**Introduction:** Neuroleptic malignant syndrome (NMS) may be a life-threatening neurologic crisis primarily emerging as an idiosyncratic reaction to antipsychotic agent use, and characterized by a particular clinical syndrome of mental status alter, rigidity, fever and dysautonomia. Mortality results straightforwardly from the dysautonomic manifestations of the disease and from systemic complications.
**Objectives:** To describe an unusual clinical case in order to determine the management regarding medication and electroconvulsive therapy (ECT), and provide an overview of NMS for the general practitioner with the most up-to-date information on etiology, workup, and management.
**Methods:** We report a case involving a 55-year-old man with paranoid schizophrenia disorder who presented with hyperthermia, hemodynamic instability, miosis, muscular rigidity, urinary incontinence, catatonic signs and mutism after combining several antipsychotics at the same time: long-acting injectable form of paliperidone, aripiprazol and haloperidol.
**Results:** Guidelines for specific medical treatments in NMS are based upon case reports and clinical experience. Generally used agents are dantrolene, bromocriptine, and amantadine. A conceivable approach is to start with benzodiazepines along with dantrolene in moderate or severe cases, followed by the addition of bromocriptine or amantadine. ECT is generally reserved for patients not responding to other treatments.
**Conclusions:** NMS is an uncommon adverse drug reaction, with a multifactor pathophysiology and manifestation. Early diagnosis and interruption of antipsychotic therapy is the first-line treatment, followed by supportive care and pharmacotherapy. ECT is an effective treatment when supportive treatment together with pharmacotherapy fails. It could be considered first line in severe life-threatening situations. It is advisable to consider maintenance ECT due to the high risk of relapse.

**Disclosure:** No significant relationships.
**Keywords:** antipsychotic; Syndrome; malignant; neuroleptic

## EPV0726

## Mutism. What to expect?

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**Introduction:** Mutism is the inability or unwillingness to speak, resulting in an absence or marked paucity of verbal output. Mutism is a common manifestation of psychiatric, neurological, and drug-related illnesses. Psychiatric disorders associated with mutism include schizophrenia, affective disorders, conversion reactions, dissociative states, and dementias. Neurological disorders causing mutism affect the basal ganglia, frontal lobes, or the limbic system.
**Objectives:** Outline the importance of setting a differential diagnosis of mutism in the Emergency Room.
**Methods:** Review of scientific literature based on a relevant clinical case.
**Results:** Male, 58 years old. He has lived in a residence for 3 months due to voluntary refusal to ingest. Diagnosed with paranoid personality disorder. He is refered to the Emergency Service due to sudden mutism. During this day, he has been stable and suitable with a good functionality. For 3 hours he is mutist, oppositional attitude and stiff limbs, refusing to obey simple orders. Hyperalert and hyperproxia. Not staring. After ruling out organic pathology: normal blood tests, negative urine toxins and cranial CT without alterations, he was admitted to Psychiatry for observation and, finally, he was diagnosed with Psychotic Disorder NOS.
**Conclusions:** Mutism most often occurs in association with other disturbances in behavior, thought processes, affect, or level of consciousness. The most common disorder of behavior occurring with mutism is catatonia. The differential diagnosis of mutism is complex. In some cases the diagnosis will be clarified only by careful observation and after a neurological evaluation. Published studies show neurological disorders presenting with mutism can be misdiagnosed as psychiatric.

**Disclosure:** No significant relationships.
**Keywords:** Catatonia; mutism; emergency room

## EPV0729

## Comparison between haloperidol decanoate and oral haloperidol on seeking psychiatric emergency care

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**Introduction:** Haloperidol is a first generation, high potency, low cost and widely used antipsychotic. There are inconsistencies in the literature about comparison of effectiveness between long-acting injectable haloperidol (HDLAI) with oral haloperidol (OH), as well as the combined use of both formulations (HDLAI+OH).
**Objectives:** To verify whether HDLAI reduces the number of emergency visits and hospitalizations when compared to oral OH, or in combination therapy HDLAI+OH.
**Methods:** Retrospective observational study on a Psychiatric Emergency department, including patients aged 18 to 60 years, both genders, under continuous treatment for at least 5 months with Haloperidol for any psychiatric illness, divided into 3 groups of patients (HDLAI, OH, HDLAI+OH). Dependent variables: visits and admissions. Independent variables: sex and age. Data were checked for normality (Kolmogorov-Smirnov test) and homoscedasticity (Bartlett test). For comparison of average number of visits and hospitalizations of patients Kruskal-Wallis test followed by Dunn's multiple comparison test was used. It was considered statistically significant if $p < 0.05$. This study was approved by the Ethics Committee of Maringá State University.

**Results:** No statistical difference between groups HDLAI and OH was found. The HDLAI+OH group presented higher means of emergency visits and hospitalizations with statistical significance.
**Conclusions:** It suggests the use of HDLAI can be considered an alternative as effective as oral intake. Prolonged use of associated HDLAI and oral supplementation leads to worst outcomes.

**Disclosure:** No significant relationships.
**Keywords:** haloperidol decanoate; haloperidol; recurrence; Antipsychotics

## EPV0730

### Use of verbal de-escalation in reducing need for mechanical restraint in patients with psychotic disorders during non-voluntary transfers from home to the psychiatric emergency department.

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**Introduction:** Little is known about the need for mechanical restraint during non-voluntary transfers from patient's homes to the psychiatric emergency department in patients diagnosed with Paranoid Schizophrenia. Although there is no evidence of its efficacy, one of the main tools used for the reduction of mechanical restraints is verbal de-escalation training.
**Objectives:** The aim is to describe which symptoms predispose to mechanical restrain in patients with Paranoid Schizophrenia transferred in a non-voluntary manner from home to the psychiatric emergency department, and the effect on reducing mechanical restraints after receiving verbal de-escalation training.
**Methods:** All patients with Paranoid Schizophrenia who, after being visited by a home psychiatry team, have required non-voluntary transfer from their homes to the psychiatric emergency department were selected (N = 442).
**Results:** Young age, being male, having a poor adherence to treatment, higher scores for de following variables; Excitement, Grandiosity, Suspiciousness, Hostility, Abstract thinking, Motor tension, Uncooperativeness, Poor attention, Lack of insight and Poor impulse control as well as lower scores in motor retardation on the PANSS, are related to a higher frequency of mechanical restrain (P<0,005). Before the verbal de-escalation training, 43.9% of the transferred patients required mechanical restraint, after the training, the need for restraints was reduced to 25.5% (P<0.001).
**Conclusions:** Training in verbal de-escalation has allowed an important reduction in mechanical restraints in patients with schizophrenia who have required non-voluntary transfers from home to the psychiatric emergency department.

**Disclosure:** No significant relationships.
**Keywords:** Emergency psychiatry; Mechanical retraint; Verbal de-escalation; transfers

## EPV0731

### Ekbom's syndrome in an HIV man: a case report

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**Introduction:** Ekbom's syndrome, also known as delusional parasitosis, is a neuropsychiatric disorder characterized by the delusional belief that the body is infested by parasites, small organisms or materials. Multiple etiologies have been described such as psychiatric and neurological disorders, substance intoxication or other medical conditions. We present a case of Ekbom's syndrome in an individual infected with the human immunodeficiency virus (HIV).
**Objectives:** To report a case of a patient with Ekbom's syndrome and HIV.
**Methods:** A 33-years-old man assists to the emergency unit in order to excessive drowsiness. During the evaluation an antihistamin overdose is confirmed. The patient justifies taking it by claiming to have parasites all over the skin, a fact that is ruled out. Medical history is reviewed presenting multiple visits to GP for thinking that he has parasites, performing medical examinations without alterations. Toxicological, hemogram, biochemistry, hormonal and vitamin study did not show alterations.
**Results:** Due to the symptoms presented, it was decided to start antipsychotic therapy. At the beginning, the patient is not aware of needing treatment other than antiparasitic. After optimizing the olanzapine dose to reach 20 mg / day, the patient denied experiencing tactile and visual hallucinations.
**Conclusions:** Ekbom's syndrome is a multifactorial neuropsychiatric disorder, individuals infected with HIV are at increased risk of psychotic disorders. The patient was diagnosed of psychotic disorder due to another medical condition because the history of HIV preceded the history of delusional content.

**Disclosure:** No significant relationships.
**Keywords:** psychiatry; Ekbom; HIV; emergency

# Epidemiology and Social Psychiatry

## EPV0734

### Mental health in medical, dental and pharmacist students: a cross-sectional study

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