

EV0238

Benzodiazepines abstinence syndrome with psychotic symptoms: Case report

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Introduction Several studies point to the importance that the complex formed by GABA and the benzodiazepine receptor play for cerebral dopaminergic transmission and, hence, to the pathophysiology of psychotic symptoms. The decrease in GABA neurotransmission or the hypofunction of the system in the hippocampus, cortex and other limbic prefrontal or subcortical regions has consequences as emotional dysregulation, cognitive impairment and development of positive psychotic symptoms.

Objectives We intended to show an additional practical example to the limited literature available based on a case linking the emergence of psychotic symptoms due to acute benzodiazepine withdrawal.

Methods We present the case of a 21 year old man who was sent to the emergency room of our hospital after an episode of aggressiveness on the street. The patient showed a psychotic schizophrenic syndrome with significant emotional and behavioural impact with aggressive and bizarre movements. In parallel, restlessness, sweating, tremor, increased blood pressure and tachycardia were observed. Symptoms had started abruptly two hours earlier. The patient companion explained that he usually took Alprazolam at an of over 40 mg per day. He had decided to give up this consumption abruptly four days earlier.

Discussion GABAergic deficits cause the imbalance between excitatory and inhibitory neurotransmission that may relate the pathophysiology of psychotic symptoms. The dysfunction of the GABAergic cortical interneurons could affect to the modulating response from the association cortex, which, could also relate with the appearance of these symptoms.

Conclusion This case could relate a decrease in GABAergic transmission with the appearance of psychotic symptoms.

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Mood disorders in HIV infection

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Introduction Psychiatric disorders, particularly mood disorders, have a profound effect on the use of and adherence to highly active antiretroviral therapy (HAART) among patients with human immunodeficiency virus (HIV) infection.

HIV infection and mood disorders have features in common, and each is a significant risk factor for the other.

Objective The objective is to highlight the clinicians on the importance of screening and treating affective disorders among patients with HIV infection.

Methods Two cases of HIV infected patients with comorbid mood disorder and torpid evolutions by poor adherence to treatment are reported.

A brief literature review on this subject is done.

Results Major depression has been shown to alter the function of killer lymphocytes in HIV-infected patients and may be associated with the progression of HIV disease.

HIV-positive patients with mental disorders are less likely to receive and adherence to antiretroviral therapy.

First case-report: a man 52 years old, HIV-positive since 1985 with a comorbid bipolar disorder, with recurrent depressions and poor adherence to both treatment with a rapidly exitus laetalis.

Second case-report: man 45 years old, HIV-positive since 1992 with a comorbid depressive disorder, non-adhered to both therapy and HIV-associated dementia.

Conclusions Depressive disorders are common in HIV infection. Antiretroviral regimens for HIV-infected patients require strict adherence. Untreated depression has been associated with medication nonadherence. Understanding the contribution of depression and its subsequent treatment on antiretroviral therapy adherence might direct clinicians toward earlier identification and more aggressive treatment among this population.

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The EFPT-PSUD survey

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