Olanzapine-induced leucopaenia and thrombocytopaenia in an elderly patient: a case report and review of the evidence

Yogender Kumar Malik, Swapnajeet Sahoo, Ajit Avasthi


INTRODUCTION

Blood dyscrasias (leucopaenia—total leucocyte count<3500/cumm, thrombocytopaenia—total platelet count<150 000/cumm, pancytopenia) are rare but life threatening. Existing literature is limited to case reports, which are mostly reported on second generation antipsychotics (clozapine, olanzapine, risperidone, quetiapine). Elderly individuals are at risk of developing side effects with any psychotropics. Olanzapine is commonly used for the management of psychotic symptoms as well as for the management of behavioural and psychological problems with dementia in the elderly. In this case report, we report thrombocytopaenia and leucopaenia in an elderly individual with schizophrenia which developed after initiation of olanzapine and reverted back after stoppage of the drug. This case report highlights that the elderly are susceptible to develop haematological side effects with olanzapine and hence monitoring may be essential.

SUMMARY

Haematological adverse effects of antipsychotics are rare but life threatening. Existing literature is limited to case reports, which are mostly reported on second generation antipsychotics (clozapine, olanzapine, risperidone, quetiapine). Elderly individuals are at risk of developing side effects with any psychotropics. Olanzapine is commonly used for the management of psychotic symptoms as well as for the management of behavioural and psychological problems with dementia in the elderly. In this case report, we report thrombocytopaenia and leucopaenia in an elderly individual with schizophrenia which developed after initiation of olanzapine and reverted back after stoppage of the drug. This case report highlights that the elderly are susceptible to develop haematological side effects with olanzapine and hence monitoring may be essential.

CASE DESCRIPTION

Mr G, a 62-year-old married man, retired electrician by occupation was brought by his family members with complaints of hearing of voices over the past 10 years. There was no relevant medical history or family history of mental illness. Detailed exploration of history revealed an illness of insidious onset with a continuous and progressive course which was precipitated by interpersonal problems with office colleagues. Following which initially, the patient started to harbour strong fixed false beliefs that his colleagues wanted to defame him with subsequent anger-outbursts, agitation and suspiciousness towards them. Later on, after few months, he even started to hear voices of his office colleagues in clear consciousness discussing him and commenting on his actions using derogatory language. Due to these events, there was significant socio-occupational dysfunction. He was treated with risperidone (2–4 mg/day) with good compliance for a period of 38 publications (in the age range of 16–83 years). Of all these case reports, to date only seven case reports on the haematological adverse effects of olanzapine have been reported in elderly patients, others have been reported in adolescents, youth and middle-aged subjects.

Though no particular risk factors have been evaluated in this regard, it is a well-known fact that extremes of age (children and elderly, ie, >55–60 years of age) is a risk factor for developing any adverse effect with any psychotropics. In view of this limited literature on the association of olanzapine and blood dyscrasias in the elderly, we report a case of a 62-year-old man with paranoid schizophrenia who developed leucopaenia and thrombocytopaenia while on olanzapine.
of 6 months with which there was about 60% improvement but later because of non-compliance and restarting of risperidone he did not show any response. Detailed general physical and systemic examination did not reveal any abnormality and mental status examination was suggestive of auditory hallucinations—third person discussing type, delusions of persecution and reference, low mood and suicidal ideations secondary to psychotic symptoms with absence of insight and intact cognitive functions (Mini mental state examination—28/30). A diagnosis of paranoid schizophrenia as per ICD-10 was considered. After all essential routine haematological (complete blood count) and biochemical investigations (serum electrolytes, liver function tests, lipid profile, renal function tests, serum vitamin B12 and folate), all of which came out to be normal, he was started with Olanzapine 5 mg which was gradually increased to 15 mg over a period of 3 weeks (5 mg increment in dose per week). There was reduction in psychotic symptoms by 40%–50% but on subsequent follow-ups, after 6 weeks of starting Olanzapine, the patient complained of excessive fatigue. On repeat investigations, there was evidence of total leucocyte count of 2600/cumm (baseline—9400/cumm) and total platelet count of 45 000/cumm (baseline—130 000/cumm) without any evidence/history of fever and symptoms suggestive of any local or systemic infection and intake of any other medications. Haematology consultation and detailed autoimmune workup to rule out other possible aetiologies (hepatosplenomegaly, infection and intake of any other medications. Haematological abnormalities. After ruling out all possible causes of these haematological abnormalities, olanzapine was considered to have induced these adverse effects. Leucopenia and thrombocytopenia have been rarely reported with olanzapine and the exact incidence rate is currently unavailable. In the literature search, seven published case reports on olanzapine-induced blood dyscrasias were detected just after 6 weeks of starting Olanzapine at a dosage of 15 mg/day. After ruling out all possible causes of these haematological abnormalities, olanzapine was considered to have induced these adverse effects. Leucopenia and thrombocytopenia have been rarely reported with olanzapine and the exact incidence rate is currently unavailable. In the literature search, seven published case reports on olanzapine-induced blood dyscrasias have been reported with elderly subjects (details mentioned in table 1).

### DISCUSSION

In the index elderly subject, olanzapine-associated leucopenia and thrombocytopenia were detected just after 6 weeks of starting Olanzapine and the exact incidence rate is currently unavailable. In the literature search, seven published case reports on olanzapine-induced blood dyscrasias have been reported with elderly subjects (details mentioned in table 1).

<table>
<thead>
<tr>
<th>Author/year</th>
<th>Patient details</th>
<th>Dose of olanzapine</th>
<th>Detected after days of initiation of olanzapine</th>
<th>Treatment/outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meissner et al, 1999</td>
<td>56-year-old woman with parkinsonism</td>
<td>15 mg</td>
<td>120 days</td>
<td>Reversibility of leucopenia after stoppage of olanzapine</td>
</tr>
<tr>
<td>Steinwachs et al, 1999</td>
<td>81-year-old woman with parkinsonism</td>
<td>5 mg</td>
<td>156 days</td>
<td>Reversibility of neutropaenia after stoppage of olanzapine</td>
</tr>
<tr>
<td>Teter et al, 2000</td>
<td>60-year-old woman with schizophrenia</td>
<td>10 mg</td>
<td>17 days</td>
<td>Patient had a history of treatment with clozapine and developed neutropaenia subsequent to use of olanzapine which improved after stoppage of the drug</td>
</tr>
<tr>
<td>Onofrj and Thomas, 2001</td>
<td>67-year-old man with Parkinson’s disease and psychosis</td>
<td>10 mg</td>
<td>35 days</td>
<td>Stoppage of olanzapine improved pancytopenia and thrombocytopenia in 14 days</td>
</tr>
<tr>
<td>Carrillo et al, 2004</td>
<td>78-year-old man with dementia</td>
<td>10 mg</td>
<td>21 days</td>
<td>Death</td>
</tr>
<tr>
<td>Mehta and Sanitato, 2005</td>
<td>83-year-old woman with dementia and depression</td>
<td>2.5 mg</td>
<td>1 day</td>
<td>Stoppage of olanzapine plus treated with G-CSF led to improvement</td>
</tr>
<tr>
<td>Stergiou et al, 2005</td>
<td>69-year-old woman with psychosis</td>
<td>10 mg</td>
<td>17 days</td>
<td>Stoppage of drug</td>
</tr>
</tbody>
</table>

G-CSF, granulocyte colony stimulating factor.
Pancytopenia and neutropaenia were also reported with thrombocytopaenia in two of these case reports with elderly subjects. Rechallenge with the same drug was not possible due to ethical reasons.

It was also seen that olanzapine-induced haematological abnormalities can be seen at any time of treatment duration ranging from the first day to 204 days. The index case developed leucopaenia and neutropaenia after around 42 days (6 weeks) of starting of olanzapine. Of the seven case reports, while there was reported fatality in only in one case, the others improved with stoppage of olanzapine (though one required granulocyte colony stimulating factor (G-CSF) additionally). Similarly, stoppage of olanzapine led to improvement in haematological parameters within a week, which further ascertains that olanzapine was the definite agent for inducing leucopaenia and thrombocytopaenia in the index case. The Naranjo probability score was indicating a definite association of leucopaenia and thrombocytopaenia with olanzapine in the index case.

Though the exact mechanism of action of olanzapine induced neutropaenia and leucopaenia is not known, considering it’s chemical structure and pharmacological-receptor profile are quite similar to clozapine, those mechanisms proposed for clozapine induced haematological abnormalities can be postulated for olanzapine too. Some of these proposed mechanisms are: (1) olanzapine can modulate levels of the G-CSF and can cause subsequent transient granulocytopaenia like clozapine and (2) possibly olanzapine use can also lead to formation of nitrenium cations catalysed by Flavin containing monoxenage-3 system of leucocytes like clozapine. However, both of these hypotheses are not yet proven.

It has been suggested to screen patients as high and low risk for developing olanzapine-induced haematological abnormalities (ie, high risk includes previous history of haematological diseases, family history of blood dyscrasias and any previous history of drug-induced granulocytopaenia). We further suggest that being an elderly be included under high-risk screening for olanzapine-induced haematological abnormalities and a thorough meticulous complete blood count once a month within the first 3 months be carried out so as to detect any haematological abnormality at the earliest time possible.

The index case adds to the extremely limited literature on olanzapine-induced leucopaenia and thrombocytopaenia in elderly subjects and suggests that whenever an elderly patient receiving olanzapine has objective paenia in elderly subjects and suggests that whenever a patient consent for reporting this case study.

Contributors All the authors were involved in the management of the patient. YKM has drafted the initial manuscript. SS and AA critically evaluated the existing literature and have drafted the final manuscript. All the authors have equal contribution in the preparation of the manuscript.

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REFERENCES

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