Hypomania Induced by Escitalopram: 2 Case Reports

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ABSTRACT ~Two cases, one of recurrent depression and another of major depressive disorder with hypertension switched to hypomania while on escitalopram. Both patients achieved remission with atypical antipsychotics and divalproex. The implications of diagnosis and treatment are discussed. Psychopharmacology Bulletin. 2009;42(2):89–91.

INTRODUCTION

The incidence of selective serotonin reuptake inhibitor (SSRI) induced hypomania/mania in 344 patients of major depression is reported to be 2.3%.1 Escitalopram induced activation of hypomania/mania has been described in a placebo controlled clinical trial2 and in a few case reports.3-6 I am also presenting two cases, one of recurrent depression and another of major depressive disorder with hypertension who switched to hypomania while being treated with escitalopram.

CASE REPORT-I

A 40-year-old housewife presented with the features of sadness, lethargy, lack of interest in surroundings, weeping spells and depressive ideation for the last 3 weeks. The patient was not on any medications including oral contraceptive pills and there was no history of any medical comorbidity. There was past history of one episode of major depression about 20 years back which had remitted on its own after about 3 months but family history of suicide, depression, bipolar affective disorder was absent. The patient was diagnosed as a case of recurrent depressive disorder and was prescribed escitalopram 5 mg/day to be increased to 10 mg/day thereafter up to next 12 days. However, the patient did not take the medicines and reported with severe depression after about two and half months. She was prescribed escitalopram 10 mg/day to be increased to 20 mg/day over a period of 10 days. She improved significantly over next 4 weeks and became euthymic. After three months of remission, the patient switched to hypomania. She was managed with divalproex 500 mg/day and olanzapine 5 mg/day and
achieved remission within 4 weeks which she is maintaining for the last two months now.

**CASE REPORT-II**

A 67-year-old married man presented with the complaints of decreased sleep, sadness, lack of interest in anything, short temperedness and easy fatigue. He was hypertensive for the last 20 years but was controlled on amlodipine 2.5 mg/day and losartan 25 mg/day. The patient was a social drinker and had no past or family history of depression, bipolar disorder. He was diagnosed as a case of moderate depression and was put on mirtazapine 7.5 mg/day which was increased to 22.5 mg/day. Finding no improvement after 15 days, he was gradually switched over to escitalopram 10 mg/day. Clonazepam 0.5 mg/day at bed time was also added for inducing sleep. Depressive symptoms remitted over 4 weeks and the patient was maintained on same treatment. After about three and half months, the patient switched to hypomania which was controlled with quetiapine 200 mg/day, divalproex 250 mg/day. The patient is in remission now for the last one month.

**DISCUSSION**

In recent years the diagnostic status of antidepressant induced hypomania has become a contentious issue. Many authors believe that in patients with no previous history of hypomania, brief periods of hypomania occurring within weeks of starting antidepressants should not necessarily be diagnosed as cases of bipolar disorder. In DSM–III–R, antidepressant-associated hypomania was considered as a part of ‘the bipolar spectrum’, whereas in DSM–IV it has been categorized as a ‘substance-induced mood disorder’. A consensus is reemerging to label people with depression who experience antidepressant-associated hypomania as truly bipolar.7

In the absence of any past or family history of suicide, depression, bipolar affective disorder in either case, hypomaniac switch appears to be induced by escitalopram in both the cases. Except for a possibility of boosting the effect of escitalopram by clonazepam,8 no other evidence could be found to suggest a role of amlodipine, losartan in the induction of hypomania with escitalopram in the second case. Though, there is a strong possibility of inducing hypomania by escitalopram in both the cases however, a possibility of spontaneous occurrence of hypomania and thus unfolding an underlying bipolar disorder cannot be ruled out. The present report calls for cautious use of escitalopram even in cases of unipolar depression.**
REFERENCES