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Weight Loss and Anorexia With Quetiapine

To the Editor: The second-generation antipsychotic medications represent a new generation of therapies that have greater efficacy, especially for negative symptoms, with fewer extrapyramidal side effects (1). Weight gain has become a significant issue with the use of newer antipsychotic medications, and it has been found to lead to noncompliance with medication regimens and medical complications (2). Quetiapine is a second-generation antipsychotic that blocks both dopamine and serotonin (5HT) receptors (3). Weight gain is a significant side effect associated with quetiapine use (4,5). Weight loss is an infrequent adverse effect (3). Anorexia was frequently reported in premarketing evaluations (3).

Here we report a case of anorexia and significant weight loss (more than 20 pounds) associated with quetiapine use.

Mr. A is a 68-year-old divorced white male with a history of schizophrenia, residual type. He was already taking olanzapine when we took over his outpatient care. The daily olanzapine dosage was 12.5 mg for 24 months. Mr. A's medication was cross-tapered to quetiapine because of sedation and the fact that he was not maintaining good glycemic control. Mr. A is 5 feet 6 inches in height, and he weighed 135 pounds when he started taking olanzapine. His ideal body weight is 138 pounds. He gained five pounds in 24 months while he was taking olanzapine and weighed 140 pounds when he started taking quetiapine. He tolerated quetiapine well without any significant side effects. The dosage was gradually titrated over four to six weeks to 500 mg a day.

After taking quetiapine for five months, Mr. A started to experience a significant reduction in his appetite, and he began to lose weight. Over the next four months, his weight decreased to 119 pounds. He stopped eating almost entirely and reported that he wasn't hungry at all. Because he is a smoker, he was referred to his primary care physician to rule out any possible malignancy. Laboratory examinations—complete blood count, liver function and renal function tests, and electrolytes—were performed, along with a colonoscopy and a computed tomography scan of his head, chest, and abdomen. All the results were negative. Other possibilities, including depressive symptoms and paranoid thinking (for example, a belief that his food was poisoned) were explored. Mr. A denied any changes in mood, and the staff at the group home where he resides reported that they did not observe any behavioral changes indicating a depressed mood.

We decided to stop prescribing quetiapine and resume the use of olanzapine. Within a week Mr. A started to eat and started gaining weight. Over two months he gained 14 pounds. His blood sugars are maintained with antidiabetic medications.

This case illustrates the importance of monitoring weight changes among patients who are taking second-generation antipsychotic medications. Most of the time clinicians are concerned about weight gain but not weight loss. With the newer medications, which might be weight neutral, clinicians should pay attention to weight loss as well.

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ECT Then and Now

To the Editor: In the Personal Accounts column in the January issue, Joy S. McDiarmid (1) described how she received a total of 60 electroconvulsive therapy (ECT) treatments. I am certain that the only reason that this account was allowed to be published is that the author's experiences were in the 1960s, which sets the stage for a chorus from the ECT industry that "it's not like that anymore."

The truth is that survivors of the more powerful ECT in the 1980s, 1990s, and today still experience scrambled brains: permanent severe memory loss and permanent cogni-

tive disability (2–4). As a result of the lost years and lost abilities, ECT permanently alters our lives and the lives of our families in a way that none of us was warned about and none of us would have chosen.

I had a course of modern ECT a quarter-century after Ms. McDiarmid's, at the age of 25. I lost all memory of five years of my life, the most crucial years, from what I've been told; they encompassed my college education. To regain the knowledge I lost—if I could have done it—would have taken another five years. But ECT lowered my IQ by one-third, and left me with permanent anterograde amnesia (diminished short-term memory and learning ability). The career and future I'd worked toward were lost.

I spent the next five years struggling to figure out what had happened to me and then more years trying to find out whether anything could be done to help me. Those were lost years just as truly as the years that were erased. The biggest obstacle to my rebuilding a life was professionals' denial of the brain damage and disability caused by ECT. Nothing untoward happened to me, according to the psychiatrists. But I couldn't remember, couldn't think clearly, couldn't learn. Finally I found a neuropsychologist courageous enough to diagnose brain damage from ECT. No survivor of any other type of brain trauma has to spend years simply trying to assess her losses and gain access to rehabilitative services.

Those 15 state-of-the-art, brief-pulse ECT treatments left a huge hole of more than ten years in my life, but they didn't take only my past; they stole my future.

Like Ms. McDiarmid, I would hope that today's ECT patients are given full and truthful information about ECT's permanent adverse effects and experience fewer "surprises that can affect a lifetime." However, a great deal of evidence indicates that this is not so (2–5). A literature review of 17 articles and 134 firsthand accounts that was recently published in the *British Journal of Psychiatry* found that half of ECT patients reported receiving inadequate or insufficient information about the procedure (4). The authors further noted that "the same themes arise whether the patient had received treatment a year ago or 30 years ago" and that "the proportion of people who feel coerced into ECT has increased with time."

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Ms. Andre lives in New York City. She is director of the Committee for Truth in Psychiatry.

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Use of Coercive Measures in a Psychiatric Intensive Care Unit in Slovenia

To the Editor: Coercive physical measures are commonly used in psychiatric intensive care units. A variety of methods are used in different countries, depending on tradition, availability, and legislation (1,2), and several reports have been published on the different methods used (3–5).

At the University Psychiatric Hospital in Ljubljana, Slovenia, net-beds were used for decades, but because of their unpopularity, they were abandoned in 1999, and bed-belts began to be used instead. The situation was ideal for evaluating the consequences in a naturalistic observational study. The study was approved by the national medical ethics committee. One of the goals was to evaluate the differences between patients managed with net-beds and patients managed with bed-belts. We also wanted to determine whether the management of patients changed after the abandonment of net-beds.

Data from the charts of all patients admitted during two two-month periods—from February 1 to March 31 in 1998 and in 1999—were examined. Information was collected on sociodemographic characteristics and on illness and treatment. Data from three instruments were obtained. Possible scores on the Clinical Global Impressions range from 1 to 7, with higher scores indicating greater impairment. Scores on the Global Assessment Scale range from 1 to 100, with higher scores indicating better functioning. Scores on the Brief Psychiatric Rating Scale range from 18 to 126, with higher scores indicating greater impairment. Data related to the use of coercive measures and all psychopharmacologic therapy (regular and as needed) were also obtained. Data from the two years were compared with use of the chi square test and the t test.

In 1998 a total of 332 patients (173 men, or 52 percent) were admitted, compared with a total in 1999 of 312 patients (159 men, or 48 percent). No differences were found between the two samples in sociodemographic or diagnostic characteristics. In 1998 coercive physical measures were used with 32 patients (10 percent); 24 (7 percent) were managed with net-beds, and eight (2 percent) with bed-belts. In 1999 coercive physical measures were used with 16 patients (5 percent); all were managed with bed-belts. Among the 24 patients who were managed with net-beds, 19 (79 percent) were taking antipsychotics on a required or as-needed basis. Among the 16 patients managed with bed-belts in 1999, seven (44 percent) were taking antipsychotics.

Patients managed with bed-belts had significantly higher scores on the Clinical Global Impressions than those managed with net-beds (5.6 compared with 4.9; $t=2.53$, $df=39$, $p<.05$); they had lower Global Assessment Scale scores (18 compared with 31; $t=3.16$,

df=34, p<.01) and higher Brief Psychiatric Rating Scale scores (65.3 compared with 53.9; t=2.10, df=38, p<.05). Violence was the most cited reason for use of bed-belts and confusion (delirium) for use of net-beds. Significantly more patients with schizophrenia were managed with bed-belts.

The study had several limitations, in particular the short evaluation period and the lack of baseline data. However, some changes in the use of coercive physical measures and patient characteristics were found. In 1999 fewer coercive physical interventions in general were used, and the reason for use of coercive measures changed. Use of restrictive measures (bed-belts) was reduced, and only more severely disturbed patients were subjected to these measures. Because other characteristics of patients and staff did not change, we can conclude that changes in the availability of certain coercive measures in our hospital led to an overall reduction in use of coercive measures. Attention to the use of coercive measures may increase staff tolerance of patients' disturbed behaviors.

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