

hallucinations. As relevant physical history, the patient has AHT, aortic insufficiency, and bladder cancer operated on in 2012. As psychiatric history of interest, the patient has been diagnosed since his 30s with schizoaffective disorder, Parkinson's disease and moderate-severe cognitive impairment secondary to the previous two.

As usual treatment, in addition to anticoagulation and antihypertensive therapy, the patient has been receiving L-dopa for his PD for years, antidepressant treatment with escitalopram 10mg, haloperidol 80 drops a day, divided into three doses, and lormetazepam 2mg as a hypnotic.

In addition to the symptoms described above, the patient had episodes of confusional features, as well as marked stiffness in the cogwheel and significant gait disturbance, having suffered several falls without serious repercussions.

**Results:** Due to the comorbid neurological pathology, it was decided to progressively modify the treatment, withdrawing the benzodiazepine due to the risk of confusional disorder and replacing it with trazodone. Antipsychotic treatment was gradually replaced by extended-release quetiapine, reaching a maximum dose of 800mg. Likewise, escitalopram treatment is replaced by sertraline.

With this adjustment, there was an improvement in the psychotic symptoms, as well as in the anxious symptoms. Episodes of distress are NOT observed, and the patient's functionality improves, allowing him/her to participate in daily activities, both cognitive stimulation and physiotherapy.

**Conclusions:** The Spanish Society of Psychogeriatrics recommends that before using antipsychotics, it is advisable to first treat the underlying potentially treatable causes (pain, infections, toxic effects of drugs...), assess non-pharmacological interventions and always, if the use of antipsychotics is required, assess the risk-benefit ratio.

In relation to the above, it is not surprising that in the elderly, the use of second-generation antipsychotics is recommended in the first place, as opposed to the classical ones. The latter are only recommended in emergency situations where an almost immediate effect is required.

For dopaminergic psychosis, there are only controlled trials with clozapine. However, due to prescribing difficulties, aripiprazole or quetiapine is recommended in the first instance.

**Disclosure of Interest:** None Declared

## EPV0682

### “Neuropsychiatric manifestation of hyponatremia: a case report”

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**Introduction:** “Electrolyte abnormalities are commonly encountered in daily clinical practice, and their diagnosis relies on routine laboratory results. Electrolyte disturbances can affect the brain among many other organs and tissues and must be promptly recognized, as they can lead to serious and potentially life-threatening complications if neglected or not appropriately

treated. Neurological manifestations reflect the severity of acute neuronal dysfunction and thus require urgent treatment. Acute and/or severe electrolyte imbalances can manifest with rapidly progressive neurological symptoms, seizures, and psychiatric manifestations. They are more frequently observed in patients with sodium disorders (especially hyponatremia), hypocalcemia, and hypomagnesemia.

**Objectives:** Were the psychiatric manifestations secondary to hyponatremia or epilepsy? Or is it a comorbidity? What are the risk factors? And what is the appropriate course of action for this type of patient?”

**Methods:** We present, through a clinical case, the situation of a 64-year-old patient who experienced status epilepticus secondary to hyponatremia, requiring hospitalization in the neurology department. Subsequently, she developed psychiatric manifestations with a marked change in behavior. She began experiencing symptoms of anxiety and depressive mood, headaches, somatic complaints, and social isolation. Her condition gradually worsened, necessitating hospitalization in the psychiatry department 3 years later.

**Results:** The patient was placed on Carbamazepine by her neurologist, and since then, she has not experienced epileptic seizures. Her follow-up electrolyte panel initially showed slight disturbances before normalizing. Psychiatric manifestations were concurrent with these somatic symptoms and worsened over time. During her psychiatric hospitalization three years later, after a thorough evaluation, she was prescribed Sertraline and Risperidone in combination with Carbamazepine, resulting in a significant improvement in her condition.

**Conclusions:** In summary, this case illustrates the critical impact of electrolyte abnormalities on both neurological and psychiatric health, especially in older patients. Understanding risk factors associated with electrolyte imbalances is crucial for effective diagnosis and management, particularly in the elderly. This underscores the importance of a multidisciplinary approach to address the potential serious consequences of electrolyte disturbances on overall patient well-being.

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## EPV0684

### Cytoprotective mechanism of cerebro-cognitive reserve

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**Introduction:** Consideration of the reserve problem would be incomplete without an analysis of the cytoprotective mechanism. The predominant molecular hallmark of aging and degeneration is the accumulation of altered gene products. Moreover, several conditions, including protein, lipid, or glucose oxidation, disrupt redox homeostasis and lead to the accumulation of unfolded or misfolded proteins in the aging brain in case of AD, and other neurodegenerative diseases that have as a common denominator abnormal protein production, mitochondrial dysfunction and oxidative stress. Some authors classify aging, pathological aging, and neurodegeneration as “protein conformational diseases”.