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Naso-gastric administration of risperidone to treat delusions of poisoning

Dear sir,

M was 15 years old when he was referred to the Child and Adolescent Service in a condition thought to be life-threatening. This case is interesting in its administration of antipsychotic medication and because there is evidence that both cannabis abuse [1] and rapid weight loss [2] are associated with mental disorders.

M had been a regular cannabis user for 2 years. His behaviour changed a year ago when he became socially withdrawn. He stopped going to school, believing that his classmates were making fun of him and because he had difficulty concentrating. He had mentioned suicide, and neglected himself. He slept little and would lie on the floor, screaming and crying in strange voices. M had lost weight; he had consumed almost nothing over the past three weeks and, afraid of being poisoned, would only sip water if his brother first drank from the cup.

M moved to England at the age of 10 and settled without major problems. His parents divorced 9 years ago. His mother suffered from depression; his father had previously experienced a psychotic episode and depression, and been addicted to cannabis and heroin; and his brother had used cannabis.

On presentation, M was unkempt, pale and thin; weakness made walking difficult. He spoke few words in a whisper, and there was evidence of thought interference as he found it difficult to talk and unable to elaborate. M was diagnosed with unspecified non-organic psychosis (ICD 10; F29).

Due to his fragility, M was admitted to a general medical ward for immediate rehydration. He was prescribed olanzapine 2.5 mg increasing to 5 mg the next day, but he refused to swallow tablets, and was given an injection of haloperidol 5 mg. The day after, M showed severe rigidity. Haloperidol was discontinued, and olanzapine 5 mg daily (Velotab®) and sertraline 50 mg daily were started. Non-compliance with medication and psychosis persisted so, when naso-gastric feeding was begun on his fifth day of hospital stay, all medication was stopped and risperidone liquid 1.5 mg daily was administered via the naso-gastric tube.

Improvement was rapid. Over the next couple of days he started to eat, drink, talk and walk. He was transferred to a psychiatric ward and discharged home on risperidone liquid 2 mg daily after 2 weeks. He remained stable until he used cannabis when drinking beer. This caused some deterioration in mental state, so risperidone was increased to 3 mg daily and he was cautioned against cannabis use. Six months on, M is stable; he eats and drinks normally, attends to his personal hygiene and participates in family activities.

There is evidence to suggest an association between psychosis and cannabis abuse [3]. Indeed, there is increasing evidence that the cannabinoid system may be involved in psychotic disorders [4,5]. Our patient supports others [1] in that the use of cannabis (i) precipitates psychotic disorders in vulnerable individuals (i.e. patients at high risk, e.g. family history), and (ii) exacerbates symptoms of psychosis in those that continue to use cannabis.

We believe this to be the first report of risperidone administration through a naso-gastric tube. It was appropriate in this patient who refused to swallow, afraid of being poisoned. Psychiatric disturbance has also been associated with considerable and rapid weight loss though diet, and return to a normal diet and weight has resulted in an improvement of condition [2]. Although some improvement may have been due to eating and subsequent weight gain, it was risperidone treatment that was considered to play an important role in the rehabilitation of this patient.

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Escitalopram in trichotillomania

Sir

Trichotillomania is a neglected psychiatric disorder with dermatological expression [1]. Inspite of intriguing new information about trichotillomania, the basic information about its prevalence, natural history and treatment is lacking [2]. Trichotillomania is an impulse disorder in which patients chronically pull hair from the scalp and/or other sites [3]. Hair pulling and plucking is commonest from the frontoparietal and temporal regions of scalp, although occasionally the eyelash, eyebrow, pubic hair and hair on other body sites may be involved. We report a child who presented with gradual loss of hair over scalp and there was also compulsion to pluck hair from scalp of other family members. He responded to a new SSRI, escitalopram.

Mr S, a 10-year-old boy studying in 5th standard was brought by his father to the dermatological clinic for loss of hair over scalp for last 10 months. The child was normal about 10 months back when he developed a patch of alopecia over scalp. The boy was prescribed antifungal drugs along with a scalp lotion for 2 months but without any improvement. The habit of plucking hair had increased, and he also started plucking hair of his mother and sister whenever he got an opportunity especially when they were asleep. The examination of hair from child's scalp was normal. The child was referred for psychological evaluation. All the medications were stopped. On detailed psychological evaluation in three sessions, it was found that the boy was not allowed to go outside to play with friends and was confined to the house only. This was due to parental fear that he may not get spoiled or did not meet an accident. He was not given any leisure activity at home and was continuously asked to study or sleep. The child also had the habit of nail biting. He was the youngest of three siblings. There was no past or family history of any chronic physical or psychiatric illness. The father had a furniture shop in the house itself. The boy had a good academic record. After developing this problem, the child was wearing cap all the time and even during the summer. After developing the illness, he started receiving attention from her family members.

The child was started on escitalopram 5 mg daily which was increased to 10 mg daily after one week and was also given suggestion, distraction and explanation of the nature of symptoms. The father was also counselled about the nature of illness, its onset and perpetuation. There was a gradual fall in the frequency of hair plucking and nail biting followed by complete remission. On following him up for 2 months, he did not develop the habit and started enjoying the outdoor activities with his friends.

Trichotillomania in children is commonly associated with other neurotic traits such as nail biting (as was in the present case), thumb sucking, anxiety or stress of examinations, learning disability and parental neglect [4] and there may eating of hair resulting in trichobezoar. In the present case, there were the stressors in the form of neglect and boredom. An increased incidence of co-morbid obsessive-compulsive disorder (OCD) has been noted with trichotillomania and neurological investigations have paralleled etiologic studies of OCD and have demonstrated both similarities and differences between OCD and trichotillomania [5]. Some investigators have even labeled trichotillomania as OCD spectrum disorder. Though selective serotonin reuptake inhibitors, especially fluoxetine, paroxetine, fluvoxamine, and citalopram have been found to be useful in trichotillomania [6–10], there are no reports about the role of escitalopram (which is a highly selective SSRI and a pure *S*-enantiomer of the racemic bicyclic phthalane derivative, citalopram) in trichotillomania. The condition need to be timely recognized and appropriately treated to avoid any future complications.

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