Letters to the Editor

Rabbit Syndrome Induced by Combined Lithium and Risperidone

Dear Editor: Rabbit syndrome, characterized by rapid, fine, rhythmic movements of the mouth along a vertical axis, is a rare extrapyramidal side effect (EPSE) of typical neuroleptics. We report the case of a woman with a history of bipolar disorder who exhibited rabbit syndrome as an acute extrapyramidal reaction after the addition of risperidone to lithium treatment.

Case Report
Mrs O, aged 42 years, presented with a third episode of bipolar illness (diagnosed according to DSM-IV criteria for mania) of 45 days duration; it was abrupt in onset, with the precipitating factor being malarial fever that was treated with tablet chloroquine for 4 days. Her history revealed that the first episode of mania occurred 4 years earlier and that she was treated with carbamazepine 600 mg daily for 6 months. Two years later, she had a second episode of mania, which was treated with carbamazepine 600 mg and lithium 900 mg daily for 1 year without any side effects. For the current episode, she was given lithium 800 mg daily; 2 weeks later, risperidone 2 mg daily was added. The risperidone was subsequently increased to 5 mg daily over a period of 2 weeks. At day 3 of risperidone 5-mg therapy, Mrs O exhibited the abrupt onset of abnormal perioral movements characterized by rapid, fine, rhythmic involuntary movement of her lips and jaw on a vertical axis, associated with akathisia and occasional synchronous lingual movement. Apart from akathisia and dyskinesia, no other EPSEs were seen. Her serum lithium level was 0.7 mEq/L. Her case was diagnosed as rabbit syndrome, and both the drugs were stopped. She scored 9 on the Abnormal Voluntary Movement scale. All her dyskinetic movements disappeared within 5 minutes of intravenous administration of 50 mg promethazine. Subsequently she was given olanzapine 10 mg and trihexiphenyldyl 2 mg daily, along with the same dosage of lithium, without any recurrence of dyskinetic movements.

Mrs O was taking risperidone along with lithium; hence, lithium might have been a contributing factor or risk agent. Few reports suggest that lithium may potentate neuroleptic-related EPSEs or that it may reduce synthesis of dopamine (1,2). To our best knowledge, lithium-induced rabbit syndrome is nowhere reported. Surprisingly, Mrs O was previously exposed to lithium for 6 months but did not show any abnormal movements. It is also possible that lithium might have potentiated side effects even at dosages within the therapeutic range. In 3 recently published cases, all 3 patients had developed rabbit syndrome after continuing risperidone for approximately 4 months (3–5). However, in our case, rabbit syndrome appeared at week 4 of risperidone therapy. Mouth movement is typically rapid and rhythmic in rabbit syndrome, whereas irregular and slow movements are usually noticed in cases of tardive dyskinesia. Our patient did not exhibit abnormal movement until she was taking 4 mg of risperidone, which suggests it may be a dosage-related phenomenon.

Clinicians need to be aware of this rare, acute EPSE occurring with atypical antipsychotic drugs such as risperidone, especially in patients receiving concomitant lithium therapy.

References

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Concomitance of troubles de la personnalité chez des hommes incarcérés

Parmi les 82 hommes incarcérés, 17 ne présentent pas de trouble de la personnalité. Sur les 65 hommes qui en présentent un, 16 ont une personnalité limite, 19 ont une personnalité antisociale et 25 présentent ces 2 personnalités. La plupart des hommes ont un trouble de la personnalité limite ou antisociale en concomitance avec un autre trouble: 25 ont une personnalité paranoïaque, 15 une personnalité narcissique, 4 une personnalité histrihonique, 4 une personnalité dépendante et 3, une personnalité obsessionnelle compulsive.

Ainsi, cette étude exploratoire démontre que bien des hommes incarcérés présentent un trouble de la personnalité antisociale, comme en témoigne la documentation. En effet, le trouble de la personnalité antisociale est souvent étudié chez cette population (1). Parmi les individus ayant une personnalité antisociale, 85 % ont des antécédents de violence contre autrui (2,3). La majorité d’entre eux sont des hommes et ils représentent 2 % à 3 % de la population générale (4).

La présente étude indique que le trouble de la personnalité limite est également présent chez les hommes incarcérés. Ce trouble se caractérise par de l’instabilité dans les relations interpersonnelles, au niveau de l’image de soi et de l’humeur. Environ 2 % de la population générale présente ce trouble de la personnalité, et 27 % à 67 % de ces individus ont antécédents de comportements auto-destructeurs (5). L’impulsivité et la colère font partie des critères diagnostiques décrivant le trouble de la personnalité limite (4). Raine (6) mentionne qu’en milieu carcéral, les hommes ayant commis un meurtre présentent plus souvent un trouble de la personnalité limite. Toutefois, la majorité des recherches portant sur ces individus sont réalisées en milieu psychiatrique et auprès des femmes.

En conclusion, les résultats indiquent que les hommes incarcérés présentent différents troubles de la personnalité. Il y a un nombre presque équivalent d’individus qui présentent un trouble de la personnalité limite et antisociale. Beaucoup d’hommes ont également ces 2 troubles. Cette concomitance s’avère fort importante à considérer, puisque les individus présentant ces 2 troubles de la personnalité sont plus à risque d’agir (contre eux-mêmes ou contre autrui). Les résultats démontrent également qu’il y a un nombre élevé d’individus qui ont un trouble de la personnalité paranoïaque. D’autres recherches pourraient se pencher sur les différences et similitudes entre les individus ayant une personnalité limite, antisociale et...
sur la concomitance des deux troubles (7). De plus, l’étude de l’effet de la présence du trouble de la personnalité paranoiaque serait à approfondir.

**Bibliographie**


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**Case Reports as Letters Should Stay in The Canadian Journal of Psychiatry**

Dear Editor: As a regular contributor to the Canadian Journal of Psychiatry, I wish to applaud your efforts to “raise the bar for publication” as well as your institution of “a rapid-publication policy” (1, p 1).

However, I was surprised that “to make better use of space” you have decided to “no longer accept case reports as letters” (1, p 1). Case reports as letters to the editor take up relatively little space: in any issue, they represent at most 5 to 6 pages—the same number of pages as the average article. Other major, influential psychiatry journals with much higher impact factors publish case reports as letters; they include the American Journal of Psychiatry (2), the British Journal of Psychiatry (3), and the Journal of Clinical Psychiatry (4), among others. Most important, case reports allow authors to highlight important clinical findings—especially, adverse effects of psychotropic medications—and to germinate ideas for future clinical studies. Many clinical studies actually begin as a single case report. They are interesting, and their findings are not always presentable as brief reports.

One alternative is to “raise the bar” on case reports by accepting only those letters that report good data with scientific backing. Limiting the number of letters to a maximum of 2 or 3 per issue and only accepting those letters that receive very good or excellent peer reviews could also be considered as a means to retain this method of scientific communication while “making better use of space” in the CJP.

I fear that the decision to “no longer accept case reports as letters” will lower the impact factor of the CJP and should at the very least be reconsidered.

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**References**


**Reply: Case Reports as Letters Should Stay in The Canadian Journal of Psychiatry**

Dr Margolese correctly observes that other psychiatry journals still publish some case reports. However, the vast majority of letters in both the American Journal of Psychiatry and the British Journal of Psychiatry are discussions of published papers—the same format we are now applying to the Journal.

Joel Paris, MD
Editor-in-Chief