Results/Discussion. As a result of the late diagnosis of her condition and delayed hospital stay, Ms. S developed a lot of mistrust for the services as she believe that the 19-month delay had significantly impacted her quality of life.
Conclusion. Diagnosis of psychosis secondary to Hashimoto's thyroiditis requires a high index of suspicion, missing this could lead to inappropriate use of medication and increased mobility.

Can Functional Visual Loss Occur in an Older Adult Patient With a History of Stroke: A Case Report

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Aims. Nonorganic visual loss, or functional blindness, is estimated to account for up to 5% of all presentations of blindness. This form of blindness can be ascribed to either a psychogenic aetiology or to malingering. Psychogenic blindness is often a manifestation of conversion disorder, in which a psychiatric condition impairs the normal physical functioning of the affected individual. This could lead to both motor and sensory defects, given that they are not better explained by an organic cause, which should be ruled out by investigations that prove an intact visual system. The individual would also commonly have an identifiable source of stress or trauma. Conversion disorders are less prevalent in older adults, and they may be missed where there are organic comorbidities.
Methods. A 67-year-old male with a recent history of stroke was diagnosed with a major depressive disorder, characterized by low mood, anhedonia, insomnia, fatigue, poor appetite, poor concentration, feelings of guilt, negative feelings about life, and hopelessness. Multiple social problems and family conflicts were identified as possible precipitating factors. Sertraline led to some good initial response, although it was later discontinued. A few months later, he developed severe depression with irritability and suicidal ideation, and he was repeatedly requesting euthanasia. At this point, there was a sudden loss of his vision. Following a thorough ophthalmology evaluation, neurological assessment, and investigations including MRI of the head, cortical blindness was ruled out. As a result, he was diagnosed with visual conversion disorder. After recommencing treatment for his depression with a psychotherapeutic approach as well as vortioxetine antidepressant medication, the visual loss resolved, and the issue has not recurred since then. There was also a significant improvement in his mood. He no longer feels suicidal and appears to be brighter and more socially interactive.
Results. Uncertainty regarding aetiology might initially arise if the patient has a history of trauma or a pathological condition that could cause blindness, such as diabetic retinopathy or stroke, both of which would have been differential diagnoses in the patient in this case had they not been debunked by further investigations, which included neuro-ophthalmic assessments and radiographic studies. The patient's improvement with antidepressants and counselling further supports the diagnosis of visual conversion disorder.
Conclusion. Functional blindness, which is an aspect of conversion disorder, may be a representation of how detrimental undiagnosed and untreated depression could be.

Chromosome 22q11.2 Duplication Syndrome and Diagnostic Overshadowing: A Case Report

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Aims. Mental health comorbidity is higher in those with learning disability especially those who are within forensic services than the general population and diagnostic overshadowing is a particular problem. Hence, all behavioural or mental health related presentations are often attributed to the learning disability and vice versa without an adequate investigation of the causes of learning disability. This is a case report of a young male with mild LD with longstanding mental health and behavioural problem who was described as having a personality disorder in the community. Systematic diagnostic evaluation showed the presence of 22q11.2 Duplication Syndrome. While adding to the sparse literature on the behavioural and physical phenotype of the syndrome, it also allowed his mental health presentation to be re-formulated. This changed his treatment plan and outcome.
Methods. 28-year-old, single, Caucasian male with delayed developmental milestones who was referred to Children Mental Health Services for behavioural difficulties and ADHD-like features. In early adulthood, behavioural problems continued with aggression towards others and was under the care of a community mental health team although with lack of diagnostic clarity and poor compliance. Violence towards self and others led to several short hospital admissions, mainly because he tended to discharge himself against medical advice. The predominant diagnostic formulation was one of a young man with mild learning disability + psychosis related to substance misuse + personality disorder. Facing multiple charges of assault, the court, on medical advice, gave him a hospital order to a medium secure unit for people with learning disabilities where he went through a detailed and systematic diagnostic evaluation that revealed several new findings. Based on this, he went through the 10-point-treatment programme.
Results. Clinicians need to be aware of diagnostic overshadowing leading to misattribution and consequently poor treatment. In this case, the sensory impairments associated with 22q11.2 Duplication Syndrome affected his communication. His tunnel vision led him to bump into people in pubs and other public places giving impression of deliberate antisocial behaviour. The atypical autism, learning disability and co-existing mental illness further complicated the picture. Confirmation of the underlying genetic syndrome and its physical and behavioural phenotype led to a different diagnostic and psychological formulation from the earlier one which was based on a personality disorder. It also allowed more targeted treatment strategies and the patient could be discharged back to the community from a secure hospital setting.

Conclusion. 22q11.2 Duplication Syndrome is a rare genetic syndrome that can cause learning disability. Its physical and behavioural phenotypic features described in literature, were all present in this patient. In addition, this case report highlights three previously unreported findings: Cochlear Nerve Atresia, Tubular Vision, the Characteristic groove and skin fold on the back of the scalp and the presence of a schizoaffective mental illness.

A Tale of Two Catatonic States

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Aims. Catatonia is a psychomotor state characterised by a multitude of clinical signs such as abnormal movements, mutism and withdrawal. This condition is usually associated with medical and psychiatric aetiologies with potential of being life-threatening. It is usually managed with benzodiazepines, the commonest being lorazepam. In this piece of work, we would like to focus on the principles of care that should be considered whilst managing such presentations.
Methods. Case 1- 71, male with diagnosis of paranoid schizophrenia was brought to Emergency department (ED) via ambulance, as he was found 'unresponsive' in care home. On arrival, he was alert with GCS 11/15 and was observed to be mute, 'gesturing' and making purposeless movements. Following our assessment, he was administered 0.5mg of lorazepam whilst in resuscitation bay. Subsequently, he started making sounds and was given another dose of 0.5mg lorazepam. He then vocalised his thoughts and we established that his mental state had relapsed and he was harbouring paranoid delusions.

Case 2- 18, male with no prior psychiatric history was brought to ED by his parents following 3 day history of being mute, not 'responding', not eating or drinking and insomnia. On arrival, he was alert, pacing in the room, however remained mute. Following our assessment, he was given a 2 mg dose of lorazepam whilst in resuscitation bay as the initial 1mg showed minimal response. On later review, he was smiling, conversant and co-operative, thus allowing assessment of his unmasked mental state which was suggestive of first episode psychosis.

Following few hours, both patients reverted back to their original catatonic state.
Results. Lorazepam can be used as a diagnostic measure in conjunction to a therapeutic intervention. A positive Lorazepam Challenge test confirms the diagnosis of catatonia. It must be borne in mind that Lorazepam is only used as a temporary holding measure to assess patient's unmasked mental state and they would need further monitoring and interventions to treat the underlying cause.
Conclusion. Lorazepam Challenge test can be safely used as an assessment technique for patients presenting in acute catatonia. This should be conducted in closely monitored environments namely, resuscitation bay, HDU or ITU with appropriate support and ongoing liaison with psychiatry team. Treating teams should be mindful of various patient characteristics including age, past treatment with benzodiazepines, psychiatric history to inform dose adjustments as necessary.

Disclaimer: Unable to obtain patient consent due to unstable mental state but ensured minimal patient identifiable data included.

Schizotypal Disorder With Borderline Personality Traits: A Case Report

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Aims. Schizotypal disorder is characterized by pervasive patterns of odd behavior, appearance, or thinking. There is also a high degree of overlap in symptoms between schizotypal and borderline personality disorders. The following case describes a case of schizotypal disorder with borderline traits.
Methods. 25-year-old female presented with history of mood fluctuations with recent low mood, anxiety and an ability to read other people's thoughts. She was admitted to hospital 4 years ago and was diagnosed with emotionally unstable personality disorder (EUPD) and mixed anxiety and depression.

She reported anxiety to leave the house due to referential and persecutory ideas, odd beliefs of being able to read people's minds and predict future. She lacked friends and also had fear of abandonment. There was intermittent impulsive self-harm behavior and reportedly harmed herself indirectly through casual sex in the past and also had two failed relationships. She denied illicit drug use. Childhood was uneventful, except that schooling was difficult due to anxiety. She was treated on Quetiapine, Fluoxetine and Promethazine. Further assessments confirmed added features of unusual perceptions, smelling things, superstitious ideas regarding colours and magical thinking. Dissociative episodes of her being a devil, expressing thoughts of slitting her throat were present.

As there was minimal improvement, Aripiprazole was tried. She had poor compliance with Aripiprazole due to the belief that it was poison. She herself requested depot injection, which was started. There has since been mild improvement in her paranoia, but social anxiety is persistent. Psychoeducation about the diagnosis was challenging, after which she accepted referral for psychotherapy.
Results. The initial diagnosis of EUPD was inconsistent with other features like ideas of reference, strange beliefs, magical thinking, abnormal perceptions and social anxiety. On further assessments, a diagnostic clarification of schizotypal disorder was considered. This poses challenge in diagnosis and therapeutic approach due to the overlap of symptoms. Cognitive-perceptual distortions and affective symptoms of EUPD appear to overlap with disorganized and cognitive-perceptual symptoms of schizotypal disorder. Historically, borderline was separated from schizotypal personality disorder from an entity called borderline schizophrenia.
Conclusion. Schizotypal disorder is rarely seen as the primary reason for treatment in a clinical setting and can be misdiagnosed. The presence of co-morbid personality disorder traits can be challenging for the management decisions. It also has an impact on