An Unusual Case of Neuroleptic Malignant Syndrome on a Stable Dose of Antipsychotic

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Aims. Neuroleptic Malignant Syndrome (NMS) is a rare, life-threatening complication of antipsychotic medication. There are no gold standard tests to diagnose NMS, however various diagnostic criteria have been suggested. NMS is typically reported in patients who have recently commenced an antipsychotic or had a change in dose. This case report describes an elderly female who developed NMS after being treated with the same dose of antipsychotic for 7 years. We aimed to establish whether similar cases are commonly reported, and what the key learning outcomes are.
Methods. This case presents an 82-year-old female taking the same dose of zuclopenthixol for 7 years. She was admitted with increased confusion and was initially prescribed antibiotics for a possible infection. She later became pyrexial and developed hypertonia, at which point NMS was suspected. Her creatinine kinase titre was significantly elevated, and her antipsychotic was discontinued. A potential trigger was a significant rectal bleed occurring a few weeks prior with no other obvious triggers noted. She was switched to quetiapine but developed NMS again when this dose was increased.
Results. There are few reports of NMS occurring in patients taking a long-term and stable antipsychotic dose. One case describes NMS developing after 30 years on Clozapine with no clear trigger. Another reports NMS after 7 years on Olanzapine, however this was triggered by dehydration. This case is an example of NMS in an elderly patient with a complex medical history who was initially misdiagnosed with sepsis before NMS was suspected. This shows the importance of considering NMS not only in those who have recently commenced antipsychotics or recently changed dose, but also those who have been stable on medication for a number of years. In suspected NMS, we should aim to stop relevant medication immediately and commence conservative management. It is important to highlight these atypical presentations so that NMS can be recognised without delaying treatment, thereby reducing mortality and improving patient outcomes
Conclusion. This report highlights the importance of considering NMS in patients who have been prescribed the same dose of antipsychotic for an extended period. Awareness of potential risk factors such as medical comorbidity that may trigger an episode of NMS even in those on established antipsychotic treatment is vital. Symptoms may mimic infection and it is important to raise awareness of atypical presentations to effectively identify, and treat, NMS earlier to improve outcomes.

Fluoxetine Induced Menorrhagia

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Aims. Selective serotonin reuptake inhibitors play important role in treatment of various psychiatric disorders. Commonly prescribed SSRIs include Sertraline and Fluoxetine. Fluoxetine has a high level of serotonin reuptake inhibition and a prolonged half-life. SSRIs can increase the risk of gastro-intestinal bleeding. A recent systematic review suggested an increased risk of intracranial bleeding in patients taking SSRIs. Psychiatric patients on SSRIs may present with menstrual disorders. Currently, there is limited information on its effect on menstrual cycle. The aim of this study is to explore the possible association between Fluoxetine and menorrhagia.
Methods. Case Study ,29 years old, female patient, diagnosed with mixed anxiety and depression ICD-10 F41.2. No previous medical history of menstrual disorders. She started sertraline medications, initial dose of 50 mg, which was gradually titrated to 150 mg. After 12 weeks, Sertraline was discontinued due to limited effectiveness and was started on fluoxetine 20 mg. Dose was gradually titrated to 40 mg, Menorrhagia for 14 days was reported. Physical examination was unremarkable. A period of discontinuation of fluoxetine attempted leading to partial resolution of symptoms. However, 2 weeks later after careful examination of the risks and benefits, Fluoxetine was re-introduced. A trial of Tranexamic Acid 1 gm t.ds. for five days at the expected date of menstruation was initiated.
Results. Patient had no changes in her scheduled menstrual bleeding when she was using Sertraline. However, after 2 weeks of initiating 20 mg of fluoxetine the patient reported heavy prolonged bleeding with estimated 100% increase in volume and duration of the scheduled bleeding. Dose titration to 40 mg, led to further increase in the severity and duration of the bleeding. Changes in platelet function tests was reported 3 months after initiation of treatment; however, the results remained within the normal range. Tranexamic Acid 1 gm t.ds. for five days led to significant reduction in the severity and duration of bleeding.
Conclusion. Using the WHO-UMC Causality Categories to explore association of the study findings, it is likely/ probable that Fluoxetine is associated with menorrhagia. A likely dose effect association was observed. Possible explanation of the increased risk of bleeding relates to its inhibitory action on platelet aggregation. However, Fluoxetine can be used safely for long term when Tranexamic acid was add. Tranexamic Acid has primary effect on thrombin generation; Its secondary effects is on improving platelet function and coagulation factors, leading to successful reduction in duration and severity of the bleeding.

Moral Injury, Trance and Possession State or a Schizophrenic Illness. a Case report

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Aims. Moral Injury is a strong cognitive and emotional response occurring upon witnessing, participating in, or failing to prevent an act that goes against one's ethical code. This has been linked with Post Traumatic Stress Disorder, Depression, Suicidality, and Anxiety, amongst others. Data on its association with

Schizophrenia are however lacking. Trance and Possession Disorders defined by the ICD-10 refers to a group of disorders involving temporary loss of both the sense of personal identity and full awareness of the surrounding with individuals acting in some cases as if taken over by another personality, spirit, deity, or force with reports of such states occurring in primary psychotic disorder. This case presentation describes a 22-year-old male whose first episode of schizophrenia was preceded by moral injury
Methods. A 22-year-old male Nigerian with a strong conservative Christian religious upbringing and a history of receiving a prophecy against having intercourse with women. He started showing symptoms of a mental illness a month after attaining coitarche with a lady. This presentation was characterized by irrelevant speech, intrusive flashbacks and unusual beliefs (excessive guilt, ill health). 7 months after, he was presented to the hospital with above symptoms and disorganized behavior characterized by beliefs of being possessed by four different people, shouting in different voice textures, throwing himself on the floor. We kept in view a diagnosis of schizophrenia and placed him on oral Olanzapine 5mg nocte following which he made significant improvement within 2 weeks with no memory of the event.
Results. Different factors can be considered in the aetiopathogenesis and presentation of symptoms in this patient. According to Williamson V. et. al; An Individual's experience of moral injury may lead to feelings of shame or guilt which was present in this patient (delusion of guilt). The pathogenic effect of culture and religion(e.g through prophecy against intercourse with women) may account for this illness. Moreso, pathoplastic and pathoreactive effects of culture could be said to have contributed significantly to the presentation of a psychotic disorder with trance and possession state as a reaction to moral injury.
Conclusion. Moral Injury, not previously considered to be associated with primary psychotic disorder may not only possibly precipitate a primary psychotic disorder but also show cultural/religious differences in phenomenology.

Further studies are therefore required to explore these associations.

A Case Study to Explore Safe Psychotropic Medication(s) for a Patient Suffering From Priapism

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Aims. A 53-year-old male was admitted with non-resolving Priapism for 36 hours and was reviewed for advice regarding his psychotropic medications. He previously took Viagra about 2 days ago, and had an erection which resolved spontaneously. He underwent penile aspiration in the hospital which provided relief. Following that, he developed signs of infection which was treated with IV antibiotics. He was then waiting for further surgical correction.
Methods. He has a background history of psychotic illness and been treated with Quetiapine, Mirtazapine, Sertraline and Zopiclone, which were kept on hold during his admission. He reported that he currently suffers from depression and signs of psychosis, which take the form of auditory hallucinations and paranoid delusions.

He has been taking Viagra occasionally for years, but has not experienced side-effects like this before. He is a social drinker and previously smoked cannabis.
Results. From the above scenario, there appears to be two clinical questions:

1. Are the current medications responsible for his priapism?
2. What medication(s) would be a suitable alternative if his priapism was indeed caused by his current drug regimen?

The major causes of Priapism are: direct trauma; haematological diseases; neurological diseases; cerebrovascular diseases; Medications; TPN and Neoplasm. Apart from medication side-effects, these other causes were ruled out.

The Summary of Product Characteristics for mirtazapine, sertraline, quetiapine and zopiclone were studied for their relative risk of causing priapism, and this is summarised below:

- Mirtazapine: unknown
- Sertraline: rare
- Quetiapine: rare
- Zopiclone: not listed

However, a paper by Salonia et al found that all the above medications except Zopiclone can increase the risk of priapism. Internationally published case reports also list priapism-associated medications as: risperidone; quetiapine; sildenafil; mirtazapine; citalopram; chlorpromazine and olanzapine.

Anti-psychotics cause priapism by Alpha-1 blockade and anticholinergic actions. Most of the antipsychotics have anticholinergic action. The medication which demonstrates the least alpha-1 blockade is Amisulpride which acts by blocking dopaminergic receptors in the brain.
Conclusion. Thus, it is clear from the above discussion that Amisulpride has the least possibility to cause Priapism. The patient was advised to take low dose Amisulpride and afterwards, no other complications were noted.

Atomoxetine as an Alternative Therapy for Adolescent Adhd With Comorbid Cerebral Palsy: A Case Report

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Aims. The prevalence of Attention Deficit Hyperactivity Disorder (ADHD) in children with Cerebral Palsy (CP) is 19%. Whilst there is evidence that methylphenidate is an efficacious first line therapy for patients with ADHD, there is a lack of literature describing atomoxetine use in ADHD with comorbid CP.
Methods. Here we report the case of a 17-year old Caucasian female with ADHD and CP. The patient was referred to Child and Adolescent Mental Health Services (CAMHS) for ongoing anxiety following extensive orthopaedic surgery, which was managed with sertraline and concurrent Cognitive Behavioural Therapy.

A CAMHS assessment led to her subsequent diagnosis of ADHD resulting in an initial treatment of low-dose methylphenidate (Ritalin). This was discontinued after four days due to

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