

Letter to the Editor

Hypomanic Shift Induced by Milnacipran and ECT

We will discuss a hypomanic shift that resulted from the administration of milnacipran and ECT in a 64-year-old woman that was hospitalized 3 times due to depression. Although tricyclic and SSRI antidepressant-induced manic-hypomanic shifts have been reported, hypomania following the administration of milnacipran, an SNRI class agent, and ECT has not been reported.

Mrs. A., a 64-year-old woman, was hospitalized because of 2 depressive episodes that remitted in response to ECT and were followed-up with antidepressant drug treatment (venlafaxine 150 mg/day) at our outpatient clinic. Two years earlier she had a short hypomanic period during which time she was taking venlafaxine. Then, venlafaxine treatment was stopped and quetiapine 300 mg/day was added to the treatment regimen. The patient again complained of depressive symptoms 3.5 months before her most recent hospitalization. Mrs. A. was admitted to the hospital and because of the exacerbation of her depressive symptoms, which included not speaking, diminished interest and pleasure in normal activities, decreased appetite, and thoughts of having a malignant disease and being watched by someone through a camera. Psychological evaluation showed that she had diminished facial expressions, motor movements, speech, and nutritional intake, and limited interaction with the physician. She had decreased flow of thinking speed and process. She strongly believed that she had a malignant disease and had delusions of being controlled by a camera. Most likely, the diagnosis is major depression with psychotic features.

The patient's treatment began with milnacipran 50 mg/day, alprazolam 0.5 mg/day, and olanzapine 10 mg/day while hospitalized. After 1 week there was no improvement in her clinical condition and because her response to ECT during her previous hospitalizations was good a course of bilateral ECT was scheduled. On the 8th day of her hospitalization the first ECT treatment was administered and on the 9th day the milnacipran dose

was increased to 100 mg/day. ECT was administered 6 times—on the 8th, 10th, 13th, 17th, 19th, and 24th day of hospitalization.

On the 10th day of hospitalization her Hamilton Depression Scale score was 31. The patient's affect began to show improvement after the 13th day of hospitalization and her psychotic symptoms subsided, and olanzapine was withdrawn. She reported an increase in motor activity and speech, and excessive energy after the 3rd ECT treatment, at which time her Young Mania Rating Scale score was 11. She was diagnosed with hypomania according to DSM-IV-TR criteria. Milnacipran was discontinued and quetiapine 300 mg/day was added to the treatment regimen. Treatment continued with ECT plus quetiapine. After the patient's depressive and manic symptoms subsided she was discharged from the hospital and prescribed quetiapine 300 mg/day.

Discussion: This case was diagnosed with major depression with psychotic features and was cured with ECT. During her previous depressive episodes she was administered ECT and milnacipran, and a hypomanic shift occurred. She had a good response history to ECT treatment and during her previous depressive attacks and clinical follow-up she also had symptoms of drug-induced hypomania-manic. The patient did not have a history of spontaneous hypomania-manic episodes. Prior to the ECT treatment, milnacipran (an antidepressant) was given to the patient. Because the drug treatment did not work and she had psychotic symptoms, the treatment regimen was changed to include ECT. The patient's depressive symptoms were dramatically reduced and hypomanic symptoms occurred after the third ECT treatment. Milnacipran was thought to cause the hypomanic symptoms and was withdrawn.

The incidence rate of SSRI-induced mania-hypomania during the treatment of major depression is reported to be 2%-3% (Benvenuti et al., 2008). It is known that tricyclic antidepressants cause manic-hypomanic shift more frequently. In addition to reports of drug-induced manic-hypomanic shift, it is also reported that manic-hypoma-

nic shift might be a phenomenon that occurs naturally (Benvenuti et al., 2008). There are reports that ECT combined with antidepressant treatment enhances treatment efficiency (Baghai et al., 2006). Drug-induced manic-hypomanic shift is known to be a significant problem in bipolar disorder patients that do not use mood-stabilizing drugs (Mundo et al., 2006). In patients that do not have a diagnosed bipolar disorder, the notion that drug-induced manic-hypomanic shift is a phenomenologically bipolar disorder is controversial (Baumer et al., 2006). The classification systems of DSM-IV and ICD-10 do not include these patients in the bipolar spectrum. On the other hand, Akiskal (2002) described these patients as having bipolar III disorder and suggested that drug-induced hypomania is evidence of a predisposition to bipolar disorders. It seems that SNRIs that are similar to tricyclic antidepressants induce hypomania-mania. We aimed to report a case of ECT and milnacipran-induced hypomania. To the best of our knowledge this is the first report of milnacipran and ECT-induced hypomanic-manic shift.

References

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