



# Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

Published Bimonthly

May-June 2002 EDITION

Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

## Psychiatry in the News

In the past few months, mental illness has been in the forefront of the news. From the movie, *A Beautiful Mind*, to the Andrea Yates case, the public viewed the devastation of mental illness,

In the movie, *A Beautiful Mind*, John Nash suffered from schizophrenia. The public witnessed how he was tortured by delusions, hallucinations and how he was unable to function due to his illness. As the movie portrayed, schizophrenia can be devastating to both the individual who suffers from the illness and to the family. In this film, John Nash partially recovers without medication. According to the NIMH, most of John Nash's inventions came before his illness. With schizophrenia, someone can have brilliant thoughts, but they are hard to translate into something they can understand. In fact, untreated schizophrenia is so crippling that some patients can barely buy groceries or pay bills, let alone write a novel. It is extremely important to convey to the public that schizophrenia is an illness and disease like diabetes and heart disease and that medications can be tremendously helpful in mitigating symptoms and helping the individuals return to functioning in the community.

The beauty of the movie was also demonstrating how important family support is to a patient suffering from schizophrenia. In fact, we are so fortunate to have a strong and active family group in Rockland County-NAMI-FAMILYA. I encourage all family

members who have a loved one suffering from mental illness to join this organization. In addition, to giving support and education to family members, one can learn that families are no longer at fault for this biochemical illness and that effective treatments are available.

In the case of Andrea Yates, the public viewed the devastation of post partum depression. After Andrea Yates confessed that she had drowned her five children in a bathtub last year, the prison psychiatrist diagnosed her as having postpartum depression with psychotic features. Dr. Philip Resnick of Case Western Reserve University took the witness stand for the defense at Yates murder trial and testified first that she had a combination of Schizophrenia and Depression when she killed her children. An essential point was that Andrea Yates was not taking medications two weeks prior to the drowning and had become grossly psychotic. She indeed was a victim of mental illness.

According to Richard Harding, M.D., President of the American Psychiatric Association, "The victims of mental illness are sick- just as sick as if they had cancer or chronic heart failure and as human beings deserve humane and effective treatments for their illnesses. Prisons are overloaded with mentally ill prisoners, most of whom do not receive adequate treatment. Defendants whose crimes derive from a mental illness should be sent to a hospital and treated, not cast into prison or death row."

Hopefully, these two cases John Nash and Andrea Yates will help to destigmatize mental illness and help educate the public that mental illness are biochemical disorders for which effective treatments are available.



### New York Police Debriefing

The scene was the 13th precinct in New York City. I was sitting in a circle surrounded by 25 New York City policemen, policewomen, and a "trained police peer counselor" who acted as a peer advocate. Initially, the police were initially quite guarded and hesitant to open up. By the end of the two hour debriefing sessions, many shared feelings of sadness, nightmares, and tears and feelings of anger after the 9/11 attacks. Many shared how their spouses feared for their lives and how their children became more clingy after the tragedy.

*Continued on page 6*

### In This Issue...

- 2-3 Malingering Part III
- 4-5 Neuroleptic Malignant Syndrome
- 6-7 Mental Health "Parity"

## Malingering: Part III

The most successful malingerers are those who are evaluated by young clinicians who do not trust their own judgement. The clinician has a "feeling" that something is not right, but then attributes it to an "atypical psychosis" or their inexperience, rather than recognizing it as malingering. The most important tool you can use to distinguish true

from false psychosis is your past experience with true psychosis and organicity. With significant experience, one can develop an understanding of how a schizophrenic or a bipolar patient looks. If the individual does not fit your past conception of the disorder and these individuals, trust yourself. Contrary to what people believe, individuals do not present with a huge myriad of symptoms and variations of psychiatric disorders. Having seen thousands of patients, I can tell you that the old saying that we learned many years ago, "if you hear hoofbeats, don't think of zebras," is really true. In order to assess whether the animal before you is a cow or zebra, you will look not only at its stripes, but its size, shape, the character of its skin, etc. In the same manner, individuals with psychosis are evaluated not only for hallucinations or delusions, but also for thought content, thought form, method of relating, affect related to thought content, speed of speech, explanations for behavior, etc.

If you have the inclination and time to utilize simple psychometric tests, there are several very valuable tests for assessing the malingering of major mental disorders. An extremely helpful one is the SIRS, the Structured Interview of Reported Symptoms, which was created by Richard Rogers. This test takes between a half hour and an hour to administer and is scored by you, so that you would have your answers immediately. It also allows an assessment of honesty, as well as indeterminate, probable and definite feigning. The test materials can be acquired by calling 1-800-331-TEST. The SIRS professional kit, which includes the manual and ten interview booklets, is about \$75. If

you are interested in Richard Rogers' book, it is called, "Clinical Assessment of Malingering and Deception." and you can also get that from the same company, Psychological Assessment Resources, Inc.



Another extremely commonly used and very available test to assess various aspects of personality, but which is also most helpful in assessing malingering, is the MMPI. This is 567 questions or statement test. The individuals take the test themselves with a test booklet and answer sheet. You simply give them the very basic instructions at the beginning and ask them to read the first few statements to be sure that they are able to be read. The test answer sheet is then sent or faxed to an independent testing service and a narrative interpretation is returned to you. Each test costs between \$17 and \$27, depending on turn-around time. If you are interested in acquiring copies of the question booklet and answer sheets, you can call Psychometric Software. They are in Melbourne, Florida. Their phone number is (321) 729-6390. They would be happy to set you up with materials. You can then fax your answer sheet and for an additional \$5.00, you can have overnight return on the interpretation. The MMPI takes an average of an hour and a half to complete.

Let's move on now to the evaluation of claims of brain injury, generally following various accidents and head

Continued on next page 

### Executive Council

West Hudson  
Psychiatric Society

- ▲ **PRESIDENT**  
*Lois Kroplick, D.O.*
- ▲ **PRESIDENT-ELECT**  
*Andrew Hornstein, M.D.*
- ▲ **SECRETARY**  
*Dominic Ferro, M.D.*
- ▲ **TREASURER**  
*Andrew Hornstein, M.D.*
- ▲ **DELEGATE-TO-THE-ASSEMBLY**  
*Marc E. Tarle, M.D.*
- ▲ **ALTERNATE DELEGATE:**  
*Leslie Citrome, M.D., M.P.H.*
- ▲ **GOVERNMENT RELATIONS REPRESENTATIVE**  
*Paul Ducker, M.D.*
- ▲ **PUBLIC AFFAIRS**  
*Les Citrome, M.D., M.P.H.*
- ▲ **CHAIR, ETHICS COMMITTEE**  
*Alan Tuckman, M.D.*
- ▲ **EDUCATIONAL MATTERS**  
*David Brody, M.D.*
- ▲ **MANAGED CARE COMMITTEE**  
*David Brody, M.D.*
- ▲ **PRIVATE PRACTICE REPRESENTATIVE**  
*James Flax, M.D.*
- ▲ **DEPRESSION SCREENING**  
*Dominic Ferro, M.D.*
- ▲ **CHAIR, WOMENS' COMMITTEE**  
*Bharati Palkhiwala, M.D.*
- ▲ **EDITOR, NEWSLETTER**  
*Robert Sobel, M.D.*
- ▲ **CO-EDITOR, NEWSLETTER**  
*Syed Abdullah, M.D.*

Telephone (845) 638-6992

Articles published in Synapse represent the views of their respective authors and do not necessarily represent the views of the West Hudson Psychiatric Society or its members.

SYNAPSE designed by Lydia Dmitrieff

trauma. This is probably the most common type of assessment you will perform if you are involved in the evaluations of individuals following auto accidents and other head injuries, especially since we have come to recognize a large number of actual symptoms which can result from a closed head injury. We are certainly aware by now, that numerous symptoms which have come to be known as the Post Concussion Syndrome, can develop despite the absence of any discernable evidence on physical tests, including brain scans, MRIs, CAT scans, etc. I should tell you that the "Post Concussion Syndrome" has been somewhat controversial. There are those writers who believe it is a form of malingering, while others believe it is true clinical disorder, certainly with evidence of many individuals without reason to feign organic syndromes, having organic deficits following a closed head injury.

To prove a case involving a claim of brain damage, a plaintiff must be able to demonstrate first the presence of a brain insult. Second, the presence of behavioral or emotional deficits. Third, a causal connection between those deficits and the brain damage and fourth, a causal connection between the brain damage and the claimed precipitant, the head injury for example, resulting from a motor vehicle accident. One can refute the claim by successfully disproving any of these four requirements.

Dr. Phillip Resnick has refined the concept of malingering of organic deficits further into pure malingering, which is outright fabrication, partial malingering and exaggeration of genuine deficits, false imputation, which is the ascribing of actual symptoms to a cause consciously recognized as having no relationship to those symptoms, and a fourth

category of false attribution, or the honest, but erroneous ascribing of deficits to a particular organic cause.

The types of deficits which can directly result from brain damage fall into three general areas. I should point out that in my use of terms, brain damage or organic involvement refers to any deviation of brain structure or function from expected pre-morbid or optimal levels. Deficit by contrast, refers to the actual impairment, loss or aberration of intellectual, emotional, behavioral or executive functions. Therefore damage refers to the physical functioning of the central nervous system, whereas deficit refers to behavior.

Deficits which directly result from brain damage fall into three general areas, all of which can be malingered and which are not mutually exclusive. These are (1) Primary Cognitive Effects, which include disorders of perception, language, memory and movement. (2) The direct emotional effects. These include organic personality disorders, other disorders

of impulse control and effects of lateralized deficits on emotional functioning, such as the catastrophic reaction often seen in left hemisphere dysfunction and the unconcern seen in "LaBelle Indifference," seen with injuries to the right hemisphere. And finally, (3) are the emotional reactions to secondary brain damage which are not easily separable from emotional reactions to any trauma or loss, such as Acute Stress Disorder and Post Traumatic Stress Disorder.

Do not forget that functional disorders, primarily depression and schizophrenia, can interfere with cognitive functioning, but for the most part, other than what we come to know as pseudo-dementia, they are generally distinguishable from true organic deficits.

In the next article, we will learn the mechanism of assessing malingering in organic disorders. ▲

*Alan J. Tuckman, M.D.*



NOVARTIS



## Neuroleptic Malignant Syndrome and its Antecedents

**M**ore than a century and half ago, in 1832 Calmiel, a student of Esquirol, described cases of agitated hyperactive patients with auditory hallucinations who precipitously became stuporous and died with hyperthermia as high as 43.3 degrees C. This condition although of rare occurrence, became well recognized over the decades that followed.

Lethal Catatonia was described in 1874 by K.L. Kahlbaum, the famous German psychiatrist, in vivid details in a patient who is reported to have kept his head slightly above the pillow in a 'tetaniform cramp' with his eye focused on one point. He lay in this posture quietly all night. The following morning he became excited, agitated and confused. Finally he developed a tendency to assume fixed positions during which he lay stiffly extended, without reactions or speech. He pulled at the sheets and gnashed his teeth. Kahlbaum erroneously assumed the pathology to

be in the cloudy arachnoid membranes. In keeping with the thinking of his time he attributed this condition to masturbation! Kahlbaum also described the decreased sensibility to pain as evidenced by a lack of outward reaction to needle pricks. Kahlbaum came close to describing cases of Malignant Catatonia which often, but not always, resulted in death. He however made no mention of fever in his cases.

Kirby, in 1913 cites a case of a 31 year old woman who came down with catatonia "two days after the death of a 3 month old baby... For 5 years the patient remained in a catatonic state in the hospital, she was mute, showed general resistance to passive movement, muscular tension, fixed postures, hands clenched, head flexed with chin on chest. Her condition cleared up after 6.25 years. He also made no mention of fever, a feature that is seen always in what we call Neuroleptic Malignant Syndrome.

In the early part of the 20th Century,

Emil Kraepelin in describing Dementia Praecox and Paraphrenia included Catatonia as a subdivision of schizophrenia. Eugene Bleuler took the position that catatonia was only schizophrenic in the presence of the four "A's" of schizophrenia: Affect-flat; Ambivalence - intense; Associations - loose; and Autism or self-preoccupation.



In 1934 Stauder, at the University of Munich described a case: P.G., 32 years old, a farmer, always healthy and strong, a hard worker, liked solitude but is otherwise unobtrusive jumped up suddenly and attacked his relatives with a knife, could barely be contained by four nurses. On day 3 still excessively excited and violent despite a rising temperature to 102. Refuses food ..dies on day 4 after admission. Autopsy of the brain was without significance. Here was the case of a man who becomes acutely maniacal, resists his care givers and dies in a state of exhaustion and fever.

In 1946 Billig described a case of fatal catatonia: A 38 yr old woman became extremely restless, apprehensive and aggressive; on several occasions she attempted suicide..Even several persons could hardly manage her. She refused to eat, her sleep was poor. This lasted for six days. She then lapsed into shock and died. In the same year Shulack described an Exhaustion Syndrome in excited psychotic patients. "Psychotic patients who maintain a progressive motor and mental excitement are in danger of developing an exhaustion

**Doug Ward**

**Michael Mekler**

**Sheila Redmond**

**Ross Grant**

Thank you for your support of

RISPERDAL® (risperidone)

**JANSSEN**



• PHARMACEUTICA •  
• RESEARCH FOUNDATION •

Continued on next page

syndrome which may terminate in sudden death..." Shulack defines the syndrome in six parts: 1) Sustained motor and mental excitement with continual activity for 2 days to 2 weeks, 2) Rapid thready pulse, 3) Rapid loss in body weight, 4) Profuse clammy perspiration, 5) Fall in blood pressure and pulse pressure, 6) Hyperpyrexia from 100 to 104F if death does not occur.

Around 1953 chlorpromazine was introduced for the treatment of acute mania and schizophrenia. It became a widely used 'miracle drug' for psychoses across the board. It goes to the credit of the great 'drug watcher', Frank Ayd who in 1956 reported the first case of a lethal hyperpyrexia: Fatal Hyperpyrexia during Chlorpromazine Therapy. (Journal of Clinical and Experimental Psychopathology, Vol XVII, #2, June 1956). He describes the case as follows: A 41 year old man was given increasing doses of chlorpromazine to 2.5 gm/day. On the 21st day his temperature went to 108, he had several seizures and died. Although the name of the syndrome was not established at that time, Ayd concluded that "Chlorpromazine may cause sudden elevation of temperature

accompanied by perspiration and some feelings of prostration."

In 1959 Delay, et. al. reported from France that a non-phenothiazine neuroleptic, haloperidol administered to 63 women ages 19 to 73 was remarkably effective in efficacy and rapidity of action, but it produced a syndrome of hypertonic immobility in almost every case to varying degrees. This side effect, they reported, appeared progressively during the first week, sometimes within 2 or 3 days. The intensity was a function of the dose and the susceptibility of the subjects. In the majority of cases, a moderate Parkinsonian syndrome was produced with trembling. They also note akathisia of the legs. Here at the very introduction of Haldol the authors described its effects on the human motor system. "In cases where rigidity is intense, the effect is total, literally petrifying the patient. Thus, in three of the patients, difficulties in chewing and swallowing together with excessive salivation, insomnia and rapid wasting, obliged us to interrupt treatment.."

Delay, et. al. also mentioned five cases of 'crises excitomtrices' or agitated motoric crises. There were spasms of the face, tongue and throat

muscles with trismus, protrusion of the tongue, sucking or pouting movements: "Crises of spasmodic torticollis, rolling movements of the body, forced up-gaze, racing heart rate, hypersalivation, tearing, sweating, sometimes difficulty in breathing with respiratory compromise." The authors cautioned that the dose of Haldol should be moderate, 3-7 mg/day. They had used initial doses from 2mg to 25 mg.

Throughout the 60's reports of muscular rigidity, fever, salivation, dysphagia came pouring into the journals. Stelazine, Thorazine, Trilafon and even Compazine were cited as the triggering agents of this complex of side effects. In early 70's a report of three fatalities was published in the American Journal of Psychiatry. The title of this report was 'Heat Stroke in Phenothiazine Treated Patients'. Hyperthermia, muscular rigidity and death were appearing as ominous features of this condition. Some regarded it as viral encephalitis. Some suggested the use of ECT to relieve this pernicious catatonia. Some claimed success of this measure, others reported fatalities soon after the use of ECT.

In 1975 George Simpson wrote in Psychiatric Annals that " Neuroleptics and phenothiazines in particular can occasionally affect the temperature center producing hyperthermia which is treated by discontinuing the drug and taking steps to lower the temperature." Gradually a picture was emerging of impairment of thermoregulation related to the use of neuroleptics. By late 70's the term Neuroleptic Malignant Syndrome gained currency in psychiatric literature. Fever, a cardinal feature of the condition, was increasingly recognized as resulting from intense muscular rigidity, combined with a paralysis of sweating (anticholinergic effect). Some, like Max Fink and Lothar Kalinowsky, continued to

Longer lives.  
Healthier lives.  
More active lives.

Our never-ending  
commitment to you.



Lilly

Eli Lilly and Company

Continued on back page

**Psychiatry in the News, cont'd. from page 1**

They expressed feelings of sadness about two police officers who were killed in their precinct in the World Trade Center. We also discussed coping methods such as exercise, sleeping, and eating well, and reaching out to support systems such as family and friends. I encouraged those officers who felt they needed to discuss their feelings further to seek help from mental health professionals. We also reviewed the warning signals of depression and PTSD. Many of the officers were so grateful to have the debriefing session and felt quite relieved by the end of the session. I received many comments such as "We really appreciate you taking your time to do this session. It was extremely helpful."

In response to the WTC Disaster, the NYPD contracted with Columbia to coordinate the care of all of the 55,000 police officers who were impacted by the disaster. There are 2 phases to this program, a group debriefing (which was described above) and a treatment phase.

Many of the WHPS members and Mental Health Coalition members volunteered to be a part of this program. We were required to attend a half day training session in NY City where we were taught the Mitchell Method of debriefing. The second phase of the project will provide aftercare for the police who want it. The Police Foundation, which is predominately a fund-raising agency, has offered to pay for the treatment

for the police under the conditions that assure confidentiality and privacy. They will reimburse clinicians directly, won't ask the identity of the policeman or policewoman, and won't use their insurance(What a great idea!). Columbia will take the lead in evaluating the difficult cases and referring them to the appropriate clinicians.

In conclusion, I can say that my session with the NYPD was a success. Not only did I feel that I touched the lives of the police officers but it gave me a greater insight into the NYPD and how to help the secondary victims of the WTC Disaster. ▲

*Lois Kroplick, D.O.*

## **Bush Plans to Endorse Mental Health 'Parity'**

**Hill Negotiating Insurance Bill Details**

*By Dana Milbank  
Washington Post Staff Writer  
Thursday, April 25, 2002; Page A01*

President Bush is close to agreement on legislation forcing employers to expand insurance coverage for psychiatric illnesses, a position urged by mental health advocates but one that has been opposed by business groups and several key Republicans.

Bush plans to give the idea a strong endorsement Monday, when he is scheduled to speak in Albuquerque at a job training facility for people recovering from mental illnesses, congressional officials said. Those familiar with the status of negotiations, which continued yesterday, cautioned that there may not be agreement by Monday on all details of the legislation, known as "mental health parity." But they said Bush supports the idea and is likely to sign legislation this year.

An announcement of expanded mental health coverage in the home state of Sen. Pete V. Domenici (R-N.M.) would be a triumph for the lawmaker, who has a child suffering from schizophrenia and who has championed the cause for years. In a broad sense, it would require employers' health insurance plans to treat mental illness the same as other illnesses for the purposes of reimbursements and caps on payouts.

"Talks have been going on," Domenici spokesman Chris Gallegos confirmed. "At this point there is no agreement."

A weaker version of the mental parity legislation expired last fall, and Congress has been debating plans to renew and strengthen the law. Supporters said White House backing would likely provide a sufficient push to get the proposal enacted. Moreover, they added, a gesture of support for the mentally ill by the Republican president could reduce the stigma and shame of mental disorders

and could boost his "compassionate conservative" credentials.

The main opposition has come from key GOP lawmakers in the House, who object to the higher cost the requirement would impose on employers. The White House would need to persuade House conservatives to endorse the idea, which has long had strong backing from Democrats. As wife of the vice president, Tipper Gore made it her signature issue, and Senate Majority Leader Thomas A. Daschle (D-S.D.) has said he hopes to have a vote on the legislation soon.

Efforts by the White House to involve itself in mental health parity legislation could head off an election-year battle with Democrats on the subject. Last week, Daschle said he would proceed with the legislation even in the absence of an agreement with the White House. "Mental health parity, I think, is something that's going to pass," he said.

**Continued on next page** 

An earlier version of the legislation, enacted in 1996, required employers not to set higher annual or lifetime limits on mental health services than on other health services. But it allowed them to charge patients higher premiums and co-payments and offered them exemptions if compliance increased their health care costs by more than 1 percent.

Domenici and Sen. Paul D. Wellstone (D-Minn.) passed legislation in the Senate last year requiring group health plans at businesses with more than 50 employees to provide mental health coverage without higher premiums and co-payments than those for other illnesses. But the provision was opposed by House Republicans and removed in a conference between the House and Senate over a spending bill.

The issues still in dispute are whether the legislation will cover more than 200 disorders listed in the Diagnostic

and Statistical Manual of Mental Disorders, as Domenici and Wellstone have proposed, or major diseases such as schizophrenia and bipolar disorder, which the White House is believed to favor.

Also under consideration is whether employers could be exempted if the costs proved excessive. The Domenici-Wellstone legislation had no exemption. Past discussions have focused on exemptions if health care costs increase in the vicinity of 1 to 3 percent.

Negotiators are looking for ways to hold down the overall cost of the legislation, possibly without specific exemptions and limitations on diseases covered. The legislation is likely to be broader than one Bush signed into law as Texas governor in 1997. Texas, one of 26 states with mental health parity laws, includes only major mental illnesses in its law.

Congressional estimates indicate the

Domenici-Wellstone legislation would boost health care premiums by 1 percent. Opponents of that bill, who have included House Speaker J. Dennis Hastert (R-Ill.), House Whip Tom DeLay (R-Tex.) and key GOP committee leaders, argue it would increase costs on employers and workers.

Wellstone, who faces a difficult reelection battle, has not been involved in the negotiations between Domenici and the White House. "We continue to be very optimistic," said Wellstone spokeswoman Allison Dobson. Domenici updated Wellstone of his conversations in a phone call last night and said there was still no deal. ▲

*Staff writer Amy Goldstein contributed to this report.*

*2002 The Washington Post Company*

## Tips of the Trade

### Risk Management Tips for the Practice of Psychiatry

In these litigious times, the practice of psychiatry can be scary and problematic. Let's be realistic, anyone can sue anybody anytime. The key is that the plaintiff has the burden of proving the case. That, of course, is of little consolation to the psychiatrist (and insurer) with the obligation of defending the case. The more defensible the case is, the harder it is for the plaintiff to prove the case. The following are tips to making a potential lawsuit more defensible!

1. **Never** alter a patient record.
2. **Document** patient interactions objectively.
3. **Document** the rationale for each time you institute, modify, alter (change), or discontinue the course of treatment (especially with medications).
4. **Be wary** of treating patients by telephone without a follow-up office visit as soon as possible.
5. **Always** lock up prescription pads.
6. **Follow-up and document** after missed patient appointments, especially lengthy absences.
7. **Never** cross boundary lines with patients, regardless of gender. This includes, but is not limited to, business relationships, social relationships, and sexual encounters.
8. **Listen** to what your patients are telling you, a good (caring) bedside manner is still the best defense to being sued.

At some point in your career, you will encounter patients who are adept at manipulating the threat of litigation as one more aspect of their illness. Following these guidelines will help you sleep better at night.

Compliments of:  
**THE PSYCHIATRISTS' PROGRAM**  
*The APA-endorsed Professional Liability Insurance Program*

**Call:** 1-800-245-3333, ext. 389

**Email:** [TheProgram@apa-plip.com](mailto:TheProgram@apa-plip.com)

**Visit:** [www.apa-plip.com](http://www.apa-plip.com)

Managed by Professional Risk Management Services, Inc  
(In California, d/b/a Cal-Psych Insurance Agency, Inc.)

**Neuroleptic, cont'd.**

advocate the use of ECT as a treatment of NMS, others pointed out the added danger of introducing this drastic method in such physically compromised patients.

E. Horn, et, al.: (Hypothalamic Pathology in the Neuroleptic Malignant syndrome. Am. Jr. Psychiatry 1988; 145:617-620) formulated an explanation for the organic brain syndrome associated with NMS. They present the history of a 48 year old woman given two courses of ECT followed by three weeks of escalating doses of imipramine, phenelzine and perphenazine. Following this she became drowsy, spiked a temperature of 41.1 C, became hypertensive, had tachycardia to 140/minute, tachypnea 32/minute, exhibited tremors of the hands and lips, rigidity of arms and wrists, and clenched jaw. She died 24 hours later.

Autopsy showed the following significant features: Microscopic examination of multiple sections of the hypothalamus revealed conspicuous bilateral foci of pyknosis and disintegration of neurons and

sponginess of the neuropil in the anterior hypothalamus. Based on this evidence they concluded, "the presence of early necrosis in this area in our patient may indicate the relevance of this lesion to the development of NMS."

In conclusion, Neuroleptic Malignant Syndrome (NMS) is a rare but potentially lethal complication of the use of Neuroleptics and related drugs. It has been associated with all the drugs that effect the central dopaminergic system. It is estimated that 0.5 to 1% of patients receiving neuroleptics will develop NMS. clozapine and metoclopramide (Reglan the anti-heartburn drug) have also been implicated on occasions. There is fever in 100% cases, and extrapyramidal system rigidity, and cognitive changes. Two characteristic lab findings are high CPK and leucocytosis. EEG may show diffuse slowing. Tachypnea, diaphoresis, and labile BP, dystonia and chorea have been reported. Mental status changes start as drowsiness and confusion and may progress to stupor and coma.

Seizures, atrial flutter and cardiac arrhythmias may occur.

Physical exhaustion, dehydration (hence a higher rate in summer months), hyponatremia, thyrotoxicosis all increase the rate of this syndrome. Combination of haldol with Lithium also increases the risk. With early recognition and aggressive treatment there is only 5% mortality rate, which is a great improvement in recent years. The first phase of treatment is supportive with hydration and electrolyte stabilization. The most frequently used medications are Dantrolene and Bromocriptine, individually or in combination. Dantrolene can be given IV or orally. Bromocriptine is given orally or via NG tube. Duration of treatment is for at least ten days to three weeks. Resumption of neuroleptic treatment should not be considered before 3 to 6 weeks. Avoidance of the drug which triggered the NMS is imperative. ▲

*Syed Abdullah, M.D.*

SYNAPSE is available on the World Wide Web at <http://www.rfmh.org/wbps>

SYNAPSE

PO Box 741

Pomona, NY 10970-0741



1992, 1999, 2000 and 2001 APA Newsletter of the Year Award • 1993 APA Continuing Excellence Award  
 • 1995 & 2002 APA Continuing Excellence Award • 1997 5 Year Continuing Excellence Award  
 • 1998 APA Honorable Mention