parameters were measured and compared with their baseline values.
Results. A total of 125 patients (females-n = 70, males-n = 55) were included for the study. The mean age of the sample was 63.2 years (SD 10.6). Most of the participants were educated and employed. The mean HRDS score of the participants at baseline and at three months was 20.3 (SD 3.7) and 18.0 (SD 3.9) respectively. The mean HbA1C of the participants at baseline and at three months was 8.4 (SD 1.2) and 7.8 (SD 1.2) respectively. The mean CRP of the participants at baseline and at three months was 4.0 (SD 5.6) and 2.8 (SD 4.3) respectively. There was significant reduction in depressive symptoms (Z score= -6.894, P value <0.05), levels of HbA1C (Z score= -7.936, P value <0.05) and CRP levels (Z score= -6.158, P value <0.05) at follow up after treatment with escitalopram. No significant correlation was observed in these parameters across gender.
Conclusion. Treatment with escitalopram reduces the severity of depression and the ongoing inflammatory process amongst these patients.

SILENT Syndrome – a Case of Lithium Neurotoxicity on Maintenance Therapy

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doi: 10.1192/bjo.2024.694

Aims. Lithium is licensed to treat bipolar disorder, which is characterized by recurrent episodes of depression and mania/hypomania. It is also used as an adjunctive medication in patients who have inadequately responded to first and second line treatments of unipolar depression. Lithium has a narrow therapeutic index and the potential for toxicity requires levels to be closely monitored, particularly during any intercurrent illness or initiation of new medications. There is a rare but important effect of lithium toxicity of which there is little awareness: the Syndrome of Irreversible Lithium Effectuated Neurotoxicity.
Methods. A 57-year-old lady presented to the emergency department with a ten-day history of vomiting, diarrhoea, and abdominal pain. She had a history of recurrent depressive disorder managed with fluoxetine and lithium for ten years. On presentation, she was hypovolemic and required resuscitation with I.V. fluids. Clinical examination revealed significant ataxia and myoclonus. Neurological examination was limited by her inability to follow commands. She was orientated to person but not time or place. A collateral history was obtained from her husband. He reported a 3-day history of increasing confusion on a background of a 6-week history of gradual functional decline. History and examination were concerning for lithium neurotoxicity. Lithium level = 2.6mmol/L (0.4–0.8mmol/L), indicating lithium toxicity. Deterioration in renal function from baseline - urea 14.2, creatine level 120 umol/L eGFR 43mil/min. There was no evidence of infection, full blood count and CRP were within normal parameters. MRI brain showed mild degree global volume loss consistent with chronic small vessel microvascular ischaemia. She was commenced on haemodialysis in order to rapidly reduce her serum lithium levels.
Results. Lithium levels post haemodialysis were 1.2mmol/L and within days fell to <0.4mmol/L. Further lithium treatment was held during admission, but she continued to exhibit signs of neurotoxicity. Two weeks post-admission her confusion persisted (MOCA 13/30). She remained tremulous and ataxic. A diagnosis of Syndrome of Irreversible lithium-effectuated neurotoxicity (SILENT) was made. She required intensive physiotherapy and occupational therapy input. 8 weeks post admission she had returned to her cognitive baseline and was mobilising independently.
Conclusion. SILENT syndrome is a rare consequence of lithium toxicity secondary to elevated lithium levels in the central nervous system which if sustained it is thought can lead to cerebellar demyelination as was evidenced in this case by our patient's symptoms. The insidious onset of her lithium toxicity in the community led to a prolonged period of toxicity that went undetected. No clear precipitating factor was identified. Vigilance is required for toxicity and this case highlights the importance of family members being aware of the signs. A patient when confused may no longer be able to advocate clearly for themselves or seek appropriate medical attention. The patient also delayed consulting with her GP as her GP practice was located an hour and a half from her home and she could not secure an appointment during the summer months. Patients prescribed lithium require timely access to GPs for monitoring and consultations. Despite her experience with toxicity, the patient opted to restart lithium due to a recurrence of depressive symptoms. She is adhering to close monitoring of serum lithium levels. The patient and her family received thorough psycho-education regarding symptoms and signs of lithium toxicity.

Fahr's Disease (Primary Basal Ganglia Calcification) and Violence: Case Report and Literature Review

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doi: 10.1192/bjo.2024.695

Aims.

Background:
Fahr's disease is a rare and complex neuropsychiatric disorder resulting from abnormal calcium deposition in the basal ganglia and cerebral cortex. It can have a profound impact on an individual's social functioning as well as causing a wide variety of neurological symptoms, cognitive deficits and motor impairment. A number of specific mutations have recently been identified in phosphate transporter and other genes, but around half of all cases have unidentified mutations. Impulsivity, aggression and violence may pre-date the other manifestations of the illness.
Methods.

Case Report:
Patient X is a 58 year old man currently detained in an independent hospital locked rehabilitation unit following the breakdown of a care home placement. His first admission to hospital was at the age of 18 when he was diagnosed with mania. He had multiple further hospital admissions as well criminal convictions for acquisitive and violent offences. In 2005 he threatened to stab a stranger if he did not give him a cigarette and he was arrested and admitted to a medium secure unit under Section 37 with diagnoses of bipolar affective disorder and emotionally unstable

personality disorder. He remained in secure hospital care until 2018 when concerns about Parkinsonian symptoms led to him being referred to a neurologist and a diagnosis of Fahr's disease being made on the basis of his CT findings. He was transferred to a locked rehabilitation service in 2019 but continued to exhibit challenging behaviour on a daily basis. After a reduction in the frequency and severity of his behaviour he was discharged to a care home, but this broke down after a few months as his assaultive and sexually inappropriate behaviour re-emerged.

Results.

Discussion:

Fahr's disease is traditionally thought of as a late life neurological condition, but as with Huntington's disease neuropsychiatric symptoms of irritability, sexually disinhibited behaviour, impulsivity and aggression can occur early and may pre-date any neurological manifestations. Treatment is often difficult because of sensitivity to antipsychotic medication.

Conclusion. It is important to consider neuropsychiatric conditions in the assessment of adults presenting with antisocial behaviours, especially when these are associated with a change in overall functioning and an absence of adolescent conduct disorder. There is as yet no specific treatment for Fahr's disease, but early identification allows appropriate risk management strategies to be adopted.

Late-Onset Tay-Sachs Disease With a Predominantly Neuropsychiatric Presentation: Case Report and Literature Review

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doi: 10.1192/bjo.2024.696

Aims.

Background:

Late-onset Tay-Sachs disease (LOTS) is an autosomal recessive lysosomal storage disease due to a variety of mutations in the hexosaminidase-A gene which leads to accumulation of GM2 ganglioside in the brain. It typically presents in late adolescence with a slowly progressive spectrum of neurologic symptoms including lower-extremity weakness with muscle atrophy, dysarthria, incoordination, tremor and mild spasticity and/or dystonia. Psychiatric symptoms including mood disorder, psychosis and neurocognitive symptoms occur in around 50% of cases but are rarely the presenting feature.

Methods.

Case Report:

Patient X is a 35 year old man of Irish descent currently detained in an independent hospital locked rehabilitation unit following the breakdown of a care home placement. He first presented to mental health services at the age of 17 with psychomotor agitation, rapidly changeable moods, manic-like symptoms and sexual disinhibition. He was diagnosed with schizoaffective disorder, attention deficit hyperactivity disorder and Asperger's syndrome and he had several compulsory hospital admissions over the next five years before a prolonged period of rehabilitation and discharge to a residential home for people with autistic spectrum disorders. However, he continued to exhibit disruptive behaviour, often triggered by periods of insomnia and had further hospital admissions. When he was 31 his brother was diagnosed with LOTS and this led to him being tested and found to have the same mutation.

Results.

Discussion:

There had been no suspicion of a neuropsychiatric disorder prior to the diagnosis of the patient's brother with LOTS and he was treated with conventional psychotropic medication with limited success. However, when the case records were obtained from his first hospital admission there was evidence of dysarthria although the significance of this was not appreciated. With hindsight many of his other symptoms can be seen as indicative of a neuropsychiatric disorder.

Conclusion. It is important to take a family history and consider a neuropsychiatric condition in families with multiple affected individuals. There are as yet no specific treatments for LOTS, and management is aimed at symptom reduction and enhancing quality of life, but a number of disease modifying strategies are being investigated including enzyme replacement therapy, pharmaceutical chaperone therapy, substrate reduction therapy, gene therapy, and hematopoietic stem cell replacement therapy, making it even more important the condition is recognized early.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

7 Psychopharmacology

Prescribing Habits of Clinicians and Medication Journey of Patients Treated for Attention Deficit Hyperactivity Disorder (ADHD): Experience From a Large London Clinic

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doi: 10.1192/bjo.2024.697

Aims. To understand the prescribing habits and trends of clinicians in a large ADHD clinic and the medication journey of patients from point of diagnosis to the point of agreeing a shared care plan with primary care services.

Methods. This was a non-interventional retrospective study collecting information from anonymised electronic patient and prescription records. Following approval by the Clinical Governance body of the practice, in June 2023, all patients with a SCP between the years 2019 and 2021 were identified. Data collected included patient demographics, date that medication was started, discontinued, or switched along with associated reasons. Additionally, to better understand the time taken to gain publication of a SCP, the amount of clinician-patient facing time was recorded, including the number of brief follow-up appointments, number of repeat prescriptions and number of clinician to patient emails. Patient data was fully anonymised and any identifiable data removed.

Results. All but one patient was started on a stimulant medication immediately following diagnosis, in line with national prescribing