warning signs' and treated with Sertraline 100 mg. During the first consultation, the patient reported the following symptoms:

- Marked emotional overwhelm and hypervigilance.
- Intrusive thoughts related to her father, generating significant guilt.
- Thoughts in which she feels the desire to harm herself.
- Compulsive need to check everything she writes, regardless of the context, to confirm she has not written anything bad about herself or her family.
- Compulsive need to review past actions to ensure she did not say anything inappropriate (despite not having spoken).
- Compulsive need to revisit conversations to ensure she had not said anything inappropriate, which eventually led her to stop speaking altogether.
- Mixed insomnia due to anticipatory anxiety about the thoughts she might have during the night.

During this initial visit, a diagnosis of Obsessive-Compulsive Disorder with mixed obsessive thoughts and acts (ICD-10; F42.2) was made. The Y-BOCS was administered, with the patient scoring 19 for obsessions and 12 for compulsions (total score: 31, indicating severe OCD). The dose of sertraline was increased to 300 mg, and aripiprazole was added. However, aripiprazole had to be discontinued after 15 days due to poor tolerance, and risperidone was introduced, which also had to be discontinued after 15 days due to poor tolerance.
After four months of follow-up and monotherapy with sertraline, the patient presented with almost complete resolution of symptoms, a stable mood, calm demeanor, and regained control over her thoughts, along with the disappearance of the compulsive checking behavior. A Y-BOCS was administered again, with a score of 8 for obsessions and 5 for compulsions (mild severity).
Conclusions: The use of high-dose sertraline (250-400 mg/day) may be an effective alternative for maintaining monotherapy in patients with treatment-resistant obsessive-compulsive disorder. However, it is important to consider that previous studies have shown a better response but not a higher overall response rate (Ninan et al. J Clin Psychiatry 2006; 67:15-22).

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EPV1575

Clinical experience with Brexpiprazole in bipolar depression, off-label use. A six cases report

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Introduction: In 2015, the United States Food and Drug Administration (FDA) approved Brexpiprazole as an adjuvant treatment for adults with major depressive disorder and as a treatment for adults with schizophrenia. Although studies suggest that Brexpiprazole is an effective adjunctive treatment for major depressive disorder in Europe, the European Medicines Agency (EMA) approved Brexpiprazole only for the treatment of schizophrenia in adult patients.
Objectives: To observe the safety, tolerability, and efficacy of brexpiprazole in patients with bipolar depression.
Methods: We followed, during 2 months, six patients diagnosed with bipolar disorder who met DSM-5 criteria for a major depressive episode. Four of them were women, two men. All were being treated with mood stabilizing drugs (2 with valproic acid and 4 with lithium). The average age was 43 years.
Visits were conducted every 15 days. At each visit, we evaluated depressive symptom improvement, any adverse effects, and the emergence of manic or hypomanic symptoms.
All patients were informed of the off-label use of this drug and gave their consent.
Results: Five out of six patients continued treatment throughout the study; only one patient discontinued due to adverse effects (amenorrhea). All patients who maintained treatment demonstrated a subjective improvement in depressive symptoms, as observed by both, clinicians and the patients themselves. No patients presented with manic or hypomanic symptoms suggestive of a shift to a manic pole.
Conclusions: Although off-label, brexpiprazole may be beneficial for certain patients with depressive symptoms and a diagnosis of bipolar disorder. It displayed a good tolerability profile, with no observed shifts to mania in our small sample.

Disclosure of Interest: None Declared

EPV1577

When an antipsychotic working as an antidepressant, do they have a therapeutic window?

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Introduction: Therapeutic window in psychopharmacology is the range of drug concentrations that achieve desired effects safely, with treatment failure more likely when levels fall outside this optimal range. The role of dopamine receptor partial agonists (DRPA) in the treatment of depression is a case in point.
Objectives: We discussed the unique mechanisms, and effective antidepressant doses of DRPAs within their therapeutic windows.
Methods: PubMed search was conducted, focusing on randomized controlled trials, open-label studies, and reviews evaluating aripiprazole, brexpiprazole, and cariprazine as augmentation therapies for major depressive disorder in adults.
Results: Clinical trials have investigated aripiprazole, brexpiprazole, and cariprazine as adjuncts to antidepressants, and the effective antidepressant dose is generally lower than the minimal antipsychotic dose. Specifically, the antidepressant doses are 2 – 10 mg for aripiprazole (antipsychotic dose 10 – 30 mg), 2 – 3 mg for brexpiprazole (antipsychotic dose 4 mg), and 1.5 – 3 mg for cariprazine (antipsychotic dose 1.5 – 4.5 mg). This is because at subantipsychotic doses partial agonists increase the dopamine signal, but at antipsychotic doses they reduce the dopamine signal to the level of the intrinsic activity of the drug (generally 25 – 40% of the maximal dopamine signal) which is generally inadequate for an antidepressant response.