A clinical impression of moderate depression with anxiety and panic attacks and possible emerging emotionally unstable personality traits was made and she had begun psychological sessions with the therapist before referral to the medics. Fluoxetine 20 mg OD increased to 40 mg and Circadin 2 mg ON was commenced. Fluoxetine was later tapered off and Circadin stopped. Sertraline 100 mg OD increased to 200 mg was commenced and Promethazine 25 mg ON to improve sleep.

Within a month of commencement of promethazine, a sudden onset of extension of neck, blowing through lips and a high-pitched sound occurred whilst experiencing a panic attack and hyperventilating. She also stuttered and had difficulty in speaking, and her vision would go blurry. She initially refused to come off promethazine as it had helped her sleep. An impression of a tic disorder characterised by motor and vocal tics was made. There had been no recent infections or previous history or family history of tics. However, at this point, sertraline had helped with her motivation and she was able to come off promethazine and her sleep was improved by practising sleep hygiene with an accompanied cessation of tics.

Discussion. Young person is currently on 150 mg of Sertraline.

The rationale behind reporting this case is that previous studies have pointed at SSRIs, as causes of tics disorders, but promethazine is one that does a good job in improving sleep and has a side effects of movement disorder.

Conclusion. Promethazine is one medication that can cause movement disorder and a high index of suspicion coupled with a prompt cessation of medication will reduce patient's distress and improve the therapeutic relationship between health professional and young person.

Written informed consent from patient and guardian was got.

Author declares that there is no conflicting interest, financial or otherwise.

A case of pervasive refusal syndrome related to COVID19

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Objective. To highlight the importance of appropriate diagnosis and management of severe mental illness in children. Awareness of rare diagnoses such as this will reduce the delay to treatment. A challenge in Ireland is accessing psychiatric inpatient treatment for very young children, with specialist units in Ireland designed to better cater for young people aged 12+.

Case report. Michael (not his real name), age 10, was always described as a happy, calm child. He enjoyed school and loved playing outdoors. He had been progressing well with his life and neither his parents nor school had any concerns for him. Following the COVID-19 pandemic and school closures, Michael began to became more conscious of daily hygiene safety advice. However, things escalated to a very difficult level. Initially, he manifested extreme levels of anxiety with heightened levels of distress. He ran away from open doors or windows for fear he would catch the virus, insisted on changing his clothes several times per day, would become distressed if anyone touched him accidentally while he was outside and could spend hours afterwards crying and screaming.

In June 2020 he showed profound refusal to engage in basic care tasks and a dramatic social withdrawal, and ultimately required admission to hospital. He refused to eat and drink, stopped washing and toileting himself, lay in bed with the covers over this head, became non-verbal and refused to engage with any conversation or games. He showed prolonged periods of screaming. Ultimately this reached a level requiring TPN and PEG feeding and a low stimulation environment. Diagnosis of pervasive refusal disorder, secondary to severe COVID-19 related anxiety was made.

Discussion. Pervasive refusal disorder is a rare and potentially life threatening condition in children. It is described as a profound psychological response to uncontrollable events such as grief, abuse, parental conflict and migration. In this case, it was the threat of the global pandemic. Through treatment in low stimulation environments, with consistent communication and rehabilitation and medication, followed by individual and family therapies when patients are more able, patients show a slow, but generally complete recovery. Happily for Michael, he has now recovered and returned home to his family, where he has returned to all his previous activities.

Conclusion. Michael and his parents have kindly agreed to allow us to tell his story, in the hope of teaching current and future psychiatrists about this rare condition. We send them our thanks and appreciation.

Trials and tribulations of diagnosing and managing psychosis secondary to non-convulsive epilepsy

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Objective. To highlight the importance of reviewing diagnosis and management of refractory psychosis and to share that with the scientific community; and to also shed some light on the dilemma and challenges that professionals may face to diagnose and treat organic psychosis. In addition, to look at the possible similarity/dissimilarity in psychopathology between organic and primary psychosis and differences in opinions through presenting the history and course of illness of this patient.

Case report. We present the case of a 51-year-old female who had a 28-year history of treatment-resistant schizophrenia. She did not report or display any seizure activity, and an extensive investigation was unremarkable. The unusual nature of her psychopathology, which was predominantly visual hallucinations and somatic delusions, and the difficult to treat nature of her symptoms, prompted investigation with Electroencephalograph which demonstrated bilateral temporal lobe epileptic activity.

Discussion. Treatment with divalproex sodium and discontinuation of antipsychotic medication achieved an excellent response, where her visual hallucinations and somatic delusions were both remarkably ameliorated.

Conclusion. The differentiation between organic/secondary and functional/primary psychosis is an area of contention between psychiatrists and neurologists and also within each of these specialties.

The myriad of psychopathology and associated treatment resistant psychotic symptoms that patients with non-convulsive epilepsy may experience should result in building a long desired bridge between neurology and psychiatry to collaborate in managing such cases.

High-dose olanzapine in treatment resistant schizophrenia. A case report and literature review

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Objective. We report a case of a 58-year-old gentleman who was hospitalised intermittently for one year due to treatment resistant schizophrenia. Prior to hospitalisation he had been prescribed standard antipsychotics for decades without full resolution of positive psychotic symptoms. During his final admission lasting six months he was guarded, suspicious, irritable, constantly paced the corridor and displayed thought block and paranoid persecutory delusions. He would not enter the assessment room or allow any blood or ECG monitoring, however, he was compliant with oral medication. He was successfully treated with high dose olanzapine (40mg/day) and was discharged to the community. The aim of this study is to bring awareness and add to the body of evidence for the use of high-dose olanzapine in patients with treatment resistant schizophrenia in whom a trial of clozapine is not possible.
Case report. The patient gave written consent for this case report to be written and presented. An extensive literature review was performed and key papers were identified. Discussion focuses on the key areas in the literature.
Discussion. This case demonstrates that high-dose olanzapine can be used effectively as an alternative to clozapine in treatment resistant schizophrenia.
Conclusion. This case highlights the need for further evaluation of high-dose olanzapine as an alternative to clozapine in patients with treatment-resistant schizophrenia.

Facilitated early discharge in Wandsworth

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Objective. There is limited research surrounding facilitated early discharge (FD) and Home Treatment Teams (HTTs). This study aimed to compare patients who received FD with patients who were discharged without FD to identify whether there were significant differences in terms of social demographics, illness characteristics, health outcome and treatment duration. Using this data we furthermore aimed to provide proposals to help advance the effectiveness of FD, as well as suggesting concepts of where future research should lie.
Case report. A randomised sample of patients who received FD and patients who were discharged without FD was obtained from a South London Hospital. This was manually narrowed down to patients specifically treated by the Wandsworth Home Treatment Team (WHTT). Socio-demographic and clinical data were then attained from the patients' electronic records to compare and statistically analyse between the two groups.
Discussion. Patients who received FD from the WHTT were found to have significantly less previous psychiatric admissions compared to those who were discharged without FD ($p = 0.032$). All other variables were found to have no association with FD.
Conclusion. Having a high number of previous psychiatric admissions seems to be an aspect that decreases the chance of being allocated FD. This variable can be seen as an indicator of severity of illness and a challenging social environment; it could therefore be valuable to take this variable into consideration when allocating FD. Furthermore, total treatment duration was found to not be significantly different for FD and non-FD patients, thus supporting the use of CRHTTs as an equivalent alternative for inpatient admission, however, national scale research should be conducted to strengthen and expand on these findings.

Obsessive compulsive disorder: a case of extreme obsessional slowness in an 18-year-old presenting to the national OCD unit

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Objective. Obsessional slowness in OCD is a rare phenomenon on which there is minimal published literature. This is a particularly severe and atypical case of early onset OCD with extreme obsessional slowness and mutism. To the best of our knowledge, there have been no reports of similar severity published in this age group. This report seeks to provide discussion of important organic causes that may need to be considered as well as information on treatment approach.
Case report. An 18-year-old male was admitted to the National OCD Unit, Springfield Hospital with a history of autism and normal development until the age of 14, after which symptoms of OCD with fear of contamination emerged, followed by progressive motor slowness and mutism.

Due to the severity of OCD and self-neglect he had two previous admissions to CAMHS wards and required a course of ECT to treat catatonic symptoms age 17.

Pharmacological treatment has included Aripiprazole 5 mg and Fluoxetine 60 mg, which the patient was taking at admission. The latter was subsequently switched to Sertraline 250 mg and Aripiprazole increased. As it was hypothesized that his obsessional slowness stemmed from severe levels of anxiety, Buspirone was also added.

Therapy has been intensive, although communication difficulties have made targeting specific fears challenging as the exact nature of the intrusive thoughts remains unclear.
Discussion. Following combined neurology and neuropsychiatry review, the patient spent four weeks in a general hospital for further investigation as it was initially felt an organic cause was likely. Initial differentials included Juvenile Onset Parkinson's or Wilson's disease. Both were subsequently ruled out and despite multiple investigations, no obvious organic cause was found. A markedly abnormal FDG PET scan showed findings usually seen in advanced dementia, but not necessarily clinically correlating to his current presentation.

The OCD unit have continued to provide intensive input and tailored treatment programme, encouraging actions against any rules he has in place. Prompting and pacing, verbal exercises and regular stretching exercises due to stooped posture which he attributed to needing to obey certain rules have been used.
Conclusion. It is important for clinicians to be aware of obsessional slowness in OCD and this report highlights a particularly rare and severe example in a young adult who has been difficult to treat. Organic causes may need to be considered and MDT approach to treatment is essential.