


22. Di Napoli A, Di Lallo D, Pezzotti P, Forastiere F, Porta D. Effects of parental smoking and carcioembryonic antigen levels; and numerous polymorphs on Gram's stain; there was no growth on culture. Ultrasonography revealed hepatosplenomegaly with heterogeneous echotexture and multiple small hypoechoic lesions in the liver and spleen. With a clinical diagnosis of non-Hodgkin's lymphoma or metastasis, laparotomy was done; there was hemorrhagic ascites and multiple spotty black lesions all over the liver. The wedge biopsy showed multiple, variably sized, cystic, blood-filled spaces without endothelial lining [Figure 1].

Cystic blood-filled spaces in the liver can be macroscopic or microscopic, and diffuse or focal. Macroscopic and randomly distributed lesions without an endothelial lining are seen...
in peliosis hepatis. Microscopic peliosis is often confused with extreme sinusoidal dilatation and hepato cellular dropout. In sinusoidal dilatation, the liver plate structure is intact, and lesions are periporal or midzonal, especially when associated with oral contraceptives and pregnancy. In hepatocellular dropout, there is collapse of liver cell plates without loss of reticulin fibers.

It is appropriate to classify the lesions according to the apparent etiology, as this correlates with distinctive histological and clinical features. In addition to anabolic, estrogenic, or adrenocortical steroids, macroscopic peliosis hepatis has been reported in malnutrition, leukemia, tuberculosis, leprosy, vasculitis, lymphoma, and AIDS. Bacillary peliosis in human immunodeficiency virus infection can manifest as massive hemoperitoneum. In the present study, the prolonged consumption of NSAIDS might have been responsible for progressive dilatation, rupture of subcapsular cysts, and the resultant hemoperitoneum. The patient was given only palliative treatment and advised sonography during the next visit.

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REFERENCES

OLANZAPINE-INDUCED OCULOGYRIC CRISIS IN A PATIENT WITH SCHIZOPHRENIA

Sir,

Oculogyric crisis is an acute dystonic reaction characterized by sustained upward deviation of eyeballs and restlessness. Such reactions generally occur after administration of typical antipsychotics but are considered rare with atypical antipsychotics, particularly olanzapine. Until now, there are only two reports of olanzapine-induced oculogyric crisis from India, one in a patient of bipolar disorder and another in a child with post-encephalitic syndrome. Indeed, literature review on June 1, 2008, in ENTREZ PUBMED revealed only another German report in a patient with general anxiety disorder. Interestingly, although the commonest indication of olanzapine is schizophrenia, olanzapine-induced oculogyric crisis was never reported in schizophrenia. Below, we describe such a case.

A 25-year-old man, suffering from schizophrenia for 6 months, was initially treated with risperidone 8 mg/day and fluoxetine 40 mg/day (for associated depressive symptoms). But soon, fluoxetine had to be replaced by imipramine 75 mg/day for poor tolerance. The patient improved significantly.

However, once his symptoms resolved, the patient stopped taking medicine and relapsed within 2 weeks. This time, a different consultant placed him on olanzapine 10 mg/day and imipramine 75 mg/day. After 1 month with this regimen, the patient reported partial improvement, along with tremor. As olanzapine is not known to cause tremor commonly, imipramine was thought to be the reason and was stopped. Indeed, olanzapine was hiked up to 15 mg/day as the patient had partial improvement. But within a few days, the patient started having repeated episodes of sustained upward deviations of eyeballs, along with anxiety, restlessness, and backward flexions of neck, which transiently resolved with injection promethazine 25 mg. However, regular addition of trihexyphenidyl 2 mg/day failed to stop recurrences of the crises, which ultimately required replacement of olanzapine with risperidone. Naranjo's algorithm indicated a probability score of 8 of olanzapine-induced oculogyric crisis. With risperidone 3 mg/day, the patient is now maintaining remission without having tremor or oculogyric crisis any further.

High dopamine-acyetylcholine antagonism or high striatal dopamine inhibition has been suggested to underlie neuroleptic-induced oculogyric crisis. So olanzapine with an intermediate level of D2-binding affinity is not expected to cause oculogyric crisis. Probably for this, the patient did not have any problem with olanzapine at lower level except tremor. But in higher doses, olanzapine has been shown to have high D2 affinity, increasing the chance of oculogyric crisis. Also, high anticholinergic property of imipramine may have prevented the occurrence of oculogyric crisis initially until it was withdrawn. However, this does not explain the failure of trihexyphenidyl to control this side effect. It may imply that probably trihexyphenidyl is not very effective in the treatment of repeated oculogyric crisis with olanzapine. Indeed, we may need to change the antipsychotic in such a case.

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