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doi: 10.1192/bjo.2023.343

Aims. There has been growing interest in regression among adolescents and young adults with Down Syndrome. Regression can also be referred to Acute Regression, Down Syndrome Regression Disorder (DSRD), Down Syndrome Disintegrative disorder (DSDD) or Unexplained Regression in Down Syndrome (URDS) and these terms are sometimes used interchangeably. Characterised by reduction in expressive language, decreased functional skills and reduced psychomotor activity, regression can result in a significant change in the long-term needs of these individuals. Reporting this case, we wanted to highlight challenges in diagnosing, treating and supporting young people with regression in Down Syndrome.
Methods. This is Case Study of a young adult with Down Syndrome presenting with symptoms of mood disorder, apathy, new-onset vocal tics and ritualistic behaviours and profound loss of expressive language - both verbal and sign language.
Results. Diagnosis included ruling out physical causes for regression. The management remains largely symptomatic and aims to address as many as possible bio-psycho-social aspects of the concerning presentation.
Conclusion. Multitude of interventions and external events made it difficult to see what intervention was the most useful. Despite initial positive response to medication and behavioural strategies, a long term prognosis remains uncertain.

Successful Clozapine Rechallenge With Add on Filgrastim in a Case of Treatment Resistant Schizophrenia With Clozapine Associated Neutropenia: A Case Report

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doi: 10.1192/bjo.2023.344

Aims. Clozapine is the treatment of choice in treatment resistant schizophrenia (TRS). Neutropenia is a potential life threating adverse effect associated with Clozapine treatment and one of the common reasons leading to discontinuation of Clozapine treatment. Clozapine associated neutropenia can be managed with Lithium or Granulocyte Colony Stimulating factor (G-CSF).Clozapine rechallenge in patients may often seem necessary and should follow a careful and balanced risk-benefit analysis. We present a case of a patient with TRS on Clozapine who developed neutropenia which responded to Filgrastim add on therapy and was successfully continued with Clozapine treatment.
Methods. A 29 year old female with a diagnosis of Schizophrenia since age 22 years had poor response to 4 different antipsychotics and 2 episodes of Neutropenia on separate occasions with Clozapine treatment. An inpatient Clozapine rechallenge was trialled due to poor response to the ongoing antipsychotic treatment which resulted in a decrease in the absolute neutrophil count to 1.7 $*10^9$/Litre.

An MDT decision was taken to continue Clozapine treatment with add on Filgrastim due to the severe psychopathology and poor quality of life. As per the advice from the haematologist Filgrastim injections at a dose of 30 million International Units were commenced on pro re nata (prn) basis whenever ANC dropped below $2.0*10^9$/Litre. This strategy was successful and the patient did not develop agranulocytosis. Her psychotic symptoms also improved significantly and the patient was discharged to the community rehabilitation team.
Results. Clozapine is often the last resort in treating refractory psychotic symptoms and this option may get limited due to adverse effects like Neutropenia and agranulocytosis. Add on therapy with G-CSF has been used in Clozapine rechallenge with various success rate and most of the supporting data are derived from case reports and case series. It is worth noting that regular and prophylactic G-CSF in absence of low neutrophil count is avoided which could mask a developing Clozapine induced Neutropenia and result in a steep drop in neutrophils.
Conclusion. Add on therapy with Filgrastim is a viable option when considering Clozapine rechallenge with previous history of Clozapine induced Neutropenia. It is important that a haematologist is consulted and the patient is monitored closely throughout the treatment.

Atypical Neuroleptic Malignant Syndrome in the Intensive Care Unit: A Case Report

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doi: 10.1192/bjo.2023.345

Aims. Neuroleptic malignant syndrome (NMS) is a rare condition experienced by patients taking typical and/or atypical antipsychotic medications. There are well-established diagnostic criteria for NMS. However, differentiating it from serotonin syndrome and malignant hyperthermia—particularly in the intensive care setting--is problematic and thus remains a diagnosis of exclusion. A case report of a patient with atypical NMS in intensive care is described and the subsequent learning points gleaned from the patient are presented.
Methods. A 28 year-old female was admitted to the intensive care unit (ITU) following a self-inflicted traumatic injury. The patient was known to local mental health services and her medical history includes personality disorder, anxiety and depression. Regular psychiatric medications prior to hospitalization included flupentixol and quetiapine. Remifentanil was administered in a continuous infusion for sedation as the patient was intubated and ventilated. Valproic acid and levetiracetam were given for seizures.

Repeated spikes in temperature, rigidity and slightly elevated creatine kinase (CPK) were observed in the patient. Autonomic dysfunction was also noted; the patient experienced bradycardic episodes that increased in frequency and duration. On two occasions, this resulted in asystole and cardiopulmonary resuscitation (CPR) had to be commenced with return of spontaneous circulation following CPR. Mental status changes were unable to be assessed due to ongoing sedation of the patient. On the advice of the clinical pharmacist, remifentanil was switched to fentanyl. Quetiapine and flupentixol were also discontinued after consulting with the psychiatric team. In addition, the patient responded quickly to dantrolene administration and to active cooling.