Introduction. Schizophrenia is a severe mental disorder characterized by positive, negative and cognitive symptoms. Schizophrenia affects 1% of general population and one of its features is the heterogeneity of response to treatment. 20–30% of individuals with schizophrenia have treatment-resistant schizophrenia. Correctly identifying these patients could contribute to reduce burden in patients themselves, in society and in economy. In fact, TRS constitutes about 60–70% of schizophrenia's cost burden. Three key elements define the concept of treatment resistant schizophrenia. These are: 1) a confirmed diagnosis of schizophrenia based on validated criteria; 2) adequate pharmacological treatment; and 3) persistence of significant symptoms despite this treatment.

Aim of the study. Studying the particularities of the clinical evolution and the management methods of the resistant schizophrenia treatment.

Materials and methods. The number of patients included in the study is 38 people who were previously diagnosed with schizophrenia. To these patients, the BPRS scale was performed to identify the response to the administered treatment. Also in the study were taken into consideration the following criteria,such as: age, heredity, gender, number of recurrences and admissions, trigger factors, duration of psychotic episode, disease evolution over the years and what antipsychotics were administered.

Results. In the study performed on 38 patients, using the BPRS scale, were identified only 3 patients, who meet the criteria of resistant schizophrenia, the patients are male over 45 years old. Now, I am studying patient's records to analyze other aspects and criteria that influence treatment resistance. By analyzing the treatment that follows, patients develop resistance to typical antipsychotics. A pattern of superiority for olanzapine, clozapine, and risperidone was seen in other efficacy outcomes, but results were not consistent and effect sizes were usually small. In addition, relatively few RCTs were available for antipsychotics other than clozapine, haloperidol, olanzapine, and risperidone. The most surprising finding was that clozapine was not significantly better than most other drugs.

Conclusions. The clinical management of patients with treatment-resistant schizophrenia is still challenging despite years of extensive research. 2 antipsychotic drugs should be tried at adequate dosage and for an adequate period, and various factors that interfere with adherence should be ruled out before making a diagnosis of treatment-resistant schizophrenia. Clozapine should be used only when it is confirmed that patients have treatment-resistant schizophrenia and their condition fails to respond to atypical antipsychotics or typical antipsychotics. The same rule applies in identifying clozapine-resistant schizophrenia. Pharmacological augmentation strategies for managing clozapine-resistant schizophrenia are widely used in clinical practice. However, there is no strong evidence that supports augmentation as an effective treatment option. ECT may be an effective augmentation strategy in the treatment of clozapine-resistant schizophrenia. It should be emphasized that psychological and psychosocial care combined with medication treatment are the key factors in maximizing the effectiveness in the treatment of patients with treatment-resistant schizophrenia.

Key words: schizophrenia, resistance, treatment, antipsychotics, criteria.

169. POSTPARTUM-DEPRESSION

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Introduction. Pregnancy, childbirth and the postpartum period are some of the most important periods in a woman's life, in which physical and mental health changes take place. Systems and organs changes occur (uterus involution, wound healing, changes in the cardiovascular, urinary, respiratory, and muscular systems). Risk factors that predispose to postnatal depression include: previous depressive episodes, feeling of despair, anxiety in pregnancy, low self-esteem, poor relationships with the partner, low socio-cultural status and loneliness. Also, women at risk of perinatal complications, hospitalization during pregnancy or termination of pregnancy by cesarean section, premature birth are more at risk. Stress associated with caring for a child and not accepting their own body after birth can also cause depression in women. First month from the postnatal period is very important because of the possibility of depressive disorders. In the post-partum period three depressive disorders may occur (baby blues, postpartum depression and postpartum psychosis). Baby blues, so-called post-partum sadness can develop four days after the baby's birth and can last up to 12 days. Anxiety, feelings of hopelessness, sleep disorders, attention and appetite disorders, lack of interest in the child and the environment are the main symptoms of post-partum depression. Postpartum depression lasts from 3 to 9 months, sometimes up to 1 year after the birth of the child. Depressive disorders in the postnatal period can have a negative impact on the development of the mother-child relationship, with long-term social, emotional consequences. and cognitive effects on mother and child.

Aim of the study. Evaluation of the psychological particularities of the post-partum period and the possibility of the appearance of the emotional disorders and post-partum depression.

Materials and methods. All relevant information was obtained from literature review.

Results. The term postpartum depression is used to define depressive symptomatology that begins in the postnatal period and represents a complex of physical, emotional and behavioral changes. Depression, historically referred to as melancholia, was classified as a mental disorder in the 1800s, when the first efforts were made to collect statistical data on the incidence of mental illness. Since then, major depression has been included in the Statistical and Diagnostic Manual of Mental Disorders (DSM), since its inception in 1952. Thus, it has been proposed that the estimated incidence of 10-20% of postpartum depression was initially classified as a major depression subtype, referred to as "major depressive disorder, with postpartum outset" in DSM-4, and is currently classified as "major depressive disorder with outset in the peripartum period" in DSM-5, because the manifestation of symptoms begins during pregnancy in about 1/3 patients with post-partum depression. According to DSM-5 postpartum depression is a major form of depression that starts in the first 4 weeks postpartum. The diagnosis of postpartum depression is based not only on the notion of time since the outset of depression, but also on its severity. An extensive study that attempted to estimate the incidence of psychiatric disorders in pregnant and postpartum women has shown an increased risk of depression in the postpartum period compared to non-pregnant women. In general, existing data in the literature suggest that the peripartum period is a vulnerable time for depression. The prevalence of postpartum depression is considered to be about 10-20%, however the prevalence varies greatly, depending on culture and depending on the income level of the countries where the studies are conducted. Thus, it has been proposed that the estimated incidence of 10-20% of the postpartum depression may be an underestimated global problem, and how the postpartum depression is often undiagnosed / underdiagnosed, with some estimates that over 50% of women with post-partum depression remain undiagnosed.

Conclusions. Women with pre-existing psychiatric disorders have an increased risk of recurrence or exacerbation during pregnancy and should be carefully monitored. Developing a screening program and extending the intervention program to subclinical and non-clinical

symptoms would help mothers cope better with maternity challenges and the emotional problems they encounter during this period of their life.
Key words: Pospartum depression, psychiatric disorders.

170. MUNCHAUSEN SYNDROME, DIFFERENTIAL DIAGNOSIS

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Introduction. Münchausen Syndrome is a severe psychiatric disorder, also called factitious disorder imposed on self, was first characterized by Richard Asher, in 1951. This syndrome is characterized by the deliberate falsification of the history of the disease, the patient produces or invents an imagined medical pathology to benefit from investigations, medical procedures and treatment. The patient is dependent on hospitalization and aims to get the attention of the medical staff that he misleads by inventing clinical symptoms that are not real. Furthermore, standard therapeutic interventions may not be effective in persons with Munchausen syndrome, causing increased confusion for the care team.
Aim of the study. Studying the particularities of the clinical evolution and diferential diagnosis of Munchausen Syndrome.
Materials and methods. All relevant information was obtained from literature review.
Results. Munchausen syndrome is a disease that can be masked in the form of other mental illnesses. At present, it is important to make a correct difference between them. Differential diagnosis of factitious disorder is also made with somatoform disorders such as: conversion disorder; or pain disorder. The diagnosis of Munchausen syndrome is difficult because of the lack of correctness in the patient's statements. The hospitals where the patients are consulted by an interdisciplinary team, theoretically is the ideal environment to identify a factitious disorder and the place where appropriate measures would be taken to initiate the management of the disorder, especially in the case of abuse of a child, of an elderly person, or a person with disabilities. The correct diagnosis and management of cases with factitious disorders at the admitting department are fundamental for a good prognosis and a correct treatment.
Conclusions. Diagnosing Munchausen syndrome can be very hard because of all of the dishonesty associated with this disorder. Doctors must first rule out any possible physical and mental illnesses before considering a diagnosis of Munchausen syndrome. The lack of identification may lead to many unnecessary laboratory tests and procedures which may prolong hospitalizations and increase costs of health systems. So far, no effective treatments have been demonstrated through well-conducted studies, and no diagnostic criteria exist; these facts may explain the little knowledge of students and health practitioners about these conditions. Munchausen syndromes as well as Munchausen syndrome by proxy are variants of factitious disorders. They are challenging conditions in Medicine despite the current technology and knowledge on mind-body boundaries.
Key words: Munchausen syndrome; Munchausen syndrome by proxy; Factitious disorders, differential diagnosis