Within the analysed period there were 15 female patients identified on the Ardleigh ward. 5 patients attended the A&E. A support letter was available on two occasions. Compliance 40%.

Conclusion. All transfers should be managed in a sensitive way ensuring all communication is clear, to promote robust information sharing between inpatient wards and A&E.

A template of the care summary and handover letter was created, which provided a standard structure of headings that is meaningful to clinicians and patients.

Case Study

Acute Psychotic Episode Due to Milk-Alkaline Syndrome

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doi: 10.1192/bjo.2023.333

Aims/ Background. : Milk-alkali syndrome is a medical condition, which could present with psychiatric manifestations. It is caused by hypercalcemia resulting from the ingestion of large amounts of calcium and absorbable alkali. The core symptoms include hypercalcemia, metabolic alkalosis, and renal failure. Diagnosing this syndrome requires a high index of suspicion. The aim of this paper is to describe the case of Mrs. C who had psychotic symptoms because of Milk-Alkaline syndrome

Methods/ Case Report. Mrs. C was a 75-year-old white British female with a previous history of anorexia nervosa who has been clinically stable for more than 15 years. She was discharged by the community mental health services about 11 years ago but has been on a repeated dose of Gaviscon for about 8 years.

She presented to the accident and emergency (A and E) unit with a history of confusion, unsteadiness, paranoid beliefs, low mood, and reduced rate of speech. No history of infection or other physical health concerns. Routine blood showed increased calcium 3.41(2.2-2.60) and a reduced potassium level 2.9 (3.5-5.3). CT head scan did not show any acute changes.

She was stabilized and transferred to the ward for further management.

While on the ward, she had a diagnosis of Milk-Alkaline syndrome with psychiatric manifestation. Gaviscon was discontinued because the medics felt this was responsible for the electrolyte imbalance. She was also referred to the mental health liaison team (MHLT).

Following the mental health liaison team review, Mrs. C's psychiatric presentation was suspected to have been probably related to her medical condition. After a few weeks on the ward, her electrolyte became normalized; adjusted Ca 2.72 (2.2-2.6), serum ca 2.74(2.2-2.6). She had a follow-up review by the mental health team that showed her psychosis had also resolved. No medication was prescribed for her presentation. She was subsequently discharged from MHLT and referred to the GP for follow-up.

Results/ Discussion. previous case-report have shown a suspected link between Milk alkaline syndrome and acute psychosis, although the reasons for this have not been understood. The current case further emphasized this link. What is not evident however is if there were other physical health issues that might have also contributed to the patient's initial presentation.

Conclusion. Diagnosis of Milk-Alkaline Syndrome requires a high index of suspicion, missing this could lead to inappropriate use of medication. As a psychiatrist, this case has shown the importance of adequate investigation before making a definitive diagnosis, especially in a psychiatric liaison setting.

Acute Psychosis in Hashimoto's Thyroiditis

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doi: 10.1192/bjo.2023.334

Aims. Hashimoto thyroiditis was discovered by Hakaru Hashimoto in 1912 but became more recognized in the 1950s. It is an autoimmune disorder with an incidence rate of about 0.8/1000/year in men and 3.5/1000/year in women. The inheritance pattern of Hashimoto thyroiditis is not fully understood and diagnosing this condition could be challenging. Among many presentations, its effects on mental health can lead to a greater burden on a patient. There has been an increased report of acute psychiatric symptoms in this condition. Literature has described a wide spectrum of psychiatric manifestations occurring prior to, during, and after this illness. The aim of this report is to describe a woman with diagnosed psychosis secondary to Hashimoto's thyroiditis.

Methods. Ms S is a 22-year-old female who was admitted in January 2021 to the emergency department of Hospital B with a history of sudden behavioural changes: agitation, responding to unseen stimuli, and bizarre behaviour.

Her previous record reveals that she had a similar presentation in November 2019, managed with antipsychotics. The diagnosis at the time was unclear however; meningoencephalitis was suspected and later for NDMA encephalitis. After 4 months of admission to Hospital A, her behavioural changes remained unresolved but she was discharged to a care home with 2:1 support. She remained in the care home until further deterioration, which warranted a further admission to Hospital B.

Following a psychiatric review in Hospital B, she was initially diagnosed with an Acute psychotic episode with query cause and managed with IM Aripiprazole.

Due to physical health concerns and the unclear nature of her diagnosis, she was transferred to the acute medical ward and further investigation was requested.

Her result showed significantly elevated Thyroid Peroxidase Antibodies of 845 IU/ml (normal up to 24 IU/ml), lumbar puncture and NMDA antibody test were both normal, TSH level was raised to 6.73. Following further discussion with the medical team, a diagnosis of Psychosis secondary to Hashimoto's thyroiditis was made.

She was co-managed by the psychiatrist, endocrinologist and others.

Ms S became settled but due to residual psychosis, she was transferred to an inpatient psychiatric ward where her psychosis resolved, and was discharged back to the community mental health services.

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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doi: 10.1192/bjo.2023.335

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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doi: 10.1192/bjo.2023.336

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.