of SSRIs (fluoxetine and sertraline) and chocolate (which contains serotonin) leading to an itchy hive-like rash. In these cases, discontinuation of the SSRI and use of antihistamine led to a resolution of symptoms.

We report a case who developed urticaria 30 days on fluoxetine without any other identifiable triggers. Aspects of this case to support a possible rash caused by chocolate-fluoxetine interaction include the rash occurring when the patient was consuming chocolate (quantities possibly increased immediately prior to the onset of rash), rash occurring when steady-state levels of fluoxetine had just been reached, no other identifiable trigger to explain the rash in the history and the slow resolution of the rash which can be explained by the long half-life of fluoxetine.

Conclusion. This report highlights the importance of being mindful of this rare dermatological side effect of fluoxetine despite it occurring weeks after initiation. Patients should also be made aware of this possible side effect and its association with consuming chocolate.

Rapid Cycling Bipolar Affective Disorder After COVID-19 Infection Accompanied With Neurological Symptoms

Dr Abdul Raoof, Dr Shaimaa Aboelenien, Dr Adel Elagawany and Dr Derya Nurlu*

Essex Partnership University NHS Foundation Trust, Chelmsford, United Kingdom
*Corresponding author.

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Aims. This case highlights an atypical presentation of a patient with known history of Bipolar Affective Disorder who experienced rapid mood changes and atypical neurological symptoms after he was tested positive for COVID-19.

Methods. Here we present a 63 years old male patient who was an inpatient in low secure forensic unit and has a history of Bipolar Affective Disorder. Patient reported that he started to experience COVID-19 symptoms and was tested positive on 12th April 2020. It was observed that patient experienced low mood, flat effect, anhedonia and decreased appetite for more than a month after he was tested positive. According to his medical records, he experienced significant mood changes suggesting major depression and manic/hypomanic episodes, 4 times to be specific, over 6 months period after having diagnosed with COVID-19 which is correlated with diagnostic guidelines for Rapid cycling Bipolar Disorder. Patient was observed to experience 1 major depressive episode over period of 6 months before his COVID-19 diagnosis. He also reported experiencing neurological symptoms such as tremor, numbness and unsteadiness on one leg. Although it was found that his lithium level was above therapeutic range at the beginning of these symptoms, even after successful reduction of Lithium dose, patient continued to experience these symptoms for another month. There were no gross abnormalities in physical examination and his blood results were not significant. In addition to Electroencephalogram (EEG); Computed Tomography (CT) scan, Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) were conducted and the results were all insignificant. During this time, he was fairly compliant with his medications. Additionally, his mood was stabilised only partially with the medications he was taking. He did not have any other major environmental, psychological or physical changes that might explain his rapid mood cycling.

Results. Authors considered various different causes for this patient's fluctuating mood. One confounding factor that was considered was blood lithium levels. However, that was proven to be irrelevant since patient continued to experience mood changes and neurological symptoms with therapeutic lithium levels. Also no other organic reasons were found that could explain his neurological symptoms.

Conclusion. Although, authors consider that longer observation period and other confounding factors could affect findings, they cannot confidently reject the impact of COVID-19 infection on patients with enduring mental illness and recommend further research which could lead to more comprehensive guidelines

The Use of Genetic Testing in the Management of Depression

Dr Alex O'Neill-Kerr* and Dr Nneamaka Nwabunike

Berrywood Hospital, Northamptonshire Healthcare NHS Foundation Trust, Northampton, United Kingdom
*Corresponding author.

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Aims. We report on a case of depression where genetic testing was used to determine potential treatment modalities.

Methods. The patient is a 78-year-old man who had suffered from depression for 55 years. He had a serious episode in 2002. He developed a further depressive episode in 2018 which did not respond to paroxetine. He was offered TMS and was initially treated in the NHS and subsequently in the private sector. He went into remission with TMS and continues to remit with TMS however his depression became unstable and it was clear that the paroxetine was having no effect. He agreed to have a genetic test, a buccal mouth swab was taken and posted to gensense in the United States. An 18 page document and a half hour session with gensense are included in the cost of the test. The results of his genetic test and suggestions regarding treatment are detailed below.

SLC6A4 L(G)/S serotonin transporter indicating a less favourable response to SSRI medication (20% response versus 40% response). SNRI medication may be useful.

BDNF Val/Met Met carriers may have poor response to SSRIs and an improved response to SNRI's and TCA's. Met carriers have a 3 times better response to exercise than Val/Val

MTHFR A/A variant, this results in a 70% reduction) in the ability to convert folate to methyl folate (required for the manufacture of serotonin). Taking L-methylfolate supplementation (7.5mg) may improve serotonin production and provide a 2 times increase in response rate to antidepressants.

COMT Val/Val variant indicates improved response with brain stimulation therapy such as ECT and TMS

CACNA1C A/A variant which increases the anteromedial and amygdala activity and increased neuronal activity as a result of increased calcium channel receptors. This variant is associated with more depression, OCD and anxiety. Using lithium, sodium valproate and lamotrigine could be potentially useful in this group.

Results. The patient's antidepressant was switched from Paroxetine to Venlafaxine XL 150 mg, he started taking L methyl folate supplements (7.5mg daily) and was put onto sodium valproate 250 mg 3 times a day. His HAM-D went from 39 in

December 2022 to sub-baseline by the end of January 2023. He also started regular mild exercise and daily use of tDCS (Sooma and Flow).
Conclusion. We conclude that genetic testing can be a useful clinical tool and can be helpful in deciding which treatments may benefit.

Psychosis Prompts Detection of Early Stage Angioimmunoblastic T-Cell Lymphoma

Dr Li Anne Ong[1,2]* and Dr Tabitha Mok[1]

[1]Changi General Hospital (Psychiatry), Singapore and [2]Ministry of Health Holdings, Singapore
*Corresponding author.

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Aims. Angioimmunoblastic T-cell lymphoma (AITL) is a rare (2%) and aggressive form of Non-Hodgkin lymphoma, with poor prognosis and median overall survival under 3 years. Most patients with AITL present at an advanced stage (3 or 4). Neuropsychiatric manifestations of lymphoma, though rare, have been reported as associated symptoms. We present a case of successfully treated Stage 2 AITL, whose rare presentation, of florid affective and atypical psychotic phenomena without neurological deficit, eluded clinical detection of AITL for months.
Methods. A 58 year-old gentleman with a history of Major Depressive Disorder, presented to hospital with a second episode of generalised tonic clonic seizure, following 4 months of manic disorganised behaviour and multimodal hallucinations.

Atypical psychotic features (preserved insight, multimodal hallucinations resistant to high dose anti-psychotics) and new systemic symptoms prompted suspicion of underlying organic pathology. CT Thorax Abdomen and Pelvis uncovered enlarged bilateral common iliac and external iliac lymph nodes, and small sub-centimetre retroperitoneal nodes. Eventually, Stage 2 Angioimmunoblastic T-cell lymphoma (Pattern 1 & 2), with concomitant psychosis with atypical features, was diagnosed.

Olanzapine 10mg ON and 2.5mg OD PRN, Sodium Valproate EPILIM CHRONO 300mg BD and Diazepam 10mg ON were continued over 6 rounds of chemotherapy and autologous stem cell transplant. The patient remains in remission.
Results. Neuropsychiatric manifestations of lymphoma are rare and usually associated with Central Nervous system (CNS) lymphoma. Here, we observe Stage 2 AITL (without CNS involvement), can present with neuropsychiatric symptoms in the absence of neurological deficits.

We found the combination of Olanzapine, Sodium Valproate and Diazepam to be effective in managing secondary neuropsychiatric symptoms.

Limbic Encephalitis is an important consideration for similar cases despite this patient not meeting the qualifying criteria (unremarkable neuroimaging and EEG).

This case highlights the importance of a thorough history, documenting and understanding the patient's psychopathology (both reported and observed), and differentiating atypical psychotic features which raise suspicions for underlying organic pathology.
Conclusion. This case is an an eye-opener for psychiatric and non-psychiatric clinicians. It reminds us to remain vigilant in such florid psychiatric presentations and highlights the importance of thorough organic workup and psychiatric medications that may be used to successfully address psychosis secondary to lymphoma.

We hope to contribute to the increasing awareness and broadening literature of psychiatric disturbance as initial manifestations of malignant illnesses, and the association between psychiatric manifestations and the rare form of lymphoma, AITL.

Sertraline-Induced Urinary Incontinence in Adolescent: A Case Report

Dr Nacharin Phiphopthatsanee*

South London and Maudsley NHS Foundation Trust, London, United Kingdom
*Corresponding author.

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Aims. Serotonin reuptake inhibitors (SSRIs) are commonly used to treat obsessive-compulsive disorder (OCD). In the UK, sertraline and fluvoxamine are the only SSRIs licensed for use in young patients with OCD. There is currently limited evidence suggesting an increased risk of urinary incontinence with SSRI use. Literature in children and adolescents is even more scarce, with only a few published case reports of SSRI-induced urinary symptoms. This case report adds to the pre-existing evidence in support of the previous suggestion on sertraline-induced urinary incontinence.
Methods. A 14-year-old girl with a diagnosis of OCD was treated with a combination of cognitive behavioural therapy (CBT) and sertraline, which was gradually titrated in steps of 25 mg fortnightly. There was a noticeable improvement in her OCD symptoms soon after the medication was initiated. However, a few days after sertraline was increased to 100 mg, she started to report urinary incontinence, urgency, and frequency, both daytime and nighttime, which significantly impacted her quality of life. She denied other urinary symptoms or change in fluid intake. Investigations for diabetes mellitus and urinary tract infection were negative. It was therefore concluded that her urinary incontinence was related to an increase in sertraline dosage, and she was advised to take an alternating dose of 75 mg and 100 mg daily. The symptoms resolved shortly afterwards, and sertraline was subsequently titrated up to 150 mg daily without any issues.
Results. Due to its rare encounter, the association between the use of sertraline and urinary incontinence has only been quantified in a single retrospective study with an adjusted risk ratio of 2.76 (95% CI 1.47–5.21). A clear temporal relationship of symptoms, its occurrence after the dosage increase, and rapid resolution after dose reduction confirmed the role of sertraline in the development of urinary incontinence in this case. Consistent with a previous case report, the dose-dependent effect was also implied. This phenomenon might be explained pharmacologically by sertraline's serotonergic activation, which can potentiate neuromuscular cholinergic transmission in the detrusor muscle, and dopaminergic activation, which can stimulate urine micturition. However, the exact mechanism remains unclear.
Conclusion. Although sertraline-induced urinary side effects occur relatively infrequently, clinicians should be aware of and actively look for these side effects, especially in patients who are prescribed SSRIs at higher doses. It is also important to exclude other causes that may contribute to urinary incontinence.