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Introduction Psychiatric symptoms set forth brain dysfunction at several levels. Behavioral disturbances, although frequently associated to primary psychiatric disorders, call for a previous discard of neurologic treatable causes.
Case report We report the case of a 30-year-old gentleman, receiving outpatient psychological treatment and follow-up for a 3-month history of low mood, abulia, apathy, generalized malaise, weight loss and insomnia. Non-structured jealous delusions were also present. No neurological deficit was found. After CT of the brain, a space occupying lesion, suggestive of glioblastoma multiforme, was found. Further studies, including biopsy and a MR, led to the diagnosis of central nervous system Chagas, related to a previously unknown HIV infection in AIDS status, and conditioning a secondary central hipothyroidism. Careful treatment of the etiological factors, along with symptomatic relieve with low dose paliperidone, led to the resolution of the symptoms.
Discussion The majority of patients suffering from neurologic diseases develop psychiatric symptoms over the course of their illness, with or without the presence of classical disturbances, such as weakness, sensory loss or seizures. Modern psychiatry uses a complex disease model, therefore necessarily integrating anatomy, biochemistry and function during every diagnostic approach.
Conclusion It is necessary to rule out frequent treatable causes, thus involving both psychopatological and neuroscientific approach to psychiatric disturbances. However, while underlying causes are often difficult to treat, psychiatric symptoms respond to existing pharmacologic and nonpharmacologic therapies.
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EW151

Psychotic symptoms in a patient diagnosed with temporal lobe epilepsy and schizoaffective disorder

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Introduction Epilepsy is considered a complex neurological disorder, and its clinical picture can resemble many different cerebral dysfunctions, including those associated to major psychiatric disorders.
Case report We report the case of a 52-year-old gentleman, with a 30-year history of schizoaffective disorder and of complex partial epilepsy with secondary generalization. He was admitted to an emergency room due to a voluntary overdose with 8 mg of clonazepam. The patient explained how he had recently experienced visual hallucinations and insomnia, symptoms that originally led to the psychotic diagnosis. He had previously presented these symptoms, along with stupor, delusions and lability, as a prodrome of complex motor epileptic decompensations. Thus, he took the overdose not to suffer seizures. After carefully reconstructing the clinical history, psychiatric admissions had shown seizures, and periods of clinical stability had been achieved by regulating antiepileptic medication. Eslicarbazepine and lamotrigine reintroduction, and quetiapine withdrawal, led to symptomatic remission.
Discussion Epilepsy and major psychiatric disorders show a high comorbidity. There has been an effort to even include epilepsy and psychosis in a unique diagnosis (alternant psychosis). Furthermore, polimorphism and restitutio ad integrum may resemble classic cycloid psychosis. In this case, chronological study showed all symptoms could be explained by one disorder.
Conclusion Epilepsy includes a variety of neuropsychiatric symptoms. It can be difficult to withdraw psychiatric diagnoses from patients after years of follow-up. However, a carefully taken medical history clarifies temporal criteria.
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EW152

Evaluation of psychomotor/motor disturbances in elderly medical inpatients

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Introduction Traditionally psychomotor subtypes have been investigated in patients with delirium in different settings and it has been found that those with hypoactive type is the largest proportion, often missed and with the worst outcomes.
Aims and objectives We examined the psychomotor subtypes in an older age inpatients population, the effects that observed clinical variables have on psychomotor subtypes and their association with one year mortality.
Methods Prospective study. Participants were assessed using the scales CAM, APACHE II, MoCA, Barthel Index and DRS-R98. Pre-existing dementia was diagnosed according to DSM-IV criteria. Psychomotor subtypes were evaluated using the two relevant items of DRS-R98. Mortality rates were investigated one year after admission day.
Results The sample consisted of 200 participants [mean age 81.1 ± 6.5; 50% female; pre-existing cognitive impairment in 126 (63%)]. Thirty-four (17%) were identified with delirium (CAM+). Motor subtypes of the entire sample was: none: 119 (59.5%), hypo: 37 (18.5%), mixed: 15 (7.5%) and hyper: 29 (14.5%). Hypoactive and mixed subtype were significantly more frequent to delirious patients than to those without delirium, and none subtype more often to those without delirium. There was no difference in the hyperactive subtype between those with and without delirium. Hypoactive subtype was significant associated with delirium and lower scores in MoCA (cognition), while mixed was associated mainly with delirium. Predictors for one-year mortality were lower MoCA scores and severity of illness.
Conclusions Psychomotor disturbances are not unique to delirium. Hypoactivity, this "silent epidemic" is also part of a deteriorated cognition.
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EW153

Use of antipsychotics and antidepressants in patients with HIV

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Introduction Psychological distress appears in the majority of people infected with HIV. Depression is the most important affection, the prevalence in comparison with general population arises to 37%. Psychotic symptoms in patients with HIV are a very frequent