

Case Report

A Case of Possible Duloxetine-Induced Mania

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Abstract

Treatment with antidepressants can cause switching to mania or hypomania. Duloxetine is a novel serotonin and noradrenaline reuptake inhibitor (SNRI) antidepressant. According to its Summary of Product characteristics, mania is a rare side effect. We report a case of a 41 year old woman with recurrent depression and with no previous history of mania or hypomania, who developed severe mania and required management in a Psychiatric Intensive Care Unit after receiving duloxetine at 30 mg per day which is only half the recommended starting dose (German J Psychiatry 2010; 13: 54-56).

Keywords: duloxetine, mania, hypomania, switching, depression, antidepressant

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Introduction

Duloxetine is a combined serotonin (5-HT) and noradrenaline (NA) reuptake inhibitor. According to summary of product characteristics (SPC), mania is a rare side effect of duloxetine. Dunner et al. (2005) concluded that duloxetine was associated with a low incidence of treatment emerging mania, hypomania or hypomania like symptoms in patients with Major Depressive Disorder (doses ranged from 40 to 120 mg per day). According to Viktrup et al. (2004), duloxetine does not induce mania or hypomania in women with stress urinary incontinence and without a history of depression (at 80 mg per day). Searching the literature we found five reported cases implicating duloxetine in treatment emergent mania or hypomania. Peritogianis et al. (2009) reported a case of a 61 year old female with a history of recurrent depression. 3 days after receiving

duloxetine at 60 mg per day she developed a hypomanic episode. De Dios & Ezquiaga (2007) reported a case of a 58 year old male with a history of unipolar depression who had a manic syndrome with psychotic features 4 months after treatment with duloxetine at 60 mg per day. De Dios and Ezquiaga (2007) also reported another case of a 40 year old female who had mania with psychotic symptoms after 3 months of treatment with duloxetine at 120 mg per day. Desarkar et al. (2007) reported that duloxetine induced ultrarapid cycling in a 17 year old female with a history of bipolar disorder. She became hypomanic 2 days after receiving duloxetine at 40 mg per day. Meagher et al. (2006) reported case of a 46 year old male with a history of depression who developed hypomania after taking a combination of duloxetine 90 mg per day and mirtazapine 15 mg per day for a week. According to Peritogianis et al. (2009) switching appears to be dose related.

Case Report

We report a case of a 41 year old female with a several-year history of recurrent depression. She also had co-morbid fibromyalgia and Chronic Fatigue Syndrome (CFS). She had no previous history of mania or hypomania. Her sister and uncle had schizophrenia. She had been treated with various antidepressants in the past including a number of SSRIs and TCAs, venlafaxine and trazodone. All these antidepressants had to be discontinued due to inefficacy and/or intolerable adverse effects (including somnolence, depersonalisation-derealisation syndrome, sweating and photosensitivity). However, no manic or hypomanic switching was reported with any of these antidepressants. She was eventually commenced on duloxetine monotherapy at 30 mg per day. She was not taking any antidepressant immediately prior to commencement on duloxetine. Her mood initially improved but two weeks into treatment she developed insomnia, hyperactivity and sexual arousal. Around 6 weeks after treatment with duloxetine was commenced, she progressed to have a manic episode with psychotic symptoms. She had to be admitted compulsorily to a psychiatric intensive care unit. Around the time of admission her symptoms constituted irritability, psychomotor agitation, pressure of speech, flight of ideas, insomnia, auditory and visual hallucinations, grandiose and persecutory delusions, aggressive and reckless behaviour, sexual disinhibition and lack of insight. Upon admission to hospital a drug screen was negative. A head CT was within normal limits. Other investigations revealed an elevated C-reactive protein of 78 mg /L which was considered to be caused by her CFS (Spence et al., 2008). Two weeks after duloxetine was discontinued, there was no improvement in her condition. Treatment with olanzapine was initiated to which she responded well and her manic and psychotic symptoms subsided. She was discharged from hospital after three weeks.

Discussion

Lack of response to previous treatment with antidepressants may be suggestive of a pre bipolar depression (O'Donovan et al., 2008). Sharma et al. (2005) found that the majority of patients with a diagnosis of unipolar treatment resistant depression had a bipolar diathesis. According to Valles et al. (2005), there is an increased morbid risk of schizophrenia in families of inpatients with bipolar illness. Furthermore, Carta et al. (2006) found a high frequency of manic symptoms in a sample of female patients with fibromyalgia attending a rheumatology outpatient Unit. In this case, the patient had a history of lack of response to antidepressants, a family history of schizophrenia and she also had a diagnosis of fibromyalgia. Duloxetine was associated with the emergence of mania at 30 mg per day which is half the starting dose recommended by the SPC. In all studies and cases reported above, duloxetine was administered at higher doses (doses ranged between 40 mg and 120 mg per day). We conclude that even a small dose of duloxetine could possibly induce

severe manic switching in a patient with risk factors of bipolarity, even if the patient has not previously experienced such a reaction to other antidepressants including dual-action ones like TCAs and venlafaxine. In our opinion, clinicians should be cautious when prescribing duloxetine in depressed patients with risk factors of bipolarity such as previous history of resistance to treatment with antidepressants, a family history of severe mental illness and diagnosis of fibromyalgia.

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