ventriculomegaly in severe head injury. Nonetheless we cannot completely rule out a possibility of neurodevelopmental / neurodegenerative link in this case which maybe be independent of the head injury

Conclusion. There is a paucity of studies that focus on neurodevelopment and neurodegeneration as etiological basis for mania and affective disorders in general need to shift our focus on research in brain imaging in psychiatry

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Psychosis Post Uncomplicated Dengue Fever - an Uncommon Manifestation

Dr Galina Lisa D'Souza*

Father Muller Medical College, Mangalore, India
*Corresponding author.

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Aims. Dengue is caused by an arbovirus and is a common vector borne disease in south east Asia. Each year upto 400million people get infected with dengue and 40,000 die from severe dengue. Psychiatric symptoms following dengue fever is relatively uncommon. Mania is the most common psychiatric disorder reported followed by anxiety, depression and catatonia. We present to you a 19 year old girl who presented with psychosis 10 days post recovery from dengue

Methods. A 19 year old bachelors in commerce student hailing from rural south India from a middle socioeconomic family presented to us with fearfulness and decreased sleep since 1-2 days which was abrupt in onset and gradually progressive. MSE revealed a conscious and alert female with normal talk ,psychomotor activity and delusion of reference which was fleeting ,ill systematized ,hearing of voices was clear however the content of which was not elaborated upon.Her affect was fearful.Past history revealed an admission for dengue fever around 2 weeks prior to symptoms, course of which was uncomplicated and unremarkable. Diagnosis of Organic delusional disorder was made according to ICD 10 and she was started on Tablet Olanzapine 2.5mg and dose was escalated to 5mg after 3 days. Her symptoms remitted completely with 5mg and is currently doing well socially and academically

Results. Psychiatric comorbidities of dengue fever including mania, anxiety, depression, and catatonia are mentioned in literature .The exact incidence of neuropsychiatric manifestation remains unknown due to lack of studies. Literature search revealed various case reports where patients have developed psychosis during acute phase of the illness, however we did not find any case report or studies similar to ours

Conclusion. Most literature on neuropsychiatric manifestations in dengue are limited to case reports. There is a need to conduct prospective follow up studies and inclusion of regular psychiatric evaluation during various phases of dengue fever

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Complex Conflicts for the Asylum Seeker – External, Internal and Therapeutic

Dr Brid Dinneen* and Dr Jennifer Ahrens

East London NHS Foundation Trust, London, United Kingdom
*Corresponding author.

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Aims. In 2020, 82 million people worldwide were forcibly displaced. In the same year, the UK received asylum applications for over 37,500 people. 76% of initial decisions made in the year to June 2022 have been grants of protection, meaning they have been awarded refugee status or humanitarian protection. However, many people wait years for a final decision on their claim. COVID-19 has exacerbated this issue and extended the backlog further. Most refugees are survivors – of transit, war, torture, trauma, loss. Recognition of the mental health needs of these survivors in countries of settlement is growing and with it an acknowledgment of the complexities faced. Despite finding relative security in their country of asylum, settlers are often faced with new psychosocial stressors as they simultaneously contend with the impact of their trauma in a foreign settings with cultural and language differences. Providing access to good quality mental health care, one that caters to these complexities, is essential.

Methods. We report the case of a 25-year-old, single, Tigrinya speaking, male Eritrean asylum seeker. In August 2022 he arrived into the UK in the back of a lorry having left Eritrea on foot three years previously having fled conscription. Whilst migrating, he was tortured, witnessed killings, was human trafficked and enslaved. Shortly after arrival in the UK he developed a psychotic illness and was admitted to an acute psychiatric ward. Treatment resistant schizophrenia emerged, clozapine was commenced and his condition improved.

Results. The journey to clozapine was not smooth. His clinical presentation was complex, in the beginning we struggled to establish the source of his distress unsure of what was psychosis and what were symptoms of post-traumatic stress. We struggled to distinguish medication side effects from somatising. We struggled communicating, building trust, breaking down language and cultural barriers.

In order to treat the illness we had to understand it and our patient. We adopted a multidisciplinary approach to deliver, in the first instance, principals of psychological first aid: addressing the refugee agenda as part of meeting his basic needs. With time and thanks to a wonderful interpreter we were able to build trust, strong and safe lines of communication. Slowly we became better interpreters ourselves, more able to decipher his distress. The interpreter helped us to be more culturally competent, thus, building our connection stronger. As the young man's acute condition settled, he began to trust us and his psychosis abated.

Conclusion. Our case highlights the importance of holistic care when managing displaced individuals in psychiatric settings. Interpreters are invaluable to trauma informed practice, beyond facilitating verbal communication they can help us to understand the culture of the people we are supporting, helping us to provide connection beyond the words. Trust in the context of psychosis and trauma in a displaced individual is hard earned but should be prioritised.

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Regression in Down Syndrome. Case Study of a Young Adult With Down Syndrome Who Was Referred to Brent Community Learning Disability Service With 'Unexplained' Changes in Behaviour

Dr Evelina Eggleston* and Dr Kiran Purandare

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Central and North West London NHS Foundation Trust, London, United Kingdom
*Corresponding author.

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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.

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

Dr Nikhil Gauri Shankar*, Dr Rajvinder Singh Sambhi and Dr Ibrahim Alnassar

Betsi Cadwaladr University Health Board, Wrexham, United Kingdom
*Corresponding author.

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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.

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

Dr Heidi Grant*

Queen Elizabeth Hospital Kings Lynn, Kings Lynn, United Kingdom
*Corresponding author.

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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.

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