Certain clinical situations may pose a dilemma for clinicians such as concomitant use of clozapine during myelosuppressive chemotherapy. There is limited evidence-based data regarding Clozapine and chemotherapy. We report on a case of a clozapine-stabilized, Schizophrenia patient with Mild ID who was diagnosed with High Grade B-cell Non-Hodgkin's Lymphoma (NHL) requiring chemotherapy. The challenges of this complex case are detailed in this paper.

Methods. A 56-year old man with a diagnosis of Mild ID, Schizophrenia and OCD. The patient has been taking Clozapine since 2001 daily dose of 600-400 mg for the past 20 years. Unfortunately, he was diagnosed with High Grade NHL in 2023. The decision was reached to continue Clozapine while undergoing chemotherapy sessions with frequent blood monitoring. Towards the end of his chemotherapy his bloods showed dangerously low (Clozapine red alert) requiring stopping Clozapine. The patient started showing signs of relapse in his mental state and subsequently commenced on Olanzapine. He continued to show signs of relapse and didn't recover to his previous baseline; the treatment plan is adding another antipsychotic or considering re challenging Clozapine.

Results. This report contributes to a very limited literature on the concurrent use of clozapine with chemotherapy and the use of Clozapine "*outside license*". The main treatment options facing clinician is stopping or continuing clozapine during chemotherapy. The dilemma of taking the path of withdrawing a medication on which a patient is stabilized may compromise psychiatric stability, yet there is a valid argument that such inconvenience would present more favourable outcome than facing the serious haematological risks of neutropenia. There is a need for robust and close liaison between psychiatrists, oncologist, and haematologist on the various clinical considerations.

Conclusion. In summary, both clozapine and chemotherapy are known to cause neutropenia and agranulocytosis. The clinical decision to continue clozapine during chemotherapy could be challenging. Clinicians should be aware that psychotic decompensation in such patients would inevitably increase morbidity and perhaps mortality due to nonadherence to all proposed treatment, including chemotherapy. In the absence of guidelines and given the nature of treatment-resistant symptoms, clinicians should work in a multidisciplinary approach and carefully weigh the risks and benefits of continuing clozapine during chemotherapy.

A Case Study of Cognitive Impairment Associated With Levetiracetam

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Aims. In patients with cognitive impairment, it is important to assess the possible impact of medications on cognition. Levetiracetam is an antiepileptic medication used in the management of epilepsy. Its effect on cognition is unclear.

Methods. We present a case study of a 57-year-old female who developed cognitive impairment associated with levetiracetam.

She was referred to Memory Services from her GP due to cognitive impairment. Her past medical history included an optic nerve glioma which was surgically removed followed by radiotherapy, and meningiomas which were managed with stereotactic radiosurgery. She had no previous psychiatric history.

Following a first seizure, she was started on levetiracetam 250 mg BD. Over the following months, she developed worsening symptoms of poor memory, fatigue and lethargy, sleeping excessively, headaches, and subsequently, low mood and occasional suicidal thoughts. Levetiracetam dose was halved. When seen in Memory Services 3 months later, it was reported that there had been a gradual but partial improvement in her symptoms since the dose reduction. Addenbrooke's Cognitive Examination (ACE-III) score was 67/100. Short form mood scale was 3/15, below the threshold for depression. Blood tests were normal. MRI Head showed meningiomas and diffuse white matter hyperintensities, both unchanged from previous imaging.

The patient then started lamotrigine and stopped levetiracetam. On follow up (2 months after initial memory assessment), ACE-III score improved to 80/100 and it was reported that her symptoms had completely resolved.

Results. In this case, there is evidence to support a causal link between levetiracetam and the patient's cognitive impairment – there was a temporal relationship, dose response relationship, and reversibility, which are all in the Bradford Hill criteria for causation. Other causes were considered and deemed less likely, including depression; the mood symptoms were not the predominant symptoms and developed after the other symptoms, and the patient scored below the threshold score for depression on short form mood scale.

Regarding the aetiology in this case, one hypothesis is that there may have been risk factors that made this patient more susceptible to cognitive side effects from the biological effects of levetiracetam, such as previous neurosurgery and radiosurgery. Another hypothesis is that the levetiracetam may have triggered an atypical depressive episode which manifested predominantly with memory symptoms and tiredness.

Conclusion. This case study highlights the importance of reviewing medications when assessing cognitive impairment, and of obtaining a clear timeline of symptoms. There is a need for further research looking at the effect of levetiracetam on cognition.

An Interdisciplinary Approach to the Management of Ketamine Induced Uropathy

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Aims. This report describes the treatment of a patient with ketamine induced uropathy. This condition can be significantly debilitating due to its severe effect on the urinary system. This report outlines an interdisciplinary approach to the care of the patient involving addictions services, urology and primary care.

Methods. The patient presented with a history of inhalation of ketamine intermittently for four years and daily for three years. His highest daily use was 14 grams per day.

He developed multiple urinary symptoms including dysuria, urgency, incontinence, haematuria and abdominal and urethral pain. He had significant weight loss and suicidal thoughts. After