Recommendations to increase performance include discussions with referrers, changes to the referral form, and changes to referral screening.

Case Study

Rifampicin-Induced Panic Disorder in a 70-Year-Old Woman With Brucellosis: A Case Report

Dr Sunday Adeoye

Humber Teaching NHS Foundation Trust, Hull, United Kingdom

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Aims: Panic disorder, also known as paroxysmal episodic anxiety, is a severe, unpredictable, and debilitating form of anxiety that is characterised by sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalization or derealization). People that suffer from panic attack often have a secondary fear of dying or losing control. Like many other mental illnesses, the causes of panic disorder are unknown, but some predisposing factors have been identified including genetics, neurobiology, medications, psychiatric disorders, psychosocial factors and medical conditions.

Brucellosis is an infective medical condition caused by Brucella. In the UK, it is a very rare notifiable disease and transmission is usually from consumption of unpasteurised milk and cheese or from contact with infected animals. Brucellosis is considered a public health problem by many countries not only because of the economic loss it brings but it also causes chronic pain, anxiety, and depression, affecting the life quality of patients. Treatment for human brucellosis is based on combinations of antibiotics such as doxycycline, streptomycin, gentamicin, ciprofloxacin, and trimethoprim–sulfamethoxazole and rifampicin over a period of about 6 weeks. Rifampicin on the other hand has been implicated in worsening mental health conditions like anxiety and depression in many previous literatures.

The mechanism by which this occurs has been put to the drug-to-drug interaction that rifampicin might have with other medication patients are taking and the effect of rifampicin as cytochrome p450 enzyme inducers. This case report presents another perspective of rifampicin inducing and worsening panic disorder in a patient that has not previously been diagnosed with anxiety disorder.

Methods: This patient was a 70-year-old woman with background of depression, stable on sertraline, who contracted canine brucellosis from her dog. While on isolation ward in physical health hospital, she was commenced on rifampicin intravenously and oral doxycycline. She developed new onset panic attack five days into the treatment. was referred by the General practitioner following reports of new onset panic attacks. She continued to suffer from these panic attacks even when rifampicin was changed to oral after discharge from hospital. This affected her quality of life significantly. She was commenced on short course benzodiazepine after risk and benefit explained to her. Her sertraline was increased from 50 mg to 100 mg daily. Other psychological options were also explored. Patient reported good improvement within two weeks of commencement of treatment.

She reported good improvement during four-week follow up visit. She had not had panic attacks two weeks prior to the review. She had been tapered off the diazepam and she was one week left in completing her antibiotic regimen. Patient was followed up for two more weeks and discharged back to the GP.

Results: This patient presented with new onset panic attacks following commencement on rifampicin in the treatment of brucellosis. There have been reports that anxiety and depression are the commonest mental health conditions associated with brucellosis. It is therefore a possibility that the new severe debilitating form of anxiety is due to the infection with Brucella. On the other hand, there have been reports that patients treated for tuberculosis with rifampicin have increased incidence of anxiety. The mechanism of this has been linked to the inducing effect rifampicin has on liver enzyme cytochrome P450 which plays a crucial role in the metabolism of most medications. In the case of index patient, rifampicin might have had a drug-drug interaction with sertraline this patient was taking for depression. Though the sertraline was intended for treatment of depression, it is obvious that it was also helpful for premorbid anxiety for this patient. Once the beneficial effect of sertraline was reduced by the rifampicin, it led to the onset of severe and debilitating anxiety. Similar reports about interaction between rifampicin and citalopram have been reported.

Conclusion: The follow-up to this report would be to conduct a case series and observe the occurrence of drug-drug interaction between rifampicin and other common psychotropics.

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A Case of Clozapine-Induced Myocarditis: Navigating the Risks of the Gold Standard Treatment

Dr Srishti Agarwal, Dr Nitish Jayanth Kumaraswamy and Dr Manicavasakar Kathirgamar

Central and North West London NHS Foundation Trust, London, United Kingdom

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Aims: We present a case of a 36-year-old patient on clozapine who was an inpatient in a mental health rehabilitation service diagnosed with Schizophrenia. During clozapine titration, the patient complained of chest pain and elevated temperature. The patient was subsequently transferred to the emergency department for further evaluation and management. Following the discontinuation of clozapine and the initiation of brief supportive medical therapy, the patient's symptoms, ECG changes, and troponin levels fully resolved.

Methods: A 36-year-old Asian male diagnosed with paranoid schizophrenia, admitted to rehabilitation psychiatry. With no significant past medical history, clozapine was introduced in January 2024 using a slow titration protocol, resulting in minimal mental state improvement and physical deterioration. In February 2024, he developed a severe chest infection requiring a two-week hospitalization, during which clozapine was discontinued.

After discharge, clozapine was reinitiated with a slow titration protocol; however, in March 2024, the patient presented with tachycardia, elevated temperature, and chest discomfort during the titration process. ECG findings revealed sinus tachycardia with a heart rate of 112 bpm, a prolonged QTc interval of 470 ms, frequent premature ventricular complexes (PVCs), and ventricular bigeminy. Blood tests showed an elevated troponin T of 16 ng/L (normal range: 0–14). During an A&E evaluation, the patient was asymptomatic apart from the noted ECG abnormalities and was discharged within 24 hours with recommendations to reassess his medications. Clozapine was subsequently discontinued, and no antipsychotic therapy was initiated immediately.

A follow-up ECG performed one week later showed normalized findings, including a heart rate of 54 bpm and a QTc interval of 443 ms, while troponin T levels returned to normal at 14 ng/L. Clinical resolution of myocarditis-like symptoms was observed.

Results: In this case, the patient developed significant ECG abnormalities and elevated troponin levels within two months of clozapine initiation. These findings, combined with clinical symptoms, necessitated immediate discontinuation of clozapine. Subsequent resolution of cardiac abnormalities within one week strongly indicated clozapine-induced myocarditis or cardiotoxicity. This outcome aligns with existing evidence that supports stopping clozapine in the presence of significant cardiac derangements.

Conclusion: This case emphasizes the critical need for monitoring for any adverse effects from clozapine particularly in the titration phase. Regular monitoring, including ECG and blood tests, is essential to identify early signs of myocarditis or cardiotoxicity. If there are any symptoms indicating cardiac abnormalities, clozapine should be discontinued immediately and referral should be made to medical or cardiology specialist for further evaluation.

Genital Self-Mutilation in a Young Male With Psychotic Symptoms: Klingsor Syndrome – A Case Report

Dr Walaa Alnammourah, Dr Nizar Marzouqa, Dr Naim Alshaikh and Dr Iltezam Morrar

Bethlehem Psychiatric Hospital, Bethlehem, Palestine

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Aims: Genital self-mutilation (GSM) is a rare but severe form of self-harm often linked to underlying psychiatric disorders, particularly psychotic conditions. Approximately 54% of GSM cases occur in patients with psychosis, with substance use disorders being the second most common associated condition. Various triggers, including perceived rejection, lack of social support, and acute substance intoxication, have been implicated in GSM. When GSM arises from psychotic symptoms, it is referred to as Klingsor syndrome. Immediate psychiatric intervention is critical for managing such cases and preventing recurrence.

Methods: A 28-year-old divorced male was brought to the nearest hospital by his family following a penile self-amputation with a blade. Immediate surgical repair was performed. Three weeks later, he was admitted to Bethlehem Psychiatric Hospital for further evaluation and treatment. The patient had a history of self-harm that previously necessitated hospitalization. His psychiatric symptoms included commanding auditory hallucinations, delusions of reference, feelings of worthlessness, and psychotic features that emerged after cannabis use. In the weeks leading up to the self-mutilation, the patient exhibited insomnia, social withdrawal, and a growing preoccupation with self-castration. On examination, he appeared distressed, with an irritable affect and poor insight into his actions. He expressed a strong belief that his genitals were "the source of all problems" and reported suicidal ideations, stating he "needed to get rid of his penis or else would commit suicide". He also exhibited persecutory delusions, delusions of guilt, control, and thought broadcasting. A comprehensive psychiatric assessment confirmed a diagnosis of Schizoaffective Disorder, exacerbated by substance use. He was admitted to the psychiatric ward following medical stabilization and was treated with quetiapine 600 mg/day, titrated as needed, and carbamazepine for mood stabilization. Supportive psychotherapy aimed at improving insight and addressing delusional distress was initiated, alongside family psychoeducation to prevent recurrence.

Results: During his four-week inpatient stay, the patient demonstrated gradual improvement in his psychotic symptoms. His insight improved significantly, and he ceased expressing delusional beliefs about his genitals. Upon discharge, he was referred to the Community Mental Health Centre (CMHC) and enrolled in an outpatient psychiatric programme, which included ongoing medication management and psychotherapy. At the few-months follow-up, he remained adherent to his treatment plan with no recurrence of self-harm behaviours.

Conclusion: This case highlights the interplay of psychosis and substance use in GSM and underscores the necessity for early intervention and psychiatric care. A multidisciplinary treatment approach including pharmacotherapy, psychotherapy, and family support is essential for prevention of future episodes.

Idiopathic Regression in Down Syndrome

Dr Ayomipo Amiola[1], Dr Manilka Brahmana[1], Dr Ignatius Gunaratna[1] and Professor Regi Alexander[1,2]

[1]Hertfordshire Partnership University NHS Foundation Trust, Little Plumstead, United Kingdom and [2]University of Hertfordshire, Hatfield, United Kingdom

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Aims: Idiopathic Regression in Down Syndrome (IRDS) is reported to be present in 16% of people with Down syndrome however the clinical presentation is heterogeneous with no universal diagnostic criteria. It often presents in adolescence or early adulthood and there are often no known triggers. Common symptoms include language regression, mood symptoms, psychotic phenomena, motor symptoms and loss of previously acquired cognitive skills.

We present a case series of two patients who presented to the West Norfolk Community Intellectual Disability Service with symptoms suggesting IRDS.

Methods: AB (F; 34 years) has the diagnoses of Mild Learning Disability, Down syndrome, Bipolar Affective Disorder following a manic episode at the age of 18 and obsessive-compulsive disorder with predominantly compulsive acts. She was described by parents as a very sociable, active, and high achieving before she developed acute regression. Around the age of 12 years following an episode of profoundly serious pneumonia, she became catatonic, anorexic, and doubly incontinent. Clearly described episodes of depression and mania, obsessional behaviours and speech deterioration were also noted.

The diagnosis of IRDS was raised by parents in 2023 and AB is currently being assessed for immunotherapy.

XY (M; 46 years). Following a gastrointestinal infection aged 18 years, the family noticed he became more housebound, obsessional about symmetry, and depressed. No specialist investigations were