

**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 referred 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.