episodes and family history are important in differentiating from a schizoaffective pattern of disease.
Conclusion. Unremitting mania of this duration is unique in its psychiatric morbidity and devastating in its impact on the individual in terms of psychosocial functioning, quality of life, physical health and safety. It also brings unprecedented stress on the family and other support systems.

Chronic Misuse of Paracetamol in OCD Without Hepatic Injury: A Case Report and Literature Review

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Aims. Paracetamol is a commonly used antipyretic and analgesic over the counter medication. In acute or chronic overuse it is associated with dose-dependent hepatic injury. There is a narrow therapeutic margin and that consistent use of as little as 7.5 g/day may be hazardous. Unintentional overdose with paracetamol is the most common cause of acute liver failure in the United Kingdom Here we present an unusual case of a 60-year-old lady with a reported chronic history of self-medicating with an above daily recommended dose of paracetamol without evidence of hepatic injury.
Methods. A 60-year-old Caucasian lady known to psychiatric services for 20 years with Recurrent Depressive disorder, Obsessive Compulsive Disorder (OCD), Dependent Personality Disorder with Borderline personality traits. She reported consuming 32 tablets of paracetamol (16gm per day) every day for the past 11 years. She experienced obsessions of fear that if she did not take a particular number of paracetamols in a day then her friends will come to harm and her anxiety was relieved by the compulsion of consuming supratherapeutic doses of paracetamol. There was no evidence of misuse of any other medications other than paracetamol. Her blood investigations revealed liver function tests within normal limits and ultrasound of the liver was unremarkable.
Results. A literature search of "paracetamol or acetaminophen" and "no liver or hepatic" and "damage or injury" found only one case report. The case reported that studies of paracetamol metabolism were performed in a 58-year-old female with rheumatoid arthritis who had consumed 15–20 g paracetamol daily for 5 years without developing liver damage and data were compared with results in seven normal volunteers. The report concluded that a combination of slow paracetamol absorption, enhanced detoxication of paracetamol (by sulphation) and reduced metabolism to potentially cytotoxic metabolites may have reduced the risk of liver damage in this patient.
Conclusion. In OCD, misusing medications can be an uncommon presentation of compulsive acts to relieve anxiety. The diagnostic dilemma of factitious illness is probable, however supratherapeutic use of paracetamol without physical harm is rare but possible.

Association of ADHD With Congenital Conditions – Case Reviews in General Adult Clinic

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Aims. The association of ADHD with mental health and medical conditions is commonly encountered in clinical practice. Interestingly there are patients with congenital conditions who present with features of ADHD and little is known about their association and neurological basis. There is no strong literature but anecdotal reports that indicate children with congenital heart disease are more likely to suffer from mental health conditions including ADHD. The clinic however is unable to analyze such hypothesis and instead decided to evaluate cases related to Neurofibromatosis (NF1), Arnold Chiari Malformation, Transposition of great arteries, Di George syndrome to understand the longitudinal history, symptom persistence and functional impact of ADHD.
Methods.

A. Index patient aged 45 years referred for possible association of ADHD and Neurofibromatosis with issues related to long-standing trouble with sleep and movement disorder.
B. Index patient aged 41 years received a surgical repair for a Chiari malformation hoping it would improve the cognitive functioning but still suffers lot of symptoms that are consistent with clinical picture of ADHD.
C. Index patient aged 19 years referred for ADHD assessment reported history of transposition of great arteries and VSD that warranted emergency operative procedure before age 3. The behavioural symptoms that were suspected as related to physical illness and frequent attendance to hospital however did not resolve and were noted to be in line with possible ADHD.
D. Index patient aged 40 years admitted to general psychiatry following episode of psychosis and during examination presented history of Di George syndrome with brief input from Cardiology. It was apparent that patient struggled with poor understanding, lack of consistency, disorganization, distractibility, learning difficulties and the features suggested a pattern of Attention deficit disorder.

Results. Focused on

1. The qualitative analysis of developmental history, childhood rating scale, symptom comorbidity and functional impairment of such cases.
2. It studied the family history of physical and mental illness including predisposition to ADHD or neurodevelopmental conditions.
3. It also evaluated the treatment response to stimulant/non-stimulant therapy.

Conclusion. Clinically there was no typical co-relation of increased mental illness or genetic predisposition for ADHD in the family history and qualitatively the presentation did not differ from other ADHD patients and the treatment response was not variable, however it still draws attention towards the need for regular screening of all nervous and cardiac origin congenital conditions for an early intervention.

Beyond "Evidence-Based Medicine" in "Detained Patients"

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Aims. Treatments without robust evidence are not recommended. However, some patients detained in secure hospitals might need novel approaches such as: off-license use of medication, use of psychological (rather than their biological) effects of drugs. In addition, some detained patients may request for unconventional treatments they believe in. In community and capacitous patients, the clinician's role is advisory and the burden is on the patient to make the final decision and access such treatments privately. However, in a detained patient (with or without capacity), it may fall on the Responsible Clinician (RC) to deny or facilitate access to such interventions. Currently, there is no guidance for such circumstances. We have presented three real cases followed by proposing a flowchart to guide RCs.
Methods.
Case 1 (2019–2020): X with mild Learning Disability (LD) and mixed personality disorder detained under Section 3 with no leave to community. X asked for Hypericum which has been helpful with her headaches in the past. X had capacity to make that decision.
Case 2 (1996–97): Y with mild LD and aggressive behaviours responding instantly to any injection. Y lacked capacity so injections of distilled water was tried in his best interest, with equal positive effect. The question was about using distilled water as rapid tranquilisation with no side effects.
Case 3 (2020–21): Z with a treatment-resistant psychosis who has been unwell for months and detained in four different PICUs. Z's father requested N Acetyl Cysteine which had historical calming and sedative effects for Z.
Results. The main issue in case 1 is the conflict between the patient's Human Rights and RC's Duty of care. Here the patient could be potentially deprived of their right to make an 'unwise decision' should the RC bar her access to a treatment which lacks evidence but is privately available to public. This can be construed as an infringement of Article 8 of Human Rights.

The issue in case 2 and 3 is rather different. Here the conflict is between the RC's duty of care to provide evidence-based treatments and the patient's "best interest" which seems to be an intervention without robust evidence.
Conclusion. We have developed a flowchart to help RCs by navigating amongst several competing/ conflicting legal and ethical concepts such as: Patient's wish/Human rights, Patient's capacity, Bolam test, "Medical Treatment" Under Section 63, 62 or 58 of Mental Health Act 1983, Best interest, Second Opinion (SOAD) and advice from court.

The Various Faces of Creutzfeldt-Jakob Disease (CJD); a Case of CJD Presenting as Psychosis in a Middle-Aged Woman

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Aims. Creutzfeldt-Jakob disease (CJD) is a rare, progressive, fatal neurodegenerative disorder caused by an abnormal glycoprotein known as the prion protein. The core features include progressive cognitive decline, cerebellar dysfunction, personality changes, and visual disturbances. Although psychiatric symptoms are rare, they can be the primary symptom of CJD, and such presentations can pose diagnostic difficulties. In this paper, we describe the case of Ms. R, who manifested psychotic symptoms as the first signs of CJD.
Methods. Ms. R, was a 49-year-old white British female not previously known to psychiatric services, who presented with acute onset of florid psychotic symptoms. Her symptoms included auditory hallucinations, paranoia, and thought disorder. She was treated with antipsychotics for over four weeks, following her admission, but no improvement was seen. Instead, her psychosis worsened with cognitive decline, mutism, and the appearance of neurological symptoms such as jerky body movement, ataxia, and falls. All screening blood tests, chest X-ray, and CT abdomen were normal. The MRI, however revealed few patches of high T2/FLAIR signal in the deep white matter. Cerebrospinal fluid showed increased protein. Neurologist reviews suggested the possibility of sporadic CJD (sCJD) as a probable diagnosis. As her condition deteriorated, she became comatose and died four months after the appearance of the first psychiatric symptoms.
Results. It can be challenging to diagnose CJD since the clinical picture overlaps with other neuropsychiatric and neurodegenerative conditions. It requires the presence of relevant clinical findings along with positive CSF, EEG, or MRI findings to make a probable diagnosis. Regarding our case, some noteworthy observations were psychosis as the initial symptom, relatively delayed onset of neurological signs, rapid deterioration with brief duration of illness. The MRI findings were typical of those seen in sCJD, although the EEG did not suggest sCJD. A differential of variant CJD was considered because of her age, prominent psychiatric symptoms, and delayed neurological signs.
Conclusion. Creutzfeldt-Jakob disease course is rapidly progressive, and majority of patients die within one year. Therefore, awareness of early clinical features is of great significance. Among other things, this would enable patients and their families time to understand the nature of CJD, prognosis and prepare advanced directives. This case adds to the growing number of atypical presentation of CJD as well as pointing to an expanding spectrum of the disease. Therefore, clinicians should consider CJD in the differential diagnosis of new-onset psychosis, particularly if symptoms persist and worsen despite standard psychiatric treatment.

Patient Initiated Follow-Up (PIFU) Within Adult Secondary Care Mental Health Services

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Aims. The traditional 'one size fits all' model within secondary care mental health (MH) settings of regular appointments scheduled by a clinician at defined intervals isn't always responsive to an individual's changing needs. Previous reviews have shown significant levels of patient and clinician satisfaction with Patient initiated models of review in a variety of healthcare settings but its use within secondary care MH settings has been relatively limited. We describe the development and implementation of a Patient initiated follow-up (PIFU) pathway within MH services in NHS Greater Glasgow and Clyde (GG&C).
Methods. The pathway was developed by a small working group of clinicians with input from local management and eHealth colleagues with an emphasis on the principles of Realistic Medicine. There was input from peer support workers and the Mental Health network, a local service user organisation, into the development of the pathway. The pathway underwent a 'test of

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