Conclusion: Understanding such cases is vital for accurate diagnosis and effective intervention, especially given the reinforcing nature of shared delusions and the persistent nature of DP.

A Case Series Highlighting Complexities in the Management of Bipolar Disorder With Parkinson's Disease

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Aims: Evidence is emerging regarding the association between Bipolar Affective Disorder (BPAD) and Parkinson's disease (PD). Studies have shown patients with BPAD have a higher risk of developing PD. This case series explores the complexities encountered in the management of patients with PD and BPAD.
Methods: 'A' is a woman in her 70s with BPAD. Parkinsonian symptoms were noted for several years, suspected to be medication-induced. She was diagnosed with Parkinson's disease, after a positive DaT scan, treated with co-beneldopa, which induced a manic episode, requiring hospitalization. Co-beneldopa was stopped, she improved with lamotrigine and clonazepam.

'B' is a woman in her 70s with BPAD with a family history of Parkinson's disease. She was hospitalized after relapse of BPAD. She was noted to have a unilateral tremor, stooped posture and a shuffling gait. She is now being assessed for Parkinson's disease.

'C' is a woman in her 60s with BPAD, on sodium valproate and aripiprazole. She was reviewed by neurology due to bilateral tremor, rigidity and unsteady gait, and subsequently diagnosed with drug-induced parkinsonism. Due to miscommunication, GP started her on co-beneldopa, for Parkinson's disease. Subsequently, she developed mania warranting hospitalization. The ward team was unaware of the misdiagnosis. Co-beneldopa was subsequently stopped. She continued having poor oral intake, intractable mania, treated with ECT.
Results: Literature review shows BPAD is associated with Parkinson's disease (PD). Evidence indicates, a diagnosis of BPAD, increases the risk of developing PD. With no established intervention for patients with co-morbid BPAD and PD, treatment becomes complex. Proposed pathology suggests BPAD is exacerbated by heightened dopamine levels, while PD from reduced dopamine. This makes it challenging to treat one without impacting the other. Mood stabilizers and antipsychotics can contribute to drug-induced parkinsonism (DIP), which may clinically be indistinguishable from PD. Antiparkinsonian medications like dopamine agonist and pramipexole can cause manic symptoms.
Conclusion: Historically, heterogeneity in psychiatric disorders, both in presentation and response, remains the norm. In this case series, we try to highlight the complex relationship between BPAD and PD. To establish a direct causal relationship is challenging due to the various confounders. This being a niche topic with limited research, emphasizes the need for large sample studies, which could shed more light on the longitudinal course and relationship between the two disorders and help establish future treatment guidelines.

Beyond Psychiatric Illness: Paediatric Autoimmune Neuropsychiatric Syndrome Presenting as Psychosis

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Aims: Paediatric Autoimmune Neuropsychiatry Syndrome is a rare condition with exact prevalence not known due to dearth of large-scale population studies. Its diagnostic as well as treatment guidelines are not yet validated. There are a few international guidelines but none available in the UK yet.
Methods: The referral of a 15-year-girl presenting with symptoms suggestive of PANS to our team prompted us to write this case report. The patient was brought in to the A&E by her parent after an episode of bizarre and chaotic behaviour at school, which included her throwing belongings at the staff while being emotionally labile. On assessment she reported symptoms suggestive of paranoid delusions, delusional perception, auditory and gustatory hallucinations, thought broadcasting and delusional memory. She was also taking more frequent showers, with clothes on. Her sleep was disrupted.

Extensive blood and radiological investigations initially didn't yield any positive findings. Antipsychotic (olanzapine) was initiated and the patient's mental state quickly improved. Two days later blood investigations showed raised antistreptolysin O titres (200–400 U/Ml). Hence, antibiotic (phenoxymethypenicillin) was initiated. The patient was discharged and followed by our team in the community.

The patient continued to present with residual psychotic symptoms which fluctuated in the community setting. But the overall functioning significantly improved.
Results: The acute onset of psychosis, characterized by behavioural disturbances, anxiety, sleep disruption, irritability, and emotional lability, along with elevated antistreptolysin O titres, suggested a diagnostic formulation aligning with PANS.
Conclusion: The case underscores the importance of considering PANS as a differential diagnosis in school-aged children presenting with symptoms of OCD, first episode of psychoses or unexplained emotional lability.