EV0273

Neuropsychiatric manifestations in patients with HIV treated with antiretroviral drugs versus untreated

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Introduction Untreated patients for H.I.V can present various types of neuropsychiatric syndromes (NPS): subclinical cognitive symptoms, behavioral changes, agitation, personality changes, dementia complex associated with H.I.V and delirium, depressive disorder, bipolar affective disorder or manic episode. However, it is controversial whether antiretroviral induce NPS, or on the contrary, when there are patients will evolve into an AIDS stage for therapeutic resistance or noncompliance.
Aims Describe qualitatively and quantify the epidemiological point of the main subclinical and NPS symptoms in patients untreated and treated with antiretroviral drugs and their frequencies. Propose pharmacological treatments for each of the specified conditions.
Methods Search in PubMed with the words "Neuropsychiatric and antiretroviral therapy" by applying the limits: full and free texts, past 10 years, Human, English language and adults; research liaison psychiatry textbooks.
Results Results yielded 381 articles with the criteria selecting 102, the most relevant for the purposes of work. They chose four most relevant chapters in the literature.
Conclusions The most effective treatment of NPS in unmedicated patients is to start antiretroviral therapy; only if it does not improve them should be introduced psychiatric drugs as if they were functional. 50% of treated with efavirenz patients will develop NPS in the early days with gradual decrease. The dropout rate associated with these adverse events varies from 2.6–16%. Treatment of these NPS a challenge by the existence of numerous drug interactions, it is essential to know to deal with these entities to improve the quality of life of people with this chronic disease.
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Sun lupus and energy. Systemic lupus erythematosus presenting as mania

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Introduction Systemic lupus erythematosus is a chronic disease that can give neuropsychiatric episodes and systemic manifestations. About 57% of patients with SLE have neuropsychiatric manifestations in the course of their illness, however an initial presentation with neuropsychiatric clinic is rare.
Objective Describe how patients receiving corticosteroids as part of their treatment can develop mental disorders but not only them.
Method It will raise grounds with a case: 20-year-old woman recently diagnosed with SLE because of arthritis in his ankle. Treatment was initiated with prednisone 10 mg and chloroquine 200 MG. After 20 days the patient comes to the emergency after episode of turmoil at home with major affective clinical maniform. Presenting fever. The presence of fever downloads the possibility of a psychosis chloroquine or corticosteroids to be a small dose. Treatment was initiated with high doses of prednisone and immunosuppressants. In addition to associating specific anticonvulsant and antipsychotic drugs at usual doses for a manic episode.
Results Treatment of psychosis in SLE is essentially empirical, and depends on the etiology. It usually responds to the use of high doses of corticosteroids combined with immunosuppressive drugs. Psychosis induced by corticosteroids requires lowering them. It is valid concomitant use of antipsychotics.
Conclusions The presence of psychotic symptoms in a patient with systemic lupus erythematosus forces to distinguish between various etiological possibilities.
Corticosteroids may cause a variety of psychiatric symptoms. And yet, in patients with SLE these syndromes are not always attributable to the use of corticosteroids.
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Confusion between symptom and disease. Parkinson vs meningioma

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Introduction Parkinson's disease is caused by decreased dopaminergic neurons of the substantia nigra. Psychosis occurs between 20 and 40% of patients with Parkinson's disease. Dopaminergic drugs act as aggravating or precipitating factor. Before the introduction of levodopa patients had described visual hallucinations but the frequency was below 5%.
Objective Illustrated importance of treatment, reassessment after its introduction and refractoriness to answer; as well as the importance of a differential diagnosis at the onset of psychotic symptoms later in life.
Method Clinical case: female patient 75 years tracking Neurology by parkinsonism in relation to possible early Parkinson disease. She was prescribed rasagiline treatment. Begins to present visual and auditory hallucinations, delusional self-referential and injury. She had no previous psychiatric history. She went on several occasions to the emergency room, where the anti-Parkinson treatment is decreased to the withdrawal point and scheduled antipsychotics did not answer. Doses of antipsychotics are increased despite which symptoms persist and even increase psychotic symptoms. In this situation it is agreed to extend the study. Subsequently an NMR of the skull where the image is suggestive of a right occipital meningioma appears.
Results/conclusions With the emergence of psychotic symptoms later in life it will be important to ask a broad differential diagnosis, since in a large number of cases will be secondary to somatic or to drug therapies.
Parkinsonism can be a symptom of occipital meningioma, presenting in the psychotic clinic. Refractoriness, on one hand to the suspension of treatment for Parkinson's disease, such as poor response to antipsychotics, did extend the study, which ultimately gave us the diagnosis.
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