PSYCHOSIS

→ First-line treatment for corticosteroid-induced psychosis is to taper or discontinue corticosteroid therapy. [1]

→ If this is not possible because of comorbid disease or severe psychosis, consider adding low-dose atypical antipsychotics in patients with manic or hypomanic symptoms. [1]

→ tapering prednisolone dose to 40mg/day then tapering quickly to physiologic dose 7.5,g/day [1]

1st line: Atypical antipsychotics [1] [2] [3]

Olanzepine

→ IM: Short-acting injection: Initial dose: 2.5 or 5 mg; may repeat based on response and tolerability with up to 2 additional 1.25 to 5 mg doses at intervals ≥2 hours after the initial dose and ≥1 hour after the second dose; maximum: 12.5 mg per episode

→ Oral: Initial: 2.5 mg once daily, may increase dose based on response and tolerability in increments of 2.5 to 5 mg/day at intervals ≥1 week up to 10 mg/day,

Risperidone

→ Oral: Initial: 0.5 mg/day in 2 divided doses; may increase dose based on response and tolerability in increments of 0.5 mg/day at intervals ≥2 days up to 1 mg/day

In both **Olanzepine** and **Risperidone** patients without a clinically significant response after an adequate trial (eg, up to 4 weeks), taper and withdraw therapy. Only continue in patients with demonstrated benefit; attempt to taper and withdraw at regular intervals.

2nd line [1] [2] [3]

Lithium

→ Oral: Immediate release or extended release: Initial: 600 to 900 mg/day in 2 to 3 divided doses; increase based on response and tolerability by 300 to 600 mg every 1 to 5 days to usual therapeutic dose range of 900 mg/day to 1.8 g/day. After 5 to 7 days at a stable therapeutic dose, further adjust as needed based on clinical response, tolerability, and serum concentration

→ contraindicated if patient has renal disease as renal dysfunction or nephrotic syndrome so we use

Valproic acid

→ Fixed dose: Oral Initial: 500 to 750 mg/day, increase by 250 to 500 mg every 1 to 3 days to reach desired clinical effect and therapeutic serum concentration, therapeutic serum levels generally occur with daily doses of 1.5 to 2.5 g. Maximum recommended dosage: 60 mg/kg/day (manufacturer's labeling).

→ Weight-based loading dose for rapid symptom control: Oral

→ Initial: 20 to 30 mg/kg/day.

→ After 2 to 3 days, adjust dose upward or downward to reach desired clinical effect and therapeutic serum concentration, therapeutic serum levels generally occur with daily doses of 1.5 to 2.5 g.

→ To avoid intolerable adverse effects, some experts limit the initial rapid loading dose to 20 mg/kg/day (up to 2 g/day if body weight exceeds 100 kg) and then adjust based on response and serum concentration. (Maximum recommended dosage: 60 mg/kg/day)

Anticonvulsant: carbamazepine

→ Oral: Initial: 100 to 400 mg/day; may increase dose based on response and tolerability in increments of 200 mg/day every 1 to 4 days; usual dose range: 600 mg/day to 1.2 g/day; maximum dose: 1.6 g/day

→ withdraw gradually over 2 to 6 months

Screening [1]

→ The patients should be seen soon after the initiation of steroid therapy, preferably within a week. Along with monitoring weight, blood glucose and blood pressure, the patient should be asked about mood swings and symptoms of depression and mania.

[1]- Ghaemi, S. Nassir, Robert M. A Hirschfeld, and Claudia F Baldassano. 2009. Maintaining Wellness In Patients With Bipolar Disorder. [S.l.].

[2]- Hergüner, Sabri & Bilge, Ilmay & Yilmaz, Alev & Tüzün, Dilara. (2006). Steroid-induced psychosis in an adolescent: Treatment and prophylaxis with risperidone. The Turkish journal of pediatrics. 48. 244-7.

[3]- Kenna, H., Poon, A., de los Angeles, C., & Koran, L. (2011). Psychiatric complications of treatment with corticosteroids: Review with case report. Psychiatry And Clinical Neurosciences, 65(6), 549-560. doi: 10.1111/j.1440-1819.2011.02260.x