
Olanzapine in Treatment of Patients With Bipolar 1 Disorder And Panic Comorbidity: A Case Study

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Abstract

Anxiety disorders are frequently co-morbid with bipolar disorders (BP). Anxiety symptoms can have a great impact on course of illness and patient's quality of life. Olanzapine is the first antipsychotic approved as a mood stabilizing agent. In this paper two cases of BP 1 disorder where panic attacks co-occur treated with olanzapine were presented. In both cases olanzapine showed very good effects in treatment of panic symptoms within the course of BP disorder.

Key words: bipolar disorder, anxiety disorder, panic attacks, comorbidity, olanzapine

Introduction

A growing literature suggests that anxiety disorders frequently overlap with mood disorders (e.g. Wozniak et al, 2002). Panic disorder and generalized anxiety disorder (GAD) are specifically more common amongst all anxiety disorders in patients suffer from bipolar disorders (BP) compared to those with unipolar major depression (Simon et al, 2003). Recently it has been reported that 16% of patients with BP disorders, type 1 (BP1) had panic disorder with or without agoraphobia and panic attacks (Henry et al, 2003). Some results show that presence of anxiety disorders determines more severe outcome of BP1 disorder (Taman & Ozpoyraz, 2002). Frank et al (2002) found that panic symptoms in patients with BP1 disorder were associated with greater levels of depression and suicidal ideation. However, panic symptoms can be very disturbing by itself even when the patient is free from manic and depressive episodes. They can have a great impact not only on course of illness but also on the quality of life. Bipolar patients with co-morbid anxiety disorders responded less well to anticonvulsant mood stabilizing therapy compared to those without. Differences were not found when lithium was applied (Henry et al, 2003).

The treatment of BP1 disorders requires long term multi-phase approach. Olanzapine is the first antipsychotic approved as a mood stabilizing agent. Olanzapine demonstrated efficacy in treatments of acute mania (Tohen et al, 2000), bipolar depression (Shelton, 2003) and relapse prevention (Tohen et al, 2001) as monotherapy as well as in combination with other mood stabilizers and particular antidepressants. Results of olanzapine pos-

itive effects on the anxiety symptoms in various psychiatric conditions and in GAD were reported.

In this paper we describe two cases of BP1 disorder followed by panic symptoms treated with olanzapine at Psychiatric Clinic, Clinical Center University of Sarajevo.

Case 1.

A female patient, 25 years old, single, clerk, was admitted at our inpatient department three years ago. She suffered from severe depression followed by psychomotor agitation, feeling of worthlessness, delusions of guilt and hypochondriac delusion (she was convinced that she has a lethal communicable disease she spread around). The patient lost 10kg within one month due to the loss of appetite. Recurrent thoughts of death and very intensive suicidal ideation were prominent in her clinical picture. On the basis of lifetime interview it was revealed that the patient experienced one manic episode six months prior to this depressive episode treated in another psychiatric hospital with typical antipsychotics. Manic episode lasted one month. After discharge from that hospital she discontinued medication.

Upon admission to our hospital due to the severe psychotic depressive episode described above, olanzapine (10mg per day) with fluoxetine (20mg per day) were administered. Six weeks later all depressive symptoms withdraw. Preventive treatment was continued on ambulatory basis with olanzapine (10mg per day) only. For the period of one and half year she remained in stable remission with a good life quality level. Unfortunately, her financial situation was not allowed her to remain on olanzapine treatment. It was not possible to get olanzapine free of charge through National Health Insurance System at the time. As a substitute, she was put on carbamazepine only at the dosage corresponded to a therapeutic level. One month later she reported depressive signs on subsyndromal level followed with irritability. Levopromazine (100mg per day) was added to the treatment. Fifteen days later the subdepressive symptoms were reduced. Soon after the reduction of these symptoms, on the regular follow up panic attacks were found. Even after introduction of paroxetine panic symptoms did not disappear. On the contrary, panic attacks became more frequent, almost daily with presence of agoraphobia for the next six months. Her every day functioning

became impaired. She complained that these symptoms disturbed her life as much as depressive and manic symptoms.

Repeated introduction of olanzapine was considered in the treatment. Three months later on olanzapine monotherapy, majority of panic symptoms disappeared. The patient regained stable up to date (last six months).

Case 2.

Male patient 21 year old, single, student was admitted to our hospital one and half year ago because of manic episode. A manic episode was characterized with euphoric mood, thoughts racing, pressure to keep talking, psychomotor agitation, decreased need for sleep, increased goal directive activities, sexual indiscretion and delusions of grandiosity. A depressive episode preceded this manic one. It lasted six months. Psychomotor retardation, loss of interest, recurrent thoughts of death and suicidal ideation were prominent. At that time he had left a university. He was studying in a foreign country where he was seen by a psychiatrist and treated with 20 mg of fluoxetine ambulatory, without any effects. Immediate shift to a manic episode lead him to return to B&H and referral to our hospital. At the beginning of a treatment at our Department due to the manic episode described above haloperidol (10mg per day i.m.) and carbamazepine (400mg per day) were administrated. Ten days later patient developed extrapyramidal side effects. Haloperidol was replaced by olanzapine (10mg per day). Complete remission was achieved four weeks later and the patient had continued his treatment on regular ambulatory basis. In the meantime he reenrolled to our University and became a student with excellent grades. Six months later dose of olanzapine was reduced to 5mg per day. Carbamazepine concentrations were regularly checked and they were within therapeutical range. Fifteen days later he came and reported that he had two attacks of panic. They came completely unexpected. He experienced acceleration in the heart rate, shortness of breath, chest pain, sweating and fear of dying. Sertraline up to 100 mg was added to the previous treatment, but without therapeutical effects. Panic attacks became more frequent and he started to avoid lectures and socializing.

After three months sertraline was excluded and olanzapine was increased up to 12,5mg daily. Panic attacks were reduced. His olanzapine dose was reduced to 10 mg daily two months later in combination with carbamazepine and he remained in a stable remission concerning BP1 disorder without panic symptoms (last five months).

Discussion

Panic symptoms are often co-morbid with BP1 disorder. Interestingly, in the case of both patients described in our paper panic attacks as well as any other symptoms of anxiety disorders were not detected prior to onset of BP1 disorder. Olanzapine was introduced at early stage treatment of BP1 disorder in both cases with a very good results in acute and maintains phases. Exclusively because of financial reasons and not due to any side effects olanzapine was excluded (case 1) and dose was reduced (case 2). In a second case dose of 5 mg was obviously very low and in interaction with carbamazepine olanzapine serum levels might become even lower than expected (Lucas et al, 1998).

It remains probable that at this crucial moment in the treatment patients felt insecure fearing that a new manic or depressed episode will appear. Therefore, there is a possibility that in anticipating of those events panic and phobic symptoms developed as a consequence of extremely unpleasant experience of BP1 episodes complicated with social stigma. It seems to that prominence of specific symptoms in depressive episodes made these two patients more susceptible to panic disorder within the course of BP1 disorder by itself. Panic symptoms were most likely controlled and suppressed by olanzapine anxiolytic effects described elsewhere (e.g. Kliser et al, 2000) during the treatment period. In favor to this hypothesis is the fact that the re-introduction of olanzapine in therapeutically optimal dosages lead to the significant improvement of panic symptoms. It remains unclear why selective serotonin reuptake inhibitors (SSRIs) did not have any effect on panic symptoms. However, these findings could be accidental, so further thorough research is needed.

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