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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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