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).

Disclosure of Interest: None Declared

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.

Conclusions: DRPAs can increase or reduce the dopamine signal depending on receptor occupancy. At higher receptor occupancy they reduce the dopamine signal, while at lower receptor occupancy (when unoccupied receptors can interact with endogenous dopamine) their intrinsic activity can increase the dopamine signal. Understanding the drug-receptor relationship is crucial, as the assumption that higher doses are always more effective is incorrect.

Disclosure of Interest: None Declared

EPV1578

Examine the effects of Atomoxtine alone versus Atomoxtine combined with Risperidone at sample of Egyptian children suffering from ADHD

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Introduction: A frequent developmental condition of inattention that may or may not be accompanied by hyperactivity is known as Attention Deficit Hyperactivity Disorder.[1]One's inability to focus, excessive activity, and behavior that is inappropriate for their age, all of these traits are indicative of ADHD.[2]The data for Atomoxetine indicates that it is safe and effective in treating ADHD in children and teenagers[3]. For kids and teenagers with disruptive behaviors, ADHD, and developmental disorders, Risperidone may be a safe, effective medication. Numerous investigations have demonstrated the high effectiveness of risperidone[4]

Objectives: To study the Efficacy of Atomoxetine alone vs. Atomoxtine with Antipsychotic (Risperidone) on ADHD children.

Methods: This follow-up study was carried out from January to June 2024 on 54 ADHD children (6–18 years old) who were receiving treatment at the psychiatry clinic at Al Hussian University Hospital in Cairo, Egypt. This study was authorized by the Al-Azhar Faculty of Medicine's Ethical Committee. Following an explanation of the purpose of the study and the acquisition of verbal agreement, all children underwent semi-structured clinical interviews and were excluded from other psychiatric & medical conditions.

Based on the DSM IV criteria, ADHD has been diagnosed in all of the study children. Conner's 2 test for ADHD, or SCID, was used for every child in the study. Implementing medicinal treatment for every child and monitoring their progress, who were divided into two groups. The first group, which consisted of 27 children diagnosed as ADHD children, received only Atomoxetine, independent of the kind of ADHD. In contrast, 27 recently diagnosed children with ADHD, irrespective of their kind of ADHD, received a combination of Atomoxetine and antipsychotic(Risperidone) medication in the second group.

SPSS 20.0 was employed. The qualitative data were expressed in terms of percentages and figures, and the significance of the outcomes was assessed at the 5% level.

Results: When Atomoxetine was administered to 27 children, it demonstrated a moderate level of efficacy to 12 from 27 patients (44.4%) for all children with ADHD, regardless of type, but it significantly improved the inattention type of ADHD in 4 from 4 patients (100%).Given to 27 children, the combination of Atomoxetine and Risperidone demonstrated greater effect on 24 from 27 patients with (88.9%) for all ADHD children, and it showed a discernible improvement on 9 out of 9 with (100%) for ADHD hyperactivity type.

Conclusions: All types of ADHD are responsive to Atomoxetine or Atomoxetine / Antipsychotic (Risperidone) combination, But Atomoxetine effect is more on Attention deficit variant than other variants, while Antipsychotic (Risperidone) is more effective on hyperactivity and aggression.

Disclosure of Interest: None Declared

EPV1579

Clozapine-induced Agranulocytosis: A Case Presentation and Literature Review

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Introduction: Clozapine has the strongest evidence for efficacy for schizophrenia that has proved refractory to adequate trials of standard antipsychotic medication. Its use is limited to these cases due to the uncommon but severe adverse effect agranulocytosis or severe neutropenia, defined as a neutrophil count under 500/microL. It is seen in 0,4 % of clozapine patients and it usually occurs in the first three months. Risk is managed with close blood count (BC) monitoring protocol.

Objectives: This work aims to improve the understanding and management of this condition.

Methods: With this purpose, we present a clinical report and rewiew its management in literature.

Results: We present the case of a 60-year-old man with the diagnosis of resistant schizophrenia who is hospitalized in the acute Psychiatry Unit due to decompensation, where clozapine is initiated with gradual dose augmentation and weekly BC. After improvement of psychotic symptoms, the patient is transferred to a subacute care facility. Two months later, BC revealed mild neutropenia (1000/microL; defined as 1000-1500/microL) becoming severe (100/microL) on the next test one week later. Clozapine is then interrupted and replaced with olanzapine. Neutrophils descend to zero within one day and three days later, with all granulocytes in low levels, the patient presents fever and diarrhea, being finally hospitalized in Internal Medicine. Empirical intravenous antibiotic therapy is prescribed as well as filgastrim, a granulocite-colony stimulating factor (G-CSF). Antibiotic is adjusted after *Enterococo Faecalis* is isolated in blood cultives. Despite eleven days without clozapine and eight days with G-CSF, agranulocytosis persisted. Taking in consideration the severity of the case and the non existence of acute psychotic symptoms, olanzapine is interrupted and benzodiacepine medication is increased, with BC normalization within three days and remission of digestive symptoms and fever. G-CSF is interrupted and the patient is re-transferred to the subacute unit, with initiation of aripiprazol in the following days.

Upon the appereance of mild neutropenia, closer blood monitorization is recommended (three times a week); with interruption of clozapine and daily monitoring in case of moderate or severe neutropenia. In relation to when to reintroduce antipsychotic treatment,