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Status epilepticus in a patient treated with olanzapine and mirtazapine

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Objective: To report a case of status epilepticus in a patient receiving olanzapine, with no previous history of seizure and no confirmed underlying cause for seizure.

Case Summary: A 48-year-old woman with low weight and psychotic disorder not otherwise specified, was admitted because of provoked vomiting and anorexia. She developed generalized tonic-clonic seizures that progressed to status epilepticus during her hospitalization. Two days earlier, treatment switched from mirtazapine 30 mg plus quetiapine to mirtazapine 30 mg plus olanzapine - with quick titration up to 30mg. No other toxic, metabolic, electrolyte or anatomic abnormality was identified. Olanzapine was discontinued and the patient was started on intravenous phenytoin, which was discontinued without complications one month later. The patient remained seizure free.

Discussion: To our knowledge this is the second case of status epilepticus described that has been associated with the use of olanzapine, in a patient with no other confirmed predisposing factors for seizure. Olanzapine is an atypical antipsychotic that shares many pharmacological properties with clozapine. However, clozapine has been noted to induce dose-dependent seizures in about 10% of patients, whereas manufacturer's trials gave a seizure rate of 0,88% for olanzapine, similar to other antipsychotics. In our patient it is possible that seizures were induced due to the abrupt change in pharmacotherapy and the quick titration to high dose.

Conclusions: Although olanzapine has infrequently been associated with epileptogenic risk, it should be used cautiously especially when other predisposing factors exist.

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The increased need for liaison psychiatry in surgical patients due to the high prevalence of undiagnosed anxiety and depression

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Background and aims: Depression is the most common mental disease in patients hospitalized with physical illness. Disorders of anxiety and depression in general hospitals are frequently underdiagnosed and inappropriately treated. Our objective was to assess the prevalence of undiagnosed anxiety and depression in surgical inpatients and assess the referral rate and utilization of liaison psychiatry services.

Methods: A prospective multi-centre study of surgical admissions (n=96) to two surgical services at two separate institutions between 1/01/05 and 31/12/05. The surgical services included general surgery and cardiothoracic surgery. Data was collected prospectively utilizing the computerized hospital inpatient system (HIS) and supplemented with data from medical records. The Hospital Anxiety and Depression (HAD) scale was used to evaluate all patients in the study cohort. Patients with a documented psychiatric history and established psychiatric diagnosis were excluded.

Results: We had 96 individuals in our patient cohort. The mean age was 59.6 years. There was a slight female predominance with a female: male ratio of 1.18:1. Surgical procedures were performed in 68.75% of our patient cohort. 12.5% of patients were discovered to suffer with significant depression. 18.75% of patients suffered with significant anxiety. 8.3% of patients had significant mixed anxiety and depression. 22.9% of patients warranted referral to liaison psychiatry services for further assessment and management.

Conclusions: Disorders of anxiety and depression are highly prevalent in surgical inpatients. There needs to be an increased awareness of the possibility of undiagnosed psychiatric disorders in such patients along with prompt and appropriate use of liaison psychiatry services.

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Improvement of tardive dyskinesia with aripiprazol use. Case report and review of 4 cases

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Tardive dyskinesia (TD) is a severe side effect of antipsychotic treatment. Factors considered as predisposing include age, gender, emotional disorders, diabetes, development of EPS during early treatment, prolonged administration and use of high doses of conventional antipsychotics. The second generation antipsychotics are of significantly lower risk. Furthermore, there is evidence that they may have a therapeutic effect on TD. This is well established for clozapine and there are reports also for risperidone, olanzapine, quetiapine and amilsulpride. Aripiprazole inhibits central dopaminergic neuron activity by a partial agonistic effect on the presynaptic D2 dopamine autoreceptor and also acts as an antagonist at postsynaptic D2 dopamine receptors. Through this mechanism, aripiprazole exerts activity as a dopamine agonist in hypodopaminergic states, while acting as a dopamine antagonist when dopaminergic activity is increased. There is also evidence from basic science studies that aripiprazole causes little D2 receptor up-regulation.

Case report: We report a case of an 84 year old woman with lingual-facial-buccal TD, due to treament for 10 years with Haloperidol 2 mg/day, after a single psychotic episode. A decision to switch to aripiprazole 10 mg/day was made. Over the next month, her TD gradually disappeared, and re-emerged after three months when the patient gave up treatment against our advice. We also review four other cases reported in the last two years with similar findings. These properties may play a role in both prevention of the emergence of TD and the treatment of TD. Aripiprazole may provide alternate pharmacotherapy to treat psychoses and TD.

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Survey of facilities available in psychiatric clinics to check blood pressure, ECG and associated training requirements

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Background: Psychotropic drugs including some of the new generation of antidepressants and antipsychotics can have important effects on the cardiovascular system including changes in blood pressure and effects on the QTc interval. It is good practice to check ECG and blood pressure (BP) before the administration of certain psychotropic agents. It has been suggested that Psychiatrists should be able to interpret ECG's.

Aims and Method: The aim of our study was to assess the facilities available in the Psychiatric clinic to check blood pressure and arrange ECG's. We were also interested to find out whether psychiatrists were confident in interpreting ECG's and clarify any associated training requirements. So, we carried out an anonymous postal survey of 260 consultant psychiatrists in the North West of England. Data were analysed with the Statistical Package of Social Sciences (SPSS) version 13 for windows.

Results: 132 consultants returned the completed questionnaires giving a response rate of 50.7%. A majority of respondents (59%) felt that it was difficult to arrange for ECG in the clinic and worryingly an even higher percentage (61.4%) lacked facilities to check blood pressure. Only a small minority (12.9%) felt confident about identifying QT prolongation on ECG. An overwhelming percentage of respondents (81.8%) respondents felt that doctors working in psychiatry should have regular training in interpreting ECG's.

Conclusions: This survey highlights the lack of facilities in mental health clinics to check blood pressure and arrange simple medical procedures like ECG. It also highlights the need for regular ECG training for psychiatrists

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Coercion and antipsychotic medication for voluntary out-patients: Depot versus oral

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Background: Some clinicians consider depot antipsychotics to be stigmatizing and coercive. Former coercion studies have predominantly considered hospital admission rather than medication. This cross-sectional study investigated patients' perspectives of coercion for depot and oral antipsychotics.

Methods: 72 participants, with schizophrenia or schizoaffective disorder on voluntary maintenance medication were randomly selected for further in-depth interviews as a sub-sample from an antipsychotic attitudinal study. The MacArthur Admission Experience (short form) was adapted to explore coercion regarding medication. Scores were compared for formulation groups (depot versus oral).

Results: Only 9 (12.5%) had no concerns about coercion. Coercion scores were higher for depot than oral in terms of total score (mean 4.39 vs 2.80, p=0.027), perceived coercion (2.52 vs 1.73, p=0.041) and negative pressures subscales (1.17 vs 0.33, p=0.009). No significant differences were found for the ''voice'' subscale (0.70 vs 0.73) and affective reactions. Specifically, more participants on depot felt that people try to force them to take medication (30% vs 2%, p<0.001).

Conclusions: To our knowledge, this is study is unique in that it reports specifically on coercion regarding both depot and oral antipsychotics, using systematic quantitative methodology. Participants felt that treatment with depots was more coercive than with oral antipsychotics and was associated with a relative lack of true autonomy. One reason for this might be that depots are ''given'' rather than ''taken''; thus the ''power of others'' may be seen as more potent. Greater perceived coercion may explain why some consider depots to be a more stigmatizing form of treatment.

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Depression - Causes and remedies

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The events of life are present in all forms of depression. The major cause of the events who determine depression is the behavior of the others, whether or not it is a reaction to the subject's behavior. In parallel with biological cures and psychotherapy interventions, the author uses a form of re-socialization by religious education, with three objectives: 1) the initiation in the study of human behavior, insisting on the instincts and their actions; 2) The Decalogue- the first step of the greatest importance towards the education of the instincts 3) The Christian belief- the human aspiration to perfection, a maximum of (re)socialization of the human being. Human ontogenesis repeats the evolution of Humanity, but not everyone becomes an adult. Immaturity with moral retardation affects millions of ours contemporary.

Keywords: DEPRESSION, DECALOQUE, CHRISTIANITY, MORAL RETARDATION.

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Ziprasidone in hospitalized patients with schizophrenia: Evidence supporting rapid dose titration

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Optimal dosing of psychotherapeutic agents has implications for both symptom control and patient compliance. Trials of ziprasidone in bipolar mania and schizophrenia suggest a target dose of 120-160 mg/d and that rapid titration to this level provides maximum symptom improvement. In this report, data from 2 similarly designed fixed-dose placebo-controlled studies of ziprasidone (rapidly titrated to target doses of 40, 80, 120, or 160 mg/d) in patients with acute schizophrenia were pooled. 369 patients received ziprasidone and 171 patients received placebo. Efficacy was assessed using PANSS at Weeks 1 and 6 (LOCF endpoint) of treatment. Tolerability was assessed by discontinuations (all-cause and due to adverse events). There was a significant linear dose-response relationship between ziprasidone dose and PANSS total score ($F = 12.32$, $P \leq 0.001$). All ziprasidone doses produced statistically significant improvement in PANSS total score; the largest effect size (0.52) was observed for the 160 mg/d group. At Week 6, least-squares mean PANSS total score decreases from baseline were 9.98, 9.54, 11.71, and 14.87 in 40, 80, 120, and 160 mg/d groups, respectively. The corresponding placebo decrease was 2.79. At Week 1, decreases from baseline were 6.18, 5.70, 7.80, and 8.96 in 40, 80, 120, and 160 mg/d groups, respectively. The corresponding placebo decrease was 0.84. Tolerability of ziprasidone 160 mg/d (all-cause/AE discontinuations at week 6: 22%/15% versus 35%/0% for placebo) was comparable with that of lower doses. Rapid titration of ziprasidone to 160 mg/d was associated with greater efficacy compared with lower doses and was well tolerated.

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Use of long lasting risperidone in hospitalized patients

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