of SSRIs (fluoxetine and sertraline) and chocolate (which contains serotonin) leading to an itchy hive-like rash. In these cases, discontinuation of the SSRI and use of antihistamine led to a resolution of symptoms.

We report a case who developed urticaria 30 days on fluoxetine without any other identifiable triggers. Aspects of this case to support a possible rash caused by chocolate-fluoxetine interaction include the rash occurring when the patient was consuming chocolate (quantities possibly increased immediately prior to the onset of rash), rash occurring when steady-state levels of fluoxetine had just been reached, no other identifiable trigger to explain the rash in the history and the slow resolution of the rash which can be explained by the long half-life of fluoxetine.

Conclusion. This report highlights the importance of being mindful of this rare dermatological side effect of fluoxetine despite it occurring weeks after initiation. Patients should also be made aware of this possible side effect and its association with consuming chocolate.

Rapid Cycling Bipolar Affective Disorder After COVID-19 Infection Accompanied With Neurological Symptoms

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Aims. This case highlights an atypical presentation of a patient with known history of Bipolar Affective Disorder who experienced rapid mood changes and atypical neurological symptoms after he was tested positive for COVID-19.

Methods. Here we present a 63 years old male patient who was an inpatient in low secure forensic unit and has a history of Bipolar Affective Disorder. Patient reported that he started to experience COVID-19 symptoms and was tested positive on 12th April 2020. It was observed that patient experienced low mood, flat effect, anhedonia and decreased appetite for more than a month after he was tested positive. According to his medical records, he experienced significant mood changes suggesting major depression and manic/hypomanic episodes, 4 times to be specific, over 6 months period after having diagnosed with COVID-19 which is correlated with diagnostic guidelines for Rapid cycling Bipolar Disorder. Patient was observed to experience 1 major depressive episode over period of 6 months before his COVID-19 diagnosis. He also reported experiencing neurological symptoms such as tremor, numbness and unsteadiness on one leg. Although it was found that his lithium level was above therapeutic range at the beginning of these symptoms, even after successful reduction of Lithium dose, patient continued to experience these symptoms for another month. There were no gross abnormalities in physical examination and his blood results were not significant. In addition to Electroencephalogram (EEG); Computed Tomography (CT) scan, Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) were conducted and the results were all insignificant. During this time, he was fairly compliant with his medications. Additionally, his mood was stabilised only partially with the medications he was taking. He did not have any other major environmental, psychological or physical changes that might explain his rapid mood cycling.

Results. Authors considered various different causes for this patient's fluctuating mood. One confounding factor that was considered was blood lithium levels. However, that was proven to be irrelevant since patient continued to experience mood changes and neurological symptoms with therapeutic lithium levels. Also no other organic reasons were found that could explain his neurological symptoms.

Conclusion. Although, authors consider that longer observation period and other confounding factors could affect findings, they cannot confidently reject the impact of COVID-19 infection on patients with enduring mental illness and recommend further research which could lead to more comprehensive guidelines

The Use of Genetic Testing in the Management of Depression

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Aims. We report on a case of depression where genetic testing was used to determine potential treatment modalities.

Methods. The patient is a 78-year-old man who had suffered from depression for 55 years. He had a serious episode in 2002. He developed a further depressive episode in 2018 which did not respond to paroxetine. He was offered TMS and was initially treated in the NHS and subsequently in the private sector. He went into remission with TMS and continues to remit with TMS however his depression became unstable and it was clear that the paroxetine was having no effect. He agreed to have a genetic test, a buccal mouth swab was taken and posted to gensense in the United States. An 18 page document and a half hour session with gensense are included in the cost of the test. The results of his genetic test and suggestions regarding treatment are detailed below.

SLC6A4 L(G)/S serotonin transporter indicating a less favourable response to SSRI medication (20% response versus 40% response). SNRI medication may be useful.

BDNF Val/Met Met carriers may have poor response to SSRIs and an improved response to SNRI's and TCA's. Met carriers have a 3 times better response to exercise than Val/Val

MTHFR A/A variant, this results in a 70% reduction) in the ability to convert folate to methyl folate (required for the manufacture of serotonin). Taking L-methylfolate supplementation (7.5mg) may improve serotonin production and provide a 2 times increase in response rate to antidepressants.

COMT Val/Val variant indicates improved response with brain stimulation therapy such as ECT and TMS

CACNA1C A/A variant which increases the anteromedial and amygdala activity and increased neuronal activity as a result of increased calcium channel receptors. This variant is associated with more depression, OCD and anxiety. Using lithium, sodium valproate and lamotrigine could be potentially useful in this group.

Results. The patient's antidepressant was switched from Paroxetine to Venlafaxine XL 150 mg, he started taking L methyl folate supplements (7.5mg daily) and was put onto sodium valproate 250 mg 3 times a day. His HAM-D went from 39 in