RISPERIDONE-INDUCED OCULOGYRIC CRISIS

Sir,

Risperidone in low doses (< 6 mg) is reported to be relatively free from extrapyramidal side effects including dystonia, akathisia, drug-induced parkinsonism and tardive dyskinesia (Thomas and Lewis, 1998). A double blind study, which included 388 schizophrenic patients drawn from 20 sites in the United States, reported that the incidence of extrapyramidal symptoms in patients receiving 6 mg of risperidone was no higher than that in patients receiving placebo (Marder and Meibach, 1994). To our knowledge, few cases of dystonic reactions and one case of oculogyric crisis (OGC) as part of the dystonic reaction during risperidone treatment have been reported in the literature (Dickson et al., 1994; Radford et al., 1995; Faulk et al., 1996). We report two patients with schizophrenia who developed OGC crises during risperidone treatment

Case 1: Ms. A, a 22-year-old girl with DSM-IV paranoid schizophrenia for 8 months was hospitalised and treatment was initiated in the form of risperidone 1 mg b.i.d. on first day and 2 mg b.i.d. from second day onwards. Patient did not receive any concomitant medication except lorazepam 2 mg h.s. After four days of treatment with risperidone, Ms. A started having repeated episodes of upward deviation and fixation of eyeballs, with no other associated dystonic reaction, which would be relieved after giving promethazine, 25 mg i.m. Tablet trihexyphenidyl 2 mg t.i.d. was added which successfully prevented these episodes

Case 2: Mrs. S, a 40-year-old lady with DSM-IV undifferentiated schizophrenia for 17 years presented with prominent negative symptoms. During 17 years of her illness, she received trials of various antipsycotics including chlorpromazine, haloperidol, trifluoperazine and fluphenazine decanoate without significant improvement in negative symptoms. After hospitalisation, previous medications were gradually discontinued and risperidone was started with gradual dosage increment, i.e. 1 mg b.i.d. on first day, 2mg b.i.d. on second day and 3 mg b.i.d. then on. On the sixth day of treatment, she developed episodes of upward fixed gaze, which used to subside on giving promethazine, 25mg i.m. The frequency of such episodes did

not decrease after reduction of risperidone dosage to 2 mg b.i.d. Addition of trihexyphenidyl 2 mg b.i.d. stopped further episodes.

OGC is described as a form of acute drug-induced dyskinesia, where attack begins as a fixed stare and the eyes rotate upwards or sideways and fix in position. The most common cause of OGC is treatment with antipsychotics or other antidopaminergic drug. Risperidone is being considered as a first line antipsychotic due to relative freedom from extrapyramidal symptoms in therapeutic dose range. Studies using multiple doses of risperidone have shown that this medication causes a dose-related increase in extrapyramidal side effects (Marder and Meibach,1994; Peuskens, 1995). Several of these studies indicate that the severity of extrapyramidal side effects with risperidone is lower than with conventional antipsychotic medications. In our cases, occurrence of OGC during risperidone treatment suggests that acute dystonic reactions and extrapyramidal symptoms can occur with low doses of risperidone also, though the risk may be lower than conventional antipsychotics. To ensure compliance, we should monitor patients closely during treatment with antipsychotic medications, whether conventional or atypical.

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