

First Manic Episode After A Single Dose of 30 mg Duloxetine

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Dear Editor,

Manic episodes can be induced by antidepressants especially with the use of serotonin and noradrenalin reuptake inhibitors (SNRI). SNRIs, like duloxetine, have effects on serotonergic and noradrenergic neurotransmitter systems. Acute and early age onset mood disorder, seasonal pattern, comorbid psychiatric disorder, a personal history of antidepressant-induced manic episode, family history of bipolar mood disorder are the risk factors for an antidepressant-induced manic episode. Mania can be an adverse effect of antidepressant use (1). Manic switch rates with the use of antidepressant treatment are in a range between 9% and 25% (2). Recurrence of affective episodes can be increased with the use of antidepressants and a mood disorder characterized with manic and/or hypomanic episodes without depressive episodes may occur (3,4). Mania is reported frequently with the use of tricyclic antidepressant use but it is accepted that all antidepressant medications can cause hypomanic/manic switch (5,6). One of the antidepressants causing manic switch is duloxetine molecule which is a SNRI. It has a well-balanced inhibition on serotonin and noradrenalin reuptake (7). Personal history of acute and

early-age-onset depressive episode, seasonal pattern, being female, chronicity of mood episodes and comorbidity, family history of bipolar mood disorder are the features pointing high risk for manic switch (2,9,10). In this paper a 65 years old female patient diagnosed with generalized anxiety disorder who had no previous psychiatric diagnosis or treatment, but after a single dose of 30 mg duloxetine emerging manic episode and treated with the diagnosis of drug induced mania is presented.

A 65 year-old female patient admitted to our outpatient clinic with the complaints of anxiety, restlessness, worry of that something might happen bad, tachycardia, sweating, abdominal ache, headache that had exacerbated for the last two weeks. She had applied to neurology one week ago and because examination and brain imaging findings were normal she had been referred to psychiatry. There was no abnormality in complete blood count, routine biochemistry and thyroid hormone parameters. On her psychiatric examination, self-care was enough, psychomotor activity was increased, involvement to the interview was decreased due to anxiety. Her affect and mood were anxious, somatic signs of anxiety, anticipation anxiety were observed. Memory and

cognitive functions were compatible with her age, conscious is clear and she was well oriented and cooperated. Mini Mental State Exam score was 23. Insight and judgment were normal. Hamilton Depression Rating Scale and Hamilton Anxiety Rating Scale scores were 12 and 28 respectively. Structured Clinical Interview for DSM-IV Axis I Disorders was administered to the patient and mixed anxiety disorder (otherwise unspecified) was diagnosed. Duloxetine 30 mg/day was initiated and recommended to increase 60 mg/day a week later and a polyclinic visit has been arranged at the end of second week. The following day she was admitted to outpatient clinic by her relatives with the complaints of insomnia, excessive talking, irritability, hyperactivity, anger, aggression, paranoid ideas, desire to run away from home which had emerged after a single dose of 30 mg duloxetine. Delirium is excluded because of the clear conscious state, well orientation and cooperation of the patient. Irritability, logorrhea, aggression, flight of ideas, incoherent speech, insomnia, anxiety, reference and paranoid ideas, dysphoric mood and elevated affect were detected on her psychiatric examination. Young Mania Rating Scale score was 29. Structured Clinical Interview for DSM-IV Axis I Disorders was administered to the patient and drug induced bipolar disorder (manic episode) has been considered. The present symptoms of the patient were related to an increased mood. Manic episode was diagnosed and referral to another center which had an enclosed service was approved. It was learned that the patient treated with the diagnosis of drug induced bipolar mood disorder (manic episode) in another center for 3 weeks and all the symptoms were recovered in 15 days.

Duloxetine is a dual-effective antidepressant and a member of nonselective SNRI. In some studies manic shift rates in depressive patients receiving duloxetine

was found between 0.1- 0.2% (12). But it is not clear yet that duloxetine causes a manic episode. It was considered that duloxetine did not induce mania or hypomania in females who had stress incontinence (1). However, in a 58 year-old male who had no psychiatric treatment or family history 2 months after starting treatment with duloxetine 60 mg/day, a psychotic manic episode occurred and in another case, 40 year-old patient who had a history of bulimia and alcohol abuse, manic episode emerged after 3 months of treatment (13). Another case study reporting a duloxetine induced hypomania emphasized that duloxetine and milnasipran was not behind of venlafaxine regarding SNRI-induced mania (14). Manic switch was seen 25% of 158 inpatient especially with tricyclic antidepressants but very rare in the group taking mood stabilizers like valproic acid, lithium, carbamazepine (15). In this case receiving no mood stabilizer before, with the use of a SNRI molecule duloxetine increasing noradrenergic discharge like tricyclic antidepressants, manic switch was emerged.

In our case; without risk factors (2) that are family history of bipolar disorder, hyperthymic/cyclothymic mood features, acute onset of depression, early-age-onset depression, seasonal pattern, comorbidity or being chronic, a manic episode emerged. Also, while appreciating that antidepressant induced bipolar mania starts typically simultaneously with antidepressant response in the first 4-8 weeks (4), in this case with a single dose of 30 mg/day duloxetine induced manic episode showed that SNRI like duloxetine might cause manic episode independent from dose and manic episode risk factors. SNRI are commonly used drugs which might cause manic episodes independent from any mood episode. Therefore, careful monitoring dose is very important for clinic follow-up and treatment.

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