

Lithium Toxicity: A Case Report

Dr Iqra Ain Ali and Dr Imtiaz Ahmed Dogar
Faisalabad Medical University, Faisalabad, Pakistan

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Aims: A 46-year-old female with a 30-year history of bipolar disorder presented with muscle stiffness, slurred speech, and altered sensorium, following fever, vomiting, and diarrhoea. She had been on lithium (400 mg daily) without regular monitoring. Examination showed confusion, hyperreflexia, tachycardia, and dehydration. Laboratory results revealed elevated serum lithium (3.4 mEq/L), renal dysfunction, hypernatremia, and echogenic kidneys. The diagnosis of lithium toxicity with acute kidney injury and dehydration-induced impaired excretion was confirmed. After discontinuing lithium, she underwent haemodialysis, and her condition improved. She developed lithium-induced diabetes insipidus, and long-term monitoring is required.

Methods: Case report.

Results: This case highlights the complexities of chronic lithium toxicity, presenting with neurological, systemic, and renal symptoms. Lithium accumulation exceeds renal clearance, particularly in the presence of factors like dehydration and acute kidney injury (AKI), leading to elevated serum lithium levels (3.4 mEq/L). The patient, with a history of bipolar disorder and long-term lithium use, developed classic neurological signs, including altered sensorium, tremors, hyperreflexia, and hypertonia, along with systemic manifestations such as anaemia, elevated AST, and abdominal symptoms. Lithium-induced nephrogenic diabetes insipidus (NDI) was confirmed, with persistent hypernatremia and polyuria despite normalized lithium levels.

Management included immediate discontinuation of lithium, hydration with intravenous Ringer's lactate, and two sessions of haemodialysis, which effectively reduced lithium levels. Empirical ceftriaxone addressed a suspected infection, and quetiapine was initiated for mood stabilization. Long-term monitoring, including regular serum lithium and renal function checks, is crucial for patients on chronic lithium therapy, especially those with risk factors.

The case emphasizes the need for therapeutic drug monitoring, patient education on hydration, and early toxicity recognition. Despite clinical improvement, the patient's prognosis remains guarded due to chronic damage from prolonged lithium exposure, including persistent NDI and hypernatremia.

Conclusion: Chronic lithium toxicity remains a preventable yet potentially life-threatening condition. Early recognition, regular monitoring, and timely intervention are paramount in mitigating its systemic, neurological, and renal effects. This case serves as a reminder of the importance of patient education, family involvement, and coordinated care to improve outcomes in bipolar affective disorder patients on lithium therapy.

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.

Capgras Syndrome in Schizophrenia: A Case Report of Delusional Misidentification and Its Clinical Implications

Dr Duaa Fatima, Dr Ateeq-Ur-Rehman Sheikh, Dr Sadaf Ghulam Jelani, Dr Palvisha Sajid and Dr Imtiaz Ahmad Dogar
Faisalabad Medical University, Faisalabad, Pakistan

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Aims: Capgras syndrome (CS) is a rare delusional misidentification syndrome characterized by the belief that a close relative has been replaced by an identical impostor. It is commonly associated with schizophrenia and other psychiatric disorders.

A 43-year-old married Asian female presented with a 5-year history of behavioural changes, including social withdrawal, suspiciousness, reduced self-care, and irrelevant speech. Her symptoms began following a familial conflict, leading to social isolation, self-neglect, and delusional misidentification, including Capgras syndrome, where she believed her mother had been replaced by an impostor. She later developed grandiose delusions, claiming to be a significant political figure. Despite initial improvement with antipsychotic treatment, she discontinued medication, resulting in symptom relapse and aggressive behaviour.

Methods: Case report.

Results: Capgras syndrome, first described in 1923, involves the delusional belief that familiar individuals have been replaced by impostors. It is often associated with psychiatric disorders, such as schizophrenia, and neurodegenerative conditions. This case aligns with the dual-route model of face recognition, suggesting impaired implicit-affective processing alongside intact conscious recognition. The patient's aggressive behaviour underscores the potential for violence in Capgras syndrome, highlighting the need for careful risk assessment and management. Non-adherence to treatment remains a significant challenge in managing such cases.

Conclusion: This case highlights the importance of early recognition and sustained treatment adherence in Capgras syndrome associated with schizophrenia to prevent deterioration and improve outcomes.

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EUPD: A Case Study Highlighting the High Stakes of First Impressions and the Dangers of Groupthink

Dr Aisha Duale
St Helens and Knowsley NHS Trust, Liverpool, United Kingdom

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Aims: Emotionally unstable personality disorder (EUPD) is a mental disorder that can be one of the most misunderstood diagnoses. It is a controversial and stigmatised condition among healthcare professionals which may lead to sub-standard levels of care and sub-therapeutic patient experience.

Methods: A 47-year-old female was admitted to an inpatient unit four times over five years. She exhibited visual and auditory hallucinations and fixed delusions. This patient had a diagnosis of Paranoid Schizophrenia.

During the fourth admission, she was admitted under Section 2 after she was found walking on the M57 in the middle of the night with suicidal ideation.

The clerking doctor had made note, upon admission, of self-harm behaviours that had occurred five years prior. On the ward, the patient would walk around half-naked and behave bizarrely towards staff and other service users. After discussion, the nursing staff concluded that the patient “knew what she was doing” and must have a diagnosis of EUPD considering her record of self-harm and odd behaviour on the ward. This was then included in the handover sheet, with a query, which was shared amongst ward staff.

The resulting stigma led to staff behaving in a discriminatory manner including avoidance of the patient and unchallenged refusals

during medication administration. The negative approach of the ward staff dissipated when the patient's behaviours settled with an antipsychotic. An informal meeting was conducted with the ward staff to highlight the potential iatrogenic harm that stigma can cause. Staff were evidently remorseful and understood the importance of engaging with all patients with the same standard of care, regardless of diagnosis.

Results: The stigma associated with EUPD is so potent that it may filter through to patients without the diagnosis based on loose associations. Healthcare professionals may distance themselves from patients with EUPD which may perpetuate sensitivities such as rejection and abandonment. This study highlights that this stigma poses a risk to the wider patient cohort should similar risk profiles or symptoms be displayed.

Conclusion: Mitigating the negative impact of an EUPD diagnosis must start with an acceptance and recognition of the dangers that staff narrative can have on patient care. This case study demonstrates the dangerous impact of stigma whereby a place of safety, the hospital, becomes the antithesis of therapeutic intervention. Of course, a more conclusive outcome would be to revisit the use of this diagnostic label and review policies in the management of EUPD in the inpatient setting.

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Effective Management of Ketamine-Induced Bladder Syndrome With Baclofen During Ketamine Detoxification: A Case Report

Dr Foroughzohra Esmaeilpour, Dr Mounika Iderapalli and Dr Edwin Ugoh

Essex Partnership University Trust, Chelmsford, United Kingdom

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Aims: Ketamine, a dissociative anaesthetic, is used therapeutically to treat mental health disorders like depression, anxiety, and PTSD. However, its recreational misuse can lead to severe physical and psychological consequences. A concerning long-term effect of ketamine misuse is ketamine-induced bladder syndrome (KIBS), which presents with symptoms such as urinary urgency, frequency, and pain. As dependence on ketamine develops, the severity of KIBS increases, potentially leading to significant organ damage. In such cases, ketamine detoxification becomes essential for reducing or eliminating ketamine from the system while managing withdrawal symptoms and psychological distress. While no FDA-approved medication exists for ketamine detoxification, treatment generally focuses on addressing withdrawal symptoms, psychological and physical dependence, and related complications.

Methods: This case involves a 23-year-old woman with a complex mental health history, including ADHD, Borderline Personality Disorder (BPD), anxiety, and previous self-harm attempts, well-documented by community mental health services. Her substance use began at age 18, starting with ketamine use during university. Over time, her ketamine consumption escalated from 0.5 grams every few months to 3.5–5 grams, causing both physical and psychological harm. Her usage pattern varied; sometimes she refrained from use for a day or two, but often she would use it continuously for 3 to 4 days, followed by a break. At times, she alternated days of use, with usage depending on her mood, occasionally taking the entire dose at once.

Approximately four years after initiating ketamine use, she developed significant bladder pain, frequent urinary tract infections (UTIs), and a constant urge to urinate. To manage these symptoms, she began using pregabalin, initially obtained illegally but later prescribed at a dosage of up to 600 mg daily by her GP. Despite this, her bladder pain remained inadequately controlled, and she resorted to using paracetamol and co-codamol, which proved ineffective. She also visited a urologist biweekly. She underwent two private ketamine detoxifications in 2021, although relapse occurred a few days later.

Considering her ketamine addiction and bladder pain, she underwent detoxification treatment. Managing her bladder pain was a key focus of her treatment. Diazepam was prescribed for anxiety, and in addition to pregabalin, baclofen was added to address the bladder pain. During detox, the patient reported significant improvement in bladder pain.

Results: One of the most challenging aspects of ketamine-induced bladder syndrome is the chronic bladder pain. Baclofen, a GABA-B receptor agonist, helped relax smooth muscles, including those in the bladder, reducing spasticity and discomfort. Baclofen also alleviated neuropathic pain, which contributed to ketamine-induced bladder dysfunction. Baclofen's ability to manage neuropathic pain makes it a valuable option when traditional painkillers fail. By inhibiting pain signal transmission, baclofen provides relief from discomfort and reduces urinary urgency and frequency. In this case, baclofen effectively alleviated bladder pain, reducing reliance on pregabalin during detoxification. Despite the complexities of her treatment plan, baclofen was vital in improving the patient's quality of life during detox.

Conclusion: Baclofen proves to be an effective alternative for managing ketamine-induced bladder pain, particularly when traditional treatments fail. This case emphasizes the importance of a multidisciplinary approach to address both physical and psychological challenges during ketamine detoxification. By managing bladder pain and other withdrawal symptoms, patients can experience a sustainable detox process, ultimately improving their chances of recovery and decreasing the risk of relapse.

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Clozapine Rechallenge in Treatment-Resistant Schizophrenia: Clinical and Ethical Considerations After Ileus

Dr Lily Farakish¹, Dr Laura Raducu² and Dr Anthony Soares³

¹Mersey Care NHS Foundation Trust, Liverpool, United Kingdom;

²Essex Partnership University NHS Foundation Trust, Basildon,

United Kingdom and ³Re:Cognition Health, London, United Kingdom

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Aims: Clozapine is the cornerstone of treatment for treatment-resistant schizophrenia. It primarily acts by inhibiting dopamine D2 receptors based on the hyperdopaminergic theory of psychosis. Additionally, second-generation antipsychotics (SGAs) interact with serotonin receptors (5-HT_{2A} and 5-HT_{1A}), mitigating extrapyramidal side effects. However, widespread activity on D2 receptors and additional anticholinergic effects can impact gastrointestinal motility, leading to complications such as paralytic ileus. Clozapine has potent anticholinergic activity and is associated with higher risks of paralytic ileus compared with other SGAs.

Methods: A male in his late 40s with treatment-resistant schizophrenia, anxiety and panic attacks underwent an elective