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BRIEF REPORT

Risperidone as an Antidote to Hallucinogenics — Should it be Prescribed?

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A novel clinical and ethical problem is discussed. There are patients who want to use atypical neuroleptics as a self-administered antidote to illicit drugs. Copyright © 2000 John Wiley & Sons, Ltd.

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A CASE STUDY

A 20-year-old male prisoner had kept in his possession risperidone and perphenazine tablets, even though prison staff would confiscate drugs which have not been prescribed. He had been one of a gang who used various illicit drugs like cannabis, amphetamines and LSD, preferring hallucinogenics. Drug abuse had continued in the prison. He reported predominantly visual hallucinations and received 3 mg haloperidol and 50 mg promazine daily. After a vacation from prison he began to suffer from psychotic symptoms: emotional lability, crying and laughing without any apparent cause, anxiety, disorganized thoughts and reported visual and auditory hallucinations.

In the hospital, he claimed that he had exaggerated his description of hallucinations in order to get risperidone, which he preferred as an antidote to symptoms induced by hallucinogenics and stimulants, as well as by cannabis withdrawal. Urine screening for illicit drugs remained positive only for cannabinoids, apparently because of their long elimination time. No further psychotic symptoms emerged in the course of his 4-day stay at the hospital, where he was given 2–4 mg risperidone daily and 50 mg hydroxyzine at night. He was diagnosed with narcomania and predominantly hallucinatory psychosis induced by multiple psychoactive drugs.

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According to the anamnesis, our patient had used 0·5–2 mg risperidone in order to counteract symptoms induced by hallucinogenic and stimulant drugs. He had concocted this self-treatment when one of his friends had been prescribed risperidone. He asked for a prescription for the drug in order to be able to use it once he was out of prison, and admitted his intention to deal tablets to his friends as well.

DISCUSSION

It is well known that drug abusers favour benzodiazepines and opioids to counteract overstimulation or 'bad trips' caused by stimulating and hallucinogenic drugs. They avoid neuroleptics because of their potential to flatten emotional experiences.

Risperidone, an atypical and non-sedative neuroleptic, can be used to block dopaminergic and 5-HT_2-mediated effects of amphetamines (Misra and Kofoed, 1997) and LSD. When treating patients with polysubstance misuse, however, one has to note certain limitations. In certain individuals, LSD is associated with apparently lifelong continuous visual disturbances, characterized in DSM-IV as hallucinogen-persisting perception disorder (HPPD). The hallucinogenic mechanism of LSD is known to act in part as postsynaptic 5-HT_2 receptors. Abraham and Mamen (1996) described three HPPD patients treated with risperidone who

experienced an exacerbation of LSD-like panic and visual symptoms. The authors concluded that HPPD may be a relative contraindication for the use of risperidone. Wines and Weiss (1999) reported that after receiving risperidone for several days, two opioid dependent patients exhibited symptoms of opioid withdrawal, despite having no change in their opioid doses. These withdrawal symptoms resolved soon after risperidone was discontinued. This finding suggests the possibility that risperidone may precipitate opioid withdrawal in opioid-dependent patients.

In the case described here, self-administration of risperidone for unwanted effects of illicit drugs was reported successful. It may be possible without unwanted sedation or blunting of affects. Is prescribing atypical neuroleptics for this kind of use the lesser of two evils, or harmful and unethical because it can make the use of illicit drugs easier? Bearing in mind the principle 'First, do no harm', we though it was better to refuse in the vague hope that information about risks of drug abuse would have some positive effect. However, since drug-induced psychoses may generate dangerous states, which may lead to fatality, we are not totally convinced that doctors should have the right or duty to always refuse when such a prescription is asked for. Should prescription of atypical neuroleptics to selected patients be equated with other forms of harm reduction, like needle exchange programs to prevent hepatitis and HIV infections?

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