fictitious landownership claims. Upon examination, AB appeared conscious but restless, agitated, and inattentive for the past 15 days.

Blood work unveiled thyroid abnormalities, with elevated thyroid-stimulating hormone (TSH) (>100 mIU/L) and decreased free triiodothyronine (T3). AB denied prior hypothyroidism diagnoses, though his mother had a history managed with levothyroxine. Notably, no apparent physical symptoms of hypothyroidism were observed.

AB's social history included occasional alcohol (30ml once in a blue moon) and tobacco use (3–4 cigarettes/day). Three days before admission, he ceased smoking, and his last social drink occurred a month earlier.

Diagnosed with acute mania per ICD-10, AB commenced treatment with Tab. diazepam 5mg HS and levothyroxine 100 mcg daily. With this regimen, he showed improved goal-directed behavior and reduced grandiosity, although mild restlessness persisted. Continuing the treatment, the endocrinology team increased levothyroxine to 300 mcg daily, leading to stabilized restlessness. Remarkably, psychosis and mania resolved after two weeks without antipsychotics or mood stabilizers, accompanied by a downward trend in TSH (83.10 mIU/L) and an upward trend in free T3 (0.70 ng/mL) and free T4 (5.03 mg/dL). At discharge, AB showed no residual psychotic or manic symptoms, and levothyroxine was maintained at 300 mcg daily, with diazepam discontinued after a few days.

Results. In the above case rare effect of hypothyroidism was observed. The coexistence of hypothyroidism with depression, bipolar disorder and psychosis has been reported, dating back to the late 1800s. In 1949, Asher reported 14 cases of psychosis with hypothyroidism, 9 of which recovered with thyroid hormone treatment alone. Numerous cases have since linked psychosis to hypothyroidism. The majority of these cases were managed with a combination of antipsychotic medication and thyroid replacement, however in some cases maintenance therapy included thyroid replacement alone. There was no correlation between the degree of hypothyroidism and the severity of psychiatric symptoms. Psychosis usually remits after 1 week of thyroid replacement, with earlier resolution with the addition of antipsychotic medications. Although psychosis is less commonly associated with hypothyroidism than depression, it is a possible manifestation of the disorder.

Hypothyroidism is a common co-morbidity in bipolar disorder. The association between hypothyroidism and mania is less clear. Mania with concomitant hypothyroidism has been reported in patients previously undiagnosed with psychiatric illness. Patients presenting with acute manic episodes and hypothyroidism have improved clinically with a combination of psychotropic medications and thyroid hormone. But in this case patient's manic condition improved with levothyroxine alone.

Delineating aetiology of psychiatric symptoms in our patient is not difficult. AB's description of manic & psychotic symptoms with no past or family history of bipolar illness would suggest the diagnosis of acute mania. It is possible that hypothyroidism aggravated an underlying psychiatric illness or induced a manic episode with psychotic features. Treatment with levothyroxine & diazepam was considered for this patient to see whether the patient improves with levothyroxine alone & to prove mania is secondary to hypothyroidism. It is possible that levothyroxine contributed to improvement of ABs psychotic and manic symptoms. It is surmised psychotic symptoms completely resolved when the TSH, T3, T4 levels returned to normal.

Conclusion. Thyroid function should be investigated in all patients presenting with mania or psychotic symptoms. Without an underlying psychiatric illness, thyroid hormone replacement may suffice in the treatment of acute onset psychosis in the context of severe hypothyroidism. However, during an acute manic episode, treatment with thyroid hormone therapy alone may not suffice in some cases, and likely requires concomitant therapy with an antipsychotic or mood stabilizer.

Identifying Organisational Factors Related to Increased Risk of Depression in Usher Syndrome Patients: A Case Report

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Aims. Usher syndrome (USH) is the leading genetic aetiology of congenital hearing loss and progressive vision loss. It is linked with a high prevalence of mental health issues, including depression. Previous literature attribute this to communication barriers, constraints in mobility, and general feelings of dependency and uncertainty. However, there is little literature considering poor mental health in USH patients as a consequence of gaps in service provision on a national level.

Methods. The present report is the case of a 54 year old woman, who was born with USH Type IIa, and was previously diagnosed with depression and retinitis pigmentosa. The patient was recruited via the RareBeacons charity through volunteer sampling. A semi-structured interview was conducted, with 3 main categories: the impact of diagnosis, interpersonal relationships, and challenges in day-to-day life. A common theme of self-isolation was found, largely due to inefficient communication between healthcare providers, including but not limited to years of waiting for hearing aid treatment exacerbating symptoms of social withdrawal. The patient also reported inadequacies in physician knowledge regarding USH and their general unwillingness to be educated further. Unprofessional physician attitudes and lack of sensitivity towards the patient's deafblindness over time led the patient to feel distrust towards the system, which further compromises care.

Results. Areas of improvement on a systemic scale were identified, including increasing awareness of deafblindness in both the medical community and the general public through patient advocacy, as well as streamlining dedicated support pathways. The patient found formal support to be unhelpful, conversely emphasising the impact of informal support, namely web-based support group platforms. Support groups can provide a sense of community and belonging, alongside sharing valuable resources – often overlooked yet vital in USH, a rare condition with little official support. Subsequent research may include expansion of this case report to yield quantitative data, alongside investigating further factors increasing depression in USH patients (e.g. psychosocial, genetic and biological factors).

Conclusion. This report concludes that the gaping inadequacies of the current medical system poses a significant psychological, emotional and social burden on USH patients.