

Quetiapine in post-transplant acute mania/bipolar disorder NOS



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There is no medication specifically approved for the treatment of bipolar disorder not otherwise specified (BD-NOS), substance-induced mood disorders and mood disorders due to a general medical condition. We report the case of a man whose post-transplant BD-NOS was treated successfully with quetiapine.

Mr G, a 58-year-old man with cystic fibrosis and no history of psychiatric disorders, as documented by a pre-transplant SCID evaluation, received lung transplantation in December 2004. The patient underwent the post-transplant course with no medical or psychiatric complications until 6 wk after the transplant, when he developed decreased need for sleep, euphoria, irritability, grandiosity, pressured speech, flights of ideas, increased sexual drive, mystical and grandiose delusions. His symptoms led him to a poor adherence to the post-transplant immunosuppressant treatment and to other dangerous behaviours such as not wearing the facemask and having sexual intercourse despite medical advice to the contrary. A diagnosis of bipolar I disorder was deemed unlikely, given the age of the patient, the absence of any family and personal history of mood disorders and/or suicide attempts, and the clinical situation in which the symptoms developed. This impression was reinforced by absence of any mood disorders symptoms during the 2 years' observation that followed the resolution of the manic syndrome. At the time of the onset of the symptoms described above, the patient's treatment included cyclosporine 350 mg/d, prednisone 25 mg/d, furosemide 25 mg/d, aciclovir 600 mg/d, trimethoprim/sulfamethoxazole 160/800 mg every other day, calcium levofolate pentahydrate 7.5 mg/d, omeprazole 20 mg/d, acetylsalicylic acid 100 mg/d. We originally made a diagnosis of a corticosteroid-induced mood disturbance with manic features. However, upon a more thorough revision of the specific case, we revised our own diagnosis. In fact: (1) the patient had been on steroids for a long period prior to the transplant without any sign or symptom of

mania; (2) a role of the other medications and/or of the patient's general medical condition and/or of the transplantation itself could not be ruled out; (3) we could not exclude that he had under-reported some symptoms, out of concerns of being deemed ineligible for the transplantation; (4) he endorsed isolated traits of hyperthymic temperament. Therefore, we diagnosed him with BD-NOS, based on the DSM provision that permits formulation of this diagnosis in the case of 'situations in which the clinician has concluded that a bipolar disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced'. We prescribed quetiapine. An atypical antipsychotic was preferred over a classic mood stabilizer because of several factors including: the presence of psychotic symptoms, the risk of an interaction between corticosteroids and lithium, via corticosteroid-induced changes in sodium balance, and the risk of interactions between carbamazepine and his other medications. Quetiapine was started at 50 mg/d and titrated up to 200 mg/d by day 4. The patient's psychiatric symptoms gradually improved, until complete resolution 1 wk after reaching 200 mg/d. The patient was maintained on quetiapine for 6 months, and then switched to divalproex because of complaints of somnolence and difficulties with erection that he attributed to quetiapine. The decision to continue the anti-manic treatment after the resolution of his psychiatric symptoms was primarily due to the fact that he needed to continue taking the immunosuppressants. However, the patient discontinued divalproex of his own accord after 24 wk of treatment and, as of July 2007, he is still symptom free.

This case suggests the potential efficacy of quetiapine in mood disorders induced by a medication or by a medical condition and highlights the diagnostic difficulties for cases such as the one we have described. We hope that DSM-V will maintain the diagnosis of BD-NOS or provide better diagnostic categories/criteria for situations similar to the case that we have reported.

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Statement of Interest

None.

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