Case Report

"Mr. B.," a 65-year-old man with schizophrenia, was involuntarily admitted for psychotic exacerbation. On admission, he was taking 30 mg/day of olanzapine to abate symptoms of psychosis, aggression, and dangerous wandering. Despite intensive case management and adequate trials with haloperidol, risperidone, and olanzapine, he was refractory to treatment and required annual hospitalizations. Mr. B had not had a previous trial of clozapine. After obtaining informed consent, we initiated treatment with clozapine and increased the dosage by 12.5 mg/day, while olanzapine was gradually reduced with plans to discontinue. Docusate sodium, 100 mg b.i.d., was initiated prophylactically. He was not taking additional anticholinergic medications.

Shortly after the initiation of clozapine, Mr. B complained of malaise and anorexia followed by nausea, vomiting, and diarrhea. Nine days after initiation of clozapine, which was now at a dosage of 100 mg/day and the olanzapine dosage at 10 mg/day, he became tachypneic and hypotensive. He was transferred to the intensive care unit, treated with pressors, and intubated.

Mr. B's medical history included gastroesophageal reflux disease, a prostatetectomy for benign prostatic hyperplasia, and a remote history of small bowel obstruction that was managed conservatively, while olanzapine was continued for treatment of psychosis.

While in the intensive care unit, a CT scan of the abdomen led to the diagnosis of adynamic ileus. A chest X-ray revealed an infiltrate suggestive of aspiration, and colonoscopy demonstrated diverticulosis without evidence of malignancy. Clozapine was discontinued, and olanzapine, which had been discontinued during evaluation in the intensive care unit, was restarted. The patient stabilized after 3 weeks and was returned to the psychiatric unit.

Within 10 days, the patient again developed diarrhea, tachypnea, and tachycardia requiring medical stabilization. He died 3 days later. Although an autopsy was not performed, it was suspected that he died from complications of ileus.

Discussion

Adynamic ileus is an infrequently encountered but serious complication of clozapine with a mortality rate approaching 28% (3). Anticholinergic effects are thought to be the cause (4). One study found that the median time from the first dose of clozapine to onset of ileus was greater than 1,500 days (4). In this case, the patient developed ileus within 9 days of initiation of clozapine and died 5 weeks later. He had no known risk factors for ileus such as malignancy or recent surgery; however, he was taking olanzapine, another highly anticholinergic medication, at the time of decompensation. It is possible that the combination of these two drugs, even for a brief duration for cross-tapering, contributed to this patient's rapid development of ileus and subsequent death. This case highlights the importance of carefully monitoring patients taking clozapine for potentially fatal gastrointestinal side effects, especially when treatment includes other anticholinergics, as this may result in serious consequences in a much shorter time frame than the literature has suggested (4).

References

1. McEvoy JP, Lieberman JA, Stroup TS, Davis SM, Meltzer HY, Rosenheck RA, Swartz MS, Perkins DO, Keefe RSE, Davis CE, Severe J, Hsiao JK: Effectiveness of clozapine versus olanzapine, quetiapine, and risperidone in patients with chronic schizophrenia who did not respond to prior atypical antipsychotic treatment. Am J Psychiatry 2006; 163:600–610
2. Asenjo Lobos C, Komossa K, Rummel-Kluge C, Hunger H, Schmid F, Schwarz S, Leucht S: Clozapine versus other atypical antipsychotics for schizophrenia. Cochrane Database Syst Rev 2010; 11:CD006633
3. Palmer SE, McLean RM, Ellis PM, Harrison-Woolrych M: Life-threatening clozapine-induced gastrointestinal hypomotility: an analysis of 102 cases. J Clin Psychiatry 2008; 69:759–768
4. Nielsen J, Meyer JM: Risk factors for ileus in patients with schizophrenia. Schizophr Bull (Epub ahead of print, Nov 26, 2010)

SARAH M. FAYAD, M.D.
DAWN M. BRUIJNZEEL, M.D.
Gainesville, Fla.

The authors report no financial relationships with commercial interests.

This letter (doi: 10.1176/appi.ajp.2012.11111625) was accepted for publication in February 2012.

Mental Health Insurance Parity in Oregon

To the Editor: While I found the article by McConnell et al. (1) in the January issue to be of great interest, I believe there may be other factors contributing to cost control in Oregon than those addressed by the authors. It is my impression, albeit without specific evidence, that insurance reimbursement rates in Oregon are lower than those in many other states, and I am definitely aware that insurance companies have been lowering such rates in recent years. Related to this, we are seeing a declining number of psychiatrists in Oregon as retirement attrition continues, with fewer new psychiatrists starting practices. In addition, insurance companies have highly restrictive panels that make it difficult to find nurse practitioners, social workers, and psychologists.

As a result, we are seeing more colleagues who have 3-month or longer waiting lists or who are closing practices to new patients. I believe that lack of supply is helping to keep costs down, but there has been a significant impact on the availability and quality of care.

Reference

1. McConnell KJ, Gast SN, Ridgely MS, Wallace N, Jacuzzi N, Rieckmann T, McFarland BH, McCarty D: Behavioral health insurance parity: does Oregon's experience presage the national experience with the Mental Health Parity and Addiction Equity Act? Am J Psychiatry 2012; 169:31–38

CHARLES H. KUTTNER, M.D.
Portland, Ore.

The author reports no financial relationships with commercial interests.

This letter (doi: 10.1176/appi.ajp.2012.12010097) was accepted for publication in February 2012.

Response to Kuttner Letter

To the Editor: We appreciate the opportunity to respond to Dr. Kuttner's observations that reimbursement rates in Oregon are lower than in many other states. He speculates that declining reimbursement, combined with restrictive networks, may have led to a shortage of behavioral health pro-