CLOMIPRAMINE-INDUCED AFFECTIVE PSYCHOSIS AND COPROLALIA IN TOURETTE SYNDROME

Sir,

In comparison to obsessive-compulsive disorder (OCD), attention deficit-hyperactivity disorder (ADHD), depression and self-injurious behaviour, association of psychosis, especially manic psychosis with Tourette syndrome (TS) is less well-studied (Bleich et al., 1985). Moreover, antidepressant-induced manic psychosis has not been alluded in the literature on association of bipolar disorder and TS (Kerbeshian et al., 1995; Berthier et al., 1998). A case of clomipramine-induced mania in a patient of TS presenting with exacerbation of tics and emergence of coprolalia is described.

MM, an 18-year-old male, was diagnosed with TS at the age of nine years. Over these years, he developed motor tics (simple and complex) as well as simple vocal tics. There was no evidence of any coprophenomena until the present exacerbation. He was initially treated with pimozide for five years and discontinued the medicine when the tics were substantially decreased. However, on stopping the drug, the tics re-emerged, albeit with a milder intensity. Family history revealed chronic motor tic disorder in father and obsessive-compulsive behaviour in mother and brother. On his part, patient never displayed any obsessive-compulsive behaviour but premorbidly was described as being hyperactive.

A month before the patient's referral, he was observed to be remaining aloof, appeared sad with occasional crying spells, was less interested in studies and expressed hopelessness and worthlessness. Diagnosing him with a mild depressive episode, a general practitioner prescribed him clomipramine, which was titrated up to 75 mg/day. Two weeks after starting clomipramine, the patient became more talkative, started remaining cheerful and his sleep decreased. His condition gradually deteriorated so that at the time of presentation he had marked hyperactivity, aggressive behaviour, pressure of speech, flight of ideas, grandiose delusions and auditory hallucinations. In addition, his tics had worsened considerably and presently he had developed de novo coprolalia. He was initially treated with parenteral haloperidol and lorazepam and later valproate at 800 mg/day was added. His manic symptoms subsided but the coprolalia persisted in a milder form.

This case illustrates medication-induced affective psychosis in a patient with TS. Psychosis per se is a rare presentation in TS and that induced by antidepressants has not been documented. The antidepressant-induced manic psychosis was associated with worsening of existing tics, which is similar to previous reports (Berthier et al., 1998). Though clomipramine has been associated with exacerbation of tics (Kumar & Lang, 1997), emergence of new-onset coprolalia due to antidepressants has only been anecdotally cited (Delgado et al., 1990). Such an observation encourages further exploration of the role of antidepressant-induced cycling as a course modifier in TS.

Another point that needs to be addressed is whether there is a subgroup of TS patients who are prone for bipolarity. A study showed that the risk of bipolar disorder in a group of patients with TS is at least four times greater than would be expected by chance (Kerbeshian et al., 1995). The defining characteristics of this sub-group of patients include male adolescents who have mild tics and comorbid psychiatric diagnoses (Berthier et al., 1998). Our patient had all these characteristics and thus it could be argued that his propensity for bipolarity was unmasked by the antidepressant. Hence, through this report authors emphasize exercising caution while prescribing antidepressants to such patients of TS as defined above. This is pertinent to cases of TS with comorbid OCD wherein antidepressants are prescribed to treat the latter condition. Use of antidepressants with a lesser potential for causing a manic switch such as selective serotonin reuptake inhibitors or concurrent use of mood stabilizers can be explored in a similar situation.

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