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Introduction Trichotillomania is described as a recurrent failure to resist impulses to pull out hairs. It is usually associated with obsessive-compulsive disorder and body dismorphic disorder. It is usually confined to one or two sites in the body.
Objective The aim of our work is to describe a case of delusional infestation with secondary trichotillomania and briefly review the theoretical aspects of this clinical presentation.
Methods We searched online databases and reviewed current case reports published, using the keywords "delusional infestation", "Ekbom syndrome" and "trichotillomania" and compared similarities in the presentation, development and outcome. We present a clinical vignette of a 38-year-old female, with no relevant psychiatric history. The patient developed severe itching that she believed was caused by bugs that lived inside her hair follicles, so she pulled out completely all of her eyebrows, eyelashes, pubic and underarms hairs. She maintained some hair on her head, that she repeatedly pulled out and proceeded to break in order to kill the bugs. She claimed to have absolutely no itchiness in the hairless areas of her body.
Results The patient was referred to psychiatric consultation and was started on oral antipsychotics but, as the review from literature suggested, the clinical evolution only became satisfactory when an antidepressant (SSRI) was added.
Conclusion Although, trichotillomania is more commonly seen in clinical practice in association with other psychiatric disorders, it may also present itself as a symptom of delusional activity.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV1422

Malignant catatonia and neuroleptic malignant syndrome: How different/similar are they?

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Introduction Catatonia is a neuropsychiatric syndrome that appears in medical, neurological or psychiatric conditions. There are presentation variants: "malignant catatonia" (MC) subtype shares many characteristics with the neuroleptic malignant syndrome (NMS), possibly reflecting common pathophysiology.
Objectives/methods We present a clinical vignette and review the literature available on online databases about MC/NMS.
Results We present a man, 41-years-old, black ethnicity, with no relevant medical history. He had two previous episodes compatible with brief psychosis, the last one in 2013, and a history of adverse reactions to low doses of antipsychotics. Since the last episode he was asymptomatic on olanzapine 2.5 mg id. He acutely presented to the Emergency Room with mutism, negativism, immobility and delusional speech, similar to the previous episodes mentioned and was admitted to a psychiatric infirmary, where his clinical condition worsened, showing muscle rigidity, hemodynamic instability, leukocytosis, rhabdomyolysis and fever. Supportive care was provided, olanzapine was suspended and electroconvulsive therapy (ECT) was initiated. After two months, he was discharged with no psychotic symptoms. He is still under ECT and no antipsychotic medication was reintroduced.
Discussion/conclusion Many studies suggest that clinical or laboratory tests do not distinguish MC from NMS and that they are the same entity. These two conditions are life-threatening and key to treatment is a high suspicion level. There is no specific treatment; supportive care and stopping involved medications are the most widely used measures. ECT is a useful alternative to medication.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Gynecomastia induced by trazodone: A case report

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Introduction Trazodone is a heterocyclic antidepressant that exerts its effect via the inhibition of selective serotonin reuptake and the antagonism of 5-HT2A and 5-HT2 C receptors. Antidepressant-induced gynecomastia and galactorrhea and increases in prolactin levels have rarely been reported.
Case report A 73-year-old man presented to the psychiatric clinic with depressive symptoms and insomnia that was the reason that his GP introduced paroxetine 20 mg/day three months before. One month later because the insomnia persisted, trazodone (100 mg/day) was added to the treatment. At a 2-month follow-up, the patient reported improvement in depressive symptoms but also presented gynecomastia on the left side that is non-tender on palpation. No other medications were noted. Laboratory testing was within normal limits, with the exception of on elevated prolactin level (38.2 ng/mL). Ultrasonography indicated normal results. Treatment included the tapering and discontinuation of trazodone with continued paroxetine therapy. Lorazepam was initiated for the treatment of insomnia. Two weeks later, the prolactin level was 13.1 ng/mL and gynecomastia was practically resolved. Lorazepam was initiated for the treatment of insomnia.
Conclusions Effects of trazodone on PRL are unclear, there is one study reported that trazodone increases the PRL level, and another one reported that trazodone reduces them, in our case, the trazodone use led to hyperprolactinemia via hypothalamic postsynaptic receptor stimulation and it should be remembered that gynecomastia and galactorrhea may appear as a rare side effect of trazodone.
Disclosure of interest The authors have not supplied their declaration of competing interest.
Further readings
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EV1424

Why Portugal is pushing towards migration?

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Background International professional mobility is a reality, people have skills they can put in the global marketplace. The increasing migration of health professionals to wealthy countries is a phenomenon known as "brain drain".
Objectives/Aims This work aims to present the push factors that pressure people to migrate from Portugal.
Methods A cross-sectional survey was carried out with the psychiatric trainees in Portugal. A self-administered structured