HUMAN PSYCHOPHARMACOLOGY
*Hum Psychopharmacol Clin Exp* 2003; **18**: 559–560.

*LETTER TO THE EDITOR*

# Quetiapine as adjunctive treatment of a case of rapid-cycling bipolar disorder with comorbidity

Dear Editor

Though several mood stabilizers are available for the treatment and maintenance of rapid-cycling bipolar disorder, there are still a number of patients unresponsive to either monotherapy or combination treatment (Post *et al.*, 2000). Even more complex is the treatment of comorbidity with axis I or II DSM diagnoses, and/or when drug related side effects complicate the clinical presentation. Here we report on a patient suffering from rapid-cycling bipolar disorder with obsessive–compulsive disorder comorbidity; this condition was further complicated by a neuroleptic-induced tardive chronic akathisia.

*Case Report*. Mrs A is a 53-year-old woman with a rapid cycling bipolar II disorder with obsessive–compulsive disorder (OCD) comorbidity. One brother suffers from cyclothymic disorder and another committed suicide when he was 38 years old.

When she was 38 years old she began to show compulsive washing behaviour and obsessive erotic thinking; shortly after, she suffered from a first depressive episode followed by euphoric/dysphoric mania, developing a rapid cycling course with mood switches about every 14 days with partial or no free interval. Psychotic features were also present in some episodes with guilt and religious delusions, and auditory hallucinations.

She had several hospitalizations but attempts to stabilize her mood with lithium, carbamazepine, valproate (in monotherapy or combination) with the adjunct of classical neuroleptics (medium–high doses) or adequate trials of atypical antipsychotics (risperidone, olanzapine and clozapine) and benzodiazepines failed. During clozapine treatment obsessive–compulsive symptomatology worsened. Because of persisting obsessions and compulsions, several antidepressants (particularly clomipramine and serotonin reuptake inhibitors—SRIs) were also prescribed with only partial relief from the symptoms.

Five years ago severe persistent akathisia and extrapyramidal signs (tremors to the distal segments of the upper limbs particularly of the left hand) appeared. All therapies were largely ineffective and hospitalizations for both psychotic depressive episodes and mania frequently recurred with a progressive worsening of motor disorders.

She was unable to manage her family any longer due to the rapid mood switches and was given a disability pension.

Six months ago, during the index hospitalization for a manic episode, it was decided to maintain lithium (600 mg/day, plasma level 0.65 mEq/l) and gabapentin (1200 mg/day) therapy. The subject assumed this therapy a long time ago (i.e. about 10 years lithium, 2 years gabapentin). The reason for the low level of lithium was due to a previous observation of increased motor disorders (i.e. tremors) with higher doses. Nevertheless the plasma level was within the recommended range. Adjunctive therapy with quetiapine, titrated to 600 mg /day, was then introduced. Within 1 week the motor disorders disappeared. Moreover, 2 weeks later a remarkable functional and psychopathological improvement with only a low-grade hypomania and no mood cycling was obtained. This improvement was maintained at the 6-month follow-up with the same medication as at discharge from the hospital. At this time she complained of fatigue and slight hypersomnia only. No obsessive–compulsive symptoms appeared. The patient is now living with her family without social support.

This case suggests that quetiapine may be a safe and effective add-on medication in rapid cycling bipolar disorder, confirming a growing body of literature (Vieta *et al.*, 2002). The combination of bipolar

disorder and OCD is not rare, and these patients pose a difficult clinical situation, because some treatments may improve their mood but worsen OCD, and vice-versa. The co-existence of EPS makes the choice of quetiapine sensible. Tardive akathisia is a potentially irreversible side effect of classical neuroleptics. This condition could be related to neuroleptic induced tardive dyskinesia, that some atypical antipsychotics seem able to reverse (Glazer, 2000).

Also relevant is the lack of recurrence of obsessive–compulsive symptoms. The augmentation of SRIs with atypical antipsychotics for the management of treatment-resistant obsessive–compulsive disorder is gaining increasing acceptance. Quetiapine may be particularly useful in this context (Atmaca *et al.*, 2002). No data are, however, available for its use in OCD without antidepressants. Current treatment options for patients with rapid-cycling bipolar disorder are often scarcely effective and are associated with troublesome side effects. It is likely that tailored treatments to the patients' features are needed. Quetiapine could be an important and valuable resource, although it deserves further controlled study in this context.

## REFERENCES

Atmaca M, Kuloglu M, Tezcan E, Gecici O. 2002. Quetiapine augmentation in patients with treatment resistant obsessive-compulsive disorder: a single-blind, placebo-controlled study. *Int Clin Psychopharmacol* **17**: 115–119.

Glazer WM. 2000. Extrapyramidal side effects, tardive dyskinesia, and the concept of atypicality. *J Clin Psychiatry* **61**(Suppl. 3): 16–21.

Post RM, Frye MA, Denicoff KD, *et al.* 2000. Emerging trends in the treatment of rapid cycling bipolar disorder: a selective review. *Bipolar Disord* **2**: 305–315.

Vieta E, Perramon G, Padrell E, *et al.* 2002. Quetiapine in the treatment of rapid cycling bipolar disorder. *Bipolar Disord* **4**: 335–340.

PAOLO STRATTA[1], STEFANO DE CATALDO[1], GIORGIO MANCINI[1], DANIELA GIANFELICE[2], OSVALDO RINALDI[2] AND ALESSANDRO ROSSI[2]
[1]*Department of Mental Health AUSL 4 L'Aquila, Italy*
[2]*Department of Experimental Medicine University of L'Aquila, Italy*

Published online in Wiley InterScience (www.interscience.wiley.com).
**DOI**: 10.1002/hup.523

 