during medication administration. The negative approach of the ward staff dissipated when the patient's behaviours settled with an antipsychotic. An informal meeting was conducted with the ward staff to highlight the potential iatrogenic harm that stigma can cause. Staff were evidently remorseful and understood the importance of engaging with all patients with the same standard of care, regardless of diagnosis.

Results: The stigma associated with EUPD is so potent that it may filter through to patients without the diagnosis based on loose associations. Healthcare professionals may distance themselves from patients with EUPD which may perpetuate sensitivities such as rejection and abandonment. This study highlights that this stigma poses a risk to the wider patient cohort should similar risk profiles or symptoms be displayed.

Conclusion: Mitigating the negative impact of an EUPD diagnosis must start with an acceptance and recognition of the dangers that staff narrative can have on patient care. This case study demonstrates the dangerous impact of stigma whereby a place of safety, the hospital, becomes the antithesis of therapeutic intervention. Of course, a more conclusive outcome would be to revisit the use of this diagnostic label and review policies in the management of EUPD in the inpatient setting.

Effective Management of Ketamine-Induced Bladder Syndrome With Baclofen During Ketamine Detoxification: A Case Report

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Aims: Ketamine, a dissociative anaesthetic, is used therapeutically to treat mental health disorders like depression, anxiety, and PTSD. However, its recreational misuse can lead to severe physical and psychological consequences. A concerning long-term effect of ketamine misuse is ketamine-induced bladder syndrome (KIBS), which presents with symptoms such as urinary urgency, frequency, and pain. As dependence on ketamine develops, the severity of KIBS increases, potentially leading to significant organ damage. In such cases, ketamine detoxification becomes essential for reducing or eliminating ketamine from the system while managing withdrawal symptoms and psychological distress. While no FDA-approved medication exists for ketamine detoxification, treatment generally focuses on addressing withdrawal symptoms, psychological and physical dependence, and related complications.

Methods: This case involves a 23-year-old woman with a complex mental health history, including ADHD, Borderline Personality Disorder (BPD), anxiety, and previous self-harm attempts, well-documented by community mental health services. Her substance use began at age 18, starting with ketamine use during university. Over time, her ketamine consumption escalated from 0.5 grams every few months to 3.5–5 grams, causing both physical and psychological harm. Her usage pattern varied; sometimes she refrained from use for a day or two, but often she would use it continuously for 3 to 4 days, followed by a break. At times, she alternated days of use, with usage depending on her mood, occasionally taking the entire dose at once.

Approximately four years after initiating ketamine use, she developed significant bladder pain, frequent urinary tract infections (UTIs), and a constant urge to urinate. To manage these symptoms, she began using pregabalin, initially obtained illegally but later prescribed at a dosage of up to 600 mg daily by her GP. Despite this, her bladder pain remained inadequately controlled, and she resorted to using paracetamol and co-codamol, which proved ineffective. She also visited a urologist biweekly. She underwent two private ketamine detoxifications in 2021, although relapse occurred a few days later.

Considering her ketamine addiction and bladder pain, she underwent detoxification treatment. Managing her bladder pain was a key focus of her treatment. Diazepam was prescribed for anxiety, and in addition to pregabalin, baclofen was added to address the bladder pain. During detox, the patient reported significant improvement in bladder pain.

Results: One of the most challenging aspects of ketamine-induced bladder syndrome is the chronic bladder pain. Baclofen, a GABA-B receptor agonist, helped relax smooth muscles, including those in the bladder, reducing spasticity and discomfort. Baclofen also alleviated neuropathic pain, which contributed to ketamine-induced bladder dysfunction. Baclofen's ability to manage neuropathic pain makes it a valuable option when traditional painkillers fail. By inhibiting pain signal transmission, baclofen provides relief from discomfort and reduces urinary urgency and frequency. In this case, baclofen effectively alleviated bladder pain, reducing reliance on pregabalin during detoxification. Despite the complexities of her treatment plan, baclofen was vital in improving the patient's quality of life during detox.

Conclusion: Baclofen proves to be an effective alternative for managing ketamine-induced bladder pain, particularly when traditional treatments fail. This case emphasizes the importance of a multidisciplinary approach to address both physical and psychological challenges during ketamine detoxification. By managing bladder pain and other withdrawal symptoms, patients can experience a sustainable detox process, ultimately improving their chances of recovery and decreasing the risk of relapse.

Clozapine Rechallenge in Treatment-Resistant Schizophrenia: Clinical and Ethical Considerations After Ileus

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Aims: Clozapine is the cornerstone of treatment for treatment-resistant schizophrenia. It primarily acts by inhibiting dopamine D2 receptors based on the hyperdopaminergic theory of psychosis. Additionally, second-generation antipsychotics (SGAs) interact with serotonin receptors (5-HT2A and 5-HT1A), mitigating extrapyramidal side effects. However, widespread activity on D2 receptors and additional anticholinergic effects can impact gastrointestinal motility, leading to complications such as paralytic ileus. Clozapine has potent anticholinergic activity and is associated with higher risks of paralytic ileus compared with other SGAs.

Methods: A male in his late 40s with treatment-resistant schizophrenia, anxiety and panic attacks underwent an elective

inguino-sacrotal hernia repair with mesh reconstruction. Psychiatric history was significant for past suicide attempts, including a self-defenestration leading to traumatic brain injury, aggression towards his elderly father and past clozapine-induced neutropenia. He was an ex-smoker. Medications included clozapine 100 mg twice daily, amisulpride 200 mg twice daily, lithium carbonate 625 mg once daily, and hyoscine hydrobromide 300 mcg twice daily.

Postoperatively, the patient developed constipation and abdominal distension consistent with a paralytic ileus. He was placed nil by mouth and managed with nasogastric decompression. During a three-day lapse in antipsychotic treatment on the surgical ward, his mental health deteriorated, presenting with acute psychotic symptoms. The patient lacked insight into his mental health at this time.

Given the failure of alternative antipsychotics previously, the multidisciplinary team (MDT) faced a complex risk-benefit analysis. The potential dangers of reintroducing clozapine, including worsening ileus, were weighed against its irreplaceable role in managing his psychosis, suicidality, and aggression. Ultimately, clozapine was restarted cautiously with haematological and gastrointestinal response closely monitored. Psychosis subsequently improved with no recurrence of ileus, allowing him to continue clozapine treatment.

Results: This case highlights the complexities of managing antipsychotic treatment in patients with comorbid physical conditions. Clozapine's advantage of reducing suicidality and violence were balanced with its potent anticholinergic activity, warranting caution in patients at risk of gastrointestinal complications. The decision to restart clozapine was made after evaluating the significant risks of psychotic relapse. Close MDT monitoring facilitated safe reintroduction, demonstrating necessary case-by-case risk assessments when managing antipsychotics in medically vulnerable patients.

Conclusion: Rechallenging clozapine posed significant clinical and ethical challenges, requiring an evidence-based MDT approach. This case underscores the importance of balancing psychiatric needs with medical risks, particularly in treatment-resistant schizophrenia. It also highlights the role of ongoing monitoring and individualised treatment plans in managing complex psychopharmacological decisions. Further studies are warranted to explore safety of clozapine in patients with gastrointestinal-motility disorders.

Psychosis Triggered by Intensive Meditation: A Case Report and Review of Risk Factors

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Aims: Meditation is widely regarded as a beneficial practice for mental well-being, but intensive forms, such as those practiced during retreats, can pose risks. In vulnerable individuals, prolonged meditation may trigger psychosis. This case explores a psychotic episode in a previously healthy individual during an intensive meditation retreat, with a focus on clinical presentation, management, and implications for practice.

Methods: Case report.

Patient overview: Demographics: Female, 31 years old, with no ongoing mental health treatment. Psychiatric history: Previous drug-induced psychosis 6 years ago, resolved without recurrence. Substance use: Denied drug use since the prior episode. Admission toxicology screening (urine drug screen) was negative.

Retreat context: Attended a 7-day meditation retreat involving intensive mindfulness practices, minimal social interaction, and prolonged sitting meditations. Psychotic symptoms began after 3 days, prompting early withdrawal from the retreat.

Clinical presentation: Visual hallucinations: Reported seeing people's faces transform into demonic appearances. Auditory hallucinations: Hearing voices reinforcing delusions. Persecutory delusions: Believed she and her family were in grave danger, and that her death was the only way to save them. Behavioural changes: Heightened distress and withdrawal from the retreat.

Management and outcome: Admitted to the psychiatric unit. Started on olanzapine 5 mg daily. Rapid symptom resolution within 6 days. Discharged with no residual psychotic symptoms.

Literature review: Intense meditation practices, especially during retreats, can lead to adverse psychological effects, including psychosis, depersonalisation, and emotional dysregulation. Risk factors identified in literature:

Pre-existing vulnerability (e.g., history of psychosis or trauma).

Retreat conditions (e.g., fasting, sleep deprivation, and isolation).

Lack of individualised guidance or screening.

Meditation-induced psychosis has been noted to present with symptoms such as hallucinations, paranoia, and altered states of consciousness. Recovery is typically rapid with antipsychotic treatment.

Results: Mechanisms: Prolonged meditation may disrupt normal cognitive and emotional regulation, leading to altered reality testing. Psychotic symptoms could result from sensory deprivation, emotional overload, or resurfacing of unresolved trauma.

Case-specific insights: While the patient had a history of drug-induced psychosis, her 6-year symptom-free period and negative toxicology suggest that meditation-induced stress was the primary trigger. The rapid response to low-dose olanzapine highlights the transient nature of the condition.

Implications for practice: Pre-retreat mental health screenings are crucial to identify vulnerable individuals. Retreats should offer tailored practices and provide professional mental health support. Awareness among clinicians is necessary to distinguish between culturally induced altered states and pathological psychosis.

Conclusion: This case underscores the potential for intensive meditation to induce psychosis, even in individuals without active mental illness. Clinicians and meditation facilitators must collaborate to mitigate risks, particularly for individuals with prior psychiatric vulnerabilities.

The Role of Doxazosin in PTSD-Related Nightmares: A Case of Comorbid Anorexia Nervosa

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Aims: This case involves a 32-year-old female with a history of Anorexia Nervosa and Post-Traumatic Stress Disorder (PTSD) admitted for restricted eating. During admission, she reported worsening PTSD symptoms, including nightmares, linked to a reduction in her doxazosin dose. Doxazosin, an alpha-1 adrenergic antagonist, is used off-label to treat PTSD-related nightmares by