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Intranasal Quetiapine Abuse

TO THE EDITOR: We would like to report on the widespread "abuse" of quetiapine among inmates in the Los Angeles County Jail—"the largest mental health institution in the world." Anecdotal reports from clinicians and staff estimate that as many as 30% of the inmates seen in psychiatric services report malingered psychotic symptoms (typically endorsing "hearing voices" or ill-defined "paranoia") in order to specifically obtain quetiapine. A history of substance dependence is common among those engaging in this practice. In addition to oral administration, the drug is also taken intranasally by snorting pulverized tablets. Such abusive self-administration seems to be driven by quetiapine's sedative and anxiolytic effects (to help with sleep or to "calm down") rather than by its antipsychotic properties. Accordingly, the drug has a "street value" (it is sold to other inmates for money) and is sometimes referred to simply as "quell."

Although the prevalence of this behavior beyond this narrow forensic population is unknown, the possibility of such an abuse potential is both curious and clinically pertinent. For example, it suggests that quetiapine is indeed associated with a better subjective response than its conventional antipsychotic counterparts (1). It also appears to give lie to the clinical myth that only psychotic patients will ask for and take antipsychotic medications. In our collective clinical experience, many patients (in particular, those with substance dependence) complain of "hearing voices" in order to procure hospital admission, disability income, or psychotropic medications (2). The "voices" are usually vague, highly suggestive of malingering (3), and occur in the absence of other symptoms (such as clear-cut delusions or thought disorganization) that would warrant a diagnosis of schizophrenia. While antipsychotic medications are not typically recognized as drugs with abuse potential, the use of intranasal quetiapine suggests otherwise and underscores the importance of recognizing malingered psychosis in clinical settings. This phenomenon is reminiscent of the era before the widespread use of atypical antipsychotic compounds, when a select group of patients would inappropriately seek and self-administer not only anticholinergics, such as trihexyphenidyl (4), but also low-potency antipsychotics, such as thioridazine or chlorpromazine. Finally, since the monosymptomatic "voices" endorsed by patients are often assumed to represent psychosis and therefore lead to reflexive prescription of antipsychotic medications, further investigative efforts aimed at distinguishing this clinical presentation from schizophrenia would be useful. If these entities could be reliably disentangled, it would help to reduce the diagnostic heterogeneity of schizophrenia and the unnecessary exposure of patients to the potentially harmful side effects of antipsychotic medications.

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Atomoxetine and Nonresponders to Stimulants

TO THE EDITOR: Atomoxetine has been recently introduced for the management of attention deficit hyperactivity disorder (ADHD) (1), and a vigorous campaign is ongoing to encourage physicians to write prescriptions for this drug. A media blitz is being directed to consumers, encouraging them to seek this medication. Before this expensive norepinephrine enhancer is used as a first-line medication to treat ADHD, its advantages relative to the generically prescribed stimulants need to be established. Ideally, a placebo-controlled blinded study model such as the one previously used by us to study another norepinephrine enhancer, imipramine (2), should be used. Because the costs of administering atomoxetine are about $90 per month and generic stimulants cost, on average, about $25 per month, atomoxetine's role as a first-line therapy should be supported by research.

With this in mind, we evaluated this drug effectiveness in our clinical program by employing measures used routinely to gather data in our program among children who were nonresponders to clinical trials of stimulants.

Seven patients were selected from our clinic (which was previously described [3]). Their average age was 10.5 years, and their IQ was 75.6. Their IQ is deemed average by the New York City Board of Education in its special education program, in which most children have an artificially deflated performance that is most likely consequent to comorbid learning disabilities. All patients were diagnosed with ADHD by using standard DSM-IV criteria. In accordance with the company's recommendations, we used doses of atomoxetine starting with 0.5 mg/kg/day for 3 days and then increased them up to 1.4 mg/kg/day. Parents of the children consented to treatment in accordance with routine hospital procedure.

We measured behavioral changes at baseline (without drug) and at either 1.2 mg/kg/day or when behavioral exacerbation obligated discontinuation by using the 10-item hyperactivity index derived from the Conners Teacher's Rating Scale (4).

In this open-label clinical observation of children taking atomoxetine, no change was seen. Tests performed between