

Olanzapine-induced skin rash: A case report

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Abstract

Skin rashes have been reported after the start of various antipsychotic drugs in the scientific literature. It is important that psychiatrists be aware of antipsychotic-induced skin reactions in patients on antipsychotic medication which can be an uncommon yet possible occurrence. Patients with psychiatric problems may be prone to skin reactions and may not report the same as they may not be aware of the same. We herewith report a case of skin reaction with Olanzapine in a patient with schizophrenia.

Keywords: Schizophrenia, Skin rash, Skin reaction, Antipsychotics, Olanzapine.

Introduction

Antipsychotic drugs, especially the atypical antipsychotics have been used widely in the management of schizophrenia in patients worldwide with Risperidone and Olanzapine being the oldest amongst these drugs.¹ It is prudent in patients with schizophrenia using atypical antipsychotics to monitor stringently for side effects like weight gain, elevated lipids, and hyperglycemia.² It has been documented in literature that many of the atypical antipsychotics may cause skin reactions that range from benign skin rashes and urticaria to major systemic skin reactions in patients with schizophrenia.³ Olanzapine has been used in the management of positive and negative symptoms in schizophrenia⁴ and aggressive behavior that may be seen in these patients.⁵ Olanzapine has been reported to cause skin rash and reactions which may at times need medical and dermatological attention.⁶⁻⁷ We report herewith a case of a 34-year male patient that developed skin reactions after being started on Olanzapine.

Case Report

A 34-year-old married Hindi speaking Hindu male, educated up to the 9th standard in a Hindi medium school, presented to our outpatient department with complaints of low mood, feeling that people are against him and that they are plotting to harm him along with disturbed sleep, social withdrawal and aloofness, aggressive behavior, hearing voices inaudible to others and paranoia since the past 6 months. He was apparently alright till 6 months back when his father expired of a heart attack and he began to suspect that someone may have poisoned his father. As per the spouse of the patient, he started having low mood most of the day, showed a decreased interest in routine household activities, would mutter and gesticulate, laugh to self, keep away from social gatherings, would be lost in himself and his world and would get irritable and aggressive many times a day. He would also keep tabs on whom his wife was speaking to and would close the windows and doors of his house. The patient also showed decreased self-care and anger. He feared that people were plotting to kill him and would hear derogatory voices towards him.

The patient would react to these voices and get abusive, throw things and get aggressive towards anyone that tried to

ask him what was happening during these phases. There was no history of head injury or epilepsy. There was no history of other psychiatric complaints in the past prior to the current illness.

On mental status examination, the patient conveyed mood as being anxious and expressed ideas of hopelessness along with paranoia, delusions of persecution and delusions of reference. He complained of auditory hallucinations which were 2nd and 3rd person and ego dystonic in nature. He also harbored aggressive thoughts towards the voices though he could not recognize them. He was diagnosed as having Schizophrenia and was started on oral Olanzapine 5mg at night which was increased in 2 days to 10mg. All his routine blood investigations were within normal limits. After a week on follow up, he reported improvement in all his psychotic features and reduced aggression towards family members. We increased the dose of Olanzapine to 15mg at night. Post starting this dosage, within 48 hours he presented with complaints of red dot like rashes all over the body and itching over rashes along with increased sedation.

A dermatology opinion was taken as she was diagnosed as drug-induced reaction secondary to Olanzapine as there was a temporal relationship of rashes over body and increase in the dosage of Olanzapine. He was prescribed Prednisolone 10mg once a day for 3 days and Cetirizine 10mg at night for a week which caused the rash to subside. Olanzapine was discontinued immediately. He was suggested regarding restarting Olanzapine at a lower dose and observing since it had helped his symptoms but the patient and his spouse refused considering the skin rash that had occurred. A Naranjo algorithm scale was applied and a score of +4 was obtained that did indicate a relationship between Olanzapine and the skin rash. The patient consented for the case report to be published but refused to be photographed for the rash.

Discussion

The patient in our case developed a drug-induced rash that subsided easily with treatment. The patient refused a re-challenge with the drug and we could not corroboratively confirm the evidence. Skin rashes with Olanzapine have been previously reported in the literature and have been seen to be

more frequent in patients with schizophrenia.⁸ Psychiatrists need to exercise caution about drug-induced rashes in patients on antipsychotics. In our case luckily the patient did not have any other concomitant drugs that may have caused or aggravated the existing skin reaction.

Conclusion

Multiple drug use interactions between drugs from various specialties may lead to skin reactions in psychiatric patients⁹ and one must be aware of the same when treating patients with atypical antipsychotics. It is best that medication is started at a low dose and stringent monitoring of side effects be done to avoid such reactions.

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