Results. Main diagnostic criteria for NMS include hyperthermia, rigidity, mental status changes and autonomic dysfunction. The definition of atypical NMS includes three of these four criteria. Serotonin syndrome was ruled out as the patient was not taking any selective serotonin reuptake inhibitors (SSRI) nor selective serotonin-norepinephrine reuptake inhibitors (SNRI). Malignant hyperthermia was also considered as the patient had received a volatile anaesthetic gas, isoflurane, for sedation purposes; however, symptoms persisted long after it was stopped.
Conclusion. Atypical NMS is a diagnosis of exclusion that must be considered in patients in an intensive care setting who experience refractory hyperthermia. A multidisciplinary team is essential in caring for critical care patients who exhibit symptoms of NMS, including psychiatry, neurology, and clinical pharmacy.

Change of Focus: Interventions of Occupational Therapy From a Psychodynamic Perspective

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Aims. Strictly speaking, occupational therapy interventions in mental health help clients through different activities to improve and develop skills that allow them to become increasingly independent and self-sufficient. Occupational therapy evaluation includes areas such as activities of daily life, play/leisure, productivity, study, work, and social participation. Occupational therapy also considers the impact of the context on the areas mentioned, but usually does not include the psychodynamic aspects of the client.
Methods. Male patient in his early thirties who was suffering an acute psychotic episode. He was experiencing a mystical delusion, with grandiose ideas of personal significance and delusions of reference. His mood was elevated, in consonance with the content of his thoughts. He was disorganised and needed help to maintain his daily routine. He said that he was experiencing a Maslow's Peak-Experience not a psychotic episode although he acceded to take medication. In an attempt to avoid involuntary admission to a mental health clinic (he refused to be admitted, as did his family), we tailored a home approach, with the inclusion of an occupational therapist on the team. Our first approach was unfruitful. Our attempts to help him to organize himself and his daily routine did not work. He was so fixated with his delusional project that any other idea or plan was rapidly discarded. So, we decided to change our approach and took his delusional project as the activity to organise and plan about. We agreed with him that we were going to help him with his project, but that there were no guarantees of success. Occupational therapy interventions helped him organise his project step by step and accept the frustration that his plan was impossible to achieve. Eventually, the episode ended with no need of admission.
Results. Changing the focus of the occupational therapy interventions, paused the interventions that were aimed at activities of the daily life, and taking the delusional project as the main and the most important activity of the client at this point allowed us to build a stronger therapeutic alliance and helped the client deal with the psychotic process and tolerate the constraints of reality.
Conclusion. The introduction of a psychodynamic point of view in the planning of occupational therapy interventions enriches the realm of occupational therapy and allowed, in this case, a flexible and creative approach that opened the path to a home treatment plan avoiding involuntary admission.

"It's All in the Head" Well! Not Always: Mental Health Patients Are Not Immune to Physical Pain

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Aims. Emotionally unstable personality disorder (EUPD) patients are known to frequently present to acute hospitals with pain symptoms. Multiple pain syndromes like fibromyalgia, chronic fatigue syndrome etc. are also commonly diagnosed in this group of population. It can be difficult to differentiate psychosomatic pain from physical pain during these hospital presentations. Failure to exclude physical causes of pain can lead to inadequate pain relief and missed serious diagnosis.
Methods. We describe a 29-year-old lady known to have Type 1 Diabetes, chronic pancreatitis and past history of several overdoses. She was being supported by Home Treatment Team (HTT) before coming to the hospital. She presented to the Emergency Department (ED) after ingesting 40 tablets of Pregabalin. She was referred to mental health liaison service for ongoing suicidal thoughts. On assessment, she admitted taking multiple overdoses to relieve her of severe abdominal pain. Her pain symptoms had been attributed as attention seeking behaviour. She disclosed feelings of rejection and abandonment by hospital staff. Liaison team negotiated with emergency department staff to complete a physical health examination that revealed tenderness and guarding in the abdomen. She was booked for elective cholecystectomy after surgical review. However, she had to be admitted from ED for laparoscopic cholecystectomy because of worsening of pain and vomiting. She was referred to Pain Management Team after surgery. The team was cautious in providing her with pain medications considering past history of overdoses. She was unable to tolerate pain and voiced thoughts of overdose. We liaised with Pain Management Team to optimise her analgesics and arranged daily supervision of pain medications with HTT
Results. Our patient's physical symptoms of acute cholecystitis and frequent overdoses with pain medications were attributed to her personality disorder that resulted in dismissal of her real pain that "Its is all in the head". This led to persistent pain affecting her mental health.
Conclusion. Patients diagnosed with EUPD should be carefully assessed to exclude organic causes of pain before attributing their symptoms to mental health disorders. A thorough assessment and treatment of physical symptoms can improve their mental health as well as reduce attendance in health facilities.