

ings of "nervousness" and being "keyed-up") was described as qualitatively different from that of akathisia. A regimen of temazepam, 30 mg h.s., effectively relieved the risperidone-associated insomnia in these two patients.

The behavioral stimulation observed may have been due to neuroleptic withdrawal, a syndrome that has been attributed to the cholinergic, dopaminergic, and adrenergic effects of these medications (1). Cholinergic rebound, in particular, may have contributed to the behavioral stimulation seen in the patients who discontinued clozapine or concomitant antiparkinsonian medications. The first patient, however, continued to take an unaltered dose of benztropine mesylate during risperidone initiation. This finding suggests that risperidone may produce behavioral stimulation. When compared to placebo in a large controlled trial, higher doses of risperidone (greater than 10 mg/day) have been associated with a trend toward increases in anxiety and agitation (2).

The observations reported here suggest that the initiation of risperidone may be associated with symptoms of behavioral stimulation. Because many acutely ill patients will likely be switched to risperidone treatment in a similarly abrupt fashion, it is important to note that this phenomenon appears to be self-limited and may be partially relieved by the use of benzodiazepines.

REFERENCES

1. Dilsaver SC: Heterocyclic antidepressant, monoamine oxidase inhibitor and neuroleptic withdrawal phenomena. *Prog Neuropsychopharmacol Biol Psychiatry* 1990; 14:137-161
2. Chouinard G, Jones B, Remington G, Bloom D, Addington D, MacEwan GW, Labelle A, Beauclair L, Arnott W: A Canadian multicenter placebo-controlled study of fixed doses of risperidone and haloperidol in the treatment of chronic schizophrenic patients. *J Clin Psychopharmacol* 1993; 13:25-40

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Prolonged Erection Associated With Risperidone Treatment

TO THE EDITOR: In the package insert of risperidone, Janssen Pharmaceutica lists priapism as a possible side effect of treatment. This warning is based on a single case report (out of 1,300 patients) of a 50-year-old man who required surgical intervention for priapism after 11 months of risperidone monotherapy. We report here a case of prolonged erection after 6 days of risperidone treatment in a physically healthy patient with schizoaffective disorder. This patient had a history of retrograde ejaculation that was secondary to thioridazine treatment.

Mr. A, a 41-year-old Hispanic man, was admitted to the hospital after his auditory hallucinations became more intense. While hospitalized, Mr. A complained of excess sedation from his regimen of chlorpromazine, 300 mg/day, and carbamazepine, 500 mg/day. He requested a less sedating agent. He was started on a regimen of risperidone, 3 mg b.i.d., and for 5 days there were no side effects. Late in the morning of the sixth day he experienced an unwanted penile erection that lasted 30 minutes and resolved spontaneously. He reported this problem on the seventh day of treatment after he had experienced several 15-minute episodes over 5 hours. He denied sexual thoughts, physical stimulation, or

a history of trauma before or during these episodes of prolonged erection. He also denied tenderness, difficulty urinating, or pain. Results of a physical examination and complete laboratory workup revealed no abnormality.

Prolonged unwanted erections are frequently described in the literature as precursors of priapism (1). After physical etiologies, medications have been noted to cause 15%–41% of all episodes of priapism (2). Psychotropic medications are the most commonly implicated drugs, with trazodone, chlorpromazine, and thioridazine being the most frequently reported causative agents. The mechanism of penile dysfunction is thought to involve the α -adrenergic antagonist properties found in many psychotropic medications (2). Risperidone, with α -1 and α -2 adrenergic antagonist properties, may be reasonably expected to cause similar problems, especially in patients with a prior history of erectile dysfunction while taking other psychotropic medications. While priapism is diagnosed after 1 hour of unwanted penile erection (3), incidents of prolonged unwanted erections such as those described in this patient may serve as a warning of potentially more serious erectile dysfunction in the future.

REFERENCES

1. Griffith SR, Zil JS: Priapism in a patient receiving antipsychotic therapy. *Psychosomatics* 1984; 25:629-631
2. Thompson JW Jr, Ware MR, Blashfield RK: Psychotropic medication and priapism: a comprehensive review. *J Clin Psychiatry* 1990; 51:430-433
3. Winter CC: Priapism, in *Urologic Surgery*. Edited by Glenn JF. Philadelphia, JB Lippincott, 1991

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Risperidone Treatment for a Tourette's Disorder Patient With Comorbid Obsessive-Compulsive Disorder

TO THE EDITOR: Clinical evidence suggests that some Tourette's disorder patients with comorbid obsessive-compulsive disorder require a treatment combination of a neuroleptic and a selective serotonin reuptake inhibitor (1). I report a case of Tourette's and obsessive-compulsive disorders that was complicated by major depression; the response to risperidone augmentation of fluoxetine was superior to that of other typical conjoint medication strategies.

Mr. A was a 31-year-old married man who developed obsessive-compulsive disorder at age 15 and severe motor tics at age 18. He had simple and complex motor tics that were complicated by episodic tongue biting and required multiple courses of antibiotics. He spent 6–8 hours each day compulsively counting his grunting and coughing tics. He heard frequent, intrusive clicking sounds and had egodystonic thoughts of losing control and stabbing his wife. Mr. A was disturbed by contamination fears and so abstained from sexual intercourse for 2 years. He was hospitalized twice for major depression, and he attempted suicide three times. Previous treatments included regimens of clomipramine with and without haloperidol, pimozide, or trifluoperazine; fluoxetine with and without clomipramine; and numerous combinations of clonazepam, alprazolam, and lorazepam, with minimal results at best.