Conclusion: Conclusion- Although uncommon, functional cognitive disorder should be considered as a differential diagnosis in people presenting with cognitive difficulties where the clinical picture does not fit the picture of a neuro-degenerative condition like dementia. A misdiagnosis as dementia will a profound impact on a person's personal, social and occupational aspects of life. The right diagnosis can provide re-assurance to people and enable them to be sign-posted to the right support services. This can reduce distress, stop people from being sent for unnecessary investigations, being misdiagnosed as a dementia and enable them to access the appropriate help for their symptoms.

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Recognition and Management of Oculogyric Crisis in a Learning Disability Setting

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Aims: Oculogyric Crisis (OCG) is one of the few presentations within psychiatry considered an emergency due to the potential features which can make OCG life-threatening. OCG is poorly understood and can be difficult to recognise due to other features which may mask the classical presentation of a fixed upper gaze of the eyes with associated anxiety and hallucinations. This case study looks at how we have managed a patient within a low secure forensic service with this presentation.
Methods: Our male patient in their 30's was admitted with a working diagnosis of treatment resistant schizophrenia. There were frequent episodes of this gentleman becoming acutely unwell with vivid hallucinations and aggression directed towards staff and other patients. Due to staffing concerns regarding autonomic function, the associated eye movements were missed and as such this was not recognised as OCG which is an acute dystonic reaction.
Results: During these episodes, there were many times where our patient would appear in an immobile state, with an inability to speak or follow commands with marked feelings of reference and ideas of persecution. This would include refusals to take prescribed medication because of visual hallucinations of seeing his medication and food and drink being contaminated. Episodes of seclusion were due to aggression towards others he believed were after him. Frequent emergency department attendances were required due to autonomic and conscious level disturbance.

Our patient was admitted on a regular depot of zuclopenthixol which we gradually reduced to nothing following the recognition of OCG. We also supplemented this with procyclidine, which helped to reduce symptoms.

Following these changes, we initially noticed a marked improvement in our patient's presentation as he was engaging well with the ward staff and other patients. There was no longer any requirement for frequent hospital visits and the absence of a movement disorder.

However, they appear to have escalated again following complete cessation of the depot. We need to understand if this is an exacerbation of OGC, which the literature does document when antipsychotic medication is withdrawn or an exacerbation of the schizophrenia due to reduction in antipsychotic medication, even though he remains on an oral atypical antipsychotic known to have minimal risk for side effects.

Conclusion: OCG is a rare but serious condition. However, if it is recognised early, an individualised approach based on the patient and clinical picture may improve long term outcomes whilst considering alternative diagnoses.

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When Delirium Is Not Delirium: A Case of Late-Life Mania Initially Attributed to Medication Effects

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Aims: Acute behavioural disturbance in older adults frequently presents diagnostic challenges, particularly when symptoms arise in the context of polypharmacy, physical illness, and sleep disruption. Delirium is often the initial working diagnosis in such presentations; however, evolving clinical features may indicate an underlying primary psychiatric disorder. Distinguishing between delirium and late-onset affective illness is especially complex in older adults with pre-existing psychiatric vulnerability and medication exposure.
Methods: This case describes a 67-year-old woman with a background of recurrent depressive disorder, anxiety, and obsessive–compulsive disorder who presented with acute confusion, severe insomnia, behavioural disorganisation, and pressured speech following recent changes to her analgesic regimen, including the initiation of tramadol.

The initial presentation was characterised by fluctuating cognition, psychomotor agitation, disinhibition, and paranoid ideation. A provisional diagnosis of medication-induced delirium with hypomanic features was made. Tramadol was identified as a likely precipitating factor, given its opioid and serotonergic properties and the patient's increased vulnerability as an older adult.

Management initially focused on withdrawal of potentially offending medications, optimisation of physical health, and symptomatic treatment with antipsychotic and benzodiazepine medications. Due to impaired insight, behavioural disturbance, and risk of self-neglect, the patient required detention under the Mental Health Act for assessment and treatment.

Over the course of admission, features typically associated with delirium improved, including confusion and disorientation. However, the patient continued to demonstrate sustained mood elevation, reduced need for sleep, increased goal-directed activity, pressured speech, and intrusive behaviour, with preserved cognition. These symptoms were non-fluctuating and persistent.

Collateral history obtained during admission revealed a possible family history of bipolar affective disorder. In light of the clinical course and longitudinal observation, the diagnosis was revised to a manic episode, likely precipitated by medication exposure and sleep deprivation.
Results: This case illustrates the diagnostic complexity of acute mental state changes in older adults, particularly in the context of polypharmacy and pre-existing affective disorders. While delirium is a common and appropriate initial diagnosis in such presentations, persistence of non-fluctuating manic symptoms following resolution of cognitive disturbance should prompt reconsideration of the diagnosis.

Tramadol has recognised serotonergic and noradrenergic properties and has been associated with both delirium and affective destabilisation, particularly in vulnerable populations. Sleep

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