

Letters to the Editor

Zenker's Diverticulum and Psychosis in the Elderly

Dear Editor:

Zenker's diverticulum is a pouch protruding posteriorly above the upper esophageal sphincter (1). A small diverticulum may be asymptomatic, while a large one may produce dysphagia, food regurgitation, weight loss, and gastroesophageal reflux symptoms. Pneumonia has been reported as a complication in 12% of cases (2). I present the case of an elderly man whose recurrent complications of a Zenker's diverticulum exacerbated a pre-existing psychotic illness. I am not aware of any similar cases in the literature.

Case Report

A 70-year-old man presented with a several-year history of monthly exacerbations of psychotic symptoms. The episodes are characterized by the patient yelling and talking loudly to himself. As well, he displays agitation, poor attention, and disorientation as to date—and often year and at times, place—together with fluctuation in symptoms. He has a 50-year history of a psychotic illness and a diagnosis of chronic, undifferentiated schizophrenia. He currently receives olanzapine 20 mg daily at bedtime.

During the episodes of increased psychosis, physical examination and chest x-rays have revealed pneumonia; antibiotic treatment is followed by improvement in the agitation and psychosis. When a swallowing study was performed, the patient's upper esophagus filled with the bolus, with evidence of a Zenker's diverticulum.

This man's recurrent episodes of increased psychosis are consistent with repeated episodes of delirium superimposed on his schizophrenia. The delirium appears to be associated with pneumonia that is in turn likely related to

aspiration caused by the Zenker's diverticulum. Delirium is a frequent complication of pneumonia, with increased morbidity and mortality in the elderly (3,4). Since fever is frequently absent, delirium may be the only manifestation of pneumonia in the elderly (5).

Treatment recommendations should take into account measures to prevent aspiration. These include a moist solid diet, using a chin-tuck head posture to drink thin liquids (which should be given separately from meals), and good oral hygiene to decrease oral bacteria and the risk of pneumonia if aspiration occurs. Consultation with a gastroenterologist is important to assess esophageal function. Surgical correction of the Zenker's diverticulum is often not considered in the elderly, owing to concerns about increased surgical risk. Nevertheless, the surgery has been found to be safe and effective, with resolution of symptoms and improved quality of life for most patients (2).

References

1. Acker E. Zenker's diverticulum. *Dig Dis* 1998;16:144–51.
2. Crescenzo DG, Trastek VF, Allen MS, Deschamps C, Pairolero PC. Zenker's diverticulum in the elderly: is operation justified? *Ann Thorac Surg* 1998;66:347–50.
3. Curyto KJ, Johnson J, Ten Have T, Mossey J, Knott K, Katz IR. Survival of hospitalized elderly patients with delirium: a prospective study. *Am J Geriatr Psychiatry* 2001;9:141–7.
4. Bross MH, Tatum NO. Delirium in the elderly patient. *Am Fam Physician* 1994;50:1325–32.
5. Torres A, El-Ebiary M, Riquelme R, Ruiz M, Celis R. Community-acquired pneumonia in the elderly. *Semin Respir Infect* 1999;14:173–83.

JP Cooper, MD, FRCPC *Toronto, Ontario*

Anorgasmia and Withdrawal Syndrome in a Woman Taking Gabapentin

Dear Editor:

Gabapentin is used to manage many psychiatric conditions, notably anxiety and bipolar disorders (BDs). However,

clinical studies to support this practice are few (1).

Four case reports describe anorgasmia in men taking gabapentin but none describe anorgasmia in women (2–5). In these cases, desire and arousal were maintained; orgasm returned after the patients either stopped taking gabapentin or reduced the dosage to less than 1000 mg daily.

A gabapentin-withdrawal syndrome that is similar to benzodiazepine or alcohol withdrawal has been described. It includes tachycardia, diaphoresis, headache, and gastrointestinal cramps (6). Although gabapentin's mode of action is unknown, the similarity in withdrawal symptoms has been put forward as indirect evidence that gabapentin acts at the GABA receptor, where alcohol and benzodiazepines are known to act.

We describe anorgasmia in a woman taking gabapentin. When gabapentin was tapered, she had symptoms similar to the described withdrawal syndrome. Interestingly, her anorgasmia resolved in the same 24-hour period within which these withdrawal symptoms ended. We briefly discuss the implications of these occurrences.

Case Report

A 35-year-old married woman was referred to an ambulatory psychiatry clinic for assessment of a mood disorder for which her general practitioner had prescribed various antidepressants over a 2-year period, with no sustained benefit.

A history review revealed hypomanic episodes. She was diagnosed with BD II, and gabapentin treatment was started. She was taking no other medications. Gabapentin was titrated over a 2-month period to a daily dosage of 3600 mg. On this medication, her hypomania symptoms improved moderately. Six months after starting gabapentin, the patient presented with depression symptoms. Lithium was added, and therapeutic blood levels were achieved within 1 month at a dosage of

900 mg daily. At this dosage, her depression resolved. Once euthymic, she reported anorgasmia that had begun 3 to 4 months previously (that is, well before lithium therapy). She described having been able to reach orgasm easily and frequently, prior to starting gabapentin. While taking gabapentin, her libido and arousal had remained at her usual high pretreatment level.

In light of the case reports of anorgasmia in men taking gabapentin, we discontinued this medication over a 6-week period. During discontinuation, the patient spontaneously reported diaphoresis, tremulousness, and gastrointestinal cramps. These symptoms continued for 8 days after the last gabapentin dosage. Anorgasmia persisted until 9 days after her last gabapentin dosage. Thus, her discontinuation symptoms and anorgasmia resolved within 24 hours of each other.

Discussion

As stated earlier, this is the first case report of a woman with gabapentin-related anorgasmia. It may be an idiosyncratic reaction in this patient, but we speculate that this symptom may in fact be more common than previously recognized in both women and men taking gabapentin. We do not have a physiological explanation for this symptom: gabapentin's mechanism of action is still unclear.

Further, in this patient, both anorgasmia and withdrawal symptoms resolved within 24 hours of each other, 8 to 9 days after the last dosage of gabapentin. Because gabapentin's mechanism of action is not known, we do not know whether this temporal relation is coincidental.

Until these phenomena with regard to gabapentin are more clearly understood, it seems prudent to inquire about sexual dysfunction in patients taking this medication and to advise patients discontinuing gabapentin about possible withdrawal symptoms.

References

1. Ghaemi SN, Gaughan S. Novel anticonvulsants: a new generation of mood stabilisers? *Harv Rev Psychiatry* 2000;8(1):1-7.
2. Labbate AL, Rubey RN. Gabapentin-induced ejaculatory failure and anorgasmia. *Am J Psychiatry* 1999;156:972.
3. Clark D, Elliot J. Gabapentin-induced anorgasmia. *Neurology* 1999;53:2209.
4. Montes JM, Ferrando L. Gabapentin-induced anorgasmia as a cause of non-compliance in a bipolar patient. *Bipolar Disorders* 2001;3:52.
5. Brannon GE, Rolland PD. Anorgasmia in a patient with bipolar disorder type I treated with gabapentin. *J Clin Psychopharmacol* 2000;20:379-81.
6. Norton JW. Gabapentin withdrawal syndrome. *Clin Neuropharmacol* 2001;24:245-6.

Rodney Drabkin, MB,ChB, CCFP; Laura Calhoun, MD, FRCP *Winnipeg, Manitoba*

Stage-Oriented Trauma Treatment Using Dialectical Behaviour Therapy

Dear Editor:

Chronic childhood trauma that begins at an early age is thought to be an important etiological factor in the development of borderline personality disorder (BPD). Between 60% and 90% of patients with a diagnosis of BPD have a history of developmentally adverse interpersonal traumas (1-3). Impaired capacity to self-regulate has been linked to self-mutilation and high-risk behaviours in this patient population (4). We present a preliminary case series of patients with a history of psychological trauma who met DSM-IV criteria for posttraumatic stress disorder (PTSD) and BPD. These patients were treated within a specialized traumatic stress service using stage-oriented trauma treatment (5). According to this treatment strategy, a stabilization phase is essential before trauma-focused therapy can begin. Stabilization treatment was provided using the dialectical behavioural therapy (DBT) model (4). This model effectively treats impaired emotion regulation and BPD (6) by reducing dysfunctional behaviours and hospitalization and improving treatment retention (7,8).

Data came from 18 female patients who completed 1 year of DBT within the Traumatic Stress Service, a specialized program for treating psychological trauma that is affiliated with an acute care general hospital university teaching centre. Most of the program is outpatient-based. To ensure continuity of care, the inpatient treatment is provided by the team responsible for outpatient therapy. The patient group had a mean age of 35 years (SD 9); the mean duration of psychiatric illness was 19 years (SD 12). All patients fulfilled the DSM-IV criteria for PTSD and BPD, based on clinical interview. Comorbidities included dysthymia ($n = 11$), major depression ($n = 10$), dissociative disorder not otherwise specified (NOS) ($n = 9$), eating disorder NOS ($n = 6$), substance use disorder ($n = 4$), panic disorder ($n = 2$), bipolar disorder ($n = 1$), and schizoaffective disorder ($n = 1$). We assessed clinical outcome by measuring outpatient, inpatient, and emergency health care resource use at the London Health Sciences Centre; employment and school attendance were considered to reflect successful functioning. We compared the data for 1 year immediately prior to starting the program with the data for the first year of program attendance.

The 1-year outcome data show a 65% decrease in the duration of inpatient stay (before-treatment total = 1083 inpatient days, mean 64 days per patient [SD 38]; after-treatment total = 384 inpatient days, mean 23 days per patient [SD 29]). The 1-year outcome data also show a 45% decrease in the number of emergency room visits (before-treatment total = 85 emergency room visits, mean 6 visits per patient [SD 5]; after-treatment total = 47 emergency room visits, mean 4 visits per patient [SD 4]). Lastly, these data show a 153% increase in outpatient visits (before-treatment total = 656 outpatient visits, mean 39 visits per patient [SD 28]; after-treatment total = 1661 outpatient visits, mean 98 visits per

patient [SD 29]). The 700% increase in employment and school attendance was striking: 1 patient was working before treatment, compared with 8 patients working or attending school at 1-year follow-up.

By recognizing that childhood trauma is central in many cases of BPD, we have been able to incorporate DBT-based proactive outpatient management as part of a comprehensive stage-oriented trauma treatment program. This has helped to gradually shift the treatment emphasis from crisis management of the dysregulated self to functional recovery, active involvement in meaningful life activities, and successful engagement with the environment.

References

1. Herman JL, Perry JC, van der Kolk BA. Childhood trauma in borderline personality disorder. *Am J Psychiatry* 1989;146:490–5.
2. Paris J, Zweig F. A critical review of the role of childhood sexual abuse in the etiology of borderline personality disorder. *Can J Psychiatry* 1992;158:1034–9.
3. Ogata SN, Silk KR, Goodrich S, Lohr NE, Westen D, Hill EM. Childhood sexual and physical abuse in adult patients with borderline personality disorder. *Am J Psychiatry* 1990;147:1008–13.
4. Linehan, MM. *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press; 1993.
5. Chu JA. *Rebuilding shattered lives*. New York: John Wiley and Sons; 1998.
6. McMain S, Korman LM, Dimeff L. Dialectical behavior therapy and the treatment of emotion dysregulation. *J Clin Psychology* 2001;57:183–96.
7. Rizvi SL, Linehan MM. Dialectical behavioral therapy for borderline personality disorder. *Curr Psychiatry Rep* 2001;3(1):64–9.
8. Fox S. Integrating dialectical behavioral therapy into a community mental health program. *Psychiatr Serv* 1998;49:1338–40.

Ruth A Lanius, MD, PhD, FRCPC;
Isolda Tuhan, MD, FRCPC *London, Ontario*

Sexual Sadism With Lust-Murder Proclivities in a Female?

Dear Editor:

While there are sparse reports of sexually sadistic proclivities in females (1–3), its most extreme subtype, lust-murder, has to my knowledge only been reported in male subjects (4).

Case Report

A heterosexual woman in her late 20s was referred for a forensic psychological assessment to determine her fitness to stand trial on charges of arson. Her mother's pregnancy history, as well as her birth, growth and milestones, medical screening, and mental status exam all yielded unremarkable findings. Her psychological history unsheathed depressive episodes that resulted in trials of antidepressants, some self-reported episodes of panic attacks, and an episode of mania or hypomania that she had experienced 10 to 15 years earlier. She reported a psychosocial history that included a single incident of childhood sexual abuse and numerous incidences of physical violence against childhood peers, together with other antisocial behaviours (for example, truancy, fire setting, cruelty to animals, and some experimentation with substances). Further, she reported multiple paraphilic and fetishistic interests (for example, "men in diapers"); a personal study of sexual torture techniques; a history of adult homicidal ideation (that is, wanting to stab or shoot others); a captivation with, and admiration for, the most notorious serial homicidal criminals, along with a yearning to attain membership within that pantheon; the suppression of inordinate anger and hostility that was perennially at the point of exploding (for example, "feeling like a dormant volcano"), along with episodes of explosive dyscontrol; and an escalation of sadistic acts over time, culminating in meticulously planned, albeit thwarted, sexual homicides motivated by self-reported thrill seeking. A psychometric examination revealed prominent features of psychopathic personality disorder, with additional borderline features and negativistic features associated with an elevated potential for criminality. However, there was no evidence of a mood or thought disorder of any genre.

The patient's predatory sexual and homicidal proclivities involved a process of painstaking planning to murder young

males toward whom she was sexually attracted. For example, she amassed photographic and informational files on her intended victims' daily schedules. In one case, she had planned to use a knife to kill a 13-year-old delivery boy after luring him to a secluded park; in another, she had planned the dispatch of a particular adult male musician.

This case appeared to clearly meet the DSM-IV "essential features" criteria for a sexually sadistic paraphilia (that is, recurrent, intense, sexually arousing fantasies and sexual urges or behaviours regarding the psychological or physical suffering or humiliation of others) (5). It also exhibited correlates found among the more serious sexually sadistic and homicidal offenders (for example, fetishism). To my knowledge, this is the first description of a possible case of a lust-murder paraphilia in a female.

References

1. Kinsey AC, Pomeroy WB, Maratin CE, Gebhard PH. *Sexual behaviour in the human female*. Philadelphia: Saunders; 1953.
2. Hunt M. *Sexual behaviour in the 1970s*. New York: Playboy Press; 1974.
3. Arndt W, Foehl J, Good F. Specific sexual fantasy themes: a multidimensional study. *J Pers Soc Psychol* 1985;48:472–80.
4. Hucker SJ. Sexual sadism: psychopathology and theory. In: Laws DR, O'Donohue W, editors. *Sexual deviance: theory, assessment, and treatment*. New York: Guilford Press; 1997.
5. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington (DC): APA; 1994.

Larry C Litman, PhD, CPsych, FACAPP,
FPPR, FSMI, FICPP *London, Ontario*

Topiramate-Induced Suicidality

Dear Editor:

Topiramate is a novel antiepileptic medication used as an adjunctive mood stabilizer in some patients with bipolar disorder (BD) (1). Its association with appetite suppression and weight loss makes it appealing both to patients and to clinicians. Even though topiramate has been reported to be safe, psychiatric side

effects in neurology (2) and BD (3) patients warrant caution. I describe a case of severe suicidal symptoms associated with topiramate in a BD patient.

Case Report

Ms Y, aged 41 years, has a 7-year history of BD. For the first 5 years, she did well on lithium carbonate. However, lithium was discontinued owing to intolerable dermatological conditions. She was taking carbamazepine 400 mg twice daily and levothyroxine 0.15 mg daily (for hypothyroidism) when topiramate was added as an adjuvant mood stabilizer and because of weight gain. The topiramate dosage was gradually increased to 50 mg 3 times daily. A few weeks after she had begun the 150-mg daily dosage of topiramate, Ms Y noticed the onset of sudden and severe suicidal symptoms. She had made her will and started putting her life in order, when her husband suspected a serious problem and brought her to our attention. She was obviously suffering from depression and admitted to planning to take her life. Topiramate was the only medication recently increased, and we were aware of its association with psychiatric symptoms. It was therefore stopped immediately, and Ms Y was closely monitored. Within a week, her mood stabilized: she became euthymic, and her suicidal symptoms cleared completely.

Among obese subjects with BD, the weight loss potential of topiramate may be beneficial and significant (4,5). Side effects, such as sedation, nausea, headache, dizziness, and cognitive effects, have been reported in 82% of BD patients taking topiramate, with 36% discontinuing treatment because of side effects (5). Topiramate has also been associated with development of depressive and psychotic symptoms in patients with epilepsy and BD (2,6).

To my knowledge, this is the first report of severe suicidality associated with topiramate use in a patient with BD. Depression and suicidality are common

features of mood disorder patients; however, the close temporal relation of new-onset suicidal symptoms and the addition of topiramate, together with the speedy resolution after its discontinuation, highlight a possible relation between topiramate and the suicidal behaviour.

Topiramate has some usefulness in the management of psychiatric illness, especially when there is associated obesity. Nevertheless, clinicians should be aware that topiramate may be associated with the development of serious psychiatric symptoms, including severe suicidality, through a poorly understood mechanism that may involve multiple neurotransmitters.

References

1. McElroy SL, Suppes T, Keck PE, Frye MA, Denicoff KD, Altshuler LL, and others. Open-label adjunctive topiramate in the treatment of bipolar disorders. *Biol Psychiatry* 2000;47:1025-33.
2. Khan A, Faught E, Gilliam F, Kuzniecky R. Acute psychotic symptoms induced by topiramate. *Seizure* 1999;8:235-7.
3. Klufas A, Thompson D. Topiramate-induced depression. *J Clin Psychiatry* 2001;62:653.
4. Chengappa KN, Rathore D, Levine J, Atzert R, Solai L, Parepally H, and others. Topiramate as add-on treatment for patients with bipolar mania. *Bipolar Disord* 1999;1:42-53.
5. Ghaemi SN, Manwani SG, Katzow JJ, Goodwin FK. Topiramate treatment of bipolar spectrum disorders: a retrospective chart review. *Ann Clin Psychiatry* 2001;13:185-9.
6. Andrade C. Confusion and dysphoria with low-dose topiramate in a patient with bipolar disorder. *Bipolar Disord* 2001;3:211-2.

G Abraham, MD, FRCPC
Kingston, Ontario

Bright-Light Therapy in Somatization Disorder

Dear Editor:

The core features of somatization disorder are recurrent and multiple physical complaints that are not fully explained by physical factors and that result in medical attention or significant impairment. Somatization disorder (SD) is a chronic but fluctuating disorder that rarely remits completely. It is difficult to treat, and there appears to be no single

superior treatment approach (1). We report a case of SD treated with bright-light therapy.

Case Report

Ms K is a 39-year-old, married woman with a history of depression, SD, and 4 suicide attempts. She reported experiencing somatic complaints and depressive symptoms after she was married. She was treated for 4 years with tioridazine, alprazolam, and mirtazapine, until her last suicide attempt resulted in hospitalization. Her presenting symptoms were irritability, low mood, and frequent crying episodes. Additional somatic complaints were headache, low back pain, and dysmenorrhea. She was diagnosed with major depressive disorder (MDD) and SD according to DSM-IV criteria. Her cardiological, neurosurgical, neurological, gastroenterological, and ophthalmological examinations and routine laboratory examinations, including thyroid hormones, were all normal. She was started on a regimen of venlafaxine 150 mg daily and zopiclone 7.5 mg daily, as needed, for her sleep problems. On the fifteenth day, she continued to complain of somatic symptoms and long durations of sleep latency. Zopiclone was discontinued, and bright-light therapy was started. Light exposure was scheduled in the early morning because of her delayed sleep-wake pattern. We used a light box and an active light-treatment condition of 10 000-lux white light for 30 minutes (Sadelite, Northern Light Technologies, Montreal, Quebec, Canada). We used the Visual Analog Scale (VAS) to measure her subjective somatic complaints, sleep, and appetite changes. After 2 weeks of light therapy, her Hamilton Depression Rating Scale (HDRS) score fell from 41 to 11. Her multiple subjective somatic complaints showed 80% to 90% improvement, and sleep latency shortened. We found no difference between morning and evening measurements of subjective complaints. She was discharged from the hospital

with a regimen of venlafaxine 150 mg daily.

Light therapy quickly reduced the somatic symptoms and augmented the antidepressant therapy success in this patient (2). The reduction rate of the somatic symptoms was highest for the first 3 days of light therapy. Beyond the antidepressant effects, this case report suggests that light therapy could be useful for treating SD. SD patients with concurrent seasonal affective disorder (SAD) may be most likely to respond to light therapy and bright light, which may act as a strong zeitgeber to synchronize their circadian rhythms.

References

1. Lipowski ZJ. Somatization: the concept and its clinical application. *Am J Psychiatry* 1988;145:1358–68.
2. Prasko J, Horacek J, Klaschka J, Kosova J, Ondrackova I, Sipek J. Bright light therapy and/or imipramine for inpatients with recurrent non-seasonal depression. *Neuroendocrinol Lett* 2002;23:109–13.

Okan Caliyurt, MD *Edirne, Turkey*

Venlafaxine-Induced Delirium

Dear Editor:

Venlafaxine has been associated with delirium but, typically, only in the context of serotonin syndrome. We are aware of only a single report of isolated delirium attributable to venlafaxine (1). Venlafaxine inhibits serotonin and norepinephrine reuptake. It is also a weak inhibitor of dopamine reuptake. Interestingly, venlafaxine has one of the highest incidences of precipitating serotonin syndrome and has even been shown to elicit serotonin syndrome on its own (2,3). We report a case of isolated delirium in an individual receiving venlafaxine and ibuprofen.

Case Report

Ms A, aged 46 years, presented to the emergency department disoriented, with auditory hallucinations, loose associations, irritability, and a disorganized thought process. Collateral history revealed that the onset of symptoms

developed suddenly, in the previous 36 hours. Her medical history was noncontributory. Her psychiatric history included dysthymia and alcohol dependence, although she claimed to have abstained from alcohol for the past 5 years. She had a long history of ibuprofen consumption (600 mg orally 3 times daily) and felt that this helped her with irritability and reduced her craving for nicotine. Approximately 4 weeks prior to presenting, she was started on venlafaxine 37.5 mg orally each morning and 75 mg orally at bedtime, for depression. She was given a sample of venlafaxine and admitted to taking more than the recommended amount, owing to an unclear understanding of the prescribed dosage.

Other causes of delirium were investigated through examination and laboratory values. Her initial blood pressure was 170/94, with a subsequent recording of 140/79. The rest of her physical and neurological exam was within normal limits. Blood alcohol level was undetected, and other laboratory values, including thyroid-stimulating hormone (TSH), complete blood count (CBC), and a basic metabolic panel, were essentially normal. Regrettably, a serum venlafaxine level was not drawn.

Ms A was admitted to the psychiatric unit and started on venlafaxine (extended release) 150 mg daily and olanzapine 5 mg daily at bedtime. Two days after admission, the patient's delirium resolved and she was discharged on venlafaxine (extended release) 150 mg daily. Discontinuation of ibuprofen was advised. Follow-up 6 weeks later revealed no residual effects of the delirium.

The delirium illustrated in Ms A was most likely produced by high levels of venlafaxine. To our knowledge, there is no literature to support the idea that ibuprofen interacts with venlafaxine; however, it is plausible, considering that both are metabolized by the liver. Whether this patient's delirium was on the continuum of serotonin syndrome, even though she clearly did not demonstrate autonomic

instability or neuromuscular changes, remains unresolved. When high levels of venlafaxine are suspected, a high index of suspicion for serotonin syndrome and delirium is warranted. Owing to venlafaxine's increased popularity, we encourage further investigation of the therapeutic index and potential drug interactions of venlafaxine.

References

1. Pfeffer F, Grube M. An organic psychosis due to a venlafaxine-propafenone interaction. *International Journal of Psychiatry and Medicine* 2001;31:433–41.
2. Kolecki P. Isolated venlafaxine-induced serotonin syndrome. *J Emerg Med* 1997;15:491–3.
3. Mason PJ, Morris VA, Balczak TJ. Serotonin syndrome. *Medicine (Baltimore)* 2000;79:201–9.

Christopher Howe, Medical Student;
Sajid Ravasia, MD *Fargo, North Dakota*

New Dosage-Reduction Regime to Avoid Paroxetine Discontinuation Syndrome

Dear Editor:

The serotonin reuptake inhibitor (SRI) discontinuation syndrome appears soon after an SRI or venlafaxine is stopped or decreased. Its symptoms are dizziness, instability, paraesthesia, nausea, fatigue, chills, anxiety, and insomnia (1), which usually develop within the first 24 hours after dosage reduction. With venlafaxine, symptoms can sometimes occur within the first 6 hours. It is unclear whether this syndrome should be thought of in terms of abstinence, similar to that appearing after withdrawal of other medication (that is, benzodiazepines) or in terms of withdrawal from toxic substances (for example, heroin). This distinction is relevant on clinical and legal grounds, since it could be asserted that a patient who develops the syndrome has become addicted to the drug.

More often reported after withdrawal of paroxetine, the syndrome has raised concern inasmuch as it can become difficult to stop a treatment. Where no controlled-release or liquid forms are marketed,

tapering as slowly as possible is the only way to prevent the syndrome; in some cases, currently unavailable dosage forms could be necessary. It is also mandatory to completely inform patients regarding the characteristics of the problem.

We previously proposed a regime to discontinue paroxetine that, even though helpful in diminishing syndrome incidence, did not prove as successful as we had expected (2). More recently, we have tried other strategies that proved more effective, although still not always successful. Therefore, we feel that an even slower dosage reduction should be attempted. If we are to achieve this in countries such as Spain, where only 20-mg tablets are available, manufacturers must produce new forms properly grooved to allow smaller dosages.

Our current method of discontinuing paroxetine in patients on 20-mg daily dosage is to taper it down every 20 days, as follows:

Day 1: 20 mg and 15 mg daily on alternate days

Day 21: 15 mg daily

Day 41: 15 mg and 10 mg daily on alternate days

Day 61: 10 mg daily

Day 81: 10 mg and 5 mg daily on alternate days

Day 101: 5 mg daily

Day 121: 5 mg daily and no medication on alternate days

Day 141: stop medication

Even though it is not coherent with paroxetine's pharmacokinetic and pharmacodynamic properties, this approach has proved helpful. Nevertheless, it is not always effective, and we are therefore planning to taper off every 30 days instead. However, in the absence of controlled-release or liquid forms, 2.5-mg decrements would be more appropriate.

References

1. Schatzberg AF, Haddad P, Kaplan EM, Lejoyeux M, Rosenbaum JF, Young AH, and others. Serotonin reuptake inhibitor discontinuation syndrome: a hypothetical definition. Discontinuation Consensus Panel. *J Clin Psychiatry* 1997;58 (Suppl) 7:5-10.
2. Pacheco L, Malo P, Aragües E, Etxebeste M. More cases of paroxetine withdrawal syndrome [letter]. *Br J Psychiatry* 1996;169:384.

Luis Pacheco Yáñez, MD; Pablo Malo, MD; María Etxebeste, MD; Enrique Aragües, MD; Juan Medrano, MD *Bilbao, Spain*

Risperidone-Induced Galactorrhea: A Case Series

Dear Editor:

Although galactorrhea induced by atypical antipsychotics, particularly risperidone, has been reported (1-5), the clinical course of this adverse effects has not been adequately described. This report addresses the issue.

Case Report 1

A 31-year-old woman suffering her fourth affective episode (specifically, amitriptyline-precipitated mania) was started on risperidone 4 mg daily, along with ongoing carbamazepine 800 mg daily and lithium 900 mg daily. During the seventh week of treatment, she developed galactorrhea without other features of hyperprolactinemia. At that time, because she was found to have hypothyroidism (triiodothyronine [T₃], 30.0 µg/dl; thyroxine [T₄], 2.5 µg/dl; thyroid-stimulating hormone [TSH], 3.9 µU/ml), thyroxine 25 µg daily was added. Simultaneously, trifluoperazine (5 mg daily) was started in place of risperidone, with which her galactorrhea and manic symptoms disappeared over 2 months.

Case Report 2

A 26-year-old woman suffering from major depression with catatonia received 7 doses of electroconvulsive therapy and then began haloperidol 5 mg daily and fluoxetine 20 mg daily. However, haloperidol was later discontinued, owing

to extrapyramidal symptoms (EPS), and she began taking risperidone 2 mg daily and trihexyphenidyl 2 mg daily. Her depression and EPS improved after 3 weeks, but after 1 month of treatment, she developed galactorrhea without other hyperprolactinemic features. Her thyroid profile was normal. Consequently, her risperidone was discontinued, and within 2 weeks and while on fluoxetine, her galactorrhea remitted.

Case Report 3

A 24-year-old woman was treated with sertraline 50 mg daily and risperidone 3 mg daily for major depression with psychotic features and comorbid obsessive-compulsive disorder (OCD). During week 3, she developed galactorrhea without other hyperprolactinemic features; consequently, risperidone was stopped. She was euthyroid. Despite improvement in her symptoms, except for galactorrhea, she discontinued medications during week 6 of therapy. This led to exacerbated depressive, psychotic, and OC symptoms, and her galactorrhea persisted. She was then given sertraline 100 mg daily, along with chlorpromazine 100 mg daily, and within 2 weeks, despite only partial improvement in her psychopathology, her galactorrhea disappeared.

Case Report 4

A 34-year-old woman was taking carbamazepine 800 mg daily and haloperidol 5 mg daily to treat bipolar affective disorder diagnosed according to DSM-IV criteria. Because she developed signs of tardive dyskinesia, her haloperidol was stopped and risperidone 4 mg daily was started. After 3 months of treatment, she gradually developed amenorrhea and, 5 months later, galactorrhea. Having had a normal thyroid profile and prolactin level (that is, 1.006 ng/ml, where a normal level is 20.0 ng/ml), she had no other hyperprolactinemic features. Owing to the distressful galactorrhea, risperidone was discontinued, and both

amenorrhea and galactorrhea had vanished 1 month later.

Discussion

Although all patients had clinical galactorrhea, 3 were unwilling to have prolactin levels measured. Apart from hypothyroidism (6), fluoxetine, sertraline, fluvoxamine, and paroxetine therapy have been reported to cause galactorrhea (7–10). However, given that this patient's galactorrhea had a definite onset and offset with risperidone therapy, risperidone appears to be the main etiological agent for galactorrhea in this series.

There are 3 noteworthy observations in this report. First, galactorrhea can occur after many weeks of risperidone treatment (in 1 patient, it appeared during the seventh week). Second, even small dosages of risperidone (2 to 4 mg daily) can cause galactorrhea—a finding documented earlier (3)—but whether such effect is caused by potent D₂ antagonism, by drug interaction between risperidone and specific serotonin reuptake inhibitors, or by an idiosyncratic reaction needs investigation. Third, galactorrhea usually persists during risperidone treatment, and at times even after risperidone discontinuation. All these observations need further exploration.

References

- Turrone P, Kapur S, Seeman MV, Flint AJ. Elevation of prolactin levels by atypical antipsychotics. *Am J Psychiatry* 2002;159:133–5.
- Popli A, Gupta S, Rangwani SR. Risperidone induced galactorrhea associated with a prolactin elevation. *Ann Clin Psychiatry* 1998;10:31–3.
- Yong-Ku K, Min-Soo L. Risperidone and associated amenorrhea: a report of 5 cases. *J Clin Psychiatry* 1999;60:315–7.
- Dickson RA, Dalby JT, Williams R, Edwards AL. Risperidone-induced prolactin elevations in premenopausal women with schizophrenia. *Am J Psychiatry* 1995;152:1102–3.
- Potenza MN, Wasylink S, Epperson CN, McDougle CJ. Olanzapine augmentation of fluoxetine in the treatment of trichotillomania. *Am J Psychiatry* 1998;155:1299–300.
- Wilson JD. Endocrine disorders of the breast. In: Fauci AS, Martin JB, Braunwald E, Kasper DL, Isselbacher KJ, Hauser SL, and others, editors. *Harrison's principles of internal medicine*. 14th ed. New York: McGraw-Hill; 1998. p 2116–7.
- Arya DK, Taylor WS. Lactation associated with fluoxetine treatment. *Aust N Z J Psychiatry* 1995;29:697.
- Branzo MR, Stahl SM. Galactorrhea induced by sertraline. *Am J Psychiatry* 1993;150:1269–70.
- Jeffries J, Bezchlibnyk BK, Remington G. Amenorrhea and galactorrhea associated with fluvoxamine in a loxapine treated patient. *J Clin Psychopharmacol* 1992;12:296–7.
- Gonzalez E, Minguez L, Sanguino RM. Galactorrhea after paroxetine treatment. *Pharmacopsychiatry* 2000;33:118.

Subhash Chandra Gupta, DPM; K Jagadheesan, MD; Soumya Basu, DPM; Sarita E Paul, MD *Jharkhand, India*

Gamma Hydroxybutyrate Withdrawal in an Orthopedic Trauma Patient

Dear Editor

Gamma hydroxybutyrate (GHB) is a chemical initially developed in the 1960s as an anesthetic agent. It is now being investigated for use in the management of narcolepsy (1) and withdrawal from opiates (2) and alcohol (3). Recreationally, it is used as a drug that induces euphoria (4), as a supplement for bodybuilders (5), and as a sexual enhancer (6). We present a case of GHB withdrawal in a 32-year-old trauma patient.

Case Report

Mr C, a 32-year-old man with a 2-year history of panic disorder, presented to the hospital following a car accident. He did not lose consciousness but suffered multiple fractures of his pelvic girdle. His vital signs were within normal limits and his CT head and toxicology screen were negative. He did not experience any panic attacks around the time of the accident or upon admission. On his second day in hospital, his heart rate rose to 110 beats per minute. He continued to remain tachycardic, and the following day, his blood pressure rose to 170/100. On his seventh day in hospital (1 day after surgery), he began to complain of confusion. Shortly thereafter, he became agitated and began having visual and auditory hallucinations. Psychiatry was consulted and he was found to be delirious according to DSM-IV criteria (7).

Risperidone was initiated (initially 1 mg orally at night, with 0.5 mg every 2 hours as needed, then 2 mg at night the following day), with minimal effect. Collateral information suggested that chronic GHB

use for anxiety (1 to 5 “capsules” daily for 2 years) might be related to this resistance. We reviewed the literature and found that Mr C's autonomic instability and delirium were consistent with GHB withdrawal (6). Benzodiazepines have been shown to effectively sedate patients suffering from GHB withdrawal, although the appropriate dosages remain unknown (6). We initiated treatment with diazepam 10 mg daily on day 3 of his delirium. Twenty-four hours later, his delirium had resolved and his sleep-wake cycle returned to normal. His vital signs normalized within 3 days.

Mr C's presentation had several aspects consistent with GHB withdrawal: autonomic changes within 24 hours of discontinuing GHB use, anxiety, restlessness, confusion, delirium, visual hallucinations, and resistance to neuroleptics. However, the late onset of the delirium and the relatively quick response to diazepam are not as consistent with most reports of GHB withdrawal. Mr C's case is complicated by several factors. First, he presented as a trauma patient rather than as a patient with withdrawal symptoms, as has been seen in most case reports. Second, he had surgery and was given morphine during his hospital stay, both of which are known to cause delirium. However, it is most likely that he was experiencing GHB withdrawal, because many of his symptoms preceded both the surgery and his brief morphine use. We present this case to illustrate both the importance of considering GHB withdrawal in the differential of the causes of delirium and the need to treat the cause (in this case, GHB withdrawal was treated with diazepam), rather than attempting to manage the symptoms with a neuroleptic.

References

- Mamelak M, Scharf MB, Woods M. Treatment of narcolepsy with gamma-hydroxybutyrate. A review of clinical sleep lab findings. *Sleep* 1986;9:285–9.
- Gallimberti L, Cibin M, Pagnin P, Sabbion R, Pani PP, Pirastu R, and others. Gamma hydroxybutyric acid in the treatment of opiate withdrawal syndrome. *Neuropsychopharmacology* 1993;9:77–81.
- Addolorato G, Balducci G, Capristo E, Attilia ML, Taggi F, Gasbarrini G, and others. Gamma-hydroxybutyric acid (GHB) in the treatment of alcohol withdrawal syndrome: a randomized comparative study versus benzodiazepine. *Alcohol Clin Exp Res* 1999;23:1596–604.

- Galloway GP, Frederick SL, Staggers FE, and others. Gamma-hydroxybutyrate: an emerging drug of abuse that causes physical dependence. *Addiction* 1997;92:89-96.
- Dyer JE. Gamma-hydroxybutyrate: a health-food product producing coma and seizure-like activity. *Am J Emerg Med* 1991;9:321-4.
- Dyer JE, Roth B, Hyma B. Gamma-hydroxybutyrate withdrawal syndrome. *Ann Emerg Med* 2001;37:147-53.
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Text revision. Washington (DC): American Psychiatric Association; 2000.

Brad Slagel, BSc; Edward Kingstone, MD, D Psych, FRCPC; Shree Bhalerao, BSc, BA, Pgd, MD, FRCPC *Toronto, Ontario*

Version française de la Wender Utah Rating Scale (WURS)

Cher éditeur,

La WURS a été élaborée pour faciliter le diagnostic rétrospectif dans l'enfance du trouble d'hyperactivité avec déficit de l'attention (THADA). Les 61 items forment un questionnaire auto-administré à 5 niveaux de réponse. Les symptômes du THADA, les perturbations comportementales, les affections médicales et les troubles d'apprentissage sont explorés. Dans l'analyse originale, un score seuil de 46 obtenu au total des 25 items jugés les plus discriminants permet de classer correctement 86 % des sujets dans la catégorie THADA, 99 %, dans celle des contrôles et 81 %, dans celle des déprimés. Depuis, de nombreux travaux ont porté sur les qualités de l'instrument.

La cohésion interne a été jugée bonne dans différentes populations : parents d'enfants THADA, adultes suspects de THADA, étudiants. Une structure factorielle en 5 facteurs a été trouvée chez 620 parents d'enfants THADA. Les symptômes de l'attention et d'impulsivité se dispersent sur plusieurs facteurs. D'autres auteurs ont trouvé une structure en 3 facteurs.

Globalement, la WURS se montre sensible mais peu spécifique (50 % de faux positifs). Roy-Birnes et coll. ont classé en 3 groupes 143 sujets suspects de THADA (THADA établi, suspecté et exclu). Comparée à d'autres tests, y

compris les tests neuropsychologiques, la WURS se révèle toutefois l'instrument le plus discriminant.

Nous avons réalisé une traduction et une première évaluation des propriétés de la WURS. Nos objectifs sont de fournir aux cliniciens francophones un instrument d'aide au diagnostic.

Deux traductions françaises indépendantes ont abouti à une version finale obtenue par consensus. Une retraduction anglaise indépendante de l'instrument a été soumise à l'auteur pour accord sur le contenu. Une version définitive a été administrée anonymement à 63 sujets volontaires pour évaluer la compréhension et mesurer la cohésion interne. Les remarques concernant les difficultés de passation ont été recueillies par entretien. La répartition des scores, la moyenne et la déviation standard, la distribution des items, les corrélations entre les différents scores obtenus et la cohésion interne ont été calculées. Après traduction, moins de 15 % des items ont nécessité la recherche d'un consensus, les autres items étant quasi identiques dans les deux traductions indépendantes. La retraduction anglaise a été approuvée par l'auteur, sauf 4 items devant être légèrement modifiés (items 11, 19, 31, 37). Le sens de 7 items a nécessité confirmation par l'auteur.

La compréhension a été bonne. Tous les items ont donné lieu à une réponse. Seuls les items 60 et 61 ont dû être explicités à quelques sujets. Le score total moyen pour l'ensemble des sujets est de 53,5 DS 18,1 (item 33 exclu pour les femmes uniquement), pour les femmes de 54,5 DS 20,6 et pour les hommes de 52,3 DS 14,8. Les scores moyens obtenus à la WURS-25 sont de 20,2 DS 11,3 pour l'ensemble des sujets (femmes 21,3 DS 13,0; hommes 18,7 DS 8,7). Aucune différence significative n'est constatée entre les sexes. Pour l'analyse d'items, la corrélation des items a été calculée par rapport au score total diminué de l'item en question. Seuls 29 items présentent une corrélation statistiquement significative. Dix-neuf d'entre eux (65 %) sont inclus dans la WURS-25. La cohésion interne est comparable à celle qui est constatée dans les autres travaux sur la

WURS totale, et identique pour la WURS-25 (alpha de Cronbach 0,84).

On peut tirer un certain nombre de remarques de ce travail préliminaire. La traduction est fiable, vérifiée par la retraduction anglaise et la compréhension est bonne. Les remarques formulées par certains sujets soulignent la nécessité de préciser la période d'évaluation durant l'enfance, par exemple de 6 à 10 ans, et le mode de réponse aux deux derniers items. Stein et coll. ont proposé que la période d'évaluation soit délimitée aux années de scolarité primaire. Pour les items 60 et 61, des procédés précis de cotation sont nécessaires. Nos résultats confirment le bon niveau de cohésion interne dans une population de langue différente, comparable aux niveaux constatés dans les autres études, et soulignent la pertinence pour le calcul du score total de la majorité des 25 items retenus dans l'analyse originale. Un échantillon plus important est nécessaire pour analyser la structure factorielle encore mal définie. Les propriétés de l'instrument dans différentes populations cliniques doivent être explorées.

Bibliographie

- Roy-Byrne PL, Scheele J, Brinkley N, Ward C, Wiatrak J, Russo B, et autres. Adult attention-deficit hyperactivity disorder: assessment guidelines based on clinical presentation to a specialty clinic. *Compr Psychiatry* 1997;38:133-140.
- Stein MA, Sandoval R, Szumowski E, Roizen N, Reinecke MA, Blondis TA, et autres. Psychometric characteristics of the Wender Utah Rating Scale (WURS): reliability and factor structure for men and women. *Psychopharmacol Bull* 1995;31:425-33.
- Ward MF, Wender PH, Reimherr FW. The Wender Utah Rating Scale: an aid in the retrospective diagnosis of childhood attention deficit hyperactivity disorder [published erratum appears in *Am J Psychiatry* 1993;150:1280]. *Am J Psychiatry* 1993;150:885-90.
- Fossati A, Di Ceglie A, Acquarini E, Donati D, Donini M, Novella L, et autres. The retrospective assessment of childhood attention deficit hyperactivity disorder in adults: Reliability and validity of the Italian version of the Wender Utah Rating Scale. *Compr Psychiatry* 2001;42:326-36.

FJ Baylé, MD, MO Krebs, MD, PhD

Paris, France

C Martin, MD, MP Bouvard, MD, PhD

Bordeaux, France

P Wender, MD

Andover, Massachusetts