Aims: This case presentation explores an extreme form of self-harm by M, a woman in her late fifties, with historical diagnosis of schizophrenia, later revised to mixed personality disorder with anxious-avoidant, impulsive and antisocial traits. She experienced significant trauma in childhood in the form of physical abuse by father, needing hospital admission. Additionally, she has multiple medical comorbidities including Multiple Sclerosis and multiple transient ischaemic attacks, and two previous incidents of self-harm, including an intentional overdose requiring intensive care and tracheostomy. She has received trazodone and flupentixol depot intermittently since the 1980s, stopped in November 2025 by a covering consultant, against M's wishes, due to absence of psychotic symptoms and worsening of physical health comorbidities.
Methods: M was admitted to the ward informally after presenting to the Emergency Department with suicidal ideation and thoughts of jumping in front of a lorry if not admitted. She quickly became comfortable in the ward setting but was noted to have personality changes compared to the community, including selective engagement with staff members. She became dependent on staff for Activities of Daily Living (ADLs), despite Occupational Therapy deeming her able of independent ADLs. Her behaviour became disruptive and challenging, including stripping naked, spreading faeces, and pulling her hair. This escalated to M attempting to remove her left eye from the orbit with her fingers, requiring an emergency lateral canthotomy and emergency repair of her ruptured globe in theatre, and resulted in loss of vision from that eye. M appeared to enjoy the attention she received during this incident. She has since attempted to remove her right eye, requiring close observation and frequent interventions by staff to prevent this.
Results: M's complex, lengthy psychiatric presentation and physical health comorbidities resulted in challenges in her management. Her presentation appears to be on the neurotic rather than psychotic spectrum, with antipsychotics prescribed for agitation. She has periods of lucidity before dissociation, with bizarre, disinhibited behaviour. Her distressed family queried the possibility of Munchausen Syndrome. Early severe trauma can present with challenging behavioural traits, emotional dysregulation and fight-flight response, leading to fluctuating withdrawal and aggression depending on context and perceived unmet needs.
Conclusion: This case is an example of a complex patient with multiple diagnostic and management challenges which culminated in rare and extreme self-harm resulting in loss of sight. It highlights the importance of collateral history and multi-disciplinary approach regarding diagnosis and management, contributing to the literature on mixed personality disorder.

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Two Sides of the Same Coin: The Intersection Between Psychiatry and Acute Care

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Aims: Psychiatric inpatient units are often geographically, organisationally and culturally distinct from tertiary care hospitals, creating separation. When these two worlds inevitably collide, challenges often arise. Evidently, there is a limited understanding of each team's challenges and, in this game of tug-of-war, patients bear the ultimate price.
Methods: Case Presentation

A 67-year-old man with dementia was admitted to a psychiatric inpatient unit for management of behavioural and psychological symptoms. During admission, he developed an acute change in mental state, consistent with delirium. He was therefore referred to tertiary care, where investigations revealed urinary retention, with an estimated three litres in the bladder.

Despite discussions between the emergency department (ED) and Psychiatry, the patient was discharged back to the psychiatry unit, with advice for catheterisation and intravenous (IV) antibiotics. Unfortunately, mental health wards could not perform these tasks due to a lack of experience, staff and equipment. Hence, the patient was transferred back to ED. On re-presentation, twenty-four hours after initial escalation, the patient became unconscious, was intubated and admitted to intensive care.
Results: This case illustrates the systemic challenges posed by the mental-physical health interface. From a psychiatric perspective, there was a sense of frustration and helplessness, whilst ED was similarly challenged due to the complexity of the patient's confusion. Pressures on services to remain efficient and meet targets, coupled with the disconnect between psychiatry and acute care, led to poor understanding of each party's limitations, meaning the underlying cause of the patient's life-threatening distress remained untreated. Limitations include a psychiatric unit's inability to administer IV medications, lack of medically trained psychiatry staff and the increasing demands placed on services. Inadequate awareness of these challenges, along with the patient's dementia, legal status, and psychiatric admission, may have subtly influenced how their needs were prioritised.
Conclusion: The structural separation between mental health services and acute medical care within the UK healthcare system continues to widen, despite ongoing efforts from psychiatry liaison services. This case underscores the need for a shared understanding of resources, capabilities and clinical responsibility across services. Fragmentation between teams can lead to ambiguity, with acute medical services overestimating the capabilities of psychiatric units due to their designation as tertiary hospitals, while mental health services lack the infrastructure to deliver routine medical care.

Improved education, cross-service exposure and enhanced ward provisions may strengthen communication, clarify escalation pathways and, ultimately, improve patient outcomes.

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When Depression Mimics Dementia: A Case of Acute Cognitive Decline in Later Life

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Aims: Rapid cognitive decline in later life often prompts urgent assessment for neurodegenerative dementia. However, severe depression and anxiety can produce profound but potentially reversible cognitive impairment, frequently described as depressive pseudodementia. Presentations characterised by abrupt onset, marked functional impairment, prominent subjective memory complaints, preserved insight, and disproportionate distress should raise suspicion for affective pathology. Failure to recognise reversible causes can lead to misdiagnosis, unnecessary investigations, and distress for patients and families.
Methods: Mr X is a 71-year-old White British retired man who presented with a two-week history of rapidly progressive cognitive