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## Priapism Associated with Aripiprazole and Quetiapine in an 8-Year-Old Boy with Autism



To the Editor,

Priapism is defined as the painful and prolonged state of penile erection in the absence of any sexual desire and arousal. It is one of the most serious and relatively rare adverse effects of the psychotropic medications and needs immediate attention as it can lead to long-term devastating consequences such as impotence, urinary retention, and gangrene<sup>1</sup>.

Alpha-adrenergic blockage mediated by the alpha receptors in the corpora cavernosa of the penis is

thought to be related to priapism associated with antipsychotics<sup>1,2</sup>.

### Case Presentation

An 8 year-old boy with autism spectrum disorder, without any other medical disease, presented to our clinic with irritability, hyperactivity, and peer relationship problems. He had been on medication with risperidone before, but discontinued because of decreased responsiveness. He had only been taking quetiapine 25 mg/day for sleep disturbance for 6 months.

Aripiprazole 2.5 mg was started and the dosage was increased to 5 mg after one week. He also continued to take quetiapine in the same dosage. In the second week, family requested an urgent visit because of spontaneous, hour-long, recurrent, painful penile erections. No other adverse reactions were reported by the parents. Urology consultation was requested and priapism was diagnosed, but no medical intervention was needed. It was thought to be related with aripiprazole combination and the medication was stopped (Naranjo ADR probability scale score was +8). In a few days after stopping aripiprazole, priapism spontaneously disappeared, while the patient continued with quetiapine 25 mg/day.

### Discussion

Priapism has been associated with nearly all the atypical antipsychotic medications. It is relatively well documented in adults, but reports in children are sporadic. According to literature review, there are only two cases of priapism in children with aripiprazole use and only one case with quetiapine. Negin and Murphy<sup>3</sup> reported priapism in an adolescent after addition of oxcarbazepine to the patient's existing regimen of aripiprazole and lithium. Goetz and Surman<sup>4</sup> reported prolonged penile erections associated with the use of atomoxetine and aripiprazole in an 11 year-old boy and Baytunca et al. reported priapism in a 13 year-old boy with quetiapine and oros methylphenidate to the best of our knowledge, this case is the first report, of priapism in a child with aripiprazole and quetiapine, and as it is thought to be related with combination therapy, it may indicate the potential risk for priapism in pediatric use of aripiprazole and quetiapine together.

Clinicians should be aware of such rare side effects

of antipsychotic use, especially in combination therapy and monitor patients closely. Parent education will also help to increase the awareness, promote early diagnosis, and reduce the long-term consequences of priapism, especially in children with mental and psychiatric disorders, such as in this case.

**Keywords:** aripiprazole, quetiapine, priapism, autism, child

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## Sertraline-Induced Diplopia



To the Editor,

Eye movements are controlled by extraocular muscles that are innervated from oculomotor nerves and the supranuclear centrum. Diplopia can occur as these structures damage, thus both eyes cannot look in the same direction<sup>1</sup>. Sertraline, a selective serotonin reuptake inhibitor (SSRI), is mainly prescribed for the treatment of depressive disorders (83%), anxiety disorders (11%) and occasionally for management of other disorders (6%) such as negative symptoms in eating disorders<sup>2</sup>. As well as its needed effects, sertraline may cause unwanted side effects that require medical attention. At the same time in the literature, sertraline is rarely reported to cause diplopia<sup>3</sup>. Here, we present a case of sertraline-related diplopia.

A.P, a 14 year-old girl patient came our outpatient clinic in winter 2013 with anhedonia, sadness, hypersomnia, declining concentration, thought rumination, and feelings of worthlessness. It was learned that the symptoms had begun 2 months before. During the past several months before her last presentation, she experienced worsening of her depressed mood and requested treatment. Patient was prescribed sertraline 25 mg/d and the drug was titrated up to 50 mg/d for 1 week. A week later, she complained of acute diplopia. She had no other acute medical conditions or medication changes at the time she developed ocular symptoms. As diplopia was a new symptom we examined her for possible underlying causes. The patient was evaluated by an ophthalmologist and neurologist. According to ophthalmologist examination the patient presented with horizontal binocular diplopia. Anterior segment, retinal biomicroscopy evaluations and pupillary reactions were normal bilaterally. Extraocular movements were free for all gaze positions without any signs of ptosis. Primary gaze position was orthotropic by Hirschberg test. Neither heterophoria nor heterotropia was defined using cover-uncover test.