Lithium Toxicity: A Case Report

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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

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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 imposter. 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

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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