient clinic. Clomipramine, 75 mg/day, alprazolam, 1 mg/day, and trifluoperazine, 2 mg/day, treatment was started. He said that he benefited from trifluoperazine and after discontinuation of alprazolam, he was discharged. After discharge, his symptoms decreased but he was not feeling comfortable when he was away from the hospital and he started to stay at a hotel near to the hospital. Meanwhile, he gradually increased the dose of trifluoperazine to 5 mg/day and from 5 to 20 mg himself. Three years later, the patient had been taking 20 mg trifluoperazine daily and he was sleeping in the hospital's waiting rooms. He said that, whenever he was away from the hospital, his symptoms occurred and he turned back to the emergency service. One year ago, when the patient was presented to our outpatient clinic, he had been staying in the hospital's waiting room for 2 months. He was taking fluoxetine, 40 mg/day for 2 years and trifluoperazine, 20 mg/day. The patient reported that, if he ever tried to reduce or could not take trifluoperazine, he experienced palpitation, anxiety, restlessness, and craving for it, and every attempt to reduce the dose had failed. Most of the reports of abuse or addiction to antipsychotic drugs are regarding quetiapine and mostly, patients were known cases of psychotic disorders and have a past or continuing drug abuse history. Unlike, our patient has no substance, alcohol, or other drug abuse. There are only a few case reports about trifluoperazine abuse/withdrawal in the literature. Similarly, our patient is non-psychotic, but the dose of trifluoperazine in this case is unusual. We know that self-medication and safety seeking behaviours are common in patients with panic disorder. Nevertheless, the patient is in the "safety zone" for the panic attack, the symptoms occur once he does not take the medicine. Even trifluoperazine is known as no abuse potential, clinicians should be cautious about use.

[Abstract:0563][Psychopharmacology]

Side effect due to zuclopenthixol treatment: incontinence or enuresis?

Leyla Bozatlı, Hasan Cem Aykutlu and Işık Görker

Department of Child and Adolescent Psychiatry, Trakya University, Edirne, Turkey

E-mail address: leylyabozatli@gmail.com

ABSTRACT

Constant and repeated violations of the fundamental rights of others and age-appropriate social rules are defined as conduct disorder (CD). CD could cause serious losses for both individual and society if it is not well recognized and treated. Atypic antipsychotics have an important role in the pharmacological treatment of CD. Although risperidone and aripiprazole are the most commonly used agents in the treatment of CD, zuclopenthixol could be used in the resistant cases. Sedation, constipation, tachycardia, dizziness, orthostatic hypotension, and slight increases in liver function tests are common side effects of zuclopenthixol treatment but enuresis diurnal/nocturna is known as a rare side in the literature. In this case report, we are going to present and discuss the enuresis diurnal/nocturna side effect of zuclopenthixol treatment in a 14-year-old boy with CD.

Case presentation: 14-year-old boy who is diagnosed with ADHD and learning disorder and CD has been followed in our outpatient clinic for 10 years. In the first 7 years of his follow-up, he had responded well to the various treatments with risperidone, aripiprazole, haloperidol, methylphenidate, atomoxetine, carbamazepine, and valproic acid. But in the last 3 years, there was a significant decline in treatment response and well-being. Zuclopenthixol had been started in the last drug trial and diurnal/nocturnal urinary incontinence was detected on the second day of the treatment. Zuclopenthixol is used in the treatment of acute and chronic psychosis and disruptive behaviours of patients with intellectual disability. Even the urinary incontinence is described as a rare side effect of zuclopenthixol, we could suggest that it could be seen much more. Further studies are needed to re-evaluate the side effects of zuclopenthixol.

KEYWORDS

Conduct disorder; zuclopenthixol; side effect; incontinence; enuresis

[Abstract:0565][Psychosomatic Medicine and Liaison Psychiatry]

Arnold-Chiari type I malformation associated with major depressive disorder: a case report

Oğuzhan Sapdüzen[a] and Çiçek Hocaoğlu[b]

[a]Medical School, Recep Tayyip Erdogan University, Rize, Turkey; [b]Medical School, Department of Psychiatry, Recep Tayyip Erdogan University, Rize, Turkey

E-mail address: cicekh@gmail.com

ABSTRACT
Arnold-Chiari type I malformation (ACM) is a congenital anomaly characterized by downward herniation of the cerebellar tonsils into the spinal canal. This type of ACM is considered an adult type. Patients are usually children and adults are often asymptomatic. Arnold-Chiari syndrome causes non-specific symptoms such as occipital pain, tinnitus, upper extremity pain and specific symptoms such as unilateral hypoglossal nerve and vocal cord paralysis, hemifacial spasm, nystagmus, ataxia, trigeminal and glossopharyngeal neuralgia and loss of hearing in both ears. The anomaly may present in a variety of ways and at times with vague symptoms. Diagnosis is often difficult and therefore delayed. Most commonly, ACM can be misdiagnosed as multiple sclerosis, musculoskeletal dystrophy, or other degenerative diseases. It may present rarely as psychiatric disorders.
Case presentation: Here, a patient who was initially diagnosed as a major depressive disorder but found out to be ACM after 4 years is presented. This situation also highlights the need for psychological evaluation in CM-I in terms of providing guidance for psychoeducation and psychotherapy.

KEYWORDS
Arnold-Chiari type I malformation; diagnosis; differential diagnosis; major depressive disorder; psychiatric symptom

[Abstract:0567][Mood disorders]

Genital self mutilation in a patient with geriatric depression

Alphan Anak, Ayşe Sakallı Kani, Fatih Baz and Mesut Yılmaz

Department of Psychiatry, Marmara University, Istanbul, Turkey

E-mail address: alphananak@gmail.com

ABSTRACT
Self-mutilation is defined as the deliberate direct injuring of body tissue, often done without suicidal aim. Genital self-mutilation (GSM) is a very rare and a severe form of self-injurious behaviour. The majority of GSM cases in the literature have been patients with psychosis. Patients with sexual conflict associated with guilt, a history of past suicide attempts or other self-destructive behaviours, depression, severe childhood deprivation, and major premorbid personality disorder are the other groups at risk for genital self-amputation. Most of the cases with GSM in the literature were presented between the ages of 20–29. Here, we aimed to present an elderly patient with psychotic depression who had demonstrated GSM without a previous psychiatric history.
Case presentation: A 78-year-old, married, male patient was brought to the emergency room by his family on the cutting of his penis with a kitchen knife and flushing his tissue down to the toilet. The patient said that he had cut his penis because he had difficulty in urinating. According to information from his family, he had concerns about his financial situation for five months and he had had social isolation, unhappiness, pessimism, and feelings of guilt for a few months. One month before the amputation of the penis, the patient began to think that his penis was getting smaller and he needs to show that his penis has shrunk to the child he lived with. There was no psychiatric history in his past. The patient was intervened by the urology clinic and was admitted to the psychiatric inpatient unit. The patient was diagnosed with depression with psychotic features. To exclude underlying organic cause, cranial CT and MRI images were acquired. Routine blood tests, ECG, and lung x-ray were obtained. No pathology was detected. Venlafaxine 75 mg was started and titrated to 225 mg/day and olanzapine 10 mg/day was started. After observation of no clinical improvement with adequate medical treatment for one month, 10 sessions of ECT were administered. One month after his admission, the nihilistic delusions of the patient's disappeared and the severity of depressive symptoms decreased. The patient was discharged after two months stay at psychiatric inpatient unit. It is not clear what prompts a man to divest himself of his own genitalia. Greilsheimer and Groves were able to identify two general groups in their series of 52 cases of genital self-mutilation. The most common group consisted of psychotic patients (87%). The other group consisted of nonpsychotic persons with character disorders, transvestites who anticipated their own gender conversion surgery or patients with complex religious or cultural beliefs. Management of genital self-mutilation injury has been a challenging problem. Evaluation and treatment of these patients require close collaboration among surgeons, psychiatrists, and experienced medical personnel.

KEYWORDS
Amputation; depression; elderly; genital; self-harm

[Abstract:0568][Disruptive behavior disorders]

A rare known topic 'Pyromania': a case report

Yeliz Doymaz[a], Ece Ayyıldız[a], Mehmet Baltacıoğlu[b] and Çiçek Hocaoğlu[c]

[a]Medical School, Recep Tayyip Erdogan University, Rize, Turkey; [b]Rize State Hospital, Psychiatry Clinic, Rize, Turkey; [c]Medical School, Department of Psychiatry, Recep Tayyip Erdogan University, Rize, Turkey

E-mail address: cicekh@gmail.com

ABSTRACT

Pathological Fire Setting (Pyromania) is a rare, impulse control disorder characterized by the desire to set fires is repetitive and destructive to other people or property. People with pyromania are deeply fascinated by fire and related paraphernalia. They cannot stop their impulse to set fires, may participate in other fire-related activities, and experience feelings of satisfaction or a release of built-up inner tension or anxiety once a fire is set. Pyromania can affect adolescents and adults, and is more common in males than in females, though it can occur in both, and especially in people with learning disabilities and who lack social skills. Very little is known about the aetiology, prevalence, and treatment. This disorder usually begins during puberty and lasts until late adulthood. In some patients, it may last throughout the person's life. Patients with pyromania are likely to suffer from comorbid conditions like mood disorders. The patients usually seek treatment for the comorbid psychiatric complaints, rather than the pyromaniac behaviour itself. The literature lacks sufficient knowledge and controlled studies about the treatment of pyromania. Regarding the treatment of SSRIs, there are case reports and case series, using mood stabilizers, antipsychotics. Cognitive behavioural therapy techniques are also used in the treatment of pyromania.

Case presentation: Here, a young male patient is presented with diminishing pyromania symptoms after aripiprazole is added to his cognitive behavioural therapy and fluoxetine treatment. He also suffers from the comorbidities of major depressive disorder and conduct disorder. There have been few systematic studies of individuals with pyromania. Pyromania appears to be associated with high rates of psychiatric comorbidity. Research is needed to optimize patient care for individuals with this disorder.

KEYWORDS

Diagnosis; impulse control disorder; pyromania; pathological fire-setting; treatment; impulse control disorder

[Abstract:0571][Psychopharmacology]

Agranulocytosis following chemotherapy in a patient receiving clozapine treatment

Selvi Ceran Kayıpmaz[a], Nurhak Çağatay Birer[a], Ali Ercan Altınöz[b] and Arzu Oğuz[c]

[a]Department of Psychiatry, School of Medicine, Başkent University, Ankara, Turkey; [b]Department of Psychiatry, School of Medicine, Eskişehir Osmangazi University, Eskişehir, Turkey; [c]Department of Medical Oncology, School of Medicine, Başkent University, Ankara, Turkey

E-mail address: ercanaltinoz@hotmail.com

ABSTRACT

Clozapine is known to be superior to classical antipsychotics in the treatment of resistant schizophrenia. However, because of the side effect profile, it is usually used in cases where typical and atypical antipsychotics are not responded to, rather than being preferred as the first treatment. One of the major side effects is agranulocytosis.The aim of this article is to discuss this clinical dilemma in a case of successful clozapine treatment despite neutropenia with chemotherapy.

Case presentation: A 47-year-old woman was diagnosed with schizophrenia 22 years ago. Clozapine therapy was started on the basis of not having enough benefit from combined antipsychotic treatment and it was increased to 500 mg per day. After 20 years of remission for schizophrenia, both breast cancer and over cancer were diagnosed within the same year. The patient has administrated chemotherapy while receiving clozapine treatment. This case report presents how both clozapine and chemotherapy treatments were managed on behalf of neutropenia. When the literature is reviewed, studies published on the co-use of clozapine and chemotherapy are limited to only 23 case reports. Seven of these clozapine treatments were discontinued at the beginning but were restarted with the worsening of the mental status in six of them. In some cases, the use of granulocyte-macrophage colony-stimulating factor (GMCSf) has been mentioned but the use of pro-active GMCSF has only been reported in two cases. Following such cases, the cooperation of medical oncology and psychiatry is very important for the patient's mental status and physical health.

KEYWORDS

Agranulocytes; chemotherapy; clozapine; neutropenia; schizophrenia

[Abstract:0573][Psychopharmacology]

A case report of faecal incontinence associated with lorazepam

Sümeyra Güngören[a], Hamza Ayaydın[a] and İsmail Akaltun[b]

[a]Harran University School of Medicine, Department of Child and Adolescent Psychiatry, Sanliurfa, Turkey; [b]Gaziantep Dr. Ersin Arslan Research and Training Hospital, Gaziantep, Turkey

E-mail address: s.zencirli@hotmail.com

ABSTRACT

Lorazepam is a short-acting benzodiazepine that can be used to provide sedation and prevent some side effects of antipsychotics in the treatment of psychotic disorders, although not antipsychotic activity. This article aims to present a patient who developed faecal incontinence after lorazepam treatment.

Case presentation: A 14-year-old girl was brought to our Department of Child and Adolescent Psychiatry by her family. It was learned from the family that the patient's complaints started with negative symptoms such as unhappiness, social withdrawal, alogia, anhedonia about four months ago. Furthermore, there have been her suspicious minds, self-laughing, and agitations association with this suspicious mind. Patient did not describe any auditory–visual hallucinations. There was a decrease in appetite and sleep. She had no insight. The patient was diagnosed with 'Schizophreniform Disorder' according to DSM-5 diagnostic criteria and olanzapine 10 mg/day and lorazepam 3 mg/day were started. The patient complained of faecal incontinence (during the daytime and night-time) after the beginning of drug treatment. The parents described also urgency with faecal incontinence. Stool examinations were within normal limits and neurological examination was normal at the time. Lorazepam was stopped, and the complaints declined on the first day and it did not happen again during the treatment. The treatment of the patient has continued as olanzapine 30 mg/day, haloperidol 15 mg/day, and fluoxetine 20 mg/day, and the symptoms of the patient have shown a significant improvement. In the present case, rectal incontinence (during the day-time and night-time) developed with the onset of lorazepam and olanzapine. There are a lot of case reports of faecal–urinary incontinence due to antipsychotics such as risperidone, olanzapine, and clozapine but no such side effects due to benzodiazepines have been found in the literature. We preferred to stop lorazepam first because of the possibility of sedation, and then this side effect was terminated dramatically. Benzodiazepines have antispasmodic effects and which are used for musculer relaxation. In diseases such as rheumatoid arthritis, there are benzodiazepines and non-benzodiazepines are used for this purpose, especially alprazolam, lorazepam, and diazepam. Benzodiazepines may indirectly relax skeletal muscle by blocking postsynaptic neurons in the spinal cord and the descending reticular formation in the brain. In the present case, the development of rectal incontinence after lorazepam may be related to this similar mechanism. The sedative effects of lorazepam may lead to the inability to wake up during sleep and might cause faecal incontinence. Because our case experienced incontinence not only during the night time, and her parents reported no difficulty of the patients in waking up during the treatment, incontinence does not seem to be related to sedation. Remission of the incontinence with discontinuation drug indicates that faecal incontinence was clearly related to lorazepam treatment. There is no such side effect after lorazepam treatment in the literature and it is noteworthy that this case is the first in the literature.

KEYWORDS

Adolescent; antipsychotic; hallucination; incontinence; lorazepam

[Abstract:0577][Schizophrenia and other psychotic disorders]

Clinical case series: experience and management of emotion

Semra Ulusoy Kaymak[a], Serdar Süleyman Can[b], Görkem Karakaş Uğurlu[b], Murat İlhan Atagün[b], Mustafa Uğurlu[b] and Ali Çayköylü[b]

[a]Ankara Ataturk Research and Training and Training Hospital, Psychiatry Clinic, Ankara, Turkey; [b]Ankara Yildirim Beyazit University School of Medicine, Department of Psychiatry, Ankara, Turkey

E-mail address: acaykoylu@hotmail.com

ABSTRACT

It has been always very difficult and stressful to be the relative of a cancer patient. When this relative has a diagnosis of schizophrenia, the emotional and behavioural responses become more complicated. Here, we present emotional dysregulation of schizophrenia patients who have a first degree relative with cancer.

KEYWORDS

Cancer relative; schizophrenia; emotional dysregulation; expressed emotion; management

[Abstract:0580][Other]

Malingering by proxy: a child pretending to suffer from a posttraumatic stress disorder

Sema Çam Salihoglu, Berna Gündüz Çıtır, Hacer Gizem Gerçek and Hatice Aksu

Department of Child and Adolescent Psychiatry, Adnan Menderes University School of Medicine, Aydın, Turkey

E-mail address: ssalihoglu82@hotmail.com

ABSTRACT

The deliberate production or pretending of signs or symptoms in a child by a caretaker is defined as factitious disorder by proxy. It is not well recognized that the false illness characteristics may also be the result of a parent instructing the child to malinger. Malingerers have well-defined motivations such as having a financial gain, insurance fraud, and shirking of some obligations. Here, we report a child who had feigned signs and exaggerated symptoms as having a posttraumatic stress disorder (PTSD) for the purpose of getting a compensation from insurance.

Case presentation: A boy, X, was brought to our outpatient unit by his father as a legal case. He is 8½ years old in the third grade in a primary school. He had an accident 14 months ago. He hit the electric pole while he was playing football in the public play garden. He shocked by the electric and felt down and he had been taken to an emergency unit. Fortunately, he had no physical injury, but he had some psychiatric symptoms. His father told that X had encopresis, difficulty in sleeping, and enuresis since that event happened. His father also reported that X could not touch any electrical devices even television or lights because X was afraid of electricity. X could not go to the play gardens. The child had approved all his father's statements. His father had blamed the municipality for the accident and had proposed that his child was emotionally affected. We did not consider any diagnosis and decided to follow up. However, the child was not anxious and he had different and inconsistent reports in every interview. At 3 months of duration, after a good therapeutic alliance the child confessed that he was very well and he could touch every electric plugs, he could go out and play football. His life has not changed since that accident happened. We reported that no psychopathology was present in his forensic file. We have to consider simulation when unexpected symptoms or signs are observed in the clinical presentation. Child psychiatrists are encouraged to make a proper protection from parental harm. Careful confrontation and understanding the motivation beneath the malingering are recommended.

KEYWORDS

Malingering by proxy; trauma; paediatric simulation; legal case; case report

[Abstract:0586][Psychopharmacology]

Hyperammonemic encephalopathy without hepatic dysfunction due to treatment with valproate: two cases

Mustafa Dinçer[a], Abdullah Akgün[b], Şahin Bodur[a], Abdullah Bolu[b], Cemil Çelik[b] and Mehmet Ayhan Cöngöloğlu[a]

[a]Gülhane Research and Training Hospital, Department of Child and Adolescent Psychiatry, Ankara, Turkey; [b]Gülhane Research and Training Hospital, Psychiatry Department, Ankara, Turkey

E-mail address: mustaa63@hotmail.com

ABSTRACT

Valproate-induced hyperammonemia is almost seen in 50% of patients treated with VPA, some of whom may develop encephalopathy. Valproate-induced hyperammonemic encephalopathy (NE) is a well-known subject and there are numerous publications in the current literature. Although there is substantial evidence for this side effect in patients with neurological disorders, the data in the psychiatric area are limited. When we look at publications, it seems that VHE is seen more often because it starts earlier in psychiatric patients, but we think that it is often missed. Here, we presented two cases in which we followed up and treated with VHE diagnosis.

Case presentation:

Case 1: A 38-year-old woman who is under treatment for bipolar disorder 1 for 20 years was admitted to our clinic with a libidinal increase, excessive talking, decreased sleep, increased motor activity, and self-harm starting a week ago. The treatment was gradually reduced to oxcarbazepine 600 mg/day, quetiapine 300 mg/day, olanzapine 30 mg/day, and valproate 1000 mg/day. After 1 week, the patient's valproate level was 64.10. On the 10th day of hospitalization, there were findings such as lethargy, sedation, blurring of consciousness, loss

KEYWORDS

Bipolar disorder; encephalopathy; hyperammonemia; side effects; valproic acid

of eye contact, and noncompliance with commands; but pathological reflexes and meningeal irritation signs were absent. The patient's condition stabilized after 36 h of stopping valproic acid and 24 h after the administration of NaCl solution.
Case 2: A 32-year-old woman with bipolar disorder diagnosed for 15 years. The psychiatric examination at the time the patient was admitted was as follows; it was observed that her interest in the surroundings increased, her clothing and self-care was good, affect was cheerful, speech volume and speed increased, voice tone was high, psychomotor activity was increased, and there were also grandiose ideations and mystical delusions in thought content. The current status of the patient was evaluated as a manic episode. No abnormality was observed in blood values and no additional pathology was detected in the examination of the patient. Treatment with valproic acid 1000 mg/day was then added. Ten days after starting valproic acid treatment, symptoms such as sleeping tendency, blurring of consciousness, and difficulty in speaking emerged. In the tests performed, blood valproic acid level was 121 µg/mL and blood ammonia level was 154 mg/dl. Approximately 24 h after stopping valproic acid treatment, the patient's medical condition improved. Blood ammonia levels decreased to 36 mg/dl. No additional morbidity was observed in the patient's follow-up. Adjustment of dose or discontinuation of VPA may be necessary in the symptomatic patients with altered mental status. It is also important to check the ammonia levels immediately in these patients. Supportive care and discontinuation of VPA is currently the mainstay of treatment for VHE. L-carnitine replacement, discontinuation of other drugs, hydration, lactulose, rifaximin, neomycin, protein restriction, carglumic acid, haemodialysis, L-ornithine-L-aspartate, L-arginine, charcoal, furosemide, aceglutamide, mannitol, and other supportive treatments for CNS or other comorbidities are sometimes useful.

[Abstract:0588][Psychopharmacology]

Olanzapine-induced hepatotoxicity: a case report

Ali Hakan Öztürk, Dudu Demiröz, İsmet Esra Çiçek, Hilal Seven and İbrahim Eren

Konya Research and Training Hospital, Beyhekim Psyciatry Clinic, Health Sciences University, Konya, Turkey

E-mail address: drsevenhilal@hotmail.com

ABSTRACT
Olanzapine is an atypical antipsychotic used for the treatment of psychiatric disorders. Side effects of olanzapine are common due to the blockade of serotonergic, noradrenergic, histaminergic, and muscarinic receptors. Side effects such as sedation, drowsiness, orthostatic hypotension, increased appetite, weight gain, and xerostomia are common. But hepatotoxicity, a serious side effect of olanzapine, is rarely seen in clinical practice. A few cases have been reported about this condition so far. We want to report a patient who developed olanzapine-induced hepatotoxicity.
Case presentation: A 61-year-old male, diagnosed with bipolar disorder for 35 years, also the history of hydrocephalia and lumboperitoneal shunt operation. The patient was hospitalized for the treatment of severe depressive episode with psychomotor retardation, unhappinesses, reticence, insomnia, and decreased appetite. His complaints had been continuing for last two weeks. His last treatment was lithium 1200 mg/day, aripiprazole 10 mg/day, and quetiapine 100 mg/day. Sertraline was added to the treatment for the antidepressive effect and increased up to 100 mg/day. Because of non-response to this intervention for 4 weeks, venlafaxine was started and increased up to 300 mg/day and mirtazapine 15 mg/day was augmented. Sertraline was decreased to 50 mg/day and planned to stop it. Suddenly depressive mood disappeared, mood elevation, euphoria, and psychomotor activation occurred. This condition accepted as hypomania and immediately venlafaxine decreased to 150 mg/day and sertraline was stopped. Olanzapine 5 mg/day was added for antimanic effect and mood regulation. After 8 days with this treatment suddenly symptoms such as nausea, vomiting, inappetite, and weakness were developed. In biochemical analysis, AST: 216 IU/L (N: 0–35 IU/L), ALT: 211 IU/L (N: 0–45 IU/L), ALP: 150 IU/L (N: 30–120 IU/L), GGT: 400 IU/L (N: 0–55 IU/L), and CRP: 56.6 mg/L (N: 0–5 mg/L) were determined. In haemogram, white blood cell: 15.940/ml (N: 4800–10.800/ml) and neutrophile 13500/ml (N: 1800–7700/ml) were determined. In comprehensive evaluation, any probable causes detected except for olanzapine usage. This condition accepted as olanzapine-induced hepatotoxicity. İmmediately the patient was transferred to the internal medicine clinic for the treatment of hepatotoxicity. Olanzapine usage was stopped. After 4 days follow-up in the internal medicine clinic, the patient was recovered and his laboratory findings gradually normalized. The patient has transferred our clinic for continuing psychiatric treatment. Drugs can induce hepatotoxicity in some patients. Drug-associated hepatotoxicity is usually dose dependent and accompanying any other factor may precipitate developing it. Atypical antipsychotics commonly cause an isolated asymptomatic increase in the aminotransferase levels. Among these atypical antipsychotics, mostly transient, asymptomatic increase in hepatic enzymes has been reported with olanzapine, however olanzapine rarely may induce a clinical

KEYWORDS
Aminotreansferase; bipolar disorder; hepatotoxicity; olanzapine; olanzapine's side effects

and/or biological hepatic toxicity may be mortal by progress to fulminant hepatitis and cirhosis. There are a few case reports about olanzapine-induced hepatotoxicity. In our case hepatotoxicity emerged suddenly and the patient fully recovered and abnormal laboratuary findings returned to normal levels after early treatment. The patient using psychotropic medications – particularly olanzapine – must be in follow-up periodically with routine hematologic and biochemical tests. When a severe deterioration determined in periodical blood tests, we must consider drug-associated side effects and evaluate the patient comprehensively.

[Abstract:0590][Psychopharmacology]

Quetiapine and risperidone-associated priapism: a case report

Ali Hakan Öztürk, Dudu Demiröz, Hilal Seven, Hatice Yardım Özayhan and İbrahim Eren

Konya Research and Training Hospital, Beyhekim Psyciatry Clinic, Health Sciences University, Konya, Turkey

E-mail address: drsevenhilal@hotmail.com

ABSTRACT

Priapism is a urological emergency defined as a persistent penile erection that is unrelated to sexual stimulation and typically involving only the corpora cavernosa. It can occur as a rare side effect of antipsychotic medications and is mediated via their α-adrenergic antagonist effect. Thirty percent of all priapism cases caused by drugs and 50% of them caused by antipsychotics. Especially Trazodone and most of typical antipsychotics are associated with priapism. There are a few case reports about atypical antipsychotics such as Clozapine, Quetiapine, Risperidone, Olanzapine, Ziprasidone and Aripiprazole associated priapism. In this paper, we describe a case of priapism in a patient developed after risperidone and Quetiapine usage.

Case presentation: A patient, 37-year-old, male, married that diagnosed with alcohol use disorder. He had used alcohol for nearly 10 years and within this period he had hospitalized six times for the treatment of alcohol abuse. After being discharged from the hospital his alcohol abuse recurrence. In that hospitalizations, he was treated with benzodiazepine for preventing alcohol withdrawal, low-dose quetiapine (25 mg/day) for sedation and low-dose risperidone (1 mg/day) for irritability. In the last hospitalization, his treatment was arranged as diazepam 30 mg/day, quetiapine 100 mg/day, and risperidone 1 mg/day. At the first night of hospitalization after the first dose of quetiapine at 04:00, suddenly priapism with pain emerged in the patient. Priapism had never recovered for 6 hours in follow up. He consulted a urologist for evaluation and surgical intervention. Excess blood was drained from his penis by using a branule. Then all of antipsychotics usage were stopped. In a clinical follow-up, priapism has never seen since that day. It is reported that if medical or surgical intervention is delayed, prolonged priapism may cause irreversible corporal fibrosis, necrosis in cavernosal muscles and erectile dysfunction. Even sometimes it is needed to penile amputation for treatment. Prolonged priapism can have irreversible consequences with up to 50% of affected patients. It is widely accepted that alpha-adrenergic receptor blockade effect of antipsychotics causes priapism. Some articles suggest that priapism is dose dependent, conversely a few articles suggest that it is idiosyncratic. Quetiapine and risperidone have moderate alpha adrenergic receptor blockade effects. There are some publications about priapism associated with quetiapine and/or risperidone. In our case priapism of the patient may be induced by either of Risperidone and quetiapine or synergistic effects of them. Psychotropic drugs which have alpha-adrenergic receptor blockade effects are common in clinical usage. They can be used as monotherapy or combination with other drugs that have alpha-adrenergic receptor blockade characteristic. It is reasonable that combination of those drugs may increase probability of developing priapism. Which patients are vulnerable to priapism is unpredictable. Clinicians must be cautious in drug choice if a patient has a history of priapism and educate patients about priapism and how to distinguish priapism from a normal erection.

KEYWORDS

Alcohol abuse; priapism; quetiapine; risperidone; urological side effect

[Abstract:0591][Psychopharmacology]

Isotretinoin-induced mixed depressive episode with suicidal ideation: a case report

Ali Hakan Öztürk, Hatice Yardım Özayhan, Hilal Seven, Recep Başaran and İbrahim Eren

Konya Research and Training Hospital, Beyhekim Psyciatry Clinic, Health Sciences University, Konya, Turkey

E-mail address: drsevenhilal@hotmail.com

ABSTRACT
Isotretinoin is a retinoid derivate used orally or topically for treatment of severe acne vulgaris which is non-responsive to topical treatments. It is very effective in oral treatment but systemic adverse effects are common, particularly psychiatric side effects. Some psychiatric conditions such as depression, mood alterations, suicidal ideation, aggressive tendencies, anxiety, and psychosis have reported in medical publications. Isotretinoin is the only non-psychiatric drug on the FDA's top 10 list of drugs associated with depression. A black box warning for this condition has been packaging in the U.S. since 2005. In this case, we report a patient diagnosed with generalized anxiety disorder accompanying depressive symptoms who developed mixed depressive episode with suicidal ideation after adding oral isotretinoin.
Case presentation: A patient, 23-year-old male, single, diagnosed with generalized anxiety disorder. It is reported that he was introvert, anxious, and timid in childhood and adolescence. When he was 14, he had received short-term treatment for unspecified anxiety disorder with a selective serotonin reuptake inhibitor. After that, slightly anxious symptoms had been continued in social environments but he had never consulted a psychiatrist until when he was 22-year-old. One year ago the patient consulted psychiatrist with some symptoms such as anxiety, fear, tightness, shyness, unhappiness, forgetfullness, and inattention. Sertraline treatment was started. In the first 7 months, the patient responded to the treatment pretty much with 100 mg/day. Three months ago oral Isotretinoin 40 mg/day treatment was started by a dermatologist for severe acne vulgaris. With this treatment, psychiatric condition gradually deteriorated day by day. In last weeks some symptoms become evident such as unhappiness, desperation, frequent crying, irritability, restlessness, insomnia, suicidal thinking, psychomotor agitation, increased energy, emotional lability, and pressured speaking. There were some trigger factors that family and social problems, failure in education, uncertainty and anxiety about his future. Sertraline increased up to 200 mg/day but never clinical recovery was seen. The patient hospitalized after giving up suicide attempt with a suicide letter. This condition accepted as a mixed depressive episode and the treatment rearranged. The patient was treated with a combination of sertraline, quetiapine, low-dose olanzapine, and ECT three times a week. The patient becomes euthymic after 3 weeks of patient treatment. It is known that some drugs such as anticonvulsants, psychotropic drugs, corticosteroids, hormone derivates, immunomodulator drugs, some antihypertensives, some cytokines like interferon-α, substances, and oral isotretinoin. Some publications suggest that isotretinoin is associated with increased mood and anxiety disorder rate. On the contrary, other publications suggest that successful treatment with isotretinoin increases self-esteem and contribute to recovery. Mood symptoms after using oral isotretinoin are common but mixed depressive episode have rarely reported in medical publications.

KEYWORDS
ECT; isotretinoin; mixed depressive episode; mood lability; suicid thinking

[Abstract:0594][Psychopharmacology]

Mood elevation and psychotic excitation after biperiden use: a case report

Dudu Demiröz, Sehure Azra Yaşar, Osman Ak, İsmet Esra Çiçek and İbrahim Eren

Konya Research and Training Hospital, Department of Psychiatry, University of Health Science, Konya, Turkey

E-mail address: drdemiroz42@gmail.com

ABSTRACT
Anticholinergic drugs are frequently used in psychiatry for the prophylaxis and treatment of extrapyramidal symptoms caused by neuroleptics. Biperiden acts as an antagonist of muscarinic receptor activated by acetylcholine. When anticholinergic agents are taken in high doses; symptoms such as impairment in cognitive functions, confusion, disorientation, pressured speech, delirium, hallucinations (most frequently visual, less frequently auditory and tactile), paranoid thoughts, increased self-confidence, insomnia, and loss of appetite may occur. Here, we will describe a case with mood elevation and positive psychotic symptoms after a single dose, 5 mg biperiden parenteral administration.
Case presentation: 23-year-old male; his first complaints started as reduced motivation and social drive, depressive feelings, uneasiness, reducing self-care, anhedonia, 5 years ago. He has refused treatment after a period of about 2 months using olanzapine and has not received regular treatment. His complaints increased gradually and he was admitted to our outpatient clinic after his application at the request of his family and he was hospitalized. Aripiprazole and haloperidol were started with a diagnosis of negative psychosis. While using aripiprazole 30 mg/d and haloperidol 20 mg/d, 12th days of hospitalization in our clinic, he described contraction in the tongue. The patient was treated with a single dose of 5 mg biperiden parenterally with a diagnosis of dystonia. Approximately 2 hours after the biperiden treatment,

KEYWORDS
Anticholinergic drugs; biperiden; mood elevation; psychosis; psychotic exitation

nervousness, aggression, screaming, increased self-esteem, referential and persecution hallucinations were observed in the patients. The patient also had no disorientation, consciousness was open; vitals and blood biochemical values were normal. There was no disorientation, no fluctuation of consciousness, and delirium was excluded. Mood change and positive psychotic symptoms disappeared after about 6 h. The present condition of the patient was accepted as biperiden mood elevation and positive symptomatic psychotic excitation. The patient's haloperidol treatment was stopped with the cause of side effects, continued with aripiprazole 30 mg/day. In patients with negative symptoms are not adequately remedied by aripiprazole treatment and the patient's aripiprazole treatment was switched by olanzapine. He is currently treatment with olanzapine 30 mg/day. Euphoric effects of anticholinergic agents have been known from the literature but although we found reports of psychosis induced by anticholinergic agents. Koszewska and Rybanowski reported in the retrospective study that mood conversions from depression to mania occurs more frequently in tricyclic antidepressants than non-tricyclic antidepressants and added that it might be the anti-cholinergic activity that causes the higher frequency of mood conversion during tricyclic antidepressant therapy. Yıldızhan and friends reported trihexyphenidyl triggered hypomania in a bipolar patient. There was no increase in positive symptoms and mood elevation in the patient's past story and progressive clinical follow-up. Short-term mood-elevation and positive symptoms after biperiden treatment in our case suggest that this is due to anticholinergic effects of biperiden. Psychotic excitations in a psychotic patient may be seen during the course of the illness, but this may also trigger factors outside the illness. Anticholinergic agents are drugs that are used against side effects of antipsychotics during psychosis treatment and should be closely monitored for possible side effects during use.

[Abstract:0595][Schizophrenia and other psychotic disorders]

Clozapine-induced agranulocytosis: a case report

Ebru Çiftçi, Bilge Çetin İlhan, Yusuf Çokünlü, Deniz Altunova, Berrin Ünal and İbrahim Eren

Konya Research and Training Hospital, Department of Psychiatry, Health Sciences University, Konya, Turkey

E-mail address: dr.bendirzen@hotmail.com

ABSTRACT

Clozapine is an atypical antipsychotic drug from the dibenzodiazepine group, which helps to reduce positive and negative symptoms in schizophrenic patients. Restricting use and the most lethal side effect is agranulocytosis.

Case presentation: 55-year-old, married male patient. There has been a story of schizophrenia for about 26 years. Haloperidol, fluphenazine, zuclopenthixol deconate, aripiprazole, and amisulpride usage stories are available until 2013. In 2013, clozapine treatment was started with complaints of irritability, paranoid delusions, auditory and visual hallucinations and raised to 500 mg/day in 4 years. He was hospitalized with leukocyte ($2.86 \times 10^3/mm^3$) and neutrophil ($1.7 \times 10^3/mm^3$) at the outpatient clinic. Clozapine treatment continued for 3 days. Clozapine treatment was discontinued on leukocyte ($1.27 \times 10^3/mm^3$) and neutrophil ($0.1 \times 10^3/mm^3$) drop and chlorpromazine tb 300 mg/day started. Leukocytes ($1 \times 10^3/mm^3$) and neutrophils ($0.02 \times 10^3/mm^3$) dropped in haemograms. Treatment plans were made in consultation with a clinical hematologist. Filgrastim 48 miu with a hematology proposal was performed three times in total. Treatment was supplemented with vitamin B12 and folic acid. The leucocytes were elevated to $11.25 \times 10^3/mm^3$ and neutrophil ($7.44 \times 103/mm3$) after 6 days. Olanzapine therapy has begun on the auditory hallucinations and paranoid delusions in the patient and increased to 30 mg/day. Because of the continuing of psychotic symptoms, paliperidone palmitate 100 mg/30 days was added. Treatment of chlorpromazine tb in the clinically depressed patient was discontinued by reducing the dose. The patient was discharged with a haemogram of normal range and no active psychotic symptoms. The most important side effect of clozapine is agranulocytosis. The incidence of agranulocytosis is reversible in the vast majority of cases, once clozapine is withdrawn promptly. The mechanism of clozapine-related agranulocytosis is not fully understood. Evidence suggest that agranulocytosis associated with clozapine is an idiosyncratic reaction and may be immune-mediated or involve a toxic mechanism or both. Clozapine-induced agranulocytosis and severe neutropenia are contraindicated in the treatment of clozapine. Filgrastim is used in the treatment of neutropenia caused by various medical conditions and treatments. Clozapine-induced neutropenia and agranulocytosis have been shown to benefit from treatment with filgrastim. Filgrastim is a human granulocyte colony-stimulating factor (G-CSF) manufactured by recombinant DNA technology and regulates the production of neutrophils within the bone marrow. When our case was diagnosed with agranulocytosis, clozapine treatment was discontinued. Filgrastim therapy was started. Filgrastim therapy was discontinued when hematologic parameters returned to normal. In cases with agranulocytosis, hematologic healing usually occurs between 3 and 9 days. The risk of

KEYWORDS

Clozapine; schizophrenia; agranulocytosis; granulocytopenia; filgrastim

developing granulocytopenia and agranulocytosis during clozapine treatment is about 0.7–1%. The risk is the highest in the first 6 weeks and the first 18 weeks. For this reason, it is important to follow weekly haemogram values for the first 18 weeks. But despite the reduced risk, it continues after 18 weeks. In our patient, agranulocytosis developed in the fourth year of clozapine treatment. For this reason, after 18 weeks, monthly haemograms are of great importance.

[Abstract:0597][Psychopharmacology]

Rapid-onset agranulocytosis following the introduction of clozapine: a case report

Emre Subas, Selin Alkan, Suat Yalcin, Suleyman Donmezler, Sevilay Umut Kilinc, Burcu Hamurisci Yalcin, Guliz Ozgen, Ahmet Turkcan and Yasin Hasan Balcioglu

Department of Psychiatry, Bakirkoy Prof. Mazhar Osman Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Istanbul, Turkey

E-mail address: selinleli@gmail.com

ABSTRACT

Clozapine is a gold standard treatment option for drug-resistant schizophrenia which is superior to other antipsychotics with its efficacy. Nevertheless, several side-effects are well defined in clozapine treatment including clozapine-induced agranulocytosis (CIAG) which is considered as the key serious adverse reaction. 0.7–1% of the patients are reported to develop reversible agranulocytosis under clozapine treatment. This adverse reaction typically emerges between six weeks and six months; however, sooner occurrence of agranulocytosis is infrequently reported. Here we report a case with rapid-onset agranulocytosis within 25 days of the introduction of clozapine.

Case presentation: A 49-year-old man with the diagnosis of schizophrenia was admitted to our inpatient clinic due to exacerbation of the psychotic symptoms. He was presented with intensive paranoid and grandiose delusions. He had no concomitant somatic disorders and there was no history of any hematological illness in his medical records. Initially, he received 20 mg haloperidol and 10 mg biperiden intramuscular injection treatment for a week. Soon after, with the past history of non-response to two atypical antipsychotics, clozapine was introduced at 50 mg a day. The dose was gradually increased by 50 mg every 3 days up to 450 mg a day with weekly haemogram screenings. On the 25th day of treatment, the increase of the daily dose of clozapine to 450 mg resulted in a rapid decrease of absolute neutrophil count such that leukocyte count was 1320 and neutrophil count was unmeasurable. The previous haemogram performed on the 19th day was insignificant meaning that the cell destruction occurred within six days. Clozapine was immediately stopped. The patient was isolated. He was treated with granulocyte colony-stimulating factor, prophylactic antibiotics, and lithium was added to the treatment due to its leukocyte builder effect. Neutrophil count gradually increased over the days. On the 9th day of clozapine withdrawal, leukocyte and neutrophil counts were over 5600/mL and 1500/mL, respectively. The daily haemogram screening of the patient displayed a stable count of neutrophils. There have been different suggestions to explain the mechanism of CIAG including the toxicity of the drug itself or its metabolite, the pharmacodynamics of the drug and a possible secondary immune reaction. Clozapine oxidizes to reactive nitrenium ions which bind covalently to structural proteins of neutrophils and possibly causes them to be released from the marrow earlier. It is also suggested that CIAG is associated with specific Human Leukocyte Antigen alleles. In this case, after the clozapine dose was increased to 450 mg, a dramatic decrease in the granulocyte count was noted within 6 days. An acute incident occurred in a 6 days period which might be the result of a possible immune reaction can support previous findings of the mechanism of CIAG. It is also notable that CIAG occurred within 25 days after the drug was introduced considering it mainly occurs in a six weeks-six months period. This case study can also be helpful to remind clinicians the importance of weekly haemogram screenings after clozapine is introduced.

KEYWORDS

Adverse effects; agranulocytosis; clozapine; immune-mediation; psychopharmacology

[Abstract:0599][Schizophrenia and other psychotic disorders]

Postictal psychosis: a case report

Ebru Çiftçi, Bilge Çetin İlhan, Zeynep Yücehan, Deniz Altunova and İbrahim Eren

Konya Research and Training Hospital, Department of Psychiatry, Health Sciences University, Konya, Turkey

E-mail address: cyftcy88@gmail.com

ABSTRACT
Psychoses in patients with epilepsy are classified as interictal psychosis, ictal psychosis or postictal psychosis (PIP). Postictal psychosis develops after complex partial seizures, often secondary generalized tonic–clonic seizures, and often after a cluster of these seizures.
Case presentation: A 45-year-old male patient with epilepsy for 22 years. He had generalized tonic clonic seizure (JTK) epileptic seizure 3 times in the last 3 days. He was admitted to the neurology clinic because of hyponatremia (Na:116 mEq/L) and recurrent epileptic seizures. Blood sodium level and seizures was regulated as sodium replacement and 300 mg/day phenytoin Intravenous infusion (IV inf). On day 3 of treatment, persecution delusions, auditory and visual hallucinations were formed. The patient was admitted to our psychiatry clinic for attacking the service nurse with the cause of psychotic symptoms after the JTK seizure. The treatment was haloperidol amp 10 mg IV inf. and phenytoin amp 300 mg/day IV inf. Cranial MR was reported ending left frontal lobe periventricular deep white matter with arachnoid cyst 4 mm in diameter compatible with gliotic focus and EEG was reported as slower ground activities by age and very common epileptiform abnormalities. The final treatment of the patient with regressed psychomotor agitation was phenytoin capsule 300 mg/day and quetiapine XR tb 300 mg/day. The patient whose psychotic symptoms reduced was discharged 1 week later. Neuropathology of epileptic psychoses is believed to be associated with abnormal electrical discharges localized to the temporal-frontal lobe and cerebellum. PIP consists of behavioural changes that occur immediately after a set of seizures or within a week of consciousness recovery. Changes may come to exist; confusion, disorientation, delusions (usually paranoid delusions, size delusions, mystic delusions), visual and auditory hallucinations, catatonia, or combinations thereof. The symptoms may be accompanied by mood changes. Attacks are usually brief (24 hours to 3 months). Between attacks is usually normal. PIP, is often seen in epileptic seizures for more than 10 years. Our patient had a 22-year history of epilepsy. His psychotic episodes were of the character described above, and there were no psychotic episodes between seizures. Early recognition of PIP is critical to reduce mortality. Initiation of early treatment ensures rapid recovery of PIP. Often an antipsychotic drug and a benzodiazepine combination is preferred. In cases of multiple recurrences at shorter intervals, ongoing antipsychotic treatment that is increased after seizures may be beneficial. PIP is regulated by adjusting the doses of antiepileptics, low-dose antipsychotic therapy, or spontaneous recovery. The main treatment of PIP is to control seizures with antiepileptics.

KEYWORDS
Epilepsy; psychosis; quetiapine; phenytoin; hyponatremia

[Abstract:0600][Schizophrenia and other psychotic disorders]

Nonsteroidal anti-inflammatory drug-induced psychosis: a case report with single dose

Ayse Ceren Kaypak, Fatih Baz and Nese Yorguner Kupeli

Marmara University Pendik Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

E-mail address: ayseceren23@gmail.com

ABSTRACT
Nonstreroidal anti-inflammatory drugs (NSAID) are widely prescribed in clinical practice for various indications. Athough well-established side effects of NSAIDs, psychiatric ones have not studied sufficiently. The CNS side effects of these drugs are considered mainly in three categories: psychosis, aseptic meningitis, and cognitive dysfunction. These side effects are mostly seen either with chronic use or high doses as in intoxication level. Here, we present a case of psychosis induced with a single and usual dose of naproxen.
Case presentation: Ms U is 35 years old, married, housewife. The patient, who had not have any known psychiatric disorders, no alcohol or substance use disorder, or have any comorbid diseases in previous medical history, admitted to ER clinic for the first time due to headache a few weeks ago. Since routine investigations and medical work-up for excluding organic causes were normal, an IV symptomatic treatment (furosemide 40 mg, dimenhydrinate 50 mg, metoclopramide 10 mg and piracetam 1gr with dextrose solution) was administered to her in order to reduce headache, nausea, and dizziness in ER clinic. Although the complaints were relieved for a short time, she admitted to ER clinic for headache for the second time two days later. Similarly, the repeated medical work-up was normal, anew IV symptomatic treatment (pheniramine 45.5 mg, dexketoprofen trometamol 50 mg, metoclopramide 10 mg with isotonic NaCl solution) was administered and she was discharged from ER with a prescription of oral naproxen treatment (naproxen 550 mg with 30 mg of codein). It was learned that after taking a single dose of naproxen being discharged from the hospital, within few hours, she had a psychotic experience that her family as devils and would harm her. Subsequently, auditory hallucinations,

KEYWORDS
Nonsteroidal anti-inflammatory drugs; codeine; naproxen; psychosis; side effects

psychomotor agitation, dysphoric mood were accompanied by persecutory and reference delusions, and all psychotic experiences lasted 4 days after NSAID treatment. A detailed psychiatric evaluation showed that there were no stressful life events before that short psychotic episode. She had dramatically and fully recovered within few days after cessation of naproxen. To the best of our knowledge, this is the first case reported that naproxen induced psychosis, after a regular dose with single administration in the literature. This case can be categorized as substance/medication-induced psychotic disorder according to DSM-5 due to psychotic symptoms had developed soon after a NSAID exposure and involved medication is known to be capable of occurring these symptoms. Another clinical remark for the aforementioned diagnosis was the lack of evidence for an independent psychotic disorder, also with an immediate onset of symptoms and symptoms did not persist after cessation of medication. Moreover, she had no previous psychiatric history and risk factors. Confounding factors may be multiple IV medications prior to naproxen administration and we have not rechallenged medication for various reasons for that case. Clinicians should be aware that psychotic disorders can be induced with even the low doses of nonsteroidal antiinflammatory drugs and maybe the iatrogenic cause for psychiatric disorders. Further investigations and case reports are needed to clarify the possible mechanisms of this phenomena.

[Abstract:0609][Sleep disorders]

Paradoxical insomnia: a case report

Ali İnaltekin[a], İbrahim Yağcı[b] and Yüksel Kıvrak[a]

[a]Department of Psychiatry, University of Kafkas Faculty of Medicine, Kars, Turkey; [b]Kars Harakani State Hospital, Department of Psychiatry, Kars, Turkey

E-mail address: ali.inaltekin@hotmail.com

ABSTRACT

Paradoxical insomnia (sleep state misperception) was used as a diagnostic term for patients with subjective insomnia and sleepiness complaints without objective findings in the second edition of International Classification of Sleep Disorders. It ranked as the clinical subtype of chronic insomnia in the third edition of International Classification of Sleep Disorders and the time period mentioned as a diagnostic criterion was increased from one month to three months.

Case presentation: FU was a 53-year-old female. She was a married housewife who was primary school graduate living with her husband and three children in Kars. She had had the complaints of inability to sleep, daytime sleepiness and fatigue for seven months. The past medical history of the patient did not reveal smoking, use of alcohol or caffeine and any medical disease. The patient had used amitriptyline 10 mg/day and trazodone 50 mg/day treatments for one month before her admission to our clinic. Laboratory and imaging investigations were requested for the patient in order to exclude potential aetiologies. The patient whose laboratory and imaging examinations showed no pathology was admitted to the sleep laboratory for polysomnographic assessment. Her polysomnographic assessment showed that her sleep latency was 9.0 minutes, the effectiveness of sleep was 68.2%. Patients typically have the complaints of short sleep, lack of sleep, nonrefreshing sleep. However, these complaints cannot be demonstrated objectively. While diagnosing paradoxical insomnia, it should be ensured that it is not a symptom of a psychiatric disease and it is not malingering (simulation). Our patient had the complaint of "I cannot sleep at all." It could not be demonstrated in the polysomnography and another psychiatric disease could not be identified. Among the patients admitted to sleep disorders clinics, the diagnosis of paradoxical insomnia was observed to be in 9% of the patients admitted with the complaint of insomnia and in 5% of the patients admitted with the complaint of sleepiness. The diagnosis of paradoxical insomnia was shown to be 6.6% in a multi-centre field survey. Our sleep unit was founded in 2008. When 2500 patients who admitted to the sleep unit were screened, no patient was observed to have this diagnosis. The reasons underlying its low prevalence might be the cold weather conditions or high altitude of Kars or the fact that it does not come to mind as a diagnosis. Although it took place in the second edition of ICSD in 1990, the aetiology of paradoxical insomnia is not known and there is no standard treatment. As far as we could access, this is the first case with paradoxical insomnia reported in Turkey. Paradoxical insomnia was diagnosed for the first time in our sleep unit. This low prevalence may depend on the geographic and demographic characteristics of Kars province. We presented this case since she was the first patient of our clinic diagnosed with paradoxical insomnia and in order to remind that paradoxical insomnia should be considered while thinking for the diagnosis in patients with the complaint of insomnia.

KEYWORDS

Insomnia; polysomnography; sleep disorder; sleep hygiene; sleepiness

[Abstract:0620][Schizophrenia and other psychotic disorders]

Psychosis with pseudotumor cerebri and thyroid-stimulating hormone elevation: differential diagnosis of Hashimoto's encephalitis

Emine Füsun Akyüz Çim[a] and Abdullah Atli[b]

[a]Department of Psychiatry, Yuzuncu Yil University, Van, Turkey; [b]Department of Psychiatry, Dicle University, Diyarbakir, Turkey

E-mail address: drfusunakyuz@hotmail.com

ABSTRACT

Thyroid hormone abnormalities are the endocrine abnormalities which could trigger the psychotic symptoms. Pseudotumor cerebri is an intracranial pathology characterized by increased intracranial pressure without hydrocephalus and may occur secondary to thyroid hormones abnormality. Our case, the patient with pseudotumor cerebri and the elevation of TSH was evaluated, Hashimato's Encephalitis (HE) clinic in differential diagnosis.

Case presentation: A 33 years old female patient, married, has three children, housewife. About 2 months ago, total thyroidectomy was performed with the cause of thyroid papillary cancer. Thyroid hormone replacements were interrupted 15 days ago due to planned radioactive iodine treatment. On the fourth day of discontinuation of hormone replacement, psychotic symptoms and disorientation started suddenly and progressively increased. The patient was brought to the emergency service by relatives. In psychiatric examination; her time and location orientation is corrupted, could not respond properly to the questions. In the content of thought, persecution and disloyalty were detected. Visual and odours hallucinations were available. No neurological pathology was evaluated in the emergency department by neurology clinic evaluated by radiological imaging (brain magnetic resonance/tomography) and neurological examination. Electroencephalography was normal. The patient was hospitalized with brief psychotic episode and hashimato encephalitis prediagnosises. Treatment was then adjusted to 10 mg of olanzapine. Biochemical markers were normal except TSH (30.1 mIU/ml) elevation. Antitroglobulin antibody (3.51 IU/ml) and Anti TPO antibody (1.53 IU/ml) were detected at as normal limitted. Thyroid hormone replacements were started as Levotiron 150 mcg. At the fifth day of hospitalization, neurology clinic consultation was requested again because of continuing disorientation and fluctuating psychotic symptoms within the day. Contrasted MR and lumbal ponksion results were evaluated. CSF pressure couldn't measure due to patient non-compliance. CSF biochemistry was evaluated as normal. Fundoscopy revealed bilateral papilledema. Contrast-enhanced MR revealed partial empty sella. Pseudotumor cerebri was considered as a diagnosis. Acetazolamide was given at a dosage of 500 mg/day. During the second week of hospitalization, cognitive symptoms and psychotic symptoms were completely normal. TSH elevation and clinical presentation of the patient had pointed HE as a differential diagnosis. In HE clinic, impairment of cognitive function, neurological deficit and psychotic symptoms can be seen [1]. The diagnosis of HE is made by the increasing of anti-thyroid antibodies in serum. However, in our patient, there were no markers compatible with HE except for clinical presentations and TSH elevation. The elevation of TSH might be thought to be responsible for the aetiology of pseudotumor cerebri in accordance with the literature [2]. However, it should be argued that the cause of delirium in which the psychotic symptoms are prominent might be responsible only for TSH elevation or TSH and pseudotumor cerebri association.

KEYWORDS

Hashimoto's encephalitis; pseudotumor cerebri; psychosis; thyroid-stimulating hormone; disorientation

References

[1] McKeon A, McNamara B, Sweeney B. Hashimoto's encephalopathy presenting with psychosis and generalized absence status. J Neurol. 2004;251:1025–1027.

[2] Carotenuto A, Barbato F, Vacca G, et al. Idiopathic intracranial hypertension in a patient with thyroid papillary carcinoma. Neurol Sci. 2014;35(1):109–111.

[Abstract:0623][Other]

Recurrent organic dissociative fugues without psychological trauma: a case report

Emine Füsun Akyüz Çim[a] and Abdullah Atli[b]

[a]Department of Psychiatry, Yuzuncu Yil University, Van, Turkey; [b]Department of Psychiatry, Dicle University, Diyarbakir, Turkey

E-mail address: drfusunakyuz@hotmail.com

ABSTRACT
In DSM-5 the dissociative fugue was removed from a separate diagnostic category and became a subtype of dissociative amnesia, in DSM-5. In dissociative fugue, after the psychological stress the person suddenly abandons the place where he or she is, at which time it may appear to be in an organizing travel, or unorganized walking and escaping can be seen. Dissociative disorders can be formed by organic pathology. Our case is a dissociative amnesia case with recurrent fugue, which can be considered as a separate entity on the ground of the organism.
Case presentation: A 18 years old female patient, single, high school student, lived with parents and 3 siblings. The patient came to psychiatric clinic with father. She was told to escape from the home. The patient was away from for 2 weeks. The patient was found by the police while walking aimlessly on the street at the previous day. Patient did not remember anything about escaping from home. The patient expresses impulsive behaviours, anger attacks, forgetfulness, and insomnia. Apart from the long-term amnesic process, which lasted 2 weeks, amnesias in 1–2 h periods was reported once-twice a week.
The patient was admitted to the intensive care unit after a car accident in 2011. Two years ago, she had been hospitalized to the neurology clinic with sinus venous thrombosis. Coumadin and topiramate were used while 6 months for the patient. Drug use and neurological complaints had not been described for 1.5 years. The patient had not have a manifest epileptic seizure. Psychiatric evaluation; the patient's the orientation was intact, the answer's were appropriate to the questions. Mood was anxious and no psychotic symptoms were detected. EEG: Suspicious discharge consistent with paroxysmal activity in the frontal central was detected. Sleep-activated EEG was assessed as normal. Lamotrigine 25 mg was started to be gradually increased. Apart from limited amnesia attacks, which were accompanied by fugue, there were more systematic and prolonged amnesic-fugue attacks 2 weeks ago in our case. The limited episodes of the patient recovered spontaneously. However, during the last episode of systemic and long-lasting illness, was found by the police with disorganized walking around the city centre. Dissociative fugue is especially confused with complex partial epilepsy. In general, epileptic seizures forming a fugue-like picture are caused by temporal, hippocampus, septum, amygdala and limbic system. In our patient, suspicious epileptic discharges from the frontal lobe were detected. Also patient had not experienced a manifest epileptic seizure before. The duration of amnesia in epileptic seizures is shorter than in dissociative disorders. In addition, our patient and her relatives did not express any significant traumatic event before the long-term fugue. Current clinical informations make the diagnostic categorization of the patient difficult. Symptoms of amnesia did not fully meet dissociative fugue or epileptic seizures. In the light of available information, it can be considered that our patient can be evaluated in a different category from the dissociative fugue psychopathology. Epileptic discharges may be thought of as psychological stressors. Recurrent fugue attacks can be described as non-traumatic organic dissociative fugues.

KEYWORDS
Dissociative disorders; dissociative fugue; epileptic seizure; frontal lobe; psychological trauma

[Abstract:0625][Schizophrenia and other psychotic disorders]

The role of clozapine in early-onset schzopherina: a case report

Leyla Delikanli, Mustafa Tuncturk, Oguz Bilal Karakus, Ali Guven Kılıcoglu and Gul Karacetin

Bakirkoy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Hospital, Child and Adolescent Psychiatry Clinic, Istanbul, Turkey

E-mail address: leyla.delikanli@gmail.com

ABSTRACT
Schizophrenia is a disabling illness, regardless of the age onset, but when it is seen in childhood or adolescence the consequences are severe. Childhood or adolescence onset cases are defined as early-onset schizophrenia (EOS) that constitutes about 5% of all cases of schizophrenia. In terms of psychosocial functioning, the outcome of patients with EOS in is very poor. The onset of clinical symptoms arise along the critical cognitive developmental period for most of the children, and they have difficulties in acquiring basic academic skills. Atypical antipsychotics is superior to typical ones in the treatment of early-onset schizophrenia. Clozapine is a prototype of atypical antipsychotics and the first antipsychotic to be defined as atypical. Most of the existing child and adolescent psychiatric guidelines recommend a treatment trial with clozapine for both treatment-resistant cases and for treatment-intolerant cases.
Case presentation: A 14-year-old adolescent male was brought by his family to emergency pyschiatry unit with complaints of fear of being hurt, looking people in a hostile way, pissing himself, spending a lot of time with playing water, taking off clothes inappropriately, refusing to eat and having autism. As the patient refused eating and treatment, he was admitted to our inpatient clinic for differential diagnose. He diagnosed with early-onset schizophrenia. In this case, despite administration of 2 antipsychotic in effective dosage at least 4 weeks he got little improvement in symptoms so initiation of clozapine is planned. 25 mg clozapine was started

KEYWORDS
Adolescent; clozapine; early-onset schizophrenia; mutism; psychopharmacology

and increased up to 300 mg with weekly haemogram controls. After he was discharged, he examined monthly at the outpatient clinic. At 6th month of using clozapine, he managed to return school, got progress in academic and social fields. His treatment continues with 300 mg/day clozapine. Due to restricted license using clozapine "off label" and insufficient information on the beneficial dosage and side effect profiles may have led to the under usage of clozapine despite its clinical benefits in early-onset schizophrenia. Physicians and patients should be aware as there is a range of benefits from clozapine use in patients with treatment-resistant early-onset schizophrenia that may be greater than the risks associated with clozapine treatment. With regular monitoring, the risky states can be controlled and minimized.

[Abstract:0627][OCD]

Total hair, eyebrows, and eyelashes loss in trichotillomania: a case report

Merve Okuyan[a], Halil İbrahim İvelik[a], Burak Okumuş[b] and Çiçek Hocaoğlu[b]

[a]Medical School, Recep Tayyip Erdogan University, Rize, Turkey; [b]Medical School, Department of Psychiatry, Recep Tayyip Erdogan University, Rize, Turkey

E-mail address: cicekh@gmail.com

ABSTRACT

Trichotillomania is defined as significant hair loss due to individuals' repetitive self-pulling of hair. It is a chronic disorder that leads to significant distress and functional impairment and is often difficult to treat. In most cases, trichotillomania results in a total or partial scalp alopecia or hair loss, caused by repeated pulling of one's hair from, most often the head, followed by the eyelashes and eyebrows. The psychiatric comorbidity is usually seen with trichotillomania in adults. The most common psychiatric comorbidities are affective disorders, anxiety disorders, addiction disorders. The effect of trichotillomania can be quite large and serious. It has many negative effects such as either on relationships between people or causing avoid social activities. Research regarding aetiology and treatment of trichotillomania has increased over last twenty years. It has been mentioned that its aetiology is based on evolutional, genetic, neurophysiological and neurocognitive factors. Although robust evidence is not available, drugs such as clomipramine and selective serotonin reuptake inhibitors (SSRIs) or cognitive behavioural therapy are promising treatments. Habit Reversal Training (HRT), as a cognitive behavioural technique, has the highest rate of success in treating trichotillomania. The treatment of trichotillomania usually involves the participation of both psychiatrists and dermatologists.

Case presentation: In this study, a case of a female patient, who has presented only dermatology policlinic for many years with the diagnosis of alopecia totalis, eyebrows and eyelashes loss and not believing being treated in result, is presented. This case has been prepared as a good example of that trichotillomania causes the depression and the decrease in the quality of life.

KEYWORDS

Diagnosis; aetiology; hair loss; treatment; trichotillomania

References

[1] Ninan PT, Rothbaum BO, Marsteller FA, et al. A placebo-controlled trial of cognitive-behavioral therapy and clomipramine in trichotillomania. J Clin Psychiatry. 2000;61(1):47–50.

[2] Trüeb RM, Cavegn B. Trichotillomania in connection with alopecia areata. Cutis. 1996;58(1):67–70.

[3] Malakar S, Mehta PR. "i hair": a prognostic marker in alopecia areata & trichotillomania. Indian J Dermatol. 2017;62(6):658–660.

[4] Khunkhet S, Vachiramon V, Suchonwanit P. Trichoscopic clues for diagnosis of alopecia areata and trichotillomania in Asians. Int J Dermatol. 2017;56(2):161–165.

[5] Brauer L, Grant JE. Exposure and ritual prevention therapy for trichotillomania: two case reports. Clin Psychiatry. 2017;78(8):e1057.

[Abstract:0628][Schizophrenia and other psychotic disorders]

An update on differential diagnosis of short psychotic conditions based on a case report with hysterical/shared pyschosis

Kübra Kılınç, Fatih Hilmi Çetin and Serhat Türkoğlu

Department of Child and Adolescent Psychiatry, School of Medicine, Selcuk University, Konya, Turkey

E-mail address: kubradurmus_1991@hotmail.com

ABSTRACT
Hysterical psychosis is marked by a sudden and dramatic onset, temporally related to a profoundly upsetting event or circumstance; its duration seldom exceeds 3 weeks, and it most commonly occurs in women with hysterical personality. It recedes suddenly, leaves no residues, and its manifestations include hallucinations, delusions, depersonalization, grossly unusual behaviour, volatile affectivity, and only transient, circumscribed thought disorder. Hysterical psychosis appears as a polymorphic benign psychotic episode, not uniformly conceptualized. Our goal is to discuss the differential diagnosis in case rapidly starting and uncertain psychosis.
Case presentation: She was brought to the psychiatric clinic by her mother, an 11-year-old girl. She lived with her brother, her parents, in the city centre. Her mother's complaints were that she was hiding behind her mother when someone was trying to talk to her. She was afraid of everything, even from butterflies. She always said she was bored. She started not to eat anything and she was crying when the breakfast time came. Before responding to the phone, she was quiet and listened with suspicion for a while. He was having trouble falling asleep. Complaints were for a month and an initiator stress of complaints could not be detected. There was no trait to the value of the resume. She had no substance use. His older brother had a diagnosis of schizophrenia four years ago and had deorganize behaviours. His brother was partially responding to the cure. She was quiet, her affect was flat, and she was sceptical. There was no active hallucination or delusion that could be detected. Paediatric neurology consultation was made for the exclusion of organic aetiology. Prepsychotic episodes and hysterical psychosis premises were considered and risperidone 0.5 mg/day treatment was started. The patient's complaints were completely resolved within a few days. Laboratory tests and brain imaging were normal. After about 5 months the treatment was terminated. Medical conditions (substrate deficiency, CNS abnormality, systemic lupus erythematosus, metabolic disease, hepatic failure, Hashimoto thyroiditis, thyroid storm, antiphospholipid syndrome, etc.), shared psychosis, prepsychotic period, hysterical psychosis, short transient psychotic episodes can be evaluated in psychotic charts that start suddenly in the childhood age group. In our case, shared psychosis with the fact that it is the schizophrenic of his brother and hysterical psychosis with the immediate response to the low-dose antipsychotic agent was the most important differential conditions. The most common diagnosis in shared psychosis is schizophrenia, which is followed by affective disorders and delusional disorder. Shared psychotic disorder continues to be in a controversial position with significant changes in psychosocial interventions. Longer follow-up studies are needed about short psychotic conditions for determining the pathological form of the relationship between individuals, explaining psychodynamic formulations, investigating biological factors, identifying risk factors, and understanding prognosis. Reporting and monitoring of cases related short psychotic conditions are important in order to clarify these questions.

KEYWORDS
Delusion; hysterical psychosis; schizophrenia; shared; psychosis

[Abstract:0629][Mood disorders]

Normoprolactinemic galactorrhea related with venlafaxine: a case report

Abdullah Atli[a], Aslıhan Okan İbiloğlu[a] and Emine Füsun Akyüz Çim[b]

[a]Department of Psychiatry, Dicle University, Diyarbakır, Turkey; [b]Department of Psychiatry, Yuzuncu Yil University, Van, Turkey

E-mail address: abdullahatli@yandex.com

ABSTRACT
Venlafaxine is a potent serotonin and noradrenaline reuptake inhibitor (SNRI), and also weak dopamine reuptake inhibitor, used especially for the treatment of major depressive disorders as well as other psychiatric disorders. Adverse effects of venlafaxine: it often causes gastrointestinal side effects such as nausea, vomiting, weight loss, decreased/increased appetite, constipation, diarrhoea, increase in blood pressure, skin flushing, palpitation, urge difficulty, decreased libido, fatigue, headache, mouth trouble, sweating, and abnormal dreams. Additionally, rare side effects of venlafaxine including the black stool, bruxism, hallucinations, involuntary movements, dystonia, and akathisia. Hyperprolactinemia can be induced by the antipsychotics, selective serotonin reuptake inhibitors, and venlafaxine. On the other hand, hyperprolactinemia can be caused to galactorrhea, amenorrhoea, infertility, and declined libido especially in women. According to numerous studies in the literature, venlafaxine-induced hyperprolactinemia can be dose related; on the other hand, this adverse event could be probably to be reversible in the reduction of the venlafaxine dose. Indeed, venlafaxine can induce galactorrhea, with or without elevation of prolactin levels.

KEYWORDS
Venlafaxine; Depression; Serotonin; Prolactin; Normoprolactinemic Galactorrhea

Case presentation: Ms SN a 28 years old, female, single, university graduate, and midwife. The patient presented to our psychiatry outpatient clinic with complaints of crying, weakness, closure, restlessness, distraction, sleepiness, inability to enjoy life, and weight loss. Our patient had two depressive episodes, in the past. In addition, his brother is followed by the diagnosis of bipolar disorder. Although the patient was still using venlafaxine 150 mg/day, his complaints increased. The problems we have experienced in the workplace have been applied to us. The patient's venlafaxine dose was increased to 300 mg/day with a 1-month rest was recommended. In the 2nd month of the treatment, complaints of galactorrhea were detected. The patient's pituitary MR image was normal. Also, prolactin levels were evaluated as the normal range. Venlafaxine treatment was stopped at the request of the patient. Subsequently, escitalopram was started and gradually increased to 30 mg/day. The milk flow of the patient was gradually decreasing within a month and stopped. Recently, galactorrhea cases which related to Venlafaxine, in the literature. According to many studies, Venlafaxine and SSRIs are thought to cause galactoresis with similar mechanisms. We reported here a case of normoprolactinemic galactorrhea due to the increased venlafaxine dose. Venlafaxine can induce galactorrhea, with or without elevation of prolactin levels, implicating dopaminergic and/or non-dopaminergic serotonergic mechanisms, as in SSRIs mechanisms.
In our opinion, all clinicians should be careful in terms of the galactorrhea especially used to high-dose venlafaxine.

[Abstract:0632][Addiction]

A psychogenic movement disorder case associated with alcohol use disorder treatment

Abdullah Atli[a], Emine Füsun Akyüz Çim[b] and Aslıhan Okan İbiloğlu[a]

[a]Department of Psychiatry, Dicle University School of Medicine, Diyarbakır, Turkey; [b]Department of Psychiatry, Yuzuncu Yil University School of Medicine, Van, Turkey

E-mail address: abdullahatli@yandex.com

ABSTRACT
Psychogenic Movement Disorder (PMD) can occur with different symptoms, including tremor dystonia, myoclonus, tics, and parkinsonism. The exact pathophysiology of PMDs is still unclear. Some clues in the diagnosis of the PMD are including the sudden onset of symptoms, rapid progression with intermittent course, changeability of symptoms over time, as well as concurrent other somatic symptoms. Concurrent anxiety and depressive disorder symptoms are common, but not necessarily. We examined to here a male patient who diagnosis to PMDs during the treatment of alcohol dependence.
Case presentation: A 35 years old single male, living with his mother. He drinks 35 cc of alcohol a day, Furthermore, the patient has been using alcohol increasingly, for about 15 years. Our patient was treated for depressive disorder, two times in the past. His family history was also not remarkable. At the psychiatric examination, he said that he did not use any alcohol, from 2 days. Patients had withdrawal symptoms with craving. Therefore, we were decided to inpatient treatment at the hospital. After then, the treatment of alcohol detokfikasyon was started. Flexion posture in the right arm, tremor, rigidity, and slowness of movement were observed, on the 10th day of diazepam treatment in the patient. For this reason, neurology consultation was requested. All detailed investigations with right arm EMG and brain MR examination of the patient were decided as normal. After then, the treatment of levodopa and entacapone were started by the neurologist with pre-diagnosis of Parkinson's. At last, Psychogenic Movement Disorder was considered by the whole researchers. Alcohol deprivation may result in symptoms of Parkinson's as well as essential tremor-like symptoms. As in our case report, many cases in the literature, because benzodiazepine treatment is initiated, there were no seen alcohol withdrawal symptoms. MR and EMG results of the patient were evaluated as normal. At the result of the detailed investigations, Parkinson's treatment has been started for our patient, by the trained neurologist. Although there was no decline in our patient's complaints. According to the above-mentioned results of the patient, we did not consider any diagnosis of the organic movement disorders for the present case. The patient was discharged after two weeks. Complaints of our patients, who were followed up in outpatient psychiatry clinic, were gradually decreased. But it did not improve completely.

KEYWORDS
Psychogenic movement disorder; parkinsonism; alcohol use disorder; alcohol withdrawal; tremor

[Abstract:0634][Schizophrenia and other psychotic disorders]

A case of clozapıne-induced cardıomyopathy

Rukiye Tekdemir and Memduha Aydın

Department of Psychiatry, Selcuk University School of Medicine, Konya, Turkey

E-mail address: dr.rukiyetekdemir@gmail.com

ABSTRACT

Cardiovascular diseases are the most common cause of death worldwide. If psychiatric diseases are accompanied, this risk is increasing. Although this is largely related to the lifestyle of these patients, it is closely related to the drugs used. The use of typical, atypical antipsychotics is associated with an increased cardiovascular risk. Parallel to the widespread use of second-generation antipsychotics, cardiovascular risks have increased. This increase in cardiovascular events has recently attracted attention to these drugs. Cardiomyopathy is a rare but potentially lethal cardiogenic side effect of antipsychotics. In this case report, we present a case of cardiomyopathy and cardiac insufficiency diagnosed while using clozapine, which had no other aetiologic factor.

Case presentation: A 40 years old, high school graduate, single, unemployed male patient who was staying in the nursing home was consulted to our psychiatry clinic from the intensive care clinic for the arrangement of psychiatric treatment. The patient's first psychiatric complaints began 17 years ago. He was diagnosed with schizophrenia at that time. He was hospitalized for a short period of time and has partially benefited from the treatment. After discharge, he did not continue his treatment and he did not have insight. It was 2 years ago his second psychiatric admission who had not had any treatment for 15 years. That time, he was hospitalized for 2 months and started treatment of risperidone depot 50 mg biweekly. After 1 month, clozapine treatment was started and risperidone treatment was discontinued. He was discharged with clozapine 400 mg/day and increased to 600 mg/day 3 months after discharge. He continued to his controls and has benefited significantly from that treatment. He had occasional coughs and dyspnoea complaints, dependented to smoking 30 cigarettes a day. After 15 months of treatment with clozapine, he began to complain of fatigue, dyspnoea, high fever, cough, restlessness and he admitted to the emergency service with. Clozapine treatment was reduced to 200 mg/day. After a weak, he presented to the emergency department with syncope, where he had cardiopulmonary arrest. He was transferred to the intensive care clinic. Cardiomyopathy was detected in the echocardiogram performed. Cardiac insufficiency treatment was started because of his ejection fraction 30% and he was hospitalized 10 days. He had not another disease other than schizophrenia and did not have any medication used other than clozapine. One of the patient's brother was schizophrenic and there was no any cardiovascular disease in his family history. He had been smoking cigarettes for 20 years, but did not drink alcohol. Therefore, clozapine treatment was responsible for the patient's cardiomyopathy. After discharge, there was no reduction in his cardiogenic complaints. Clozapine-induced cardiomyopathy is 0.1% in Australia, where the frequency of reporting is most frequently reported. There is not found yet a study that has been done about the frequency of clozapine-induced cardiomyopathy only in our country. Only case reports are available. In general, cardiomyopathy is seen at least 8 weeks after the initiation of clozapine, usually in 6–9 months. It is usually irreversible and may result in death. Therefore, complaints such as high fever, dyspnoea, tachycardia should be taken into consideration in patients who are using clozapine.

KEYWORDS

Clozapine; cardiomyopathy; myocarditis; schizophrenia; side effect

[Abstract:0635][Psychopharmacology]

Steroid-induced psychotic depression in a multiple sclerosis patient

Nihal Taştekin, Betül Kırşavoğlu and Murat Yalçın

Department of Psychiatry, Erenkoy Mental Health Research and Training Hospital, Istanbul, Turkey

E-mail address: nihaltastekin@yahoo.com.tr

ABSTRACT

Although depression is a common comorbid disorder in multiple sclerosis (MS), it has been reported that steroid treatment can also cause psychiatric symptoms such as mood disorders, psychotic disorders, and anxiety disorders. Mania is more frequently observed than depression during steroid use. However, it has been reported that depression is more

KEYWORDS

Corticosteroids; drug-induced; multiple sclerosis; steroid-induced; psychotic depression

common during long-term steroid therapy. In this case, we wanted to address the importance of the holistic approach to the patient by assessing the occurrence of psychotic depression following short-term steroid therapy in the onset of MS disease.
Case presentation: A 37-year-old patient was brought to our hospital by her family. She did not have a history of psychiatric illness until then. We learned that she had been diagnosed with multiple sclerosis (MS) one week before and considering that an attack period, 6000 cc intravenous steroid as loading dose had been administered for 6 days. On the third day of treatment, unhappiness, nervousness, restlessness, guilt thoughts, suspiciousness, insomnia, loss of appetite, and death thoughts had occurred. She presented to our clinic with these complaints. Lorazepam 1 mg/g was given for the sedation of the patient who did not want to cooperate, had a suicidal discourse, and an insufficient insight. The patient was consulted for neurology in terms of "organic mental status due to MS attack." Neurology did not consider a new MS plaque or any acute pathology. With the pre-diagnosis of "steroid-induced psychotic depression," she was taken to woman ward due to suicide risk. Other investigations were made for the exclusion of organic aetiology, nothing remarkable was detected. Treatment was gradually increased to 10 mg/day for escitalopram and 10 mg/day for olanzapine. On the 11th day of the hospitalization, the patient was discharged in a clinical remission. Considering its effect on morbidity and mortality, early diagnosis and treatment of neuropsychiatric symptoms in MS patients are very important. Both the illness itself and the steroid drug given for treatment predispose to psychiatric symptoms. When psychotic symptoms occur, steroids should be discontinued and antipsychotic should be initiated. Haloperidol is generally recommended as an antipsychotic drug, olanzapine, and risperidone are also beneficial. Sertraline, fluvoxamine, fluoxetine, and moclobemide have been shown to be effective in MS depression, and tricyclic antidepressants should be used with caution, because of its anticholinergic side effects. Escitalopram is frequently preferred in common practice of neurology and psychiatry because of low side effect and low drug interaction. In this case, we prefer olanzapine for psychotic findings, escitalopram for depressive complaints. Although the somatic side effects of commonly used corticosteroids are well known, neuropsychiatric side effects are not well known. For this reason, every clinician should be cautious about the neuropsychiatric side effects that can be caused by corticosteroids. We should take into consideration that even if short-term steroid treatment is administered it may cause depression or psychosis as with our case so we should take notice of the importance of multidisciplinary approach to such diseases.

[Abstract:0637][Anxiety disorders]

Drug interaction between methotrexate and duloxetine using in the treatment of anxiety disorder in the patient with psoriasis vulgaris

Sibel Ayvaz and Ayşe Gülşah Kırımlı

Özel Erdem Hastanesi

E-mail address: sibelayvaz@yahoo.com

ABSTRACT
A severe increase in psoriatic rash and complaints were observed two weeks after using selected duloxetine for symptoms of anxiety disorder in the case with psoriasis vulgaris which is used methotrexate for the treatment, although it was beneficial in terms of anxiety treatment.
Case presentation: 42-year-old male patient. There was improvement in the rush of the psoriasis in one week after termination of the duloxetine treatment. The patient was evaluated with Beck Anxiety Inventory (BAI) in the beginning and termination of the treatment. This situation makes us think that while improving anxiety, duloxetine increases psoriatic rushes by reducing the efficiency of methotrexate.

KEYWORDS
Duloxetine; drug interaction; methotrexate; anxiety; psoriasis

[Abstract:0642][Mood disorders]

Weight loss supplement-induced psychotic mania

Neşe Yorguner Küpeli[a] and Kaan Kora[b]

[a]Psychiatry Department, Marmara University Pendik Research and Training Hospital, Istanbul, Turkey; [b]MD, Psychiatrist, Istanbul, Turkey

E-mail address: neseyorguner@yahoo.com

ABSTRACT
In recent years, the use of herbal medicines has increased considerably all over the world. These drugs, which are primarily used by the patients for cancer treatment, as well as weight loss supplements and painkillers, are also widely and uncontrollably preferred in the treatment of insomnia, anxiety disorder, sexual dysfunction, and depression. Here, a case who had psychotic manic episode while using a herbal medicine for weight loss purposes, with no previous history of psychiatric disorders, will be presented.
Case presentation: Ms D is 36 years old. She was brought to our hospital by her husband 3 years ago, due to the presence of irritability, reduced sleep, and increased talk, energy and sexual drive for one month. In addition to these symptoms, she had persecutory and reference delusions such as being followed or being sent secret messages. In previous medical history, the patient had not have any known psychiatric disorders, no alcohol or substance use disorder, or have any comorbid diseases, but it was found that recently the most important change in her life has been the loss of 17 kg by using the herbal weight loss medicine (Formula 7) for 3 months. Based on her family medical history, it was found that her father has alcohol use disorder. The patient's state was considered as a manic episode and risperidone 2 mg/day and valproic acid 750 mg/day were started. Since the episode was thought to be induced by the weight loss supplement she had been using, she was warned to discontinue the supplement. When the patient, with her current treatment, had a slightly less severe elevation than her first episode approximately one year after the aforementioned episode. It was learned that, although warned countless times, during this period the patient occasionally used the weight loss supplement, which was considered to induce the psychotic manic episode. She was warned once more clearly regarding the weight loss supplement. Although the patient, who is still being followed up, has occasional minor mood swings, her episodes are under control. The general belief that the use of herbal preparations is safe increases the usage rates of these preparations. Unfortunately, since each of these preparations includes various amounts and ratios of components with no clearly resolved mechanism of action, it becomes impossible to predict their side effects. The preparation used by the case presented above contains L-carnitine 10 mg, coenzyme Q10 20 mg, 400 mg garcinia, cress seed 600 mg, ginger 50 mg, green tea 25 mg, and chrome GTF 66.7 mcg. Based on the results of the screening with the aforementioned components, it was found that each one of them may have positive effects, and it was concluded that this should be supported with scientific studies to reveal novel treatment options. On the other hand, mixing substances with potentially unknown interactions into potion-like preparations without any scientific evidence and releasing these without a supervision to the market presents an important risk to our patients.

KEYWORDS
Psychotic; mania; weight; loss; supplement

[Abstract:0643][Psychopharmacology]

Valproic acid-induced neutropenia and thrombocytopenia in a patient with schizoaffective disorder: a case report

Sehure Azra Yaşar, Seher Serez Öztürk, Nafiye Yağlı, Bilge Çetin İlhan and İbrahim Eren

Konya Research and Training Hospital, Department of Psychiatry, University of Health Science, Konya, Turkey

E-mail address: azrayasar@windowslive.com

ABSTRACT
Schizoaffective disorder refers to the coexistence of continuous schizophrenic symptoms together with intermittent mood episodes. Valproic acid (VPA), a conventional antiepileptic drug, is used in the treatment of affective disorders. VPA can cause direct bone marrow suppression leading to aplastic anaemia or peripheral cytopenia affecting one or more cell lines [1].
Case presentation: A 28-year-old male patient with schizoaffective disorder presented to our outpatient clinic with complaints of irritability, insomnia, and auditory hallucinations. He was taking VPA 1500 mg/day, aripiprazole 10 mg/day, and quetiapine 50 mg/day during the past year. In laboratory tests, valproic acid level was found to be 127 µg/ml, and was seen to have leukopenia (leukocyte count of 2780/mm^3), neutropenia (neutrophil count of 1000/mm^3), and thrombocytopenia (thrombocyte count of 95,000/mm^3). Haemogram values sent to confirm current values were compatible with neutropenia (neutrophil count of 1000/mm^3) and thrombocytopenia (thrombocyte count of 103,000/mm^3). Neutropenia and thrombocytopenia were associated with VPA treatment, with the concomitant presence of elevated serum valproate levels. VPA and other medical treatments were immediately

KEYWORDS
Hematologic toxicity; leukopenia; neutropenia; thrombocytopenia; valproic acid

stopped due to neutropenia. Symptoms, vital signs, and physical examination findings were closely followed and protective measures were taken with the cause of the risk of infection. Leukocyte and neutrophil counts were increased as a result of the haemogram follow-ups, and at the end of the first week, leukopenia and neutropenia improved. Thrombocyte count increased to 150,000/mm^3 at the end of the 30 days. After leukopenia and neutropenia improved, oral paliperidone regulated as 12 mg/day and discharged with current treatment. Valproic acid is considered to be the most well tolerated antiepileptic drug. However, few cases of neutropenia or leukopenia caused by valproic acid have been reported [2]. We report a patient with neutropenia, leukopenia, and thrombocytopenia associated with VPA treatment due to high levels of VPA. Hematologic toxicities of valproate are common, vary in onset and severity, are recurrent, transient, or persistent, and usually occur with a serum valproate level >100 µg/ml [1]. Hematologic side effects should be monitored in patients receiving valproate; haematological side effects should be observed when high levels of valproic acid are seen.

References

[1] Acharya S, Bussel JB. Hematologic toxicity of sodium valproate. J Pediatr Hematol Oncol. 2000;22(1):62–65.

[2] Hsu H-C, Tseng H-K, Wang S-C. Valproic acid-induced agranulocytosis. Int J Gerontol. 2009;3(2):137–139.

[Abstract:0645][Psychopharmacology]

Hyperammonemic encephalopathy after two doses of valproic acid in the patient using levofloxacin

Abdullah Akgün, Ayşegül Taşdelen Kul, Abdullah Bolu and Kamil Nahit Özmenler

Gulhane School of Medicine, Department of Psychiatry, Health Sciences University, Ankara, Turkey

E-mail address: akgun_61@live.com

ABSTRACT

There are defined hyperammonemia cases after valproic acid use in the literature. However, there are a few cases of hyperammonemia reported after two doses of valproic acid. In this report, a case of hyperammonemic encephalopathy developed after two doses of valproic acid in the treatment of levofloxacin will be presented.

Case presentation: A 58-year-old male patient was admitted to our clinic because of his symptoms such as decreased need for sleep, irritability, talking a lot, and spending a lot of money. His symptoms have been going on for 2 months. The first symptoms of the patient began about 25 years ago in a similar manner, lasted 6–7 months, then disappeared spontaneously. The patient occasionally had similar attacks but never had received treatment, the attacks spontaneously recovered after a while. The patient was diagnosed with manic episode and valproic acid 1000 mg/day and olanzapine 10 mg/day treatment was started. When admitted to the clinic, he was using 750 mg/day of levofloxacin for 6 days. Levofloxacin 750 mg/day treatment was continued at the clinic. On the third day of admission to the clinic, it was observed that the patient was lethargic. Blood tests were performed on the patient. The blood ammonia level was 149 mg/dl, urea was 47 mg/dl, creatinine was 1.52 mg/dl, ast 47 U/L, alt 53 U/L, sodium 136 mmol/L and potassium 5.67 mmol/L. The initial blood test values of the patient were (36 hours before): urea 17 mg/dl, creatinine 0.93 mg/dl, ast 36 U/L, alt 41 U/L, sodium 135 mmol/l, and potassium 4.53 mmol/l. The patient's urine output was continuing. All treatment of the patient was stopped and intravenous fluid was given. Blood tests were repeated after 12 h. The blood ammonia level was 117 mg/dl, urea was 58 mg/dl, creatinine was 1.16 mg/dl, ast was 41 U/L, alt was 49 U/L, sodium was 134 mmol/l, and the potassium was 5.63 mmol/l. The patient was still confused. Blood tests were repeated after 36 h. The blood ammonia level was 132 mg/dl, urea was 33 mg/dl, creatinine was 0.9 mg/dl, ast was 64 U/L, alt was 67 U/L, sodium was 136 mmol/l, and the potassium was 5.15 mmol/l. The patient's confusion state was partially healed, showing fluctuations during the day. The patient was consulted for nephrology and antipotassium granule 1 × 1 was added to the treatment. Blood tests were repeated after 36 h. The blood ammonia level was 79 mg/dl, urea was 22 mg/dl, creatinine was 0.94 mg/dl, ast was 35 U/L, alt was 58 U/L, sodium was 133 mmol/l, and the potassium was 4.48 mmol/l. The patient's confusion was healed. Consciousness was clear, orientation was complete. Manic symptoms were continuing. After all, the patient was evaluated to have an acute renal failure due to antibiotherapy (levofloxacin). In addition, it was thought that the use of valproic acid exacerbated the symptoms and led to hyperammonemic encephalopathy, and also delayed the recovery of the symptoms. It was thought that the physician should be careful in such drug combinations.

KEYWORDS

Case; encephalopathy; hyperammonemic; levofloxacin; valproic acid

[Abstract:0648][Schizophrenia and other psychotic disorders]

Olfactory reference syndrome in an adolescent girl: a case report

Sümeyra Güngören[a], Hamza Ayaydın[a] and Tayfun Kara[b]

[a]Harran University School of Medicine, Department of Child and Adolescent Psychiatry, Sanliurfa, Turkey; [b]Bakirkoy Dr. Sadi Konuk Research and Training Hospital, Department of Child and Adolescent Psychiatry, Istanbul, Turkey

E-mail address: tayfunkara@hotmail.com

ABSTRACT

Olfactory reference syndrome (ORS) is a psychiatric condition characterized by concerns about perceived body odour, which may be accompanied by repetitive behaviours to mask body odour and avoidance of social situations. ORS often starts at an early age and is more common in single men. There is no established standard treatment for ORS. We aimed discussion of the clinical presentation and treatment of an adolescent case diagnosed with ORS. **Case presentation**: A 15-year-old girl was admitted to our Department of Child and Adolescent Psychiatry due to foul body odour. The patient's complaints began a year ago when his schoolmate was bothered by an odour and closed his nose. The patient certainly believed that a foul body odour had spread over her. Because of this reason, she was bathing for a long time, using too much perfume and she regularly was checking her odour and confirmed to the others. The patient was misinterpreting other people's behaviour as a reaction to her odour. In crowded environments, the anxiety of the patient was increasing (class, public transport). Furthermore, the patient had significant symptoms of depression, avoidance behaviours, and social isolation. The patient's school training success has fallen, friend relationships have become corrupted. In the psychiatric examination of the patient, the mood of the patient was depressed, there was ideas of worthlessness and intense somatic delusions in the content of thought and she had no insight. No pathological findings were found in the physical and neurological examination of the patient and laboratory findings, EEG and brain MRI examinations were normal. Risperidone 1 mg/day and sertraline 50 mg/day were initiated in the patient diagnosed with olfactory reference syndrome. There was a marked decrease in delusional thinking about the smell, an increase in course success and positive developments in friend relations after 2 months from the beginning of the treatment. Olfactory Reference Syndrome (ORS) is a rare psychiatric disorder. In The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5), there is not a diagnostic title with this name. In the DSM-5, it is located under the title of delusional disorder body type. ORS is a rare, somatic type of delusional disorder in which case we present case reports containing mostly adult patients, and our case was an adolescent girl. There are case reports of successful treatment of olanzapine, aripiprazole, quetiapine, and risperidone in the treatment of ORS in the literature. Some patients respond better to antidepressant and antipsychotic addition therapy than others, as well as our case, while others only respond to antidepressant therapy. Therefore, we think that further studies are needed about this condition.

KEYWORDS

Adolescent; delusion; depression; odour; olfactory reference syndrome

[Abstract:0650][Sleep disorders]

L-carnitine use as a triggering factor for the onset of Kleine–Levin syndrome: a case presentation

Ferhat Yaylacı[a], Önder Küçük[b] and Handan Özek Erkuran[c]

[a]Gaziosmanpasa University Hospital, Department of Child and Adolescent Psychiatry, Tokat, Turkey; [b]Tokat Mental Health Hospital, Department of Child and Adolescent Psychiatry, Tokat, Turkey; [c]Behcet Uz Children's Hospital, Department of Child and Adolescent Psychiatry, Izmir, Turkey

E-mail address: drferhatyaylaci@hotmail.com

ABSTRACT

Kleine Levin Syndrome (KLS) is a rare phenomenon characterized by repeating episodes of hypersomnia, cognitive and behavioural impairments in various degrees, compulsive eating behaviour and hypersexuality. Though still not yet clearly identified, postinfectious processes, alcohol consumption, sleep deprivation, psychological stress, getting vaccinated, head injury, and genetic factors have been presented among possible aetiological factors so far. Along with these, in a small number of cases, abnormalities in serotonin and dopamine metabolism have been reported, indicating the presence of a possible neurotransmitter imbalance within

KEYWORDS

Adolescent; ergogenic substances; Klein–Levin syndrome; L-carnitine; sleep disorder

serotonergic or dopaminergic pathways. Triggering factors such as alcohol and cannabis consumption, emerging prior to an index KLS episode or the onset of a recurring episode have been specified in the relevant literature. In this case presentation, we think that the use of L-carnitine as an ergogenic support might be the triggering factor of the episode. With its role as a mediator that is required to transport the long-chain fatty acids to the mitochondrial matrix and its contributions in causing an increase in the oxidation of fatty acids, L-carnitine helps to produce more energy from burning fat while maintaining the economic use of muscle glycogen stocks. Animal studies have shown a continuous increase in dopamine discharge within nucleus accumbens via acetyl L-carnitine application. Again, it has been shown that carnitine supplementation caused significant increases in dopamine levels within cortical, hippocampal and striatal regions of the rat brain. One case report has mentioned an increase in the severity of psychotic symptoms in a patient with bipolar disorder, following acetyl L-carnitine use. Though very limited in number, as relevant literature points out that the first episode of KLS might be precipitated by an imbalance of neurotransmitters in the dopaminergic pathway, we aimed to discuss the clinical course of our case, from this given perspective.
Case presentation: A 13-year-old boy was brought to the emergency unit of our university hospital by his family, with complaints such as emotional and behavioural disturbances, increase in sleep-time that have all manifested within a 1-week period. Following initial assessment and examination at the emergency unit, the case was admitted to the intensive care unit of the hospital in order to be monitorized and followed up with differential diagnoses as psychotic episode, manic episode, possible substance intoxication, and encephalopathy. It was learned that the case had been using L-carnitine in very large quantities, that were well beyond the recommended doses for at least 4 weeks. As part of further diagnostic tests, no specific results were obtained other than a diffuse slow-wave in the baseline electroencephalography. With supportive treatment, symptoms improved and after 10 days, the case was almost fully symptom-free. Four months later, the case was once more brought to the unit with the emergence of similar symptoms. L-carnitine might be considered as a triggering factor for the onset of index KLS episode or recurring episodes.

[Abstract:0657][Dementia syndromes]

Early onset of semantic dementia with stereotype: a case of frontotemporal dementia treated with venlafaxine

Huda Pasli[a], Yasin Hasan Balcioglu[b] and Mine Ozkan[a]

[a]Department of Psychiatry, Istanbul Medical School, Istanbul University, Istanbul, Turkey; [b]Bakirkoy Prof. Mazhar Osman Research and Training Hospital for Psychiatry, Neurology, and Neurosurgery, Forensic Psychiatry Unit, Istanbul, Turkey

E-mail address: drhudapasli@gmail.com

ABSTRACT
Frontotemporal dementia (FTD) is the third most common cause of neurodegenerative dementia and characterized by progressive impairment in emotional processing and executive functions. FTD includes a heterogeneous spectrum of symptoms and commonly manifests with early onset of behavioural disturbances, disinhibition, emotional blunting, lack of insight, and loss of sympathy and empathy. This report aimed to illustrate a newly diagnosed FTD case with an onset of symptom cluster in early-50s.
Case presentation: A 52-year-old female patient was admitted to our clinic with slowly progressive foziness, depression, memory loss, and loss of social functionality within a two-year period. Before her complaints, she had not had any psychiatric or neurological abnormalities. She had difficulties to find appropriate answers to questions, repeating the question herself, and was spontaneously answering one or two hours later. Personal and medical history did not reveal any cranial traumas, alcohol-substance use, and abnormal medical condition. In her psychiatric examination, orientation to the person was intact but to the time and to the place were impaired. Speech speed and output were decreased while her affect was blunt. Executive functions and all types of memory were inadequate. She had perseveration. Associations were slow and thought the content was poor. She had no insight. There was no deficit in neurological. Cranial imaging revealed cortical atrophy in frontal, temporal, and parietal cortices. Electroencephalography (EEG) did not display any abnormalities, while wide-panel blood screenings were normal. Neuropsychometric assessment revealed semantic dementia. Venlafaxine was introduced with 37.5 mg/daily and increased up to 150 mg. Donepezil was added for cognitive impairment. In her follow-ups, her depressive and negative symptoms were improved within one month and behavioural problems decreased. Shown cortical atrophy in the frontotemporal zone with normal EEG and absent or obscure neurological findings in early stages are characteristic for FTD.

KEYWORDS
Dementia; depression; frontotemporal dementia; memory-loss; stereotype; venlafaxine

Atrophy in anterior temporal lobe and striatum are seemed to be responsible for stereotyped movements and perseveration, while bilateral anterior and mid-temporal atrophy are blamed for semantic dementia. In FTD, cholinergic system is intact, therefore, typical anti-dementia medication is considered ineffectual. In the pharmacological intervention, behavioural disturbances and affective symptoms are needed to be targeted. Close follow-ups are necessary in cases of middle-aged progressive dementia to consider FTD in the differential diagnosis. The diagnosis should be supported by neuroimaging methods as well as neuropsychiatric tests.

[Abstract:0659][Addiction]

Capgras syndrome induced by synthetic cannabinoids: a case report

Ferda Volkan[a] and Neşe Yorguner Küpeli[b]

[a]Department of Child and Adolescent Psychiatry, Marmara University Pendik Research and Training Hospital, Istanbul, Turkey; [b]Department of Psychiatry, Marmara University Pendik Research and Training Hospital, Istanbul, Turkey

E-mail address: ferda_volkan@hotmail.com

ABSTRACT

The Capgras Syndrome comprises the delusional belief that family members or friends are imposters or "doubles." This delusion is commonly seen in the context of an existing psychotic disorder, such as schizophrenia. In recent years, the incidence of drug use disorders, especially synthetic cannabinoids, has increased in young adults. The prevalance of psychosis induced by cannabis is around 12.4–80.0%. Cannabis-induced Capgras syndrome has rarely been reported. Here, we present a case of Capgras Syndrome induced by high doses of synthetic cannabinoid.

Case presentation: Mr O is a 27-year-old, single man, who has graduated from high school and has worked in their family company. He was brought to our hospital by his family due to aggressive behaviours to his family last two months. A detailed evaluation revealed that aggressive behaviours were triggered by the delusion that foreign people took place of his parents. At the last point where aggressive behaviour occurred, the patient stabbed his father. It was learned that he has used synthetic cannabinoids for 5 years at varying frequencies. In the beginning, he was using once in a week, with the increase in delusions, he has used synthetic cannabinoids four tofive times in a day due to the increased anxiety level. The patient injured his father from his neck by attacking with a knife and was subsequently was hospitalized. After the cessation of synthetic cannabinoid, the patient was prescribed with risperidone 2 mg/day, quetiapine 300 mg/day, diazepam 5 mg/day, the symptoms of the patient were gone. Our case is important for psychosis and Capgras Syndrome that may be triggered with synthetic cannabinoid use. The protracted presence of psychotic symptoms well beyond acute intoxication, sometimes lasting months, is concerning. Physicians should be aware that the use of synthetic cannabinoids can be associated with psychosis and Capgras Syndrome examine the possible use of synthetic cannabinoids in patients with inexplicable psychotic symptoms.

KEYWORDS

Capgras; syndrome; synthetic; cannabinoids; substance; use

[Abstract:0661][Personality disorders]

A wife–husband dissociative identity disorder case with incomplete marriage for 13 years and therapy

Mehmet Asoğlu, Özlem Beğinoğlu, Öznur Akıl, Meltem Göbelek, İsmail Karka and Faruk Pirinççioğlu

Department of Psychiatry Sanliurfa, Harran University School of Medicine, Harran, Turkey

E-mail address: mehmetasoglu@gmail.com

ABSTRACT

Dissociative Identity Disorder (DID) is a psychiatric disorder characterized by memory and identity disorders that have been described since 1800 and have been the most popular dissociative disorder. In community-based studies it has been shown that the prevalence is between 1.1% and 3%. In this case report, it is aimed to increase the awareness of DID to

KEYWORDS

Dissociative Identity Disorder; incomplete marriage; loss of erection; hypnotherapy; sexual disorder

clinicians by a husband–wife with the DID case and therapy with incomplete marriage for 13 years.

Case presentation: Mr M (35 years old) and Ms S (26 years old) presented to our psychiatry outpatient clinic complaining about incomplete marriage. Both the spouses' organic tests were normal and there was no primary sexual disorder according to DSM-5. In the anamnesis, the couple stated that the penile erection was complete during sex, but when the penis was touching the vulva, the erection completely disappeared, and after having continued to have sex for a while, the ejaculation had begun and sexual action ended. The couple had not been able to achieve sexual intercourse, even though they had been receiving a cognitive sexual therapy every month or every two months by a very successful professional psychotherapist in the field, at the external centre for about 13 years. The husband and wife were asked very carefully whether there was a voice, feeling, or message that led them through the head separately. As a result of the interview, it was determined that the husband had two alters called 2M and Satan, and that the woman had an alter called Sadness. These alterers confess that they were formed because of the trauma that resulted from their inability to provide sexual intercourse on the first night of their marriage, and subsequently, they prevented to sexual unification. With appropriate DID hypnotherapies, when they meet, they were very happy expressing the completion of sexual intercourse. DID therapies are continuing as the couple's sexual problems are resolved. More than 20 clinical outlooks have been defined for DID. The large spectrum of symptoms makes the clinician's work very difficult in terms of correct diagnosis and treatment. The average time between the first application of the cases to the mental health system and the diagnosis of DID is approximately 7–8 years. It was determined that the cases with DID had an average of three different psychiatric diagnoses until they had the correct diagnosis. In our present case, diagnosis and treatment are quite delayed because the symptoms specific to DID are not directly expressed by the patient and psychiatrists do not question it. DID patients can apply to a psychiatrist with many different symptom groups. Without considering the diagnosis of DID, it seems that the treatment approach directed to the statement has failed. Since DID patients do not come with very specific dissociative symptoms, dissociative symptoms such as "a voice, a message or a feeling of guiding you through the head" should be routinely questioned in order to avoid false diagnosis.