BIPOLAR AFFECTIVE DISORDER IN PARKINSON'S DISEASE: CLINICAL DILEMMAS

Sir,

Psychiatric disorders are a common co-occurrence in people with Parkinson's disease (PD).[1] Psychiatric symptoms may be the direct result of PD, its co-morbid pathologies, or occur as a side effect of its pharmacotherapy. About 10% of patients on treatment for PD will experience euphoria and 1% will develop mania.[2,3] We report a case of bipolar affective illness complicated by idiopathic PD and its treatment with special reference to its response to Clozapine.

The patient is a 56-year-old married lady with premorbid paranoid personality traits without family history of any neuropsychiatric illness. Her index visit was in August 2005 when she was diagnosed to have severe depression with suicidal intent, and a detailed neurological evaluation at that time did not reveal any symptoms of PD. She was treated with a course of seven bilateral brief pulse modified electro convulsive therapy and Sertraline 100 mg, and became euthymic within one month. One year later

she developed unilateral tremors for which neurology consultation was sought. She was diagnosed with left hemi Parkinsonism and started on Ropinarole 0.125 mg thrice daily and Trihexyphenidyl 1 mg thrice daily. Following poor response of PD symptoms, in Sep 2006 the neurologist started her on Selegiline 5 mg in the morning. Subsequently the patient was reported to be irritable, dysphoric and over-religious; these symptoms remitted on stopping Selegiline but there was inevitable worsening of motor symptoms. On restarting Selegiline she developed a full manic syndrome characterized by over-activity, over-talkativeness, irritability, hyper-religiosity and decreased sleep with grandiose delusions. Selegiline was stopped considering the possible interaction with Sertraline and as a doubtful precipitating factor for mania but other drugs were continued according to the neurologist's advice. Treatment options for mania were discussed with the patient and caregivers, who were willing to opt for Clozapine only after a conventional trial in view of serious side effects. The patient was started on Sodium Valproate, which was increased to 1200 mg daily (serum Valproate level of 55 microgram per ml) and Olanzapine 20 mg daily. With this treatment her manic symptoms improved but she did not become euthymic. After one month there was a worsening of manic symptoms for which the patient was started on Clozapine 12.5 mg and the dose was increased to 37.5 mg daily. Valproate and Olanzapine were tapered and stopped gradually. Two weeks after starting Clozapine the patient showed significant improvement in her manic symptoms without any worsening of motor symptoms. After 3 weeks, at the time of discharge, the patient was euthymic without any worsening of the motor symptoms of PD.

This case highlights the efficacy of Clozapine in the management of mania in PD. There is one report of two patients with long-standing idiopathic PD, without individual or family history of affective disorders, who on developing bipolar mood disorders were treated with lithium and Clozapine. Only one of them responded favorably.[4] But in our case the patient had a history of depression prior to the onset of PD and the mania responded well to a low dose of Clozapine without worsening of motor symptoms. No guidelines or strategies are available for the management of mania or bipolar illness in PD. However, guidelines are available for the prevention and management of psychosis in PD.[5] Further, the possibility of Selegiline precipitating mania in a patient who has vulnerability for a bipolar illness should not be discounted.

The authors would like to stress the need for good liaison between the various specialities and for a specialist who can manage both mood and movement problems together.

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