Corticosteroid-Induced Mania Treated with Quetiapine: A Case Report

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Dear Editor,

Corticosteroids are agents that are effectively used in the treatment of many diseases, particularly autoimmune diseases. It is estimated that neuropsychiatric side effects occur in 2–60% of patients using corticosteroids. These side effects frequently occur within the first 2-week period that corticosteroids are initiated and may vary from depression to mania, psychosis to delirium and insomnia. Studies showed that some risk factors are associated with the neuropsychiatric side effects of corticosteroid treatment. The most important factor is the dosage of corticosteroid treatment (1-3).

Although it is suggested that corticosteroid treatment should be stopped or the dosage of corticosteroids should be decreased while treating cases with corticosteroid-induced neuropsychiatric side effects; with the cases that are not eligible for this option, it is suggested that antipsychotics or mood stabilizers be added to treatment (1-4).

We aim to describe a case with corticosteroid-induced mania treated successfully with quetiapine.

A 33-year-old married woman was hospitalized for nephrotic syndrome in the nephrology inpatient clinic. She was diagnosed with focal segmental glomerulosclerosis 10 days prior to admission, and she had been administered (1 mg/kg) 60 mg/d oral prednisolone treatment since then. Although she did not have a history of psychiatric disturbance, she complained of insomnia and irritability. These complaints appeared just 1 week after the initiation of corticosteroid treatment. She could sleep for only 2 hours a day for 2 consecutive days. She was referred to the psychiatry department with the complaint of insomnia. She said that she was having trouble with her friends as they felt that she was talking a lot. Neither the patient nor her family had a history of psychiatric illness, alcoholism or drug abuse.

On mental status examination, her mood was dysphoric, and affect was labile. Her speech was loud and a bit pressured. Her attention was distractible. Thought speed was accelerated.

The Young Mania score was found to be 33. We initiated 25 mg/d quetiapine treatment and aimed to increase the dosage to 400 mg/d.

After 2 weeks, she was taking 400 mg/d quetiapine and 60 mg/d prednisolone, and her Young Mania score was 15. After decreasing the dosage of prednisolone to 10 mg/d for 2 weeks, her complaints reduced and the Young Mania score decreased to 5. All her complaints subsided after prednisolone treatment was stopped.

The underlying mechanisms for the development of neuropsychiatric side effects due to corticosteroid treatment remain unclear (1).

Some risk factors related to neuropsychiatric side effects of corticosteroids have been described. Dosages of 40 mg/d were reported to be associated with psychiatric symptoms. Furthermore, higher dosages of 80 mg/d were found to be linked with severe psychiatric disorders. Studies showed that neuropsychiatric side effects occur most frequently during the first 2 weeks of corticosteroid treatment. Although studies on gender are conflicting, being female is stated to be a risk factor. Corticosteroid-induced neuropsychiatric side effects are more prevalent if the patient had a psychiatric disorder, drug use or abuse, female sex and a family history of psychiatric disorder (3,5-7). When we evaluate our case, we can detect two risk factors: using a high dosage of corticosteroids and being a woman. Corticosteroid-induced neuropsychiatric side effects are more prevalent if the patient had a psychiatric disorder, drug use or abuse, female sex and a family history of psychiatric disorder (3,5-7). When we evaluate our case, we can detect two risk factors: using a high dosage of corticosteroids and being a woman. Furthermore, the symptoms occurred on day 7 of steroid treatment, which is reported to be the most likely period for the development of neuropsychiatric side effects.

Although it is suggested that corticosteroid-induced mania be treated with mood stabilizers, atypical antipsychotics are also useful (8,9). Despite considerable...
literature on the treatment of corticosteroid-induced psychosis with typical and atypical antipsychotics, there are only a few case studies on corticosteroid-induced mania treatment. These case studies reported that haloperidol, aripiprazole, lithium and carbamazepine were effective in treatment (10-12). Moreover, olanzapine was useful with daily 2.5–20 mg dosages in an open-label trial (9). To the best of our knowledge, there is only one corticosteroid-induced mania case treated successfully with quetiapine in the literature (13). We selected quetiapine due to its sedative and mood stabilizing effects (14), and the dosage of 400 mg/d was found to be effective for keeping the disorder under control; however, remission could only be achieved after the corticosteroid treatment was stopped. This case would have a significant place in the literature as it shows that quetiapine alone is effective in controlling neuropsychiatric side effects of corticosteroid treatment and could be a useful agent for treating corticosteroid-induced mania even if it is impossible to stop corticosteroid treatment.

It is crucial to evaluate carefully and follow up patients who are receiving corticosteroid treatment and particularly those who have risk factors. Furthermore, it is suggested that quetiapine could be an effective agent for the treatment of corticosteroid-induced mania, and further studies are warranted in this field.

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