Manic Episode Due to Escitalopram in a Patient with Episodic Obsessive compulsive Disorder: A Case Report

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ÖZET:
Dönemsel obsesif kompulsif bozukluğu olan bir hastada essitaloprama bağlı gelişen manik dönem: Bir olgu sunumu

Obsesif-kompulsif bozukluk (OKB) toplumda, çoğunlukla duygu durum ya da diğer anksiyete bozuklukları olmak üzere diğer psikiyatrik bozukluklarla beraber görülebilir. Nöbetler halinde gidiş, ani başlangıç ve aile öyküsünde duygudurum bozukluğu yönünden yüklülük bulunması OKB'da Bipolar Afektif Bozukluk eş tanısının göstergeleri olabilir. Bu tür hastalar antidepresan tedavi ile mani geliştirebilirler. Essitalopramla indüklenen manik ataklar ise literatürde nadiren bildirilmiştir. Bu yazıda essitalopram tedavisi ile manik atak geçiren bir OKB olgusu bildirilmiştir.

Anahtar sözcükler: Essitalopram, obsesif kompulsif bozukluk, bipolar bozukluk, eş tanı, SSRI

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ABSTRACT:
Manic episode due to escitalopram in a patient with episodic obsessive compulsive disorder: a case report

Obsessive- compulsive disorder (OCD) is commonly associated with other psychopathology especially mood or other anxiety disorders. An episodic course, late onset, abrupt clinical course and a family history positive for affective disorders may be markers of bipolar disorder comorbidity in OCD. Such patients may be more likely to develop mania while taking antidepressants. Mania induced by escitalopram has been reported to be rare. A case of manic switch deemed to be due to escitalopram in an OCD patient is presented.

Key words: Escitalopram, obsessive compulsive disorder, bipolar disorder, comorbidity, SSRI

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INTRODUCTION

Obsessive-compulsive disorder (OCD) may be commonly associated with other psychopathology among adults in the community, with the majority of those being mood or other anxiety disorders. The comorbidity of OCD and anxiety disorders was found to be more common among women and comorbidity with bipolar spectrum disorders was more common among men (1).

Comorbidity in OCD is thought to be associated with significantly higher levels of treatment seeking, impairment, distress and suicidality. Specifically, comorbidity with bipolar disorders is thought to increase the risk for substance abuse (1). Epizodic course, late onset, abrupt clinical course and a family history positive for affective disorders may be markers of bipolar disorder comorbidity in OCD (2). OCD patients treated with selective serotonin re-uptake inhibitor (SSRI's) can develop mania. The incidence of drug-induced manic or hypomanic episodes in OCD is reported to be about 30%. It is also reported that during the manic or hypomanic phase the obsessive-compulsive symptoms tend to improve (3). This manic switch may be especially important in OCD patients with comorbid bipolar disorder.

According to our knowledge, only two cases of mania induced by escitalopram were reported in literature (4,5). Therefore, the aim of this study is to present a case of manic switch deemed to be due to escitalopram in an OCD patient.

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Case report

A 34 year-old, married female patient with an intermediate degree of education was admitted to the outpatient unit of the psychiatry department of Kocaeli University Medical Faculty with complaints of compulsive washing and obsessions of cleanliness. These complaints started after an interpersonal stressor, lasted for three months and had a waxing and waning course. Family history was positive for generalized anxiety disorder and major depressive disorder in the mother of the index case.

The patient was diagnosed with OCD according to DSM-IV criteria and started on fluoxetine 20 mg/ d (6). Although it was planned to increase the dose to 40 mg/ day, due to side effects (i.e. nausea) the medication was changed at the second week to clomipramine (CMI) 75 mg/day, with the dose gradually being titrated to 150 mg/day. The symptoms of OCD decreased after three months of treatment with CMI. Because the patient complained of anticholinergic side effects, it was decided to maintain her on escitalopram 20 mg/day. CMI dose was gradually lowered. And escitalopram was started after a washout period of two weeks. After a month of treatment she displayed decreased sleep, increased energy and libido and inflated self-esteem. In the mental status examination the patient was noted to have decreased grooming, she was oriented to place, person and time and the amount and speed of speech were increased. No distortions were noted in memory. Spontaneous attention was increased, whereas voluntary attention was decreased. Insight, reality testing and judgement were all impaired. Intelligence was deemed to be normal in clinical examination. Abstract reasoning was found to be normal. Thought content was notable for obsessions of cleanliness, grandiosity and fear of death. Mood was dysporhic and elevated, affect was labile. Psychomotor activity was increased along with tension. Sleep was decreased and libido was increased.

Laboratory examinations including biochemistry, complete blood count, thyroid function tests, urine screen, electrocardiography, electroencephalography and cranial magnetic resonance imaging were all found to be within normal limits. Consequently the patient was judged to display manic switch due to escitalopram and the treatment was discontinued. Antimanic treatment was started with lithium 900 mg/ day and quetiapine 50 mg/day. And the latter was gradually titrated to 600 mg/day. Because of insufficient clinical response to lithium, and considering the manic symptoms, which in this case correspond to that of dysphoric mania, antimanic treatment was changed to valproate (VPA) 1000 mg/day. Quetiapine treatment was continued in the same dose. After 6 weeks of treatment with VPA, Young Mania Scale decreased from 27 to 8.

Discussion

Here, we report a case of manic switch in an OCD patient which was deemed to be due to escitalopram. Because the patient's libido was increased, clomipramine was gradually discontinued and the symptoms appeared after a month of treatment following a two week washout period, it was concluded that the patients suffered from a manic switch due to escitalopram. Recently, escitalopram was reported to cause manic switch in 5% of patients with bipolar depression and the rate was found to be equal to those of other SSRIs (7).

The features of epizodic course, late onset, abrupt clinical course and family history positive for affective disorders were reported to be markers of bipolar disorder comorbidity in OCD and were also found in our case (2). It was reported that manic or hypomanic symptoms were inversely correlated with obsessive-compulsive symptoms in OCD patients who develop mania (3). However, the severity of obsessive-compulsive symptoms increased during the manic episode in our case.

Bipolar disorder comorbidity in OCD patients was reported to be related with obsessions of symmetry and compulsions of repeating, counting, ordering and arranging. Whereas, obsessions of contamination and cleaning compulsions were reported to be related with eating disorders (8). Our case was also atypical in that the thought content was characterised with obsessions of cleanliness and cleaning compulsions.

The patients with OCD who have bipolar disorder comorbidity were reported to respond less to antiobsessive treatment (9). However, our patient

responded favourably to a trial of CMI. Alternatively, the decreased obsessive-compulsive symptoms in our patient may be a chance observation due to the waxing and waning course of the disorder.

Manic episode in OCD patients were reported to require a combination of multiple mood stabilizers or even a combination of atypical antipsychotics and a mood stabilizer (10). Similarly, our patient did not respond to a trial of lithium and required a combination of VPA and quetiapine, which is an atypical antipsychotic.

Manic episodes in OCD patients have been etiologically linked to CMI, fluoxetine and citalopram but not with escitalopram (11). As far as we know, this is the first report of manic switch in an OCD patient with escitalopram treatment.

Considering all factors, it was thought that comorbid anxiety symptoms and disorders must be considered when diagnosing and treating patients with bipolar disorder. Conversely, patients presenting with anxiety disorders must be assessed for comorbid mood disorders, including bipolar disorder.

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