Recognizing neuroleptic malignant syndrome

Geethan J. Chandran and associates, in their report of a case of neuroleptic malignant syndrome (NMS),[1] describe an 81-year-old man who was given 2 dopamine D_2 blocking agents, with a total daily dose roughly equivalent to 9 mg of haloperidol, a very high dosage for someone this age. Within 3 days, one of these drugs was stopped, but the dosage of the other was increased. Although we do not know exactly what causes NMS, high dosages, rapid dosage increases and polypharmacy are all too typical in the majority of reported cases.[2]

The neuroleptic medication was continued for another day, after the development of fever, autonomic instability, tremor, rigidity and elevated creatine kinase (CK). In our opinion, an appropriate standard of care would necessitate immediate discontinuation of all dopamine-blocking agents in probable or suspected cases of NMS.

We are also concerned that the authors reinitiated neuroleptic therapy (olanzapine) "a few days" after resolution of symptoms and normalization of the CK level, "because of its lower reported rate of NMS." Reintroduction of any dopamine-blocking agent within 2 weeks of an NMS episode places patients at immediate high risk of another episode.[3] There are now more than 36 published case reports of NMS precipitated by olanzapine (list available upon request), including one in which olanzapine triggered NMS in a patient with a history of 2 previous episodes.

Finally, the authors' statement that "treatment of NMS must be continued for 2–3 weeks until symptoms remit" is puzzling, given that NMS typically resolves in 5–7 days, longer only if depot dopamine-blocking agents have been used. In our experience (more than 50 cases, all with excellent outcomes), dantrolene and bromocriptine are unnecessary if neuroleptics are discontinued immediately and appropriate supportive care is provided.[4] Several reports[5] suggest that bromocriptine may prolong the syndrome.

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Discontinuation of benzodiazepines

The article by Lucie Baillargeon and associates[1] serves more to critique what is going on in medical practice than to contribute to medical knowledge. The use of benzodiazepines should be restricted to the treatment of status epilepticus;[2] because of their highly addictive nature, they should not be used for habitual sedation. Even the manufacturers caution against use of benzodiazepines in elderly patients or in combination with alcohol. In a health care system that is strapped for money, it is astounding that such profligate expenditure on bad medical practice is allowed and that resources are being used to support costly with-

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