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Aims. There has been growing interest in regression among adolescents and young adults with Down Syndrome. Regression can also be referred to Acute Regression, Down Syndrome Regression Disorder (DSRD), Down Syndrome Disintegrative disorder (DSDD) or Unexplained Regression in Down Syndrome (URDS) and these terms are sometimes used interchangeably. Characterised by reduction in expressive language, decreased functional skills and reduced psychomotor activity, regression can result in a significant change in the long-term needs of these individuals. Reporting this case, we wanted to highlight challenges in diagnosing, treating and supporting young people with regression in Down Syndrome.
Methods. This is Case Study of a young adult with Down Syndrome presenting with symptoms of mood disorder, apathy, new-onset vocal tics and ritualistic behaviours and profound loss of expressive language - both verbal and sign language.
Results. Diagnosis included ruling out physical causes for regression. The management remains largely symptomatic and aims to address as many as possible bio-psycho-social aspects of the concerning presentation.
Conclusion. Multitude of interventions and external events made it difficult to see what intervention was the most useful. Despite initial positive response to medication and behavioural strategies, a long term prognosis remains uncertain.

Successful Clozapine Rechallenge With Add on Filgrastim in a Case of Treatment Resistant Schizophrenia With Clozapine Associated Neutropenia: A Case Report

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Aims. Clozapine is the treatment of choice in treatment resistant schizophrenia (TRS). Neutropenia is a potential life threating adverse effect associated with Clozapine treatment and one of the common reasons leading to discontinuation of Clozapine treatment. Clozapine associated neutropenia can be managed with Lithium or Granulocyte Colony Stimulating factor (G-CSF).Clozapine rechallenge in patients may often seem necessary and should follow a careful and balanced risk-benefit analysis. We present a case of a patient with TRS on Clozapine who developed neutropenia which responded to Filgrastim add on therapy and was successfully continued with Clozapine treatment.
Methods. A 29 year old female with a diagnosis of Schizophrenia since age 22 years had poor response to 4 different antipsychotics and 2 episodes of Neutropenia on separate occasions with Clozapine treatment. An inpatient Clozapine rechallenge was trialled due to poor response to the ongoing antipsychotic treatment which resulted in a decrease in the absolute neutrophil count to 1.7 $*10^9$/Litre.

An MDT decision was taken to continue Clozapine treatment with add on Filgrastim due to the severe psychopathology and poor quality of life. As per the advice from the haematologist Filgrastim injections at a dose of 30 million International Units were commenced on pro re nata (prn) basis whenever ANC dropped below $2.0*10^9$/Litre. This strategy was successful and the patient did not develop agranulocytosis. Her psychotic symptoms also improved significantly and the patient was discharged to the community rehabilitation team.
Results. Clozapine is often the last resort in treating refractory psychotic symptoms and this option may get limited due to adverse effects like Neutropenia and agranulocytosis. Add on therapy with G-CSF has been used in Clozapine rechallenge with various success rate and most of the supporting data are derived from case reports and case series. It is worth noting that regular and prophylactic G-CSF in absence of low neutrophil count is avoided which could mask a developing Clozapine induced Neutropenia and result in a steep drop in neutrophils.
Conclusion. Add on therapy with Filgrastim is a viable option when considering Clozapine rechallenge with previous history of Clozapine induced Neutropenia. It is important that a haematologist is consulted and the patient is monitored closely throughout the treatment.

Atypical Neuroleptic Malignant Syndrome in the Intensive Care Unit: A Case Report

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Aims. Neuroleptic malignant syndrome (NMS) is a rare condition experienced by patients taking typical and/or atypical antipsychotic medications. There are well-established diagnostic criteria for NMS. However, differentiating it from serotonin syndrome and malignant hyperthermia—particularly in the intensive care setting--is problematic and thus remains a diagnosis of exclusion. A case report of a patient with atypical NMS in intensive care is described and the subsequent learning points gleaned from the patient are presented.
Methods. A 28 year-old female was admitted to the intensive care unit (ITU) following a self-inflicted traumatic injury. The patient was known to local mental health services and her medical history includes personality disorder, anxiety and depression. Regular psychiatric medications prior to hospitalization included flupentixol and quetiapine. Remifentanil was administered in a continuous infusion for sedation as the patient was intubated and ventilated. Valproic acid and levetiracetam were given for seizures.

Repeated spikes in temperature, rigidity and slightly elevated creatine kinase (CPK) were observed in the patient. Autonomic dysfunction was also noted; the patient experienced bradycardic episodes that increased in frequency and duration. On two occasions, this resulted in asystole and cardiopulmonary resuscitation (CPR) had to be commenced with return of spontaneous circulation following CPR. Mental status changes were unable to be assessed due to ongoing sedation of the patient. On the advice of the clinical pharmacist, remifentanil was switched to fentanyl. Quetiapine and flupentixol were also discontinued after consulting with the psychiatric team. In addition, the patient responded quickly to dantrolene administration and to active cooling.

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.