et al., since it illustrated the importance of treating depression during pregnancy when appropriate.

The treatment of depression during pregnancy with antidepressants is a complicated decision for both the physician and the pregnant patient. Being "on the safe side" by not using these drugs during pregnancy because of unproven potential harm is not always an option, especially if a woman is already pregnant and receiving an antidepressant. Each case requires individual evaluation, and a risk/benefit assessment must be conducted in order to serve the best interest of both the pregnant mother and her unborn child.

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Neuroleptic Malignant Syndrome With the Addition of Aripiprazole to Olanzapine

TO THE EDITOR: Second-generation antipsychotics are thought to have less severe adverse effects than traditional agents (1). Although their safety profiles have been established as single agents, they are frequently used in combinations (1, 2). We describe the case of the occurrence of neuroleptic malignant syndrome in a vulnerable patient who was receiving a specific combination of second-generation antipsychotics.

"Mr. M" was a 33-year-old African American man with mild mental retardation who was brought to the emergency room by ambulance after he had become incoherent, incontinent, and tremulous. He had been prescribed olanzapine (10 mg daily) over a 9-month period for aggressive behaviors. Aripiprazole and benztropine were added 1 month prior to presentation for continuing irritability and insomnia. Approximately 2 weeks later, aripiprazole was increased from 5 mg to 10 mg daily. Shortly afterward, the patient's mother reported that he had stopped walking, refused to eat and drink, discontinued self-care, and developed generalized stiffness, weakness, pain, and cold sweats.

There was no prior history of movement disorders, illegal drug use, allergies, or falls. After standard emergency room evaluation of the patient's airway, breathing, and circulation, psychiatry and neurology consults recommended medications, neuroimaging, and intravenous hydration. On exam, Mr. M was alert, verbally incoherent, and had elevated temperature, diaphoresis, tachycardia, and muscular rigidity. Laboratory examinations revealed leukocytosis; mildly elevated levels of blood urea nitrogen; hypokalemia; and elevated levels of alanine aminotransferase, aspartate aminotransferase, and creatinine phosphokinase (peak=3,210 U/liter). A noncontrasted head computed tomography scan, chest X-ray, lumbar puncture, CSF, urine, and blood cultures were all negative. The patient was admitted to the medical intensive care unit and started on bromocriptine, lorazepam (intravenous), and antibiotics, which were discontinued after the cultures were evaluated.

After his symptoms improved and his creatinine phosphokinase levels were normalized, Mr. M was transferred to a medical unit where some fluctuation of blood pressure, sweating, rigidity, tremors, and confusion continued. Dantrolene (intravenous) was added to his treatment regimen. Approximately 5 weeks from the onset of neuroleptic malignant syndrome, most of his symptoms were resolved. However, his hospital course was prolonged by pneumonia and urinary tract and skin infections.

The present case describes the evolution of neuroleptic malignant syndrome following the addition of low-dose aripiprazole to olanzapine. Data are accumulating on the risk of neuroleptic malignant syndrome with second-generation antipsychotics (3, 4), including aripiprazole at therapeutic doses. Benztropine can contribute to delirium, and mental retardation is a risk factor for neuroleptic malignant syndrome (5). However, the addition of an agent with high dopamine receptor affinity (1) to existing second-generation antipsychotic treatment appears to have been a key factor in this case.

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Anorexia Nervosa and Mercury Toxicity

TO THE EDITOR: Neuropsychiatric symptoms as a result of mercury poisoning following the excessive consumption of large predatory fish (methyl mercury levels >1 ppm) are well documented but often misdiagnosed.

Mercury toxicity secondary to the excessive consumption of tuna was observed in a 47-year-old woman with a 30-year history of anorexia nervosa. The patient's prolonged abuse of laxatives resulted in a small bowel obstruction and rectal prolapse 7 years prior to the detection of mercury intoxication. The rectal prolapse was treated with total proctocolectomy and ileostomy. A low fiber diet was recommended thereafter, and the patient commenced a diet consisting of two cans of tuna and one muffin daily for the subsequent 7 years until she came to our unit for observation and treatment of anorexia nervosa.

The patient presented with a 1-month history of depressive symptoms, refusal to eat, fatigue, weakness, anxiety, insomnia, irritability, and "confusion." She weighed 73.7 lbs, which was approximately 53% of her ideal body weight, and was afraid that her bowels would stop working. She reported increased sensitivity to loud noise and ringing sounds in the absence of auditory stimuli. A neuropsychological assessment revealed less than normal scores for processing speed, working memory, and attention. Her premorbid IQ was estimated within the 61st percentile. Her current full-scale intelligence quotient score was within the 45th percentile, with a verbal intelligence quotient score within the 75th percentile and a performance IQ score within the 30th percentile. Her memory was stronger for verbal information (scoring in the 50th percentile) relative to nonverbal information (scoring in the 4th–10th percentile). Psychiatric examination revealed longstanding symptoms consistent with anorexia nervosa, but due to her most recent symptoms of irritability and weakness as well as her neuropsychological deficits, a mercury level evaluation was obtained.

The patient's plasma mercury levels were markedly elevated at 74 mcg/dl (normal=<10 mcg/dl) on two repeated measurements. A complete blood count, electrolytes, amylase, and lipase were all unremarkable, but liver enzymes showed slight elevation. The patient underwent chelation therapy, with succimer 10 mg/kg t.i.d. for 5 days and then 10 mg/kg b.i.d. for the following 14 days. The mercury toxicity motivated her to change her diet and broaden her food repertoire. Although her attitudes toward food with high residue did not change, the patient became afraid of eating any type of fish.

More than 200 neuropsychiatric symptoms have been attributed to mercury poisoning in the medical literature (1–3). Our patient's symptoms, including low mood, irritability, insomnia, cognitive impairment, and fatigue, may have been primarily mood symptoms, a consequence of severe malnutrition, or are attributable to mercury poisoning. Interestingly, mercury poisoning as a result of dental amalgam fillings may cause an anorexic syndrome (anorexia hydrargyrum) (4). To our knowledge, this is the first report of mercury intoxication secondary to anorexia nervosa. We are currently following our patient to monitor her psychiatric and neurological response to chelation. Longitudinal observation and treatment of malnutrition and depressive and anxiety symptoms may clarify the extent to which our patient's symptoms were attributable to mercury intoxication.

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Intranasal Zaleplon Abuse

TO THE EDITOR: Nonbenzodiazepine hypnotic agents were developed to minimize the adverse effects of benzodiazepines. These hypnotics bind to the α_1, α_2, and α_3 subunits of the gamma-aminobutyric acid type A ($GABA_A$) receptor complex. Zaleplon preferentially binds to the α_1 subunit. These compounds offer less abuse liability relative to benzodiazepines, although this is debatable under certain circumstances (1). We present the case of a patient who abused intranasal zaleplon in order to experience a "high" feeling.

"Mr. A" was a 28-year-old man with a 13-year history of polysubstance abuse (cannabis, cocaine, and heroin). He had been abusing mainly cocaine over the past 5 years and had unsuccessfully tried several treatments to achieve abstinence 1 year prior, following a prolonged stay in a monastery. As a result of sleep difficulties, he was prescribed zaleplon (10 mg/night) as needed. Over the next 3 months, the dose was gradually increased to 70–80 mg/day. Subsequently, he noticed that zaleplon had a mood uplifting effect. To boost this effect, he started taking the drug intranasally by snorting seven to eight pulverized capsules. The patient mentioned that intranasal zaleplon produced a euphoric feeling resembling that of cocaine, although less intense and of a shorter duration. This pattern of abuse persisted for almost 1 year, and withdrawal symptoms (anxiety, ner-