Onset of Bruxism Following Initiation of Olanzapine Treatment: A Case Study
Syed Sikandar Shah, MD (1); Raj Kaur, MD (1); Mitali Patnaik, MD (1); Richard C. Josiassen, PhD (2)
(1) Drexel University College of Medicine, Department of Psychiatry, Philadelphia PA
(2) Translational Neuroscience, Conshohocken, PA

Background

Mr. L is a 51-year-old African American male who was referred for medication management by his psychotherapist. His primary psychiatric diagnosis is Major Depressive Disorder with Psychotic Features (DSM5: 296.34). He was referred primarily because he was not responding to his medication regimen although he was compliant with them. He still felt depressed, was very seclusive, paranoid, with paucity of speech and thought content, and was fatigued and sleep disturbed.

At his initial visit he was taking Abilify 5mg qdaily, Bupropion 300mg XL qdaily, Klonopin 1mg tid, Trazodone 300 mg qHS and Ambien 5 mg qHS. Due to his complex polypharmacy a decision was made to slowly taper off the Abilify, Trazodone and Ambien over a period of one month. Once tapered off the medications, the patient was started on Olanzapine 5 mg qHS and he was maintained on this dose. The patient was being seen on a monthly basis and at his one-month visit he reported that his mood, sleep and appetite were markedly improved. He also looked less paranoid. At his 6th month visit he stated that he had been “...grinding his teeth for the past 2-3 weeks, 4-5 times a day and multiple times at night.” He stated further that he “... was unable to control it voluntarily.” At this 6-month visit his neurological exam was within normal limits, specifically he had no muscle rigidity, EPS, or oral-facial movements. His score on the Abnormal Involuntary Movement Scale (AIMS) was zero. After careful consideration he was diagnosed with bruxism, defined as a movement disorder with nonfunctional activity of teeth, including clenching, grinding, gnashing, and bracing of teeth. The patient noted that he had never before experienced these symptoms.

Discussion

Point 1: Why is this case important? To our knowledge this is the first reported case of bruxism being associated with Olanzapine.

Point 2: What happened when the dose of Olanzapine was reduced? The dose of Olanzapine was reduced to 2.5 mg qHS and over a period of four moths the instances of bruxism was reduced to 1-2 events per week, with none occurring at night. In addition, the patient was able to voluntarily control the movements.

Point 3: Was this TD or bruxism? When the AIMS were administered there was no obvious orolabial movement. Instead the disorder was occurring only in the with masseter muscle group.

Point 4: With Olanzapine the patient experienced a considerable degree of clinical improvement. His mood, sleep, paranoia and appetite improved, he became non-seclusive, he began to apply for employment, and his personal relationships improved (i.e. with family and significant other). In other words, it would be hard to suggest that his bruxism co-occurred with negative life events, which might suggest the etiology stress, and anxiety. It will be important to continue to follow this patient over a longer period of time to see whether the bruxism will totally disappear.

References

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