ABSTRACT: A 46 year old Caucasian male veteran with a mental health history of Bipolar Disorder was admitted to the inpatient psychiatric unit following an episode of mania. He was re-started on his outpatient medication regimen for mood stabilization with Quetiapine, Lamotrigine, and Clonazepam. He improved initially, however, on hospital Day 3, the veteran was noted to have acute worsening of manic and psychotic symptoms including, decreased need for sleep, excess energy and responding to internal stimuli. Additionally, he developed symptoms which were atypical for mania, including unprovoked agitation, depersonalization, difficulty sustaining attention, and visual hallucinations. These mental status changes were associated with, excessive motor movement, walking with bizarre postures, squatting, laying taut on the ground, and standing still for several minutes in uncomfortable positions. At this time, Seroquel was switched with Olanzapine for management of mania and psychosis. On physical exam, his vital signs were notable for tachycardia and fever, his extremities were noted to have a normal range of motion; he also experienced loss of bowel continence. The treatment team initiated a medical work up for delirium which revealed no infectious, neurological, or metabolic cause. Of note, there was concern for benzodiazepine withdrawal; however, adequate management did not relieve the symptoms. The veteran was transferred to medicine and neurology was consulted to assist with medical workup. His neuroleptic and benzodiazepine medications were discontinued at that time, except for Lamotrigine. The veteran was then transferred back to psychiatry after medical stabilization, Lamotrigine was discontinued at that time. He was started on Haloperidol, Benztropine and restarted on Clonazepam. At this time, veteran experienced improvement on his mental status exam, with resolution of mania, psychosis, and delirium. However, after two days of treatment, he developed acute rigidity in his extremities. Intramuscular Benztropine and Lorazepam improved his rigidity. Haloperidol was discontinued because of side effects and the veteran was managed with Risperidone and Ativan. He continued to show improvement in his mental status examination and was discharged on a medication regimen of Risperidone, Clonazepam, and Benztropine. The veteran experienced signs and symptoms which were atypical in nature for Bipolar Mania, such as fever, movement disorder, and delirium. This presentation is consistent with a rare medical condition, Delirious Mania for which limited research is available. Delirious mania meets the criteria for mania and delirium without an underlying medical disorder. Delirious mania is a potentially life threatening but under-recognized neuropsychiatric syndrome. Early recognition and aggressive treatment can significantly reduce morbidity and mortality.

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"Lithium Damaged My Spine" Might not Be a Delusion After All

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ABSTRACT: Background: Lithium remains to be the drug of choice for treating BPAD for the past few decades. There is extensive literature showing the effectiveness of Lithium when used as a mood stabilizing agent in bipolar spectrum disorders. However significant number of articles show that a third of the patients who receive lithium for their symptomology not only do not show any response but also may show deterioration of their clinical symptoms. (However, research shows that Lithium may negatively affect a third of the patients depending on various factors). The side effect profile of Lithium and especially its neurotoxic effects were discussed in depth in literature over the last decade. Although Lithium remains first choice as maintenance treatment for bipolar affective disorder, about half of all individuals may stop their treatment at some point, despite its proven benefits concerning the prevention of severe affective episodes and suicide.

METHODS: The authors performed a systematic literature review to recognize the significance of negative effects of Lithium in a minority of patient population and also comment on the factors influencing patient compliance. We ran a literature search on Pubmed using the following terms: "Lithium" AND ("schizoaffective disorder [MeSH terms]" OR "Bipolar Affective disorder [MeSH terms]"). Our inclusion criteria were studies which have observed effects of Lithium in schizoaffective patient population or bipolar affective patient population. Studies with other concurrent diagnoses were excluded.

CASE PRESENTATION: We discuss a fifty nine year old male with a history of multiple admissions to a forensic hospital care setting. He initially endorsed a diagnosis of Psychotic disorder NOS which was later changed to schizoaffective disorder during his subsequent admissions. He presented with affective psychotic features where his mood was labile shifting from melancholic to euphoric and a concurrent history of auditory verbal hallucinations. He displayed paranoid non-bizarre persecutory delusions and also alleged that one of his

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doctors had hated him and put him on Lithium as a form of punishment. He claims that Lithium, as a result, has significantly affected him negatively and also damaged his nerves. This led the authors to explore the significance of use of Lithiumin people with schizoaffective disorders and also bipolar affective disorders. We also discuss the disease course in the patient and his clinical response to use of various psychotropic medications.

CONCLUSIONS: The case exemplifies the negative effects of Lithium when used as a mood stabilizer in patient population that is susceptible to its adverse effects due to various factors.

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Heroin Dependence as an Enantiopathy to Quetiapine-Induced Restless Leg Syndrome

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ABSTRACT: Introduction: Use of heroin in self-management of Restless Leg Syndrome (RLS) has not heretofore been described. Such a case is presented.

METHODS: Case study: This 29 years old right handed male presented with a long history of major depressive disorder, generalized anxiety disorder and opioid dependence. The Patient felt compelled to take quetiapine since was the only drug found to be effective in controlling racing thoughts, Major Depressive Disorder with psychotic features. Prior to use of quetiapine the patient never experienced RLS. Quetiapine in doses ranging from 25 mg to 300 mg a day precipitated severe RLS whereby he was forced to move his leg all night long leading to poor sleep quality. The RLS was unresponsive to Gabapentin and Benztropine, however it was eliminated with a variety of opioids including hydrocodone, buprenorphine, buprenorphine/naloxone. Particularly sensitive to heroin, 1/2 twenty dollar bag, self-administered IV prior to sleep eliminated the RLS immediately, but when injected more than four hours before sleep it had no effect. RLS acted only when induced with quetiapine, since he wished to continue quetiapine to control his mood, he felt compelled to self-medicate with heroin to stop RLS side effects. He showed no other signs of extrapyramidal symptomatology or evidence of any other movement disorder.

RESULTS: Abnormalities in physical examination: General: Abundance of tattoos on body and face. Cranial Nerve (CN): CN I: Alcohol Sniff Test: 7 cm (anosmia). CN II: Anisocoria OD 5 mm OS 2 mm. Motor Examination: drift testing: right pronator drift. Cerebellar: Finger to Nose: end point dysmetria bilaterally. Low amplitude high frequency tremor in both upper extremities on extension. Sensory Examination: decreased graphesthesia in both upper extremities. Reflexes: 3 + knee jerks, absent ankle jerks, positive jaw jerk, bilateral palmomental reflex is present.

DISCUSSION: This patient has a long history of quetiapine use due to his major depressive disorder with psychotic features and subsequent self-administration of IV heroin reportedly to reduce the symptoms of quetiapine-induced RLS. Heroin elevates dopamine levels in forebrain by blocking inhibitory GABA interneurons near the ventral tegmental area, leading to activation of mesocorticolimbic dopaminergic neurons (Nakagawa 2008, Steidl 2011). The time frame of opioid administration has a critical impact on its efficacy in improving RLS symptoms. However, the drug's effects only up to 3 to 6 hours (Buchfuhrer 2012). In this case administration of heroin more than 4 hours before sleep would not alleviate the RLS symptoms. Patient chose the time of injection, not for hedonic pleasure of heroin, but rather to prevent RLS symptoms. In those with heroin dependence, the possibility that is a result of self-medication of underlying movement disorder warrants additional investigation. In those with RLS who are unresponsive to other treatment modalities, a trial of opioids maybe worthwhile.

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Predictors of Tardive Dyskinesia in Psychiatric Patients Taking Concomitant Antipsychotics

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ABSTRACT: Background: Tardive dyskinesia (TD) is typically caused by exposure to antipsychotics, is often irreversible, and can be debilitating. TD symptoms can increase the social stigma of patients with comorbid psychiatric disorders, negatively impact quality of life, and potentially increase medical morbidity and mortality.

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