A Seven-Year Follow-Up of an Extremely Refractory Bipolar I Patient

To the Editor:

July 30, 2007

We report the 7-year follow-up of a 40-yearold married woman previously reported as an extremely refractory depressed patient¹ who was repeatedly hospitalized in our department and treated with a variety of aggressive but unsuccessful treatment trials (including combinations) lasting at least 4 months each: fluoxetine 60 mg, venlafaxine 375 mg, haloperidol 40 mg, risperidone 6 mg, lithium plasma levels 1.0 mEq/lt, and carbamazepine plasma levels 9 µgr/mL.

The previous case report¹ concerned her temporary response to treatment with high doses of clomipramine intravenous 6 amp daily plus oral venlafaxine 225 mg in 2000. The patient had responded on day 15, with a dramatic remission of symptoms, almost to normothymic state. There were no mixed or hyperthymic features present to suggest the possibility of antidepressant-induced mood switching. This had lasted for 37 days. Then, the patient had attempted suicide unsuccessfully by swallowing pills, obeying to auditory hallucinations. The mood change had been acute (within a few hours).

The patient had originally been diagnosed as suffering from dependent and borderline personality disorder and major depression with atypical features refractory to treatment, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*,² and that was the diagnosis included in the first publication of the case.¹

First onset of symptoms was at 26 years of age with the form of free-floating anxiety and incomplete panic attacks, which were soon followed by major depression. Before presenting to our department, she had attempted suicide

once. Her psychiatric family history was blank. She was 1 mg dexamethasone suppression test non-suppressor (cut-off: $5~\mu gr/dl$), with blunted response to 30 mg dexfenfluramine challenge test (cut-off: $50~\mu U/lt$). Brain single photon emission computed tomography showed increased frontal lobe regional cerebral blood flow (standard deviation: +1.5) and reduced (SD: -0.3 to -1.4) in the rest of brain areas.

The patient had no contact with our service for the last 6 years that followed the case report. During then, she received electroconvulsive therapy without any benefit, she manifested for the first time a manic episode of mild severity that lasted ~8 months (2000–2001), and for the rest of the time she was depressed without any symptom-free intervals. She attempted suicide twice with pills and once by cutting her wrists. She frequently experienced mood congruent auditory hallucinations. During that period, she was treated with combinations of antipsychotics (mostly haloperidol and clozapine) and oxcarbazepine. There were also periods of alcohol and benzodiazepines abuse.

The patient presented to us again after her last suicidal attempt. The diagnosis changed to bipolar I disorder, current episode depressive. She was gradually put on quetiapine 1,500 mg/day, lamotrigine 300 mg/day, and topiramate 50 mg/day. She responded well to treatment, and 20 days after treatment initiation, auditory hallucinations disappeared and mood started to improve. She was dismissed after 34 days of hospitalization with her mood at almost normothymic levels.

For the next 7 months, the patient was normothymic with no residual symptoms. This was the second true normothymic interval (after the 37 days that followed clomipramine infusions) since the onset of her disease at 26 years of age, that is 14 years ago. Her body mass index at admission was 51.11 (weight: 146 kgr, height: 169 cm) and fell to 46.56 (133 kgr) at release. Seven months later, her body mass index was 38.51 (110 kgr).

The authors feel that the publication of the follow-up of this case will be of help in the clinical understanding of complex and refractory cases of depression often encountered in clinical practice.

Sincerely,
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Disclosure: The authors have received support concerning travel and accommodation expenses from various pharmaceutical companies in order to participate in medical congresses. Dr. Fountoulakis receives honoraria from AstraZeneca, Eli Lilly, and Janssen-Cilag; and a research grant from Pfizer Foundation.

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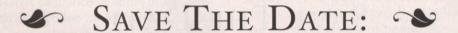
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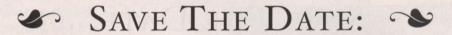
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