RISPOLEPT CONSTA AND EJACULATION DISORDER

M. Vučić Peitl, K. Ružić, V. Peitl & Đ. Ljubičić
Department for Psychiatry, University Hospital Centre Rijeka, Rijeka, Croatia
marijavp@gmail.com

It is well documented that antipsychotic medication can cause sexual side effects. Third generation antipsychotics, including risperidone, are no exception due to their potential for elevation of prolactin levels. Among men, erection disorders are relatively frequent and ejaculation disorders a bit rarer. Premature ejaculation is very often caused by certain psychological factors, but also by various illnesses, physical injuries and certain medications.

We will present the case of patient D.D., unmarried, 25 years old marine engineer who lives with his parents and has good relationships with them. His first hospitalization was during 2007, diagnosed as acute psychosis (F 23.0). Second hospitalization was at the beginning of 2008 when he was manifestly psychotic and brought to the Clinic with assistance of police officers. Paranoid symptomatology is dominant, patient noncompliant and because of that depot Rispolept Consta was started at 25 mg i.m. After 14 days, second application was at the dose of 37.5 mg i.m., with concomitant medication. The patient was released with following medications: Rispolux á 6 mg, Apaurin á 30 mg, Prazine á 200 mg, Akineton á 4 mg and Rispolept Consta á 37,5 mg i.m. One week after his release patient verbalized, with noted sedation, an ejaculation disorder, which was very unpleasant for him as he is in a steady relationship and had no similar problems before treatment. Through oftener ambulatory controls oral medication was gradually decreased and then discontinued, but ejaculation disorder persisted. Last application of depot Rispolept Consta was in July, when the patient was compliant. From May to July of 2008 he received only Rispolept Consta á 37,5 mg i.m, with no other concomitant medication. He still verbalized an ejaculation disorder and did not accept further application of the depot medication, but asked to be treated with Zyprexa Velotab, which he was taking before but stopped taking on his own. During his previous treatment with Zyprexa Velotab he had no sexual side effects and therefore we started with the dose of 10 mg daily. One month afterwards he did not verbalize any kind of an ejaculation disorder and was completely satisfied with the therapy, while psychotic symptoms were non existent.

We are faced with a dilemma and a question: Is it more important to treat psychotic symptoms in noncompliant patients or is it better to discontinue the depot medication at the first notion of an ejaculation disorder?