

(e.g. schizophrenia). We explore the differential diagnosis, the challenging diagnostic workup and the limited therapeutic options in this patient with complex visual nocturnal hallucinations.

Report of Cases: A 64 year old woman was referred with detailed and vivid visual nocturnal hallucinations (seeing her dog smoking a cigar, seeing someone in the room moving her bed, etc.). The hallucinations started 1-2 months ago, were mainly present at night (both when falling asleep and during the night) but occasionally also during the day. She had also been suffering from worsening daytime sleepiness for 3-4 months, and from memory problems for 1 year. Cataplexy and sleep paralysis were absent. Clinical neurological examination was normal. The patient had been diagnosed in the past with OSAS. She had been treated with CPAP for 3 years and recent polysomnography showed good control of her apnea. She had also been diagnosed with Crohn's disease, COPD and cardiomyopathy. Because of her age, the vivid hallucinations, and the memory problems, we first wanted to rule out Lewy Body Dementia. Neuropsychological testing ruled out dementia. MRI of the brain showed some white matter lesions, without substantial atrophy. At a subsequent multidisciplinary consultation, her cardiologist considered her cardiomyopathy as a contraindication for stimulants. Therefore, and because we believed the a priori probability for narcolepsy to be low, an additional MSLT was not considered useful. Based on further pulmonary tests, we hypothesized that hypoxia could play a role in the hallucinations and hypersomnolence. The hallucinations improved over time, the hypersomnolence remained, but we found there were no good treatment options available, considering the cardiac contraindications for stimulants.

Conclusion: There is a wide-ranging differential diagnosis for nocturnal visual hallucinations. The specific patient characteristics are important both for further diagnosis and treatment options.

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CORRECTING SLEEP/WAKE CYCLE AND REDUCING COMBATIVENESS IN AN 84-YEAR-OLD PATIENT

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Introduction: Sleep disruption is a common occurrence in hospitalized geriatric patients. Such patients frequently arrive at the emergency department for behavioral changes due to delirium, which can often be mistaken for, or compounded by, underlying dementia. Behavioral symptoms may vary, including disinhibition, aggression, distress during care, mood disturbance, and paranoia, affecting approximately 90% of patients. Effectively treating these patients is challenging; antipsychotic use is a commonly implemented treatment in hospitalized settings, but is complicated by adverse side effects and an increased risk of CVA. In this case report, we discuss the use of an antipsychotic, olanzapine, to treat an 84 year old hospitalized patient presenting with sleep disruption and changes in mental status.

Report of Cases: An 84 year old gentleman with a history of Alzheimer's dementia with worsening behavioral changes was admitted for urinary tract infection, humeral fracture secondary to mechanical fall, and increasing aggression toward his caretaker. At

home the patient was sleeping during the day and more was active and combative at night. While hospitalized, he had become aggressive with hospital staff due to his distress and was minimally oriented at baseline. We trialed the patient on olanzapine 5mg at night to facilitate sleep and reduce his aggression, in addition to environmental changes to reorient day and night. After a few days of this treatment, this patient was much more pleasant and oriented, able to hold conversation, and no longer aggressive. His initial disposition was to be transferred to a memory care facility, given increasing safety concerns expressed by the caretaker. However, following these changes, he was able to return home in the comfort of his family and caretaker.

Conclusion: Antipsychotic use in the elderly for sleep disruption and behavioral disturbances is heavily debated, though there may be some benefit to their use. The CATIE-AD trial and a Cochrane Review suggest Olanzapine may reduce aggression, particularly in Alzheimer's disease, and has the added benefit of sedation which aids in establishing sleep cycles. However, many patients discontinue antipsychotic treatment due to side effects and routine use is discouraged. When in use, regular monitoring should take place to evaluate for side effects associated with pharmacotherapy and continued therapeutic benefit should be reassessed.

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HOW TO FIX MASK LEAK FOR THOSE WITH NO TEETH

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Introduction: Mask fit is a crucial factor for patient adherence and effective use of PAP therapy. However, patients using dentures may face significant challenges to achieving a good mask seal, resulting in mask leak and inefficacy of therapy.

Report of Cases: A 67-year-old male with Obstructive Sleep Apnea (OSA) previously adherent to Bi-level Positive Airway Pressure (BPAP) therapy presented to clinic for complaints of mask leak. Due to a suspected dental infection, he had had all his teeth removed three years prior to this visit and had been instructed by his dentist to remove the dentures each night when he slept. However, removal of the dentures affected the fit of his full-face mask, and he experienced significant mask leak with return of pre-PAP symptoms. He was a habitual mouth-venter and preferred full-face masks. Despite trialing different masks, he was no longer able to tolerate his BPAP secondary to the leak and discontinued PAP therapy altogether. During his visit to the sleep center, a mask refit was performed with and without his dentures in place. While no masks sealed effectively with his dentures out, a satisfactory alternative was found if he wore his dentures. He was counseled to wear his dentures while using PAP, remove his dentures for the recommended minimum amount of time during the day instead of removing them for sleep, and to follow up with his dentist/prosthodontist for further instructions.

Conclusion: Edentulous patients may pose difficulties with mask fit, and a multi-modal approach may be necessary to effectively treat their sleep apnea. Luckily, our patient was able to find a mask that he found comfortable while wearing his dentures and had minimal leak. Alternatives may include consideration of positional therapy with lower pressures for a potential nasal mask, weight loss, hypoglossal nerve stimulator, or referral to an oral surgeon, dentist, or prosthodontist for guidelines on sleeping with dentures. Close monitoring of symptoms and download data is recommended following oral surgery and switch of mask interface.

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