Indian Journal of Psychiatry, 1999, 41 (1),81-86

Letters to the Editor

RISPERIDONE INDUCED DYSTONIC REACTION AND AKATHISIA

Sir,

Risperidone is an atypical antipsychotic with a reported lower potential for extrapyramidal side effects at therapeutic doses than haloperidol (Marder & Meibach, 1994). Till date, there are only case reports of dystonic reaction (Faulk et al., 1996) and akathisia (Rosebush et al., 1997) during risperidone treatment. This is case report of acute dystonic reaction and akathisia in a chronic schizophrenic patient during initiation with risperidone treatment.

Mr. B was a 18 year old male with DSM - IV diagnosis of chronic schizophrenia in acute exacerbation. He was not on treatment with any antipsychotic at the time of consultation. After admission and consent for treatment his regimen began with risperidone 1 mg b.i.d. on the first day and was increased to 2 mg b.i.d. on the second day and to 3 mg b.i.d. on the third day. On the fifth day, Mr. B developed acute dystonic reaction (torticollis). His only concomitant medication was alprazolam 0.25 mg t.i.d. Fifteen minutes after an injection of promethazine, 25 mg IV, the attack of dystonic reaction was resolved. Since he continued to develop intermittent dystonic reaction of the same nature he was started on an oral dose of trihexyphenydyl 2 mg at morning and afternoon and was instructed to continue risperidone and alprazolam. He had no recurrence of dystonic reaction, however, on the seventh day he started complaining of severe restlessness with objective evidence of akathisia. For the disabling akathisia he was started on propranolol, 20 mg t.i.d. which was increased to 40 mg, t.i.d. on the tenth day. Even after fifteen days of treatment with the above regimen there was no improvement for akathisia and the condition of the patient deteriorated, hence risperidone was discontinued. After a period of one week akathisia was completely subsided and he was started on a regimen of clozapine which was increased to a maximum dose 200 mg. per day over a period of one month. Follow up evaluation revealed no dystonia or akathisia but good clinical improvement.

Acute dystonic reaction and other extrapyramidal side effects have long been associated with D_2 receptor blockade of classical antipsychotics. However, for drugs like risperidone it has been proposed that release of D_2 receptor blockade at nigrostriatal level by the blockade of $5HT_2$ receptors will lead to lower incidence of EPS (Kapur and Remington, 1996). Pre clinical pharmacological tests which provides the most homologous model of EPS in non human primates has shown that both in haloperidol sensitised and drug naive monkeys risperidone produces considerable dystonic reaction at predicted antipsychotic doses (Goldstein and Snyder, 1995). This case report suggest that close patient monitoring is essential concerning the risk of extrapyramidal symptoms even for atypical antipsychotics like risperidone as it may adversely affect compliance. Being a newer antipsychotic risperidone needs further clinical experience to determine the comparative risk of extra pyramidal symptoms as opposed to typical antipsychotics.

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