Conclusion. 22q11.2 Duplication Syndrome is a rare genetic syndrome that can cause learning disability. Its physical and behavioural phenotypic features described in literature, were all present in this patient. In addition, this case report highlights three previously unreported findings: Cochlear Nerve Atresia, Tubular Vision, the Characteristic groove and skin fold on the back of the scalp and the presence of a schizoaffective mental illness.

A Tale of Two Catatonic States

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Aims. Catatonia is a psychomotor state characterised by a multitude of clinical signs such as abnormal movements, mutism and withdrawal. This condition is usually associated with medical and psychiatric aetiologies with potential of being life-threatening. It is usually managed with benzodiazepines, the commonest being lorazepam. In this piece of work, we would like to focus on the principles of care that should be considered whilst managing such presentations.
Methods. Case 1- 71, male with diagnosis of paranoid schizophrenia was brought to Emergency department (ED) via ambulance, as he was found 'unresponsive' in care home. On arrival, he was alert with GCS 11/15 and was observed to be mute, 'gesturing' and making purposeless movements. Following our assessment, he was administered 0.5mg of lorazepam whilst in resuscitation bay. Subsequently, he started making sounds and was given another dose of 0.5mg lorazepam. He then vocalised his thoughts and we established that his mental state had relapsed and he was harbouring paranoid delusions.

Case 2- 18, male with no prior psychiatric history was brought to ED by his parents following 3 day history of being mute, not 'responding', not eating or drinking and insomnia. On arrival, he was alert, pacing in the room, however remained mute. Following our assessment, he was given a 2 mg dose of lorazepam whilst in resuscitation bay as the initial 1mg showed minimal response. On later review, he was smiling, conversant and co-operative, thus allowing assessment of his unmasked mental state which was suggestive of first episode psychosis.

Following few hours, both patients reverted back to their original catatonic state.
Results. Lorazepam can be used as a diagnostic measure in conjunction to a therapeutic intervention. A positive Lorazepam Challenge test confirms the diagnosis of catatonia. It must be borne in mind that Lorazepam is only used as a temporary holding measure to assess patient's unmasked mental state and they would need further monitoring and interventions to treat the underlying cause.
Conclusion. Lorazepam Challenge test can be safely used as an assessment technique for patients presenting in acute catatonia. This should be conducted in closely monitored environments namely, resuscitation bay, HDU or ITU with appropriate support and ongoing liaison with psychiatry team. Treating teams should be mindful of various patient characteristics including age, past treatment with benzodiazepines, psychiatric history to inform dose adjustments as necessary.

Disclaimer: Unable to obtain patient consent due to unstable mental state but ensured minimal patient identifiable data included.

Schizotypal Disorder With Borderline Personality Traits: A Case Report

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Aims. Schizotypal disorder is characterized by pervasive patterns of odd behavior, appearance, or thinking. There is also a high degree of overlap in symptoms between schizotypal and borderline personality disorders. The following case describes a case of schizotypal disorder with borderline traits.
Methods. 25-year-old female presented with history of mood fluctuations with recent low mood, anxiety and an ability to read other people's thoughts. She was admitted to hospital 4 years ago and was diagnosed with emotionally unstable personality disorder (EUPD) and mixed anxiety and depression.

She reported anxiety to leave the house due to referential and persecutory ideas, odd beliefs of being able to read people's minds and predict future. She lacked friends and also had fear of abandonment. There was intermittent impulsive self-harm behavior and reportedly harmed herself indirectly through casual sex in the past and also had two failed relationships. She denied illicit drug use. Childhood was uneventful, except that schooling was difficult due to anxiety. She was treated on Quetiapine, Fluoxetine and Promethazine. Further assessments confirmed added features of unusual perceptions, smelling things, superstitious ideas regarding colours and magical thinking. Dissociative episodes of her being a devil, expressing thoughts of slitting her throat were present.

As there was minimal improvement, Aripiprazole was tried. She had poor compliance with Aripiprazole due to the belief that it was poison. She herself requested depot injection, which was started. There has since been mild improvement in her paranoia, but social anxiety is persistent. Psychoeducation about the diagnosis was challenging, after which she accepted referral for psychotherapy.
Results. The initial diagnosis of EUPD was inconsistent with other features like ideas of reference, strange beliefs, magical thinking, abnormal perceptions and social anxiety. On further assessments, a diagnostic clarification of schizotypal disorder was considered. This poses challenge in diagnosis and therapeutic approach due to the overlap of symptoms. Cognitive-perceptual distortions and affective symptoms of EUPD appear to overlap with disorganized and cognitive-perceptual symptoms of schizotypal disorder. Historically, borderline was separated from schizotypal personality disorder from an entity called borderline schizophrenia.
Conclusion. Schizotypal disorder is rarely seen as the primary reason for treatment in a clinical setting and can be misdiagnosed. The presence of co-morbid personality disorder traits can be challenging for the management decisions. It also has an impact on