PSYCHOLOGICAL MEDICINE

Use of Queatiapine in Treatment of Unremitting Anxiety: A Case Report of Schizophrenia Prodrome

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ABSTRACT

Objective: **A 21-year-old man who presented with a 17-month history of unremitting anxiety associated with panic attacks was studied.**

Result: **The anxiety with panic attacks did not abate with escitalopram 15 mg nocte and alprazolam 0.5 mg tds. At month 3, the patient reported low mood and unexplained sexual arousal in addition to the unremitting anxiety symptoms. His condition fairly improved with addition of quetiapine. At month 17, transition to psychotic disorder occurred when the patient experienced hallucinations for the first time. Quetiapine was increased to 500 mg nocte and the anxiety symptoms improved tremendously before he relapsed 6 months later due to poor compliance.**

Conclusion: **Unremitting anxiety with depression can be a dominant feature during the schizophrenia prodrome. Atypical antipsychotic quetiapine is an interesting treatment option due to its status as approved adjunctive treatment for major depressive disorder and promising efficacy for generalized anxiety disorder.**

KEY WORDS

depression, prodrome, pseudoneurotic, early intervention, quetiapine

INTRODUCTION

Schizophrenia is chronic debilitating mental disorder that involves tremendous direct and indirect costs to the patients, their families and society. Interest in identification of prodromal phase of schizophrenia is increasing as the focus now shifts to the prevention of mental illnesses. Recent findings in patients with an emerging psychotic disorder suggest that schizophrenia may present with significant neurotic symptoms. Meta-analysis of 1683 high-risk subjects showed that baseline prevalence of comorbid depressive and anxiety disorders is respectively 41% and 15%[1]. In a local study, 55% of the subjects with sub-threshold attenuated psychotic symptoms (APS) had associated depression and/or anxiety[2]. Here, we report a case of schizophrenia presenting with prominent unremitting anxiety symptoms.

CASE

The patient was a 21-year-old student living with his mother and elder sister. He was referred to the psychiatry clinic via the family physician, having presented with unremitting anxiety associated with panic attacks. The first episode was 2 month before which was described as sudden onset of burning epigastric pain which was treated as gastritis. Another episode occurred while he was talking with his friend during Friday prayer. The panic attack which lasted about half an hour was characterized by a discreet episode of sudden onset of palpitation, shortness of breath, chest tightness, numbness of extremities, burning epigastric pain and sense of impending blackout. He was also worried that he might be having a brain tumor or other neurological conditions. He searched for information regarding his symptoms and possible diagnoses from the internet and would discuss about it with the doctors. Both his father and brother were under psychiatric treatment with a diagnosis of schizophrenia and obsessive-compulsive disorder, respectively. The patient was diagnosed as panic disorder. He was treated with escitalopram and alprazolam which were titrated up to 15 mg nocte and 0.5 mg tds respectively.

After 3 months of treatment, he continued to have frequent and severe panic attacks at 1 to 3 episodes per day for almost every day resulting in very frequent visits to the emergency department. The patient slept around the hospital compound to ease him getting the medical attention whenever panic attack occurred. In addition, he stated that he was likely to become sexually aroused during sleep at home which he attributed to *jin*. He postponed his study incapacitated by the severe anxiety and low mood. Differential diagnosis of major depressive disorder was considered at this stage. In view that the patient was also at high risk for schizophrenia, quetiapine XR 50 mg nocte was started to augment the escitalopram[3,4]. His condition improved resulting in less frequent visits to the emergency department. The compliance to treatment, however, was not very good.

Seventeen months after the initial presentation, he described hearing voices of people talking about him and reciting verses from the Quran at night for the first time. The quetiapine XR was increased to 100 mg nocte. Two weeks later, the voices became more prominent and commanded him to kill himself leading to two week admission in psychiatric ward. Quetiapine XR was increased up to 500 mg nocte. His diagnosis was revised to schizophrenia. After 2 months, he experienced minimal anxiety, depressive and psychotic symptoms. He went to work in Kuala Lumpur for about 6 months. However, the symptoms recurred after his default of treatment for which quetiapine XR 500 mg was restarted and his condition had improved since then.

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DISCUSSION

The recognition that high risk subjects for schizophrenia are characterized by high prevalence of anxiety and depressive disorders in addition to their attenuated psychotic symptoms[1] is not new. The term and concept, pseudoneurotic schizophrenia, was proposed by Hoch and Polatin in 1949 to delineate a poorly defined subgroup of schizophrenia patients who presented with prominent anxiety symptoms, which masked the underlying basic mechanisms of schizophrenia[5,6]. The diagnostic term, however, is not part of current classification systems and thus has fallen out of clinical use.

Pseudoneurotic schizophrenia is characterized by presence of primary clinical symptoms which was thought to reflect the basic symptoms of schizophrenia which operate even before the onset of psychotic symptoms. Significantly, this patient had low mood and unusual sexual arousal suggesting an altered sensorimotor-autonomic integration in psychosexual functioning[5]. Clinical presentations are often dominated by the secondary clinical symptoms, many of which can be recognized as developments of various primary symptoms, or combinations of such symptoms. The term pan-anxiety is used to designate diffuse anxiety, the presence of which is marked by special intensity, duration and pervasiveness. The intensity may vary from vague disquietude to panic, but the subjective experience of anxiety is almost constantly present and is frequently dominating[6]. This patient showed, in contrast to the usual neurotic patients, an all-pervading anxiety in which everything that the patient experienced influenced this anxiety. Pan-anxiety was always manifested no matter how he tried to break through the conflict or to avoid it.

The anxiety symptoms in this patient did not remit with adequate dose of selective serotonin reuptake inhibitor and benzodiazepine. Quetiapine XR was added but at a low dose 50 mg nocte. It was chosen for its low risk of extrapyramidal side effect. A recent study suggests quetiapine has acute anxiolytic effects for patients with specific phobia[3]. In another study, quetiapine XR (50-300 mg/day) monotherapy is effective in the short term in improving symptoms of anxiety in older patients with GAD, with symptom improvement seen as early as week 1[4]. Currently, it is an approved adjunctive treatment for patients with major depressive disorder[7]. The dose of quetiapine remained at low dose 50 mg nocte for more than a year before the emergence of psychosis.

Most clinicians still hesitate to prescribe antipsychotic treatment due to ethical consideration such as false-positive identification of prodromal phase. Additionally, antipsychotics are often associated with adverse effects that are undesirable for young people, such as pronounced weight gain[8] making this option less attractive compared to other available psychological and pharmacological intervention[9] even though randomized controlled studies have demonstrated the effectiveness of antipsychotics such as risperidone[10,11], olanzapine[12] and amisulpiride[13] in reducing the conversion rate to schizophrenia. In an open-label study, aripiprazole shows a promising efficacy and safety profile for the psychosis prodrom[14].

CONCLUSION

Anxiety symptoms can be very prominent and may not respond adequately to the standard antidepressant and anxiolytic treatment during the prodromal phase of schizophrenia. Quetiapine is an interesting treatment option for patients at high risk for schizophrenia with prominent anxiety and/or depressive symptoms for the following reason: 1) it is atypical antipsychotics with low risk of extrapyramidal side effects; 2) it is already approved as adjunctive treatment for major depressive disorder; 3) it shows promising efficacy for generalized anxiety disorder.

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