

PLASMA LEVEL OF VALPROIC ACID IN TREATMENT OF SEVERE CASES OF SCHIZOAFFECTIVE PSYCHOSES AND RAPID CYCLING BIPOLAR DISORDERS

Venci F. Anastasov¹, V. Stoev¹, I. Prošev² & S. Hristovska¹

¹Psychiatric Hospital "Skopje", Skopje, Macedonia

²Medical Center Čakovec, Croatia

INTRODUCTION

Valproic acid (VPA) is a medicine of choice for schizoaffective disorders and bipolar disorders, especially rapid-cycling. Treatment efficiency depends on plasma level of VPA, which is in correlation with the daily dose of the medicine. It seems that with severe cases, the therapeutic concentration of the medicine is being achieved with larger doses of VPA during a prolonged time period.

CASE REPORT 1

Mrs. S.G., a 40-year-old woman, 19 years has a schizoaffective disorder. She developed first and second psychotic episodes consequently after her first and second childbirth (21 and 25 years old). After that, she has been in manic episodes every two years until 3 to 4 years ago, when the condition became aggravated and the frequency increased to every two months.

In the beginning of the illness the treatment was with classic antipsychotics with constantly galactorrhea. For the last three years, she was treated with lithium but with no significant effect. The treatment before VPA was: clozapine 300 mg/daily and after haloperidol up to 45 mg/daily and levopromazine 150 mg/daily. ECT is used occasionally 5 times. Afterwards, a combined treatment of haloperidol 15 mg/daily and VPA (Apilepsin) up to 1200 mg/daily, was used. This year, haloperidol has been changed to olanzapine up to 10 mg/daily. In spite of this, manic episodes

did not respond to the treatment. The patient was hospitalized before 9 months in a serious manic episode. The treatment that she used before hospitalization was: VPA (Apilepsin) 1200 mg/daily, olanzapine 5mg/daily, lithium 1200mg/daily. In the hospital, we increased the dose of olanzapine to 10 mg/daily and Apilepsin 1500mg/daily. Consequently, plasma level monitoring of VPA was below 48 µg/ml. At last, increase of the dose to 1800 mg/daily attained the therapeutic concentration of 56,5 µg/ml. On this stage, the affect has been stabilized and a good remission has been achieved in the last 5-6 months.

CASE REPORT 2

Mr. G.M., a 38-year-old man, has been diagnosed with bipolar affective disorder (rapid-cycling) 10 years ago. In the beginning he has been treated with classic antipsychotics and afterwards with lithium. 7 ECT has been applied. Six days after treatment with 1200 mg/daily of VPA (Apilepsin), the plasma level of VPA was immeasurable. After two weeks of treatment with the same dose of VPA, an optimal treatment concentration of 78,25 µg/ml has been reached with a satisfactory treatment response. When a substitution of Apilepsin with Depakine Chrono was attempted, the condition worsened. In this case, 2250 mg/daily of Depakine Chrono was required to reach a plasma level of 83,77 µg/ml.

DISCUSSION

This and other cases of severe schizoaffective psychoses and rapid-cycling bipolar disorders showed that optimal therapeutic plasma level of VPA has been slowly reached even with high doses of VPA. Where does this surplus of VPA go? We do not find explanation about this so far. How can a decrease of plasma level of VPA be

explained during substitution of Apilepsin with Depakine Chrono? Also, why is a substantially larger dosage of Depakine Chrono required to achieve the same plasma level of VPA?

LITERATUR

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Correspondence:

Venci F. Anastasov, M.D.
Psychiatric Hospital "Skopje"
MK-1000 Skopje, Macedonia
vfanasov@yahoo.com