**Results:** Case 2 This patient had a long history of stable BPAD, with no episodes of illness for over 30 years. Unfortunately they developed CKD and despite a significant reduction in lithium over time, they developed ESRD requiring haemodialysis. Lithium was discontinued leading to a manic relapse of BPAD requiring a prolonged admission and a combination of carbamezapine, olanzapine, escitalopram and clonazepam to stabilise their mental state. Following discharge home, their mental state failed to reach baseline and they reported significant anxiety symptoms and memory impairment. Following protracted assessment and support they were deemed unfit for renal transplant and a decision was then made by the patient, their family, nephrology and psychiatry to recommence lithium therapy whilst on haemodialysis. Their anxiety and functioning improved significantly following the reintroduction of low dose lithium, allowing the withdrawal of other neuroleptics.
**Conclusions:** Both cases required an individual approach to balance physical and mental health considerations. There are no clear markers to predict if a patient will respond to alternative mood stabilisers, nor is there a guarantee that kidney function will improve or stop declining when lithium is discontinued. Decisions should reflect patient preference and balance risks associated with relapse and of declining ESRD.

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## Sex differences in neurocognitive performance in older adults with bipolar disorder

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**Introduction:** In recent years, research has focused on the older adults with bipolar disorder (OABD), aged 50 years and over, a constantly growing population due to the increased of life expectancy. Actually, some authors suggest that these individuals constitute a distinct subtype with a specific and different needs such as seen in epidemiologic, clinical and cognitive features. Further research has revealed significant differences between females and males with BD in clinical and cognitive variables in middle-aged and young patients, but this topic among OABD population remains unclear.
**Objectives:** The aim of this study is to identify the distinctive profile in clinical, functional and neurocognitive variables between females and males in OABD.
**Methods:** A sample of OABD and Healthy Controls (HC) were included. Euthymic patients or in partial remission were included. Neurocognition was measured with a battery of tests that included premorbid intelligence quotient, working memory, verbal and visual memory, processing speed, language and executive functions. Independent t-test and Chi-squared test analysis were performed as appropriated.
**Results:** According to the analysis, statistically significant differences were seen between females and males. A more impaired cognitive profile is observed in women. They performed worse in the subscales of Arithmetic (F= 6.728, $p$ = <0.001), forward digits (F= 0.936, $p$= 0.019) and Total Digits (F= 1.208, $p$= 0.019) of the WAIS-III, in the Stroop Color Word Test, color reading (F= 0.130, $p$= < 0.001), in the Continuous Performance Test, block change measure (F= 2.059, $p$= 0.037), in the Rey-Osterrieth Complex Figure-copy (F= 0.005, $p$= 0.029) and in the Boston Naming Test (F= 0.011, $p$= 0.024). Nor significant differences were found in clinical neither in psychosocial functioning variables.
**Conclusions:** In view of the following results, and since no differences were observed between women and men in terms of clinical and functional outcomes, it could be said that the differences observed in cognition cannot be explained by disease-related factors. Furthermore, these results highlight the need to develop a gender-specific cognitive interventions in OABD population. In this way, we could have an impact on the course of the illness to reach a better quality of life.

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