Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) Syndrome in a Patient with Bipolar Disorder: A Case Report

Dear Sir,

Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is a severe drug reaction characterized by mucocutaneous rash, fever, multi-organ involvement, and hematologic abnormalities.1 Incidence is about one in 1000–10,000 individuals exposed to offending drugs, with 10%–20% mortality.2 Drugs such as allopurinol, sulfasalazine, and anti-convulsants have been associated in existing reports.3,4 Very few reports, however, exist in psychiatric literature.3–6 PubMed-based MeSH search (“Drug Hypersensitivity Syndrome”[Majr]) AND “Psychotropic Drugs”[Majr]) and search terms restricted to the title/abstract returned less than 10 case reports, inclusive of cross-reference search.

Mr X, 58 years, a known case of hyperlipidemia and Systemic Symptoms (DRESS) was a severe drug reaction while on quetiapine and prednisolone. In August 2015, escitalopram (5–10 mg/day) was added, and prednisolone was slowly tapered to 30 mg/day. After a week, he developed similar rashes (in face and upper extremities), with fever. Escitalopram was immediately stopped, and prednisolone increased to 40 mg/day, with improvement. Relevant investigations for fever (malarial, typhoid, and dengue serology; viral markers; and blood and urine culture) were unremarkable.

Given the severity of depressive symptoms and the caregiver’s initial refusal for modified electro-convulsive therapy (MECT), nortriptyline was added cautiously and built up to 125 mg/day, over his other medications (prednisolone 40 mg, quetiapine 200 mg/day, clonazepam 1.5 mg/day, amlodipine 5 mg, telmisartan 80 mg). Given nonimprovement, he finally received 10 sessions of MECT. The patient maintained euthymic till October 2015, when nortriptyline was stopped due to hypomania. He was euthymic on quetiapine (600 mg/day) by November 2015.

Prednisolone was successfully tapered off very slowly (by February 2016). A subsequent depressive episode (2016) was managed by the addition of nortriptyline for a few months only. As of March 2020, he continues to remain euthymic on quetiapine monotherapy (400 mg/day) and is in regular follow-ups.

This treatment-naïve patient of BD-II developed DRESS on multiple psychotropics. It is difficult to delineate the precise culprit out of the three drugs (lithium, fluoxetine, and olanzapine). Each has very few (1–3) reports in indexed literature, despite their widespread use. Further, a sequential rechallenge was deemed to be out of question, given the serious life-threatening risks and a long lag period to develop DRESS.

The choice of subsequent medication for severe depression posed a management dilemma. It was decided not to rechallenge with lithium or SSRIs (as a class), given their prior temporality. Anti-convulsants were not considered due to a strong association in the literature. Finally, nortriptyline (selective nor-epinephrine transporter) and quetiapine were found to be safe in this patient.

The use of steroids, though lifesaving, could have exacerbated the mood symptoms in this case. The available literature on DRESS is unclear on the recommended duration of steroid use, ranging from 3–4 weeks to several months.5,6 In this patient, DRESS developed after 6 weeks of exposure; this is in concurrence to the literature (mean exposure: 35.6 days; range: 7-120 days).6 Hyponatremia is not commonly associated with DRESS but has been described in a few reports.2,6

Hypothesized mechanisms for DRESS include defective metabolic enzymes, sequential virus activation, and certain HLA alleles (e.g., HLA-B*15:02 with carbamazepine).2,6 No specific allele

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associations are known for psychotropic drugs. Patch and lymphocyte transformation testing might help to identify the drug, but neither is widely used or accepted.

This article adds to the scarce reports describing psychotropic-drug-induced DRESS, along with the subsequent clinical-psychiatric management and a safe trial on quetiapine and nortriptyline. The report emphasizes the need for awareness about this rare yet potentially life-threatening drug reaction.

**Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Ethical Statement**

Written informed consent and anonymity have been ensured.

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**Gastaut-Geschwind Syndrome in a Patient of Bipolar Disorder: A Case Report**

To the Editor,

Gastaut-Geschwind Syndrome (GGS) is a constellation of symptoms commonly seen in patients with temporal lobe epilepsy. GGS can be interpreted as a manifestation of the temporo-limbic neuropsychiatric syndrome. It is characterized by personality changes and behavioral changes like hyper-religiosity, hypergraphia, compulsive documentation, an exaggerated philosophical concern, atypical sexuality (usually decreased), interpersonal stubbornness, and circumstantial thought process. Here, we present a rare case report of GGS in a patient of bipolar disorder (BD) without any evident neurological finding, which adds to the current scientific literature.

**Case Discussion**

Mr M, a 37-year-old married craftsman, was brought by his wife to the department of psychiatry in a tertiary care...