In the case described, second-degree (type II) sinoatrial block was present. The prolonged P-P interval was a direct multiple of the shorter P-P cycles. This is in contrast to second-degree type I sinoatrial block (Wenckebach type), characterized by a sinus pause after progressively decreasing P-P intervals. In such instances, the sinus pause duration is less than two P-P cycles.

The patient's ECGs also demonstrated 4:3, 5:4, and 6:5 second-degree type I sinoatrial Wenckebach block during dialysis (tracings not shown).

After dialysis, the patient's lithium level decreased to 0.41 mEq/l. There was no further evidence of sinoatrial block. In this case, renal insufficiency, likely secondary to dehydration in combination with nonsteroidal anti-inflammatory therapy, may have precipitated elevated serum levels of lithium, despite the patient's initially low dose. In the setting of dehydration and vomiting, the lithium ion is selectively resorbed in the renal tubules, sometimes accumulating to toxic levels. Indeed, the triad of hypokalemia, hypochloremia, and metabolic alkalosis observed on admission was consistent with a history of bulimia nervosa, revealed later in the patient's hospitalization. Of note, chronic lithium therapy, by itself, may result in renal insufficiency and other renal toxicity (12).

As the uses of lithium continue to expand with an increasingly larger patient population, clinicians must be mindful of the cardiac risks associated with lithium therapy, including sinoatrial block with resultant bradycardia, which can occur abruptly with chronic therapy.

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Dr. Goldberger reports no competing interests.

Oxcarbazepine in Youths With Autistic Disorder and Significant Disruptive Behaviors

TO THE EDITOR: Disruptive behaviors are a frequent reason for psychiatric visits among autistic individuals. The following case report describes beneficial effects in three consecutive oxcarbazepine-treated autistic youths with disruptive behaviors. All three patients had been conjointly engaged in behavioral therapies provided by local treatment facilities.

"A.B." is a 13-year-old Hispanic male with frequent aggression toward others and property, irregular sleep, and poor ability to follow instructions. Previous effective trials of risperidone and olanzapine were both discontinued because of elevated liver transaminases and excessive weight gain, respectively. Oxcarbazepine was titrated to 300 mg every morning and 600 mg every night over 7 days. Two weeks later, the patient's mother reported improved compliance at home, and school reports showed improved cooperation and attention span. The aggression was decreased in severity and frequency, and regular sleep was established. He has been stable on this regimen for 4 months.

"C.D." is a 19-year-old Caucasian female with dysfunctional compulsive routines, head banging, and frequent violent outbursts. Fluoxetine was titrated to 20 mg daily over 2 months. The compulsive symptoms improved dramatically, but she remained aggressive. Risperidone augmentation failed, so oxcarbazepine was titrated to 600 mg b.i.d. One month later, her tantrums were significantly reduced, and cooperativeness improved. The head banging was reduced from more than 10 spells per day to approximately once per week. The patient has been on this combination of fluoxetine and oxcarbazepine for 6 months.

"E.F." is a 4½-year-old Hispanic child whose symptoms included head banging, property destruction, hitting others, irregular sleep, and hyperactivity. Previous treatments with methylphenidate and amphetamine salts resulted in agitation; trials of guanfacine and risperidone failed. Oxcarbazepine was titrated to 150 mg every morning and 300 mg every night over 2½ months, resulting in normalized sleep schedule, improved cooperativeness, and lessened aggression. The patient has been maintaining these improvements for 3½ months.

Written informed consent was obtained from the legal guardians in all three cases. None of the patients have developed hyponatremia or other untoward outcomes.

To our knowledge, this is the first report of oxcarbazepine use in autism with disruptive behaviors. These symptoms are best managed by combining behavior modification and psychotropic agents (1). While haloperidol and risperidone have solid evidence base supporting their efficacy and effectiveness in this indication, their side-effect profiles (i.e., extrapyramidal symptoms and weight gain, respectively) are equally well documented (2). Controlled trials also support fluoxetine and fluvoxamine, but treatment-emergent behavioral activation (3) limits their clinical applicability. Oxcarbazepine has a more favorable side-effect profile, and it is available in liquid form, which is often more convenient for autistic patients. Hopefully, this report will inspire future research on the effects of oxcarbazepine in autistic individuals.

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Reprints are not available; however, Letters to the Editor can be downloaded at http://ajp.psychiatryonline.org.

Corrections

In the February issue, the article by Weisberg et al. titled "Psychiatric Treatment in Primary Care Patients With Anxiety Disorders: A Comparison of Care Received From Primary Care Providers and Psychiatrists" (Am J Psychiatry 2007; 164:276–282) contained several errors. In every instance in which "selective norepinephrine reuptake inhibitors" was used, it should read "serotonin-norepinephrine reuptake inhibitors."

In the Letter to the Editor "Suicide Attempt Following Initiation of Topiramate" (Am J Psychiatry 2007; 164: 680–681), Donald S. Christman, M.D., was incorrectly listed as the second author. Dr. Christman should be the first author.