other people suffering from mental illness, must deal with their difficulty of integration which can influence their personal and professional life and consequently their quality of life (QOL).
Objectives: The aim of our study is to assess the QOL among working patients with BD.
Methods: A cross-sectional study was carried out in the occupational medicine department of the Charles-Nicolle hospital in Tunisia. Sociodemographic and occupational data were collected from the medical records of patients with bipolar disorder who consulted our department during the period 2022 to 2023. and a telephonic survey was carried out to complete the SF 12 international scale, which is a general health questionnaire that consists of 12 questions which investigates the patient's state of health via 8 different dimensions: General health perception, Physical health, Limited physical role function, Physical pain, Vitality, Mental health, Limited emotional role function and social functioning.
Results: We enrolled a total of 46 cases where 76% with BD type 1 with an average age of 43±9 years. Most participants were female (76%) and the most frequent sectors of activity were healthcare and administration (80% and 12% respectively). BD was well balanced in 39% of cases with an average bipolar history of 7 years. The median annual absence due to psychiatric problems was 92±61 days per year. The average score was 44±18 for the General Health, 57±35 for physical health and 67±18 for mental health.
Conclusions: This study revealed that people living with BD's QOL seems to be altered. Clinicians need to be attentive to the QOL of their patients, its assessment, and its empowerment in their daily clinical practice. Future work is required to establish valid strategies to fight low QOL among patients suffering from BD.

Disclosure of Interest: None Declared

EPV0123

Diagnostic Challenges in Affective Disorders: Delirious Mania - A Case Report and Literature Review.

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Introduction: Affective disorders exhibit diverse clinical manifestations, and one distinctive subtype is delirious mania. Despite its exclusion from formal diagnostic manuals, delirious mania frequently emerges in everyday clinical practice. Recognizing it within the realm of differential diagnosis is crucial. Delirious mania is characterized by acute onset of excitement, grandiosity, emotional lability, delusions, and insomnia typical of mania, combined with disorientation and altered consciousness characteristic of delirium. Some authors consider delirious mania as a variant of classic bipolar disorder, while others associate it with catatonia. Additionally, some link it to underlying medical or neuropsychiatric causes.
Objectives: To describe the clinical case of a patient with delirious mania and emphasize the importance of recognizing this as a potencial diagnosis in patients with abrupt alterations in mental state.
Methods: Clinical case report and literature review.
Results: A 61-year-old female patient with a history of a unique depressive episode over 20 years ago, treated with Carbamazepine up to 750 mg, is admitted to the Emergency Room with acute symptoms consistent in global disorientation, agressive behavior, mutism, bradyphrenic and repetitive incoherent speech, along with visual hallucinations, all of which had developed over a few days. The gradual withdrawal of Tegretol over an 8-month period preceded her admission to the ER.
Relevant medical tests, including cranial CT, EEG, blood tests, and urine analysis, were conducted during her ER stay, all of which yielded normal results. Neurological evaluation ruled out acute neurological pathology, leading to her subsequent admission to the Psychiatry department. Throughout her admission, the patient exhibited irritability and expressed derogatory comments filled with offensive language. She gradually became more expansive, with her thought content becoming megalomaniac in a delirious range. Her speech was incoherent, verbose and had loose associations.
Treatment was reintroduced with Carbamazepine up to 600 mg/day and Olanzapine up to 20 mg/day, resulting in a rapid and comprehensive improvement of her symptoms, ultimately leading to the complete resolution of her condition.
Conclusions: This case highlights the concept of delirious mania, characterized by alterations in attention, orientation, memory, confusion, behavioral and thought fluctuations, and psychomotor disturbances which can manifest abruptly, as observed in this patient. This clinical case underscores the significance of considering delirious mania in the differential diagnosis of patients with abrupt alterations in mental state, particularly those of advanced age with a history of affective episodes. A global understanding of this condition is essential for its timely recognition and appropriate management.

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EPV0124

Unipolar and Bipolar Depression : Which Differences?

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Introduction: Depression is a common mental disorder whose management remains delicate, given the trans-nosographic nature of this syndrome. Two common types of depression are bipolar and unipolar depression. Although they share many similar symptoms, several differences between the two pathologies are suggested in prior studies.
Objectives: We aimed to compare the disease characteristics and evolution of unipolar and bipolar depressed patients.
Methods: We conducted a retrospective descriptive and analytical study among medical records of 167 patients hospitalized for a depressive episode (DE) at the Psychiatry "B" Department, Hedi Chaker University Hospital (Sfax, Tunisia), during the period

between 2015 and 2017. Patients were divided into two groups according to DSM-5 criteria: those with bipolar disorder I or II (bipolar depression) versus those with major depressive disorder (unipolar depression).
Results: The mean age of our patients was 37.6 years, with a female predominance (sex-ration F/M =1.7). The age of onset of the disease was earlier in bipolar depressed patients (29.36 versus 31.89), without a significant relationship. Family psychiatric history was significantly more prevalent in bipolar disorder patients (73.5% versus 37.3%; p<0.001). Bipolar patients are more likely to be unemployed (65.3% versus 50.8%), but without a significant relationship.
Bipolar patients were more likely to be hospitalized for suicide attempts (44.9% versus 35.6%; p=0.2).
Conclusions: Distinguishing between major depressive disorder and bipolar disorder is important because there are differences in the optimal management of these conditions.

Disclosure of Interest: None Declared

EPV0125

Manic episode in a patient with pancreatic adenocarcinoma: a case report

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Introduction: Psychiatric comorbidity is common in cancer patients, emphasizing the need for comprehensive care. While depressive symptoms in pancreatic cancer (PC) have been studied, there is limited attention given to manic symptoms. This case report aims to contribute to the knowledge of PC psychiatric comorbidities by describing a case of a 61-year-old patient with stage IV PC, with no personal or family psychiatric history, who presented a sudden onset manic episode.
Objectives: Our goal is to contribute to the growing knowledge of psychiatric comorbidities of PC focusing on manic symptoms by describing the case of a patient with stage IV PC without previous psychiatric history who presented a sudden onset of a manic episode.
Methods: We describe the mentioned clinical case. We also searched for previous case reports of maniac episodes in pancreatic cancer using a PubMed query.
Results: The patient, a 61-year-old male with stage IV PC, presented at the Emergency Room with abrupt behavioural changes suggestive of a manic episode of two weeks of evolution. The patient had been undergoing chemotherapy and short 3-day cycles of corticosteroids for the past 9 months but had been off this treatment for 20 days when the episode began. Acute organic causes were ruled out. The patient was admitted to the psychiatric unit, where organic screening was expanded and treatment with antipsychotics and a mood stabilizer was initiated with subsequent remission of symptoms after two weeks.
This article describes the case of a man with a PC diagnosis who had no prior psychiatric history and was admitted to the inpatient psychiatry unit due to a manic episode involving high-risk behavioral disturbances and megalomaniac psychotic symptoms. Several factors may have contributed to the onset of these symptoms, including corticosteroid use after chemotherapy and certain chemotherapy agents. However, due to temporal factors, these factors do not fully explain the episode.
The exact biological mechanisms behind the manic symptoms remain unknown, but hypotheses include gene-environment interactions in bipolar disorder and immunodysregulation related to the production of inflammatory cytokines. We found in the literature four cases that have reported new-onset mania as an initial symptom of PC, but the causal relationship is unclear.
Conclusions: Notably, this case differs from others due to the rapid remission of symptoms and the use of lithium therapy. While the underlying mechanisms are still unclear, this case contributes to understanding this rare complication of PC and may help in developing consensus on clinical management. Future research will further explore the pathophysiology of psychiatric symptoms in PC and appropriate therapeutic approaches.
This case shows a manic episode as a rare psychiatric complication in PC. In the literature reviewed, four other similar cases have been observed.

Disclosure of Interest: None Declared

EPV0126

Case Series: The use of Lithium in Bipolar Affective Disorder and End-Stage Renal Disease

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Introduction: Lithium is a highly effective treatment in the management of Bipolar Affective Disorder (BPAD) however it is associated with increased risk of developing chronic kidney disease. There is a lack of clear guidance on alternative approaches to managing those individuals that require cessation of lithium due to progression to end stage renal disease (ESRD).
Objectives: We discuss two patients with BPAD on lithium therapy who have developed ESRD. In both cases, lithium was discontinued due to ESRD, with alternatives trialled. In one case, the patient continues to be managed without lithium, whereas in the second, a decision was made to recommence lithium at a low dose. We reviewed the literature to provide meaningful context to the cases.
Methods: Case 1 This patient with a long history of BPAD and multiple medical co-morbidities experienced progressive decline in renal function. A decision was made to cease lithium therapy with close monitoring for signs of affective relapse. The patient was stabilised using a combination of sodium valproate and quetiapine. Since cessation of lithium, the patient has required a significant increase in support from the CMHT and more frequent admissions to manage mood and anxiety symptoms that cause significant subjective distress.