Letters to Editor

Conflicts of interest
There are no conflicts of interest.

Preethi V. Reddy, Lavanya Anuroop1, Veda Shetageri1, Raghavendra K. Kumar2, Ganeshan Gopalakrishnan1

Departments of Psychiatry and 1Child Psychiatry, National Institute of Mental Health and Neurosciences, 1Department of Psychiatry, M V Jayaram Medical College and Research Centre, Bangalore, Karnataka, India

Address for correspondence: Dr. Veda Shetageri
Department of Psychiatry, M V Jayaram Medical College and Research Centre, Hoskote, Bangalore, Karnataka, India.
E-mail: drveda_24@rediffmail.com

REFERENCES

1. Neary D, Snowden JS, Gustafson L. Frontotemporal lobar degeneration: A consensus on clinical diagnostic criteria. Neurology 1998;51:1546-54.
2. Mendez MF, Selwood A, Mastri AR. Pick’s disease versus Alzheimer’s disease: A comparison of clinical characteristics. Neurology 1993;43:289-92.
3. Pasquier F, Lebert F, Lavenu I. Diagnostic clinique des demences fronto-temporales. Rev Neurol 1998;154:217-23.
4. Robert PH, Lafont V, Snowden JS. Cite`res diagnostiques des de’gerenescences loba`res fronto-temporales. Encephale 1999;25:612-21.
5. Rascovsky K. Sensitivity of revised diagnostic criteria for the behavioural variant of frontotemporal dementia. Brain 2011;134:2456-77.
6. Iroka N, Jehangir W, Littlefield J II. Paranoid personality masking an atypical case of frontotemporal dementia. J Clin Med Res 2015;7:364-6.
7. Velakoulis D, Wauterfang M, Mocellin R. Frontotemporal dementia presenting as schizophrenia-like psychosis in young people: Clinicopathological series and review of cases. Br J Psychiatry 2009;194:298-305.
8. Manes FF. Frontotemporal dementia presenting as pathological gambling. Nat Rev Neurosci 2010;6:347-52.
9. Ibanez N. Atypical presentation of frontotemporal dementia masquerading as bipolar disorder and substance abuse: A case report. W V Med J 2012;108:16-8.
10. Pontieri FE, Tanda G, Orzi F, Di Chiara G. Effects of nicotine on the nucleus accumbens and similarity to those of addictive drugs. Nature 1996;382:255-7.
11. Perry DC, Sturm VE, Seeley WW, Miller BL, Kramer JH, Rosen HJ. Anatomical correlates of reward-seeking behaviours in behavioural variant frontotemporal dementia. Brain 2014;137:1621-6.
12. Kalkonde YV, Jawaid A, Qureshi SU, Shirani P, Wheaton M, Pinto-Patarrayo GP, et al. Medical and environmental risk factors associated with frontotemporal dementia: A case-control study in a veteran population. Alzheimer’s Dement 2012;8:204-10.
13. Cruz M, Marinho V, Fontenelle LF, Engelhardt E, Laks J. Topiramate may modulate alcohol abuse but not other compulsive behaviors in frontotemporal dementia: Case report. Cogn Behav Neurol 2008;21:104-6.
14. Iroka N, Jehangir W, Littlefield J II. Paranoid personality masking an atypical case of frontotemporal dementia. J Clin Med Res 2015;7:364-6.

Dysmorphic Delusion and Olanzapine-Induced Postpartum Dermatosis in a Case of Schizophrenia

Sir,

Olanzapine has been used widely to control psychotic symptoms in patients with schizophrenia, bipolar disorder, and aggression associated with other psychiatric disorders. Weight gain and hyperglycemia are the most serious side effects of olanzapine in long-term treatment.1,2 Olanzapine is one of the preferred drugs among atypical antipsychotics for short-term use.2 However, we encountered an acute dermatological adverse drug reaction (ADR) of olanzapine in a patient with dysmorphic delusion.

CASE REPORT

A 25-year-old lady, Mrs. G, P1L1, 6 months postpartum, presented with a 1-year history of hallucinatory behavior, hostility toward family members, disorganized behavior, and poor bonding with a physically healthy
infant. During 6 months of the postpartum period, she became socially aloof, muttering to self, not sleeping at nights, and holding a false belief that her face has turned ugly, in the absence of any visible facial skin changes. On mental status examination, poor cooperation, difficulty in establishing rapport, poverty of speech, second person auditory hallucinations, which patient refused to elaborate, and dysmorphic delusion were established. She was diagnosed with undifferentiated schizophrenia and treated by a psychiatrist with risperidone 6 mg/day for 3 months, without much improvement. When she came to our hospital, considering a failed response to treatment, risperidone was cross tapered with oral olanzapine up to 20 mg per day over 1 week. During 3 weeks of inpatient care, an improvement was noted in hallucinations, self-care, and bonding with the infant.

However, there was development of non-pruritic, non-erythematous, self-limiting papulopustular (acneiform) skin eruptions over the face, which worsened with increasing dosage of olanzapine. Despite reduction in other psychotic symptoms, the patient continued to hold the dysmorphic delusion that her face is ugly, and unfortunately, it appeared self-validating because of the recent development of acneiform eruptions.

There was no history of self-mutilation, skin excoriation, hair picking, or exposure to known allergens, and hence, diagnoses of self-induced dermatosis (acne excoriation) and hypersensitivity reaction were ruled out. Her blood glucose level, autoimmune workup, thyroid, liver and renal functions were found to be within normal limits. Her menstrual cycles were regular.

The diagnosis of olanzapine-induced acneiform dermatosis was considered after a dermatology consultation. A cognitive behavioral therapy approach was used to tackle dysmorphic delusion. The patient was reassured about probable cosmetic adverse effects of olanzapine. Her belief was shaken slowly through a course of five therapy sessions targeting overgeneralization as a main cognitive distortion. This was accompanied by disproving her beliefs by comparing pictures and mirror reflections, reassuring about the reversibility of acneiform eruptions, and video feedback with the infant. Olanzapine was continued after risk-benefit analysis and shared decision-making with patient and caregiver.

**DISCUSSION**

Some of the common facial dermatological conditions during the postpartum period include dry skin, hormonal acne, spider veins, and post-pregnancy-melasma. Skin eruptions in the perinatal period are considered as dermatoses of pregnancy.[3] A broad group named pruritic urticarial papules and plaques of pregnancy and polymorphic eruptions of pregnancy are two distinct conditions that constitute 0.5% of total cases.[4] However, till now, only six case reports have described dermatoses during the post-partum period,[5] which include lesions that are pruritic, erythematous, and inflammatory in nature. The earlier reports also highlight facial sparing and occurrence during the immediate post-partum period.[6]

In contrast, acneiform dermatosis in our case was non-pruritic, non-erythematous, restricted to facial skin, and developed around the sixth month postpartum. None of the previous reports had described the postpartum onset of acneiform dermatoses on exposure to olanzapine. Skin rash,[7] pustular eruptions,[8] hypersensitivity syndrome,[9] acneiform eruptions,[7] and pellagroid skin eruptions have been reported with oral olanzapine preparation[10] in non-postpartum cases. Pathological findings have confirmed the nature of the skin eruption after olanzapine exposure[11] in non-postpartum cases. There is no previous case report describing postpartum acneiform dermatosis with olanzapine exposure in schizophrenia. This case is interesting because the coincidental appearance of acneiform facial eruptions after treatment with olanzapine seemed to reinforce and consolidate the earlier dysmorphic delusion held by the patient.

The exact mechanism of olanzapine causing skin eruptions is sparsely studied. It is hypothesized that olanzapine acts through neurotrophic factors which work in sync with the neurohormonal system. In addition, it is possible that olanzapine alters the androgen sensitivity of end-organ sebaceous system, which is responsible for sebum formation and acneiform eruptions. In future, we need to study the exact mechanism of this adverse effect as olanzapine being one of the state of the art atypical antipsychotics, the cosmetic side effects should not limit its use. Moreover, such drug-induced dermatological adverse effect of antipsychotics can be challenging in patients with dysmorphic facial delusions.[12] Points in favor of our diagnosis were previous conclusive reports of olanzapine-induced dermatoses, the appearance of ADR after the introduction of olanzapine, dose-related severity of dermatosis, and the absence of alternative causes for dermatosis. With a Naranjo Nomogram score of 6, this case highlights acneiform facial dermatosis as a probable ADR of olanzapine.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and
due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Roshan Sutar, Sundarnag Ganjekar

Department of Psychiatry, All India Institute of Medical Sciences, Bhopal, Madhya Pradesh, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore, Karnataka, India

Address for correspondence: Dr. Roshan Sutar
Department of Psychiatry, AIIMS, Bhopal, Madhya Pradesh, India. E-mail: roshidoc@yahoo.co.in

REFERENCES

1. Himmerich H, Minkwitz J, Kirkby KC. Weight gain and metabolic changes during treatment with antipsychotics and antidepressants. Endocr Metab Immune Disord Drug Targets 2015;15:252-60.
2. Sani G, Kotsalidis GD, Vöhringer P, Pucci D, Simonetti A, Manfredi G, et al. Effectiveness of short-term olanzapine in patients with bipolar I disorder, with or without comorbidity with substance use disorder. J Clin Psychopharmacol 2013;33:231-5.
3. Park SY, Kim JH, Lee WS. Pruritic urticarial papules and plaques of pregnancy with unique distribution developing in postpartum period. Ann Dermatol 2013;25:506-8.
4. Kim EH. Pruritic urticarial papules and plaques of pregnancy occurring postpartum treated with intramuscular injection of autologous whole blood. Case Rep Dermatol 2017;9:151-6.
5. Kirkup ME, Dunnill MGS. Polymorphic eruption of pregnancy developing in the puerperium. Clin Exp Dermatol 2002;27:657-60.
6. Pritzler EC, Mikkelsen CS. Polymorphic eruption of pregnancy developing postpartum: 2 Case reports. Dermatol Rep 2012;4:e7.
7. Solfanelli A, Curto M, Dimitri-Valente G, Kotsalidis GD, Gasperoni C, Sani G, et al. Skin rash occurring with olanzapine pamoate, but not with oral olanzapine, in a male with juvenile idiopathic arthritis. J Child Adolesc Psychopharmacol 2013;23:232-4.
8. Adams BB, Mutasim DF. Pustular eruption induced by olanzapine, a novel antipsychotic agent. J Am Acad Dermatol 1999;41:851-3.
9. Raz A, Bergman R, Eilam O, Yungerman T, Hayek T. A case report of olanzapine-induced hypereosinophilia syndrome. Am J Med Sci 2001;321:156-8.
10. Singh LK, Sahu M, Praharaj SK. Olanzapine-induced reversible pellagroid skin lesion. Curr Drug Saf 2015;10(Suppl 3):251-3.
11. Molina-Ruiz AM, Molina-Ruiz RM, Zulueta T, Barabash R, Requena L. Olanzapine-induced eccrine squamous syringometaplasia. Am J Dermatopathol 2012;34:434-7.
12. Garnis-Jones S. Dermatologic side effects of psychopharmacologic agents. Dermatol Clin 1996;14:503-8.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

How to cite this article: Sutar R, Ganjekar S. Dysmorphic delusion and olanzapine-induced postpartum dermatosis in a case of schizophrenia. Indian J Psychol Med 2019;41:393-5.

© 2019 Indian Psychiatric Society - South Zonal Branch | Published by Wolters Kluwer - Medknow

Euprolactinemic Galactorrhea with Paroxetine: Exploring the Missing Link

Sir,

Selective serotonin reuptake inhibitors (SSRI) are a group of antidepressants used in psychiatric conditions such as major depressive disorder, obsessive compulsive disorders, anxiety disorder, sexual disorders, etc. Paroxetine is an SSRI which also has concomitant norepinephrine reuptake inhibitory properties. Sexual dysfunctions including loss of libido, anorgasmia, and erectile dysfunction are the frequently described adverse effects with the use of SSRIs including paroxetine. Iatrogenic hyperprolactinemia causing galactorrhea has been described with the use of SSRIs such as sertraline, escitalopram, fluoxetine, and paroxetine. However, galactorrhea in the context of a euprolactinemic state with the use of paroxetine is rarely cited, without any clear explanation of the underlying pathophysiology. We report a woman who was treated with paroxetine when she developed galactorrhea despite having normal serum prolactin levels. We also attempt to postulate the possible neurobiological explanation for this presentation.