revealed significant deficits in memory, recall, attention and language. Due to a childhood history of petite mal epilepsy, an electroencephalogram was done and it showed no epileptiform discharges. Neuroimaging identified chronic gliotic change and encephalomalacia in the left frontal lobe, consistent with previous injury. Previous oximetry and multi-channel sleep studies excluded sleep apnoea.

Zopiclone and paroxetine were gradually discontinued, and sertraline and melatonin were initiated. Risk management involved separate sleeping arrangements. Subsequently, violent sleep-related behaviours resolved. The patient was referred to Memory Services for further neurocognitive assessment.

Results: The combination of violent dream-enactment behaviours, associated injury to a bed partner, absence of epileptiform activity, structural frontal lobe injury and improvement following gradual withdrawal of long-term paroxetine and zopiclone supported a diagnosis of likely medication-induced RBD in the context of TBI.

Conclusion: This case illustrates the risks of diagnostic overshadowing in patients with established psychiatric diagnoses and highlights the importance of considering organic and iatrogenic causes when new behavioural disturbance emerges, such as violent sleep-related behaviours. This case highlights the importance of awareness of the long-term neuropsychiatric sequelae of TBI and regular medication review and rationalisation to minimise iatrogenic harm

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.

Nocturnal Enuresis Associated With Sodium Valproate in an Adult Male With First Episode Psychosis: A Case Report

Dr Annesha Mukherjee

South West London and St George's Mental Health NHS Trust, London, United Kingdom

doi: 10.1192/bjo.2026.11867

Aims: Sodium Valproate is widely used in the treatment of epilepsy and is also commonly prescribed for psychiatric disorders, particularly Bipolar Disorder. Enuresis associated with sodium valproate has been reported in paediatric populations with epilepsy, and in a case report involving a paediatric patient with Bipolar Disorder. However, data in the adult psychiatric population remains limited.

Methods: This is a case report of a 20 year old gentleman diagnosed with Unspecified nonorganic psychosis. He had a four month psychiatric admission with first episode psychosis, which included 2 months in Psychiatric Intensive Care Unit (PICU). He was initially started on Olanzapine, which was titrated up to 20mg per day, however there was no response. Due to significant aggression, Sodium Valproate was introduced and increased up to 2500mg nocte. Due to lack of response with Olanzapine, antipsychotic medication was initially changed to Haloperidol during which he developed oculogyric crises which necessitated dose reduction. Due to persisting psychotic symptoms, it was changed to Zuclopenthixol. At discharge, he was on Zuclopenthixol depot 350mg every two weeks, Sodium Valproate 2500mg nocte and Procyclidine 5mg three times a day.

During follow up in the community by the Early Intervention Service, he was noted to have extrapyramidal side effects due to which the dose of Zuclopenthixol was reduced and Procyclidine was increased. He also reported nocturnal enuresis every night. There were no other urinary symptoms, and he had not had urinary incontinence or enuresis in the past. Initially, the dose of Sodium Valproate was split to 1000mg in the morning and 1500mg at night with a view to reduce nocturnal sedation, however the symptom persisted. The dose of Sodium Valproate was then reduced to 1000mg twice a day after which nocturnal enuresis resolved completely. During subsequent follow-ups, the dose of Sodium Valproate was reduced further, with a plan to gradually reduce and stop it in the long term. He remained free of psychotic symptoms during the period of follow up, without recurrence of enuresis.

Results: The onset on nocturnal enuresis following initiation of Sodium Valproate, and resolution following dose reduction suggests a possible association between the two. This is in accordance with previous reports indicating enuresis as a dose related side effect of Sodium Valproate.

Conclusion: Nocturnal enuresis is a potentially under recognised side effect of Sodium Valproate. Clinicians should screen for this adverse effect as it may significantly impact quality of life and treatment adherence.

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.

Postpartum Psychosis Presenting With Catatonia: A Case Study

Dr Zoe Mulligan, Dr Sarah Smyth and Dr Oladapo Babatola

Bluestone Unit, Craigavon, United Kingdom

doi: 10.1192/bjo.2026.11868

Aims: Postpartum psychosis is an acute and severe psychiatric illness, often characterised as a 'psychiatric emergency' lacking distinct classification in the DSM-5. This leads to poor understanding of the condition and ambiguous management protocols. 1-2 per 1000 females are affected and this change in maternal behaviour can be characterised by affective mood symptoms but may also present with catatonic features. This case study highlights the challenge of recognising and initiating urgent management in the setting of postpartum psychosis.

Methods: Female admitted at 14 days postpartum under detention following significant concerns regarding non-communication, markedly reduced oral intake, poor sleep and rapidly deteriorating mental state. The patient suffered a similar episode after her first child. She initially displayed heightened anxiety and elated behaviour followed by mutism and flat affect. She was treated for endometritis due to elevated inflammatory markers and treated for a lower limb deep vein thrombosis. Treatment was then commenced for postpartum psychosis presenting with catatonia with lorazepam, olanzapine and mirtazapine, titrated up to effect.

Results: This case study highlighted the effectiveness of a 'lorazepam challenge' with marked improvements in mental state seen within 48 hours and discharge home soon after. The importance of antenatal screening for high-risk patients is evident here, with emphasis on a previous episode of postpartum psychosis being the strongest predictor of recurrence in subsequent pregnancies (50% recurrence risk), which went undetected due to a language barrier. Also highlighted was the need to rule out organic causes initially in the workup for a diagnosis of postpartum psychosis.

Conclusion: Postpartum psychosis is a condition requiring urgent attention and intervention with need for a multi-disciplinary team-based approach. Mother and Baby Units are vital in the setting of a postpartum psychosis in order to maintain the maternal-infant bond. Ongoing follow-up with the perinatal mental health team is vital in order to support the patient and family, to offer counselling

and to provide information regarding recurrence risks. This case study is evidence of the need for more distinct classification and national guidelines to ensure accurate treatment is initiated in a timely manner.

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.

Neurodevelopmental Crossroads: The Role of Masked Autism Spectrum Disorder in the Development of Persecutory Beliefs Within Forensic Psychiatry

Dr Anushka Musharrat

Essex Partnership University NHS foundation TRUST, Essex, United Kingdom

doi: 10.1192/bjo.2026.11869

Aims: This report details the forensic admission of Ms X, a woman in her 40s, following an index offence of Grievous Bodily Harm (GBH) driven by fixed persecutory beliefs. It underscores the clinical challenge of identifying Autism Spectrum Disorder (ASD) when masked by "social camouflaging" or obscured by somatic comorbidities. Historically, Ms X's difficulties were attributed to Chronic Fatigue Syndrome and depression. At the same time, her forensic presentation was initially diagnosed as "Delusional Disorder," illustrating the risks of diagnostic overshadowing in forensic risk assessment.

Methods: Ms X presented with persistent beliefs that an online group had compromised her devices and that neighbours were surreptitiously filming her. These beliefs culminated in her confronting neighbours while armed. On admission, her presentation diverged from primary psychosis; she exhibited limited conversational reciprocity, sensory hypersensitivities (noise and olfaction), and a narrow, obsessive preoccupation with cyber-security. A retrospective developmental history revealed core ASD traits missed due to female-typical compensation strategies, including long-standing social aversion and ritualistic behaviours. This led to a formal diagnosis of ASD, replacing the previous diagnosis of primary Delusional Disorder.

Results: The clinical formulation reframed Ms X's "delusions" as intense manifestations of autistic cognitive style. Her beliefs were formed through a concrete, literal interpretation of ambiguous stimuli; for example, interpreting the online phrase "I see you" as evidence of physical surveillance. Her inherent cognitive rigidity rendered these beliefs resistant to challenge. Furthermore, deficits in Theory of Mind caused her to misattribute neutral or ordinary environmental actions as intentional threats. Consequently, the index offence was formulated as a reactive defence rooted in neurodevelopmental rigidity and emotional dysregulation, rather than a psychotic break.

Conclusion: This case highlights the imperative for forensic practitioners to screen for masked ASD in women, particularly when intense somatic or mood symptoms are present. Understanding ASD-related rigidity is crucial for accurate risk formulation and legal mitigation. Management must shift from traditional antipsychotic protocols toward integrated, specialised psycho-social interventions–such as Neurodevelopmental Outreach Services–focused on building ASD-specific insight and adaptive coping mechanisms.

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.

Beyond Dementia: Uncovering Superficial Siderosis in the Memory Clinic

Dr Dilshana Nafisa Bapakunhi[1] and Dr Bhavana Reddy[2]

[1]Essex partnership University NHS Foundation trust, Colchester, United Kingdom and [2]Central and northwest London NHS Foundation trust, Colchester, United Kingdom

doi: 10.1192/bjo.2026.11870

Aims: Superficial siderosis of the central nervous system is a rare progressive disorder caused by chronic deposition of haemosiderin in the superficial layers of the brain and spinal cord, often following recurrent subarachnoid bleeding. The cerebellum and hindbrain structures are particularly vulnerable to iron-related toxicity. Although classically characterised by ataxia, dysarthria, and gait disturbance, cognitive impairment is increasingly recognised as part of its presentation. This overlap can obscure diagnosis, especially when patients first present to memory services with primarily cognitive complaints.

Methods: A 75-year-old woman was referred to the memory clinic with a one-year history of worsening forgetfulness, difficulty recalling recent events, and episodes of disorientation. Her family reported rapid decline in her functional abilities, and she had become dependent on her son for daily organisation. She appeared anxious during cognitive testing and showed impaired short-term memory, word-finding difficulty, and repetitive speech, although reading and writing remained intact.

Initially, her presentation resembled a primary cognitive disorder. However, neurological examination revealed significant abnormalities, including difficulty following complex commands, tongue and limb apraxia, bilateral dysdiadochokinesia, and impaired tandem walking. Although there were no cranial nerve deficits or nystagmus, prominent cerebellar signs prompted neuroimaging. MRI demonstrated severe superficial siderosis symmetrically affecting the infratentorial region with lesser supratentorial involvement.

Her cognitive and neurological function deteriorated despite antidementia medication. A neurology opinion was sought, and she required multidisciplinary involvement, including speech and language therapy for dysphagia and fallsprevention support. As the condition progressed, she developed leftsided weakness, an upgoing plantar response, and reduced ankle reflexes. Chelation therapy with deferiprone was considered but not pursued due to advanced cognitive impairment, marked ataxia, and limited potential for benefit.

Results: This case highlights an important diagnostic challenge for memoryassessment clinicians: superficial siderosis can initially present as a cognitive disorder, even though the underlying pathology is neurological. Without thorough neurological examination, such cases may be misdiagnosed as dementia, particularly when dysarthria and inconsistent cognitive testing obscure the picture. Dysarthria limits verbal responses, reduces the validity of cognitive scores, and can exaggerate perceived deficits. The patient's apraxia, coordination abnormalities, and gait disturbance indicated a broader process inconsistent with typical neurodegenerative dementia. Early recognition is essential, not because curative therapy exists, but to guide appropriate imaging, avoid unnecessary treatments, initiate timely multidisciplinary care, and prepare families for progressive decline.

Conclusion: Cognitiveled presentations of superficial siderosis are uncommon but clinically important. This case highlights the value of thorough neurological assessment in memory services, particularly when cognitive symptoms present with atypical neurological features.

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.