SERTRALINE INDUCED HYPOMANIA

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ABSTRACT

Mania due to tricyclic antidepressant use has been well reported in literature but reports of SSRI’s induced mania are less. This case reports a sertraline induced mania and discusses the use of this drug in adolescent females.

Key words : Sertraline, mania, adolescent, female

Literature suggests that antidepressants can precipitate mania or cycle acceleration. Female sex, hypothyroidism & drug induced rapid cycling have been put forth as putative risk factors (Wehr & Goodwin, 1987). While TCA’s have been the main culprit (Geller et al., 1993), reports currently suggest that SSRI’s may not be so benign either, as the following case suggests.

CASE REPORT

Miss SG, a sixteen year old female presented with an insidious onset, continuous and detonating course of one month duration characterized by decreased sleep, a belief that she was suffering from a kidney infection, a sad expression on the face and expressing that the future was bleak and she was helpless. There was no past history of mental illness or physical illness. There was a family history of recurrent depressive disorder in maternal uncle and unspecified psychosis in maternal aunt. Mental status examination revealed a young female with fair eye contact. There was adequate productivity of speech. Affect was depressed. There was anhedonia, ideas of hopelessness, helplessness and death wish. Hypochondriacal ideas were also present. She had taken tablets Dothepin HCl 75 mg for two days one week prior to consultation. She was diagnosed as having severe depressive episode and was put on tablet Sertraline 25 mg which was titrated to 50 mg after 3 days along with tablet Thioridazine 50 mg.

After two weeks of such treatment she started to interact with strangers while premorbidly she was shy. She had become much more active and used to roam around all the time. Mental status examination at this point of time revealed a well kempt and dressed female with cheerful affect, racing thoughts, talkativeness, increased self-esteem and an increase in goal directed activity. A diagnosis of SSRI induced hypomania was made. Sertraline was stopped and the patient put on Valproate 400 mg on which she is maintaining well.

DISCUSSION

There have been a number of case reports of mania with SSRI’s including Fluoxetine (Hon & Preskorn, 1989) and Paroxetine (Grubbs, 1997). Sertraline induced mania is more often reported (Heiman & March, 1996; Kat, 1996; Ghaziuddin, 1994; Loparta, 1987). Interestingly all the above case reports with the exception of Loparta (1987) were those of adolescent females similar to that of our case. The cases reported by Loparta (1987) were adult males.

In the report by Heiman & March (1996)
and one of the cases of Kat (1996) there was family history of bipolar disorder, unlike our case where there was a family history of recurrent depressive disorder. In one of the cases of Ghaziuddin (1994) there was a family history of depression. While in the previous two cases it can be argued that the patient may have been having bipolar disorder. Sertraline bringing forward the manic episode, in our case this can be argued less confidently and only a temporal follow up may reveal whether the case turns out to be bipolar or is mania a side effect of Sertraline. Interestingly in all the adolescent females the manic symptomatology occurred at doses between 25 and 50 mg of Sertraline and a time period of 2-3 weeks, similar to that of our case.

Thus it seems that adolescent depressive females are at a high risk of developing manic symptomatology on Sertraline and one must try to avoid this drug for the treatment of depression in this category.

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