continued in the mistaken belief that shock is due to hypovolaemia. Anaesthetists and surgeons need to be aware that such allergic reactions can occur.


Diabetic ketoacidosis and clozapine

Dawn Ai, T A Roper, J A Riley

Clozapine is an antipsychotic drug used for the management of schizophrenia. Due to its side-effects, it is reserved for patients unresponsive to, or intolerant of the conventional antipsychotic drugs.1 Cases of hyperglycaemia have been reported as a rare complication of clozapine. We report a case of diabetic ketoacidosis associated with the use of clozapine.

Case report

A 30-year-old Afro-Caribbean man with paranoid schizophrenia was admitted under the care of the medical team with severe vomiting for 2–3 days. He had a history of mild asthma and hidradenitis suppurativa but no previous or family history of diabetes. He had been treated previously by the psychiatrists but had not responded to conventional doses of neuroleptics. Therefore, five months prior to this admission, he had been started on clozapine. The dose was built up gradually over the subsequent weeks to 150 mg bid. His only other treatment was minocycline for hidradenitis suppurativa.

On examination he was apyrexial and clinically dehydrated but otherwise normal, with a normal full blood count. Urea and electrolytes revealed sodium to be low at 124 mmol/l, potassium 3.8 mmol/l, urea and creatinine raised at 8.0 mmol/l and 152 μmol/l, respectively, amylase normal and glucose raised at 24.9 mmol/l. Urinalysis revealed copious ketones and arterial blood gases showed pH 7.27, pCO₂ 3.2 kPa, pO₂ 13.4 kPa and bicarbonate 11.2 mmol/l. Chest X-ray and electrocardiogram were normal and toxic screen for salicylate and paracetamol was negative. A diagnosis of diabetic ketoacidosis was made and the patient was treated with a sliding scale regime of insulin, and intravenous fluid rehydration with potassium supplements.

Over the next 24 hours his blood sugar stabilised and his urea and electrolytes improved. Unfortunately the patient's psychiatric condition complicated his management. He had no insight into his illness, and would not accept his insulin injections or BM stix monitoring. After liaising with his psychiatrists it was decided that clozapine should be stopped in view of its association with hyperglycaemia. Clozapine was substituted by olanzapine, another of the newer agents for the treatment of schizophrenia. We also sought advice from a consultant diabetic physician, who suggested maximum doses of an oral hypoglycaemic agent. The patient was controlled on gliclazide 160 mg bid. Over the next two weeks his blood sugar remained stable at around 7–11 mmol/l and he was discharged back to the psychiatrists. He remains on gliclazide 80 mg bid 8 months after his initial presentation.

Discussion

Clozapine is used for people with schizophrenia who have had an inadequate response to at least two standard neuroleptics (Guide to the clozapine patient monitoring service, Sandoz Pharmaceuticals). It has an unusual neuropharmacological profile, with a low affinity for dopamine D2 receptors (unlike other antipsychotic drugs), but a high affinity for D4 and 5-HT2 receptors.2 It has good efficacy and causes fewer extrapyramidal side-effects than the conventional neuroleptics. About 30% of patients respond after 6 weeks, 49% by 6 months and 61% by a year (Information fact sheet on clozaril, Sandoz Pharmaceuticals). However, its side-effects (box 1) prevent it being used as a first-line treatment. The major complication is agranulocytosis which occurs in 0.8% of treated patients.3 Thus, initiation of the drug must be in hospital with close monitoring of the blood counts.

There are eight other cases of hyperglycaemia associated with clozapine reported in the

Keywords: plasma expanders; allergic reactions; hypotension; adverse drug reaction; Gelofusine

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Adverse drug reactions

Drugs known to cause hyperglycaemia/diabetes

Amoxapine, beta-blockers, calcium channel blockers, clonidine, corticosteroids, diazoxide, diuretics, isoniazid, oral contraceptives, phenothiazines, salbutamol, somatostatin, theophylline

Box 2

Learning points

- clozapine is an atypical antipsychotic drug used for the treatment of schizophrenia
- its side-effects, in particular agranulocytosis, restrict its use to patients unresponsive to or intolerant of conventional treatment
- diabetic ketoacidosis is associated with clozapine

Box 3

about the effect of clozapine on glucose metabolism and why black people should be at particular risk. Whether clozapine directly induces hyperglycaemia or merely acts as a trigger in people with a predisposition to diabetes remains unresolved. More research is needed to answer these questions. It is also important that physicians and psychiatrists are aware of the danger of diabetic ketoacidosis with clozapine therapy, especially in patients of Afro-Caribbean origin, those with a family history of diabetes and, of course, established diabetics. In these patients, blood glucose levels should be closely monitored.

Keywords: adverse drug reaction; clozapine; ketoacidosis; Afro-Caribbeans; diabetes

We thank Dr AV Simmons for his permission to write about this case and his suggestions and advice.


494 Adverse drug
Afro-Caribbean
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Case

Conclusion

Our case demonstrated that the drug clozapine may be associated with the development of diabetic ketoacidosis. It seems that people of Afro-Caribbean ethnic origin may be more susceptible to this side-effect. Little is known
Diabetic ketoacidosis and clozapine.

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