between the number of episodes before starting a mood stabilizer and the time to recurrence after starting a mood stabilizer. However, the former cannot predict the latter. The age, educational status of the patient, total duration of illness and number of episodes before starting mood stabilizer correlated significantly with the MoCA score. Of all, the educational status could also predict the patient's performance on the MoCA scale.
Conclusions: There were no significant differences between lithium and valproate in attenuating further episodes, the frequency of neurocognitive deficits and other adverse effects. Both drugs were equally effective and tolerable. The severity of illness was more in valproate-treated patients, and overall functioning was better in lithium-treated patients. BDNF levels did not correlate with neurocognitive deficits significantly. Future studies comprehensively assessing neurocognitive measures with a larger sample size in the early-onset bipolar disorder population would shed more light on the role of biomarkers in cognition in subjects with early-onset bipolar disorder.

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EPV0122

Secondary Mania in Older Adults: a case report and review of literature

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Introduction: Although mania is commonly associated with bipolar disorder, it can have many etiologies. Thus, "primary mania" results from bipolar disorder, whereas "secondary mania" results from pharmacological, metabolic, or neurologic causes. Older adults are at risk for secondary mania because of increased medical comorbidities and neurological changes. In one retrospective study of 50 patients with mania who were older than 65 years, it was the first manic episode for 28% of the patients and 71% had a comorbid neurological disorder.
Objectives: The etiology of mania is important because although acute symptomatic treatment of both primary and secondary mania may be similar, appropriate treatment of secondary mania includes addressing the cause. We present here two case histories of secondary mania in older adults, discuss their presentations and differential diagnosis in turn, and discuss treatment.
Methods: We will present a clinical case of a patient. Ms. A, a 63-year-old divorced woman with no prior medical or psychiatric history, was seen for an acute manic episode with mixed features. She was in her usual state of health until 2 weeks before admission, when she presented with a status epilepticus requiring a one-week hospitalization in the neurology département and treated by Carbamazepine. She then developed an abnormally excited and labile mood, motor excitability accompanied by rapid thoughts, with a total loss of desire and pleasure and thoughts of death.
Results: In our study, the patient presented a manic episode with mixed characteristics secondary to a status epilepticus.
The patient was treated both somatically and psychologically, and the evolution was positive. The patient was stabilised after being put on an antiepileptic drug associated with an antipsychotic drug.
In our study, the patient presented with a manic attack with mixed characteristics secondary to a status epilepticus.The patient was treated both somatically and psychologically, and the evolution was favourable. The patient was stabilised after being put on an antiepileptic drug associated with an antipsychotic drug.
Conclusions: Late onset psychiatric disorders often represent a challenge for the psychiatrists as far as the diagnosis and management issues are concerned. The elderly patients have generally been reported to have associated medical, especially neurological illnesses and are also prone to side effects of various psychotropic medications.

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EPV0125

The analysis of organic diseases in elderly patients diagnosed with bipolar disorders- A retrospective study

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Introduction: Both organic and psychiatric comorbidities are frequently detected in bipolar disorders (BD) and this phenomenon has a significant impact on case management in these patients. The most reported general medical conditions in patients with BD are migraine, thyroid illness, obesity, diabetes mellitus, and cardiovascular disease. The screening for comorbidities detection in BD patients is important from multiple perspectives, including the need to construct an adequate therapeutic plan, the need to increase treatment adherence, and to improve these patients' quality of life.
Objectives: To assess the prevalence of comorbid organic diseases in a clinical sample of BD patients.
Methods: A chart- and register-based analysis of BD patients (i.e., type I and II BD) evaluated in our department during a period of three years (January 2019- January 2022) was conducted in order to detect the prevalence rate of organic diseases. All patients aged over 65 years were evaluated either for acute mood episodes or presented to their treating psychiatrists for follow-up visits.
Results: A number of 87 patients were included in this analysis, 45 male and 42 female, with a mean age of 70.5 years. The most frequently detected organic comorbidities were metabolic disorders (obesity, dyslipidemia, diabetes mellitus- 36.8%), cardiovascular (arterial hypertension, arrhythmias, myocardial ischemia, deep/superficial venous thrombosis- 26.4%), digestive system-related (hepatic, gastric, intestinal diseases- 21.8%), neurologic (i.e., stroke, migraine, Parkinson's disease) (18.3%), endocrine (mainly thyroid diseases) (17.2%), and other (19.5%). A relatively high rate of organic diseases (38%) were newly diagnosed (in the last 3 months), suggesting there is a certain need to screen for organic pathology in this population, but most of the BD patients presented a long history of investigated and treated comorbid conditions.
Conclusions: Organic diseases are very common in elderly BD patients. Even where no history of somatic conditions exists, comprehensive investigations are granted in order to detect such health problems with important prognostic impact.

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