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Letters

Treatment of comorbid bipolar disorder and anxiety disorders: A great challenge to modern psychiatry

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To the Editor

Apparent comorbidity between bipolar disorder (BD) and anxiety disorders is a common condition in psychiatry with a lifetime prevalence of comorbid anxiety disorders in BD patients of 45% and higher prevalence rates for generalized anxiety disorder and social phobia.

One of the most difficult additional diagnoses to manage in BD patients is obsessive–compulsive disorder (OCD; Tonna et al. 2015), since the gold standard for one disease (serotonin reuptake inhibitors for OCD) can worsen the other (Amerio et al., 2014).

We present the case of a patient with severe OCD who developed a manic episode during treatment with citalopram. The patient is a 32-year-old Caucasian man with positive family history for recurrent depression. From the age of 21 years, he had presented recurrent, intrusive, ego-dystonic thoughts having sexual and aggressive content that led him to compulsive mental acts (specifically, praying). These symptoms met *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, criteria for OCD. No history of manic or depressive episodes was reported.

He was admitted to the inpatient service and treated with citalopram 60 mg/day with satisfactory control of obsessive–compulsive (OC) symptoms. After 3 months on citalopram 60 mg/day, he developed a manic episode. His therapy was modified to valproate 800 mg/day and olanzapine 20 mg/day. Olanzapine was gradually decreased, and valproate was continued with remission of OC symptoms and mood stabilization.

After 8 months, he decided to stop valproate and compulsive rituals increased prominently. Citalopram 20 mg/day was added to valproate with improvement of OC symptoms and mood stabilization.

In our case, positive family history for recurrent depression, manic switch induced by antidepressant and improvement of affective and OC symptoms with mood stabilizers and atypical antipsychotics support the hypothesis of an underlying bipolarity.

Considering course of illness as a key diagnostic validator, the majority of comorbid OCD cases appeared to be related to mood episodes (Amerio et al., 2015). OC symptoms appeared more often during depressive episodes, and comorbid BD and OCD cycled together, with OC symptoms often remitting during manic or hypomanic episodes.

BD-OCD clinical features would explain why these patients respond to adequate mood stabilizer treatment (Amerio et al., 2014). Only in a minority of comorbid patients with persistent OCD, despite improvement in mood episodes, addition of low doses of antidepressants could be considered while strictly monitoring emerging symptoms of mania or mixed states.

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Consent

Written informed consent was obtained from the patient for publication of this case report. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Declaration of interest

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Dr Amerio, Dr Tonna, Dr Odone and Dr Stubbs report no conflicts of interest. Dr Ghaemi has provided research consulting to Sunovion and Pfizer and has obtained a research grant from Takeda Pharmaceuticals.

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Severe alcohol use disorder after bariatric surgery

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To the Editor

The prevalence of severe obesity is increasing in Australasia, and bariatric surgery offers the most effective long-term treatment for this condition.

A recent case report in this Journal described the onset of mania following bariatric surgery (Hamdani et al., 2015) highlighting the relevance of this area for psychiatrists. Here, we report the onset of a severe alcohol use disorder (AUD) after bariatric surgery in a woman with no prior history of heavy drinking.

A 55-year-old female health professional was referred for psychiatric assessment before resuming work, having been abstinent from alcohol for 3 months while attending daily Alcoholics Anonymous meetings.

Seven years earlier her body mass index was 40, and she underwent Roux-en-Y gastric bypass surgery (RYGB). The surgery was successful, and the patient's body mass index fell to 32 within 12 months.

The patient had a lifetime history of consuming less than 20 g alcohol per week before surgery. She had never smoked or used illicit substances, but she described eating compulsively to alleviate stress and boredom. Her mother and a brother were heavy drinkers, and a maternal uncle had fatal complications of chronic alcoholism.

Twelve months after surgery, the patient received a promotion, which she found stressful. She began consuming up to 4 bottles of wine per day. Her relationships and work suffered. Over the next 2 years, she developed a severe relapsing AUD. She lost her professional practising certificate and required 6 months in residential alcohol treatment.

An increased incidence of AUDs following bariatric surgery has recently been reported; risk factors include being male, younger, a tobacco smoker or recreational substance user, having low social support and undergoing RYGB rather than laparoscopic banding (King et al., 2012; Suzuki et al., 2012).

We suggest measuring eating compulsivity and eliciting a family history of addictive behaviours might also help identify patients at risk of AUD following bariatric surgery. Patients should be advised prior to surgery about the risk of AUD. Finally, patients may be more at risk in the second year after surgery (King et al., 2012), highlighting the need for monitoring beyond the initial postoperative period. Mental health clinicians should play a role in this monitoring since much of the morbidity following bariatric surgery is psychiatric rather than surgical.

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Natural weight loss supplements – Are they psychoactive?

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To the Editor

Weight loss substitutes are advertised as quick solutions to the ever-expanding