clinical practice, also make it a substance of abuse and confer "street value" on it by the same token.

Quetiapine treatment has been demonstrated to be associated with prolonging abstinence and decreasing the number of hospitalizations in patients with alcohol dependence and posttraumatic stress disorder (3). This is hypothesized to be related to the impact of quetiapine on improving disturbed sleep but may also be related to a direct action of quetiapine in reducing the use of alcohol. The awareness of the "extra-antipsychotic" effects of quetiapine provides potential areas for further clinical research for understanding the treatment of substance abuse and anxiety disorders.

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M.Z. HUSSAIN, M.D.
Prince Albert, Sask., Canada
WAQAR WAHEED, M.D.
SEEMA HUSSAIN, M.D.
Calgary, Alta., Canada

Complications From Olanzapine in a Mentally Healthy Patient

TO THE EDITOR: Existing literature regarding atypical antipsychotics and weight gain has focused on their use in populations with acute or chronic psychotic illness. Some suggest that weight gain in this population may be due to impaired self-monitoring of food intake unrelated to treatment, making it unclear if the same applies to patients without psychotic illness (1). Weight gain in this population increases the probability of additional problems, such as hyperlipidemia, hypertension, and diabetes. We describe the case of a man without mental illness who developed multiple metabolic complications after inadvertently taking olanzapine for 2 years.

Mr. A, a 36-year-old man with chronic seasonal allergies, was given a prescription for cetirizine, 10 mg b.i.d., to be taken on an as-needed basis for his allergy symptoms. As the result of a retail pharmacy error, he received olanzapine at the same dosage. He took olanzapine for 2 years, refilling the prescription automatically outside his primary pharmacy. He had no preexisting illnesses other than seasonal allergies and sickle cell trait. He had no history of mental illness.

During treatment, Mr. A's weight increased 45 lb. Associated with this weight gain, he developed hyperlipidemia, hypertension, and sleep apnea, requiring treatment. His total cholesterol level increased from 258 to 274 mg/dl, and his triglyceride level increased from 87 to 152 mg/dl, requiring treatment with simvastatin, 10 mg/day. His diastolic blood pressure increased from 79 to 98 mm Hg requiring treatment with combination irbesartan/hydrochlorothiazide at 150 mg/day and 12.5 mg/day, respectively, and amlodipine, 10 mg/day. A formal sleep study revealed severe obstructive sleep apnea requiring treatment with continuous positive airway pressure.

The error was discovered 2 years later when Mr. A's primary care provider declined to write a prescription for his "allergy" medication, at which time the olanzapine was stopped.

Previous studies of weight gain and the use of olanzapine have evaluated mentally ill subjects. Early experience in treatment with antipsychotic medication has suggested that weight gain indicated a positive treatment response (2). A systematic review of treatment data shows that most antipsychotics are associated with some weight gain, with clozapine and olanzapine identified as most likely to produce significant weight gain (2). This case suggests that the weight gain associated with the use of olanzapine is not linked to underlying psychotic illness but to medication use alone. Recent literature supports aggressive health monitoring of schizophrenic patients (3). With an increasing trend to use atypical antipsychotics for illnesses from bipolar disorder to treatment-resistant depression, careful monitoring of weight gain and its associated effects is essential, regardless of the indication.

(The views expressed in this letter are those of the authors and do not reflect the official policy or position of the Department of the Navy, the Department of Defense, or the United States government.)

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JAMES CURTIS WEST, JR., M.D, L.C.D.R., M.C., U.S.N.R.
STEVEN J. BRASINGTON, M.D., CAPT., M.C., U.S.N.R.
Portsmouth, Va.

Antidepressant Adherence and Suicide Risk in Depressed Youth

TO THE EDITOR: The lack of adequate data on treatment adherence may be what is hampering the full understanding of the relationship between the use of selective serotonin reuptake inhibitor (SSRI) or newer-generation antidepressants and the risk of suicide in depressed children/adolescents. The clinical trial data have been analyzed and reanalyzed to answer the following question: do depressed children/adolescents treated with SSRIs and newer-generation antidepressants have a greater risk of suicide than those treated with placebo? However, adequate data do not exist to examine whether adherence mediates the relationship between antidepressant use and the risk of suicide.

This suggested mediating role of medication adherence is supported by an examination of the correlation between multiple-dose plasma elimination half-lives of the various antidepressants (venlafaxine, fluvoxamine, paroxetine, sertraline, mirtazapine, citalopram, and fluoxetine) and the risk ratio for