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Coprophagia in an Elderly Man

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Introduction: Coprophagia, or the ingestion of feces, has long been associated with psychiatric illness, but has been largely ignored in the literature. It is considered to be a variant of pica. This behavior requires an extensive medical and psychiatric differential diagnosis. Medical disorders associated with coprophagia include seizure disorders, cerebral atrophy, and tumors. Psychiatric disorders associated with coprophagia include mental retardation, alcoholism, depression, obsessive-compulsive disorder, schizophrenia, fetishes, delirium, and dementia. In animals, coprophagia is associated with boredom, thiamine deficiency, and lesions of the amygdala.

Case report: A 77-year-old man with mild mental retardation was referred for urgent psychiatric evaluation due to coprophagia. Psychiatric evaluation revealed cognitive dysfunction and depression. Laboratory evaluation was unremarkable. He was started on sertraline, 25 mg/day, with resolution of his coprophagia.

Summary: Coprophagia has been treated using behavioral interventions, supportive psychotherapy, elemental diets, tricyclic antidepressants, carbamazepine, haloperidol, and electroconvulsive therapy.

Olanzapine Improves Tardive Dyskinesia in Patients With Schizophrenia

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Introduction: Tardive dyskinesia (TD) is a potentially persistent movement disorder often associated with antipsychotic agents. Case studies and retrospective analyses have shown that olanzapine may reduce symptoms of TD. However, in these reports it is not clear whether olanzapine-induced improvements in TD symptoms were due to ameliorative, rather than "masking" effects. We report preliminary findings from a prospective study of olanzapine for the treatment of TD.

Method: Eligible schizophrenic subjects met restricted Research Diagnosis Tardive Dyskinesia criteria (restricted RD-TD) that specified for abnormal involuntary movements to be of at least moderate severity. Subjects received olanzapine, 5–20 mg/day, for 8 months within a double-blind design that included up to 2 medication reduction (75%) periods of 2 weeks' duration. TD was assessed with the Abnormal Involuntary Movement Scale (AIMS) and psychopathology with the Positive and Negative Syndrome Scale (PANSS).

Results: A significant reduction in mean AIMS total score was demonstrated at endpoint (N = 92, $p < .001$; last observation carried forward [LOCF]) as well as at each visit ($p < .001$; observed cases-OC). Approximately 70% of subjects no longer met the restricted RD-TD criteria after up to 8 months of treatment. No statistically significant rebound worsening of TD was found during the blinded drug reduction periods. A significant improvement in the PANSS total score was observed at each visit ($p < .001$; OC).

Conclusion: These data, suggesting an ameliorative rather than masking effect and the concurrent further improvement in clinical status, suggest that olanzapine may offer a potential alternative treatment for managing the schizophrenic patient with preexisting TD.

Long-Term Use of Olanzapine in Combination With Lithium or Valproate Does Not Lead to Increased Extrapyramidal Symptoms

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Introduction: Antipsychotic agents are associated with extrapyramidal symptoms (EPS), which have limited their use to short-term therapy for patients with bipolar disorder. However, EPS liability is not as prominent with newer antipsychotic agents compared to conventional antipsychotics. In this study, patients who were in remission from acute symptoms of bipolar disorder were randomized to olanzapine (N = 71) or placebo (N = 64) in combination with either lithium or valproate for 18 months of double-blind therapy.

Method: Three measures were used to evaluate EPS: established rating scales (Abnormal Involuntary Movement Scale, Simpson-Angus Scale, and Barnes Akathisia Scale), treatment-emergent adverse events, and use of anticholinergic medications. Frequency distributions for each clinical scale were constructed at baseline, endpoint, and for the change from baseline to endpoint to determine whether occurrences of EPS were homogeneous across treatment groups and whether there were changes during treatment. Due to the discrete nature of responses and low overall rates of EPS, we employed an exact test nonparametric analysis of variance (StatXact5). In addition to the 3 scales, treatment-emergent adverse events and use of anticholinergic medication were compared across therapies using the Fisher exact test.

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Results: The differences in the mean change of each EPS scale across treatment groups were not clinically or statistically significant. There was no significant improvement or worsening of any of the scales within each therapy. There were no statistically significant differences among treatments in anticholinergic medication use and treatment-emergent EPS.

Conclusion: The addition of olanzapine to either divalproex or lithium does not appear to increase risk for treatment-emergent EPS, compared to monotherapy with valproate or lithium.

Olanzapine/Fluoxetine Combination (OFC) and Olanzapine Are Effective for Bipolar Depression

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Objective: To determine the efficacy and safety of olanzapine/fluoxetine combination (OFC) and olanzapine in the treatment of bipolar depression, and to determine benefits of these treatments in heath-related quality of life (HRQL).

Method: Patients with bipolar depression and baseline Montgomery-Asberg Depression Rating Scale (MADRS) rating ≥ 20 were randomized for 8 weeks of double-blind treatment with olanzapine (5–20 mg/day, N = 370), placebo (N = 377), or the combination of olanzapine (6 or 12 mg/day) and fluoxetine (25 or 50 mg/day, N = 86).

Results: At week 1, and sustained throughout the study, improvements on MADRS for both OFC and olanzapine groups were superior to placebo. Rates of clinical response and remission were significantly greater for OFC and olanzapine compared with placebo, and those of OFC were greater than olanzapine. For HRQL, as compared with placebo and olanzapine alone, OFC treatment exhibited significantly greater improvement in 5 domains measured by the Medical Outcomes Study Short Form-36 (SF-36). Olanzapine compared to placebo showed significantly greater improvement in 3 of 8 SF-36 domains. Treatment-emergent mania (baseline YMRS < 15 and ≥ 15 anytime subsequently) did not differ significantly between groups (OFC 6.4%, olanzapine 5.7%, placebo 6.7%). Common (> 10%) adverse events occurring significantly in OFC and olanzapine groups compared to placebo were weight gain, increased appetite, dry mouth, and asthenia.

Conclusion: Both olanzapine/fluoxetine combination and olanzapine significantly improved depressive symptoms and HRQL in patients with bipolar depression, and the magnitude of effect was significantly greater with olanzapine/fluoxetine combination.

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