

An Unusual Case of Neuroleptic Malignant Syndrome on a Stable Dose of Antipsychotic

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doi: 10.1192/bjo.2023.357

Aims. Neuroleptic Malignant Syndrome (NMS) is a rare, life-threatening complication of antipsychotic medication. There are no gold standard tests to diagnose NMS, however various diagnostic criteria have been suggested. NMS is typically reported in patients who have recently commenced an antipsychotic or had a change in dose. This case report describes an elderly female who developed NMS after being treated with the same dose of antipsychotic for 7 years. We aimed to establish whether similar cases are commonly reported, and what the key learning outcomes are.

Methods. This case presents an 82-year-old female taking the same dose of zuclopenthixol for 7 years. She was admitted with increased confusion and was initially prescribed antibiotics for a possible infection. She later became pyrexial and developed hypertonia, at which point NMS was suspected. Her creatinine kinase titre was significantly elevated, and her antipsychotic was discontinued. A potential trigger was a significant rectal bleed occurring a few weeks prior with no other obvious triggers noted. She was switched to quetiapine but developed NMS again when this dose was increased.

Results. There are few reports of NMS occurring in patients taking a long-term and stable antipsychotic dose. One case describes NMS developing after 30 years on Clozapine with no clear trigger. Another reports NMS after 7 years on Olanzapine, however this was triggered by dehydration. This case is an example of NMS in an elderly patient with a complex medical history who was initially misdiagnosed with sepsis before NMS was suspected. This shows the importance of considering NMS not only in those who have recently commenced antipsychotics or recently changed dose, but also those who have been stable on medication for a number of years. In suspected NMS, we should aim to stop relevant medication immediately and commence conservative management. It is important to highlight these atypical presentations so that NMS can be recognised without delaying treatment, thereby reducing mortality and improving patient outcomes

Conclusion. This report highlights the importance of considering NMS in patients who have been prescribed the same dose of antipsychotic for an extended period. Awareness of potential risk factors such as medical comorbidity that may trigger an episode of NMS even in those on established antipsychotic treatment is vital. Symptoms may mimic infection and it is important to raise awareness of atypical presentations to effectively identify, and treat, NMS earlier to improve outcomes.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Fluoxetine Induced Menorrhagia

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doi: 10.1192/bjo.2023.358

Aims. Selective serotonin reuptake inhibitors play important role in treatment of various psychiatric disorders. Commonly prescribed SSRIs include Sertraline and Fluoxetine. Fluoxetine has a high level of serotonin reuptake inhibition and a prolonged half-life. SSRIs can increase the risk of gastro-intestinal bleeding. A recent systematic review suggested an increased risk of intracranial bleeding in patients taking SSRIs. Psychiatric patients on SSRIs may present with menstrual disorders. Currently, there is limited information on its effect on menstrual cycle. The aim of this study is to explore the possible association between Fluoxetine and menorrhagia.

Methods. Case Study, 29 years old, female patient, diagnosed with mixed anxiety and depression ICD-10 F41.2. No previous medical history of menstrual disorders. She started sertraline medications, initial dose of 50 mg, which was gradually titrated to 150 mg. After 12 weeks, Sertraline was discontinued due to limited effectiveness and was started on fluoxetine 20 mg. Dose was gradually titrated to 40 mg, Menorrhagia for 14 days was reported. Physical examination was unremarkable. A period of discontinuation of fluoxetine attempted leading to partial resolution of symptoms. However, 2 weeks later after careful examination of the risks and benefits, Fluoxetine was re-introduced. A trial of Tranexamic Acid 1 gm t.d.s. for five days at the expected date of menstruation was initiated.

Results. Patient had no changes in her scheduled menstrual bleeding when she was using Sertraline. However, after 2 weeks of initiating 20 mg of fluoxetine the patient reported heavy prolonged bleeding with estimated 100% increase in volume and duration of the scheduled bleeding. Dose titration to 40 mg, led to further increase in the severity and duration of the bleeding. Changes in platelet function tests was reported 3 months after initiation of treatment; however, the results remained within the normal range. Tranexamic Acid 1 gm t.d.s. for five days led to significant reduction in the severity and duration of bleeding.

Conclusion. Using the WHO-UMC Causality Categories to explore association of the study findings, it is likely/probable that Fluoxetine is associated with menorrhagia. A likely dose effect association was observed. Possible explanation of the increased risk of bleeding relates to its inhibitory action on platelet aggregation. However, Fluoxetine can be used safely for long term when Tranexamic acid was add. Tranexamic Acid has primary effect on thrombin generation; Its secondary effects is on improving platelet function and coagulation factors, leading to successful reduction in duration and severity of the bleeding.

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Moral Injury, Trance and Possession State or a Schizophrenic Illness. a Case report

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doi: 10.1192/bjo.2023.359

Aims. Moral Injury is a strong cognitive and emotional response occurring upon witnessing, participating in, or failing to prevent an act that goes against one's ethical code. This has been linked with Post Traumatic Stress Disorder, Depression, Suicidality, and Anxiety, amongst others. Data on its association with