tional hypodopaminergic state and upregulation of the postsynaptic D_2 receptors, of which stimulation by aripiprazole could result in exacerbation of the manic symptoms.

Although this case report adds to the literature on atypical results of atypical antipsychotics, caution needs to be used while interpreting the results, since aripiprazole is approved for the treatment of acute mania. Possible differences in response to aripiprazole in patients with bipolar affective disorder versus those with schizoaffective disorder need to be investigated. Furthermore, a drug screen was not performed to assure the patient's denial of substance abuse.

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Hyperglycemia in a 7-Year-Old Child Treated With Aripiprazole

TO THE EDITOR: Aripiprazole is a new atypical antipsychotic drug for the treatment of schizophrenia/schizoaffective disorders and bipolar disorder in adults. Recent studies suggest effectiveness of aripiprazole with minimal severe side effects in children (1). We report a case of a 7-year-old child with hyperglycemia following initiation of aripiprazole.

The patient was an overweight 7-year-old male child with the diagnosis of attention deficit/hyperactivity disorder (ADHD), combined type, mood disorders, not otherwise specified, and a positive family history of type II diabetes mellitus. From ages 4 to 6, the patient's ADHD symptoms were treated with methylphenidate. At age 6, the patient had increasing mood and behavior problems, including verbal explosiveness and physical aggression. These symptoms stabilized by increasing the dose of methylphenidate to 54 mg per day.

Nine months after the increase in methylphenidate, the child had an exacerbation of mood lability and aggression. Methylphenidate was discontinued. Aripiprazole 2.5 mg was initiated. The child's weight was 34.7 kg, and body mass index was 21.0 (98th percentile for the child's age). He was prescribed 18 mg of atomoxetine, but took atomoxetine for 1 week. Within 4 weeks of aripiprazole as the only medication, the patient developed polydipsia, polyuria, and polyphagia and was evaluated in the emergency room. At admission, vital signs were normal, his blood pressure was 117/55, his glucose was 659 mg/dl (70–105 mg/dl), and he had mild ketonuria (15 mg/dl). Weight, height, and body mass index were 34 kg, 128 cm, and 20.5 (97th percentile for age), respectively. Pertinent lab studies included sodium 127 mmol/liter (133–145 mmol/dl), chloride 91 mmol/L (96–108 mmol/dl), triglycerides 255 mg/dl (74–199 mg/dl), and hemoglobin A1c 10% (4%–6%). Insulin/islet cell antibodies were <1.0U/ml (0.0–0.9U/ml). Aripiprazole was discontinued. The child was treated with NPH and Humalin insulin. He was discharged to go home in 3 days while receiving subcutaneous insulin. After 4 weeks of insulin therapy, blood sugars normalized and insulin was discontinued. Seven months after initial presentation, the child developed insulin-dependent diabetes.

To our knowledge, this is the first report of a child developing hyperglycemia following the initiation of aripiprazole. This case is presented to highlight the following questions: 1) Was there an association between the emergence of hyperglycemia and aripiprazole administration, and 2) was the initial episode of hyperglycemia coincidental with the use of aripiprazole? This case documents the importance of obtaining a family history, physical examination, and baseline and monitoring laboratory analyses when treating with antipsychotic medications (2). Further studies are necessary to determine the relationship between metabolic abnormalities and aripiprazole treatment in children.

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Intravenous Quetiapine-Cocaine Use ("Q-Ball")

TO THE EDITOR: We have noted recent reports of quetiapine diversion and misuse among inmates in correctional settings where it is also called "quell" or "baby heroin" (1, 2). It is used orally, intranasally, and intravenously for its potent sedative and anxiolytic properties (1, 2). Inmates obtain quetiapine for illegitimate use by malingering of psychotic symptoms or obtaining it from other inmates. The high prevalence of substance use disorders in corrections and the secondary gain of serving out "easy time" with pharmacological assistance contribute to an underground economy of diverted psychoactive medications (3). Anecdotal reports from colleagues—as well as online testimonials—support the existence of quetiapine diversion and misuse in noncorrectional settings as well (4). The following case is an example of prescription medication diversion with concomitant illicit substance use seen in the local county hospital emergency room.

A 33-year-old married Caucasian male with a history of polysubstance dependence (cocaine, heroin, alcohol, benzodiazepines) reported to the local county hospital emergency room requesting assistance with drug detoxification