A follow-up ECG performed one week later showed normalized findings, including a heart rate of 54 bpm and a QTc interval of 443 ms, while troponin T levels returned to normal at 14 ng/L. Clinical resolution of myocarditis-like symptoms was observed.

Results: In this case, the patient developed significant ECG abnormalities and elevated troponin levels within two months of clozapine initiation. These findings, combined with clinical symptoms, necessitated immediate discontinuation of clozapine. Subsequent resolution of cardiac abnormalities within one week strongly indicated clozapine-induced myocarditis or cardiotoxicity. This outcome aligns with existing evidence that supports stopping clozapine in the presence of significant cardiac derangements.

Conclusion: This case emphasizes the critical need for monitoring for any adverse effects from clozapine particularly in the titration phase. Regular monitoring, including ECG and blood tests, is essential to identify early signs of myocarditis or cardiotoxicity. If there are any symptoms indicating cardiac abnormalities, clozapine should be discontinued immediately and referral should be made to medical or cardiology specialist for further evaluation.

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Genital Self-Mutilation in a Young Male With Psychotic Symptoms: Klingsor Syndrome – A Case Report

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Aims: Genital self-mutilation (GSM) is a rare but severe form of self-harm often linked to underlying psychiatric disorders, particularly psychotic conditions. Approximately 54% of GSM cases occur in patients with psychosis, with substance use disorders being the second most common associated condition. Various triggers, including perceived rejection, lack of social support, and acute substance intoxication, have been implicated in GSM. When GSM arises from psychotic symptoms, it is referred to as Klingsor syndrome. Immediate psychiatric intervention is critical for managing such cases and preventing recurrence.

Methods: A 28-year-old divorced male was brought to the nearest hospital by his family following a penile self-amputation with a blade. Immediate surgical repair was performed. Three weeks later, he was admitted to Bethlehem Psychiatric Hospital for further evaluation and treatment. The patient had a history of self-harm that previously necessitated hospitalization. His psychiatric symptoms included commanding auditory hallucinations, delusions of reference, feelings of worthlessness, and psychotic features that emerged after cannabis use. In the weeks leading up to the self-mutilation, the patient exhibited insomnia, social withdrawal, and a growing preoccupation with self-castration. On examination, he appeared distressed, with an irritable affect and poor insight into his actions. He expressed a strong belief that his genitals were "the source of all problems" and reported suicidal ideations, stating he "needed to get rid of his penis or else would commit suicide". He also exhibited persecutory delusions, delusions of guilt, control, and thought broadcasting. A comprehensive psychiatric assessment confirmed a diagnosis of Schizoaffective Disorder, exacerbated by substance use. He was admitted to the psychiatric ward following medical stabilization and was treated with quetiapine 600 mg/day, titrated as needed, and carbamazepine for mood stabilization. Supportive psychotherapy aimed at improving insight and addressing delusional distress was initiated, alongside family psychoeducation to prevent recurrence.

Results: During his four-week inpatient stay, the patient demonstrated gradual improvement in his psychotic symptoms. His insight improved significantly, and he ceased expressing delusional beliefs about his genitals. Upon discharge, he was referred to the Community Mental Health Centre (CMHC) and enrolled in an outpatient psychiatric programme, which included ongoing medication management and psychotherapy. At the few-months follow-up, he remained adherent to his treatment plan with no recurrence of self-harm behaviours.

Conclusion: This case highlights the interplay of psychosis and substance use in GSM and underscores the necessity for early intervention and psychiatric care. A multidisciplinary treatment approach including pharmacotherapy, psychotherapy, and family support is essential for prevention of future episodes.

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Idiopathic Regression in Down Syndrome

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Aims: Idiopathic Regression in Down Syndrome (IRDS) is reported to be present in 16% of people with Down syndrome however the clinical presentation is heterogeneous with no universal diagnostic criteria. It often presents in adolescence or early adulthood and there are often no known triggers. Common symptoms include language regression, mood symptoms, psychotic phenomena, motor symptoms and loss of previously acquired cognitive skills.

We present a case series of two patients who presented to the West Norfolk Community Intellectual Disability Service with symptoms suggesting IRDS.

Methods: AB (F; 34 years) has the diagnoses of Mild Learning Disability, Down syndrome, Bipolar Affective Disorder following a manic episode at the age of 18 and obsessive-compulsive disorder with predominantly compulsive acts. She was described by parents as a very sociable, active, and high achieving before she developed acute regression. Around the age of 12 years following an episode of profoundly serious pneumonia, she became catatonic, anorexic, and doubly incontinent. Clearly described episodes of depression and mania, obsessional behaviours and speech deterioration were also noted.

The diagnosis of IRDS was raised by parents in 2023 and AB is currently being assessed for immunotherapy.

XY (M; 46 years). Following a gastrointestinal infection aged 18 years, the family noticed he became more housebound, obsessional about symmetry, and depressed. No specialist investigations were

done but he was managed for depression with several antidepressants with no improvement. He was also diagnosed with dementia and started on donepezil but nothing changed. He is currently psychotropics-free and following a retrospective diagnosis of IRDS and discussion with family, they were relieved that the correct diagnosis of XY's condition has been found.
Results: A physical illness appears to have triggered the regression in both cases. Personality and mood changes especially a manic presentation which is uncommon in people with Down syndrome were also reported. Psychotropic medications were not beneficial in at least the second case. In both cases, the diagnosis of Idiopathic Regression in Down Syndrome was an acceptable explanatory model for the family.
Conclusion: We hope clinicians will make the diagnosis more promptly thus facilitating quick access to adequate treatment.

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Between Intent and Illness: A Look at Malingering vs. Factitious Behaviours

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Aims: Presented is a 33-year-old gentleman with a diagnosis of emotionally unstable personality disorder (EUPD) well-known to mental health services, including inpatient, community, liaison, and psychological care teams, with a long-standing history of self-harm and suicide attempts, which included deliberately placing himself in high-risk public areas which have at times resulted in detention under mental health legislation.
Methods: Over the past several years, this gentleman has fabricated claims of a cancer diagnosis, terminal prognosis, and multiple surgical procedures – assertions refuted by his medical records – while leveraging these falsehoods on social media and through a crowd sourcing campaign to raise funds by misrepresenting his physical health. Furthermore, he has strategically leveraged medical admissions to access medications, including strong analgesics and for a self-reported diagnosis that remains unverified.

During conducted assessments, he has expressed a desire for psychological therapy and enhanced crisis support yet consistently avoids engaging with the planned, regular support offered by teams who are familiar with his history, including appointments scheduled after episodes of self-harm.

While services have considered a factitious component in his presentation others contest it aligns more strongly with malingering. Consensus with professionals is that given his presentation there are difficulties in developing and maintaining a safe therapeutic relationship due to his disingenuity, threats of complaints, and his active avoidance of any meaningful, structured, recovery-focused work.
Results: Factitious disorder is driven by an internal need to assume the sick role and receive attention or care, with patients intentionally producing symptoms rooted in psychological need rather than for external rewards where the behaviour is characterized by a willingness to undergo invasive tests and treatments, reinforcing their patient identity. Factitious disorder is recognised as a psychiatric diagnosis warranting treatment, whereas malingering is motivated by external incentives and is not considered a mental illness but rather a behavioural strategy. Individuals who malinger tend to avoid procedures that might expose their deception and selectively engage in behaviours that yield tangible benefits.
Conclusion: This case underscores the importance of comprehensive, multidisciplinary assessments in achieving accurate diagnoses by clarifying key differences in motivation, behaviour, and clinical classification. Enhanced diagnostic clarity not only improves patient care, but also safeguards healthcare resources. Despite evident secondary gains in this case, the long-standing emotional instability and interpersonal dysfunction associated with EUPD still necessitate a balanced, empathetic therapeutic approach.

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Unmasking the Mind: A Journey Through Misdiagnosis to the True Identity of Dissociative Identity Disorder

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Aims: Dissociative Identity Disorder (DID) is a complex psychiatric condition that is often misdiagnosed due to its overlapping symptoms with other disorders such as mood and psychotic disorders. The presence of psychotic features, including auditory and visual hallucinations, disorganized behaviour, and memory gaps, can make the diagnosis of DID particularly challenging. This case study highlights a 27-year-old female whose DID diagnosis was delayed due to misinterpretation of her psychotic symptoms, which were initially attributed to other psychiatric disorders.
Methods: A 27-year-old female with a 15-year history of psychiatric care began experiencing symptoms at the age of 13, initially presenting with anxiety and panic attacks. Over time, her symptoms escalated to include episodes of auditory and visual hallucinations, disorganized speech, and erratic behaviour, leading to multiple hospitalizations. During one hospitalization, she displayed regressive behaviours, mutism, aggressive outbursts, hypomania, and dissociative amnesia. Despite extensive workups, including MRI scans and lab tests, no organic causes were found. Her diagnosis fluctuated between psychotic disorders, mood disorders, anxiety disorder, and dissociative disorder. Her mood and psychotic symptoms were initially treated as schizoaffective disorder, but the patient experienced adverse reactions to antipsychotic medications, including galactorrhoea from risperidone and weight gain from amisulpride. These medications were ineffective, prompting a reassessment of her diagnosis. A thorough review of her clinical history, including reports of memory gaps, identity disturbances, and dissociative episodes, led to the reconsideration of DID as the primary diagnosis.
Results: The psychotic features in this patient, such as hallucinations and disorganized behaviour, were secondary to her dissociative episodes, occurring during times of identity disturbance. This case underscores that psychotic symptoms in DID can easily be misinterpreted as part of a mood or psychotic disorder, especially when dissociative episodes are not initially recognized. The prolonged misdiagnosis delayed appropriate treatment, but a more comprehensive understanding of her symptoms led to the correct diagnosis and tailored management.
Conclusion: This case highlights the diagnostic challenges in identifying DID, particularly when psychotic features overlap with other psychiatric conditions. Early recognition of DID, with a thorough longitudinal assessment of both dissociative and psychotic