Dear Editor,

Endocrine and reproductive side effects associated with escitalopram are rarely reported1. There are a few case reports of euprolactinemic galactorrhea associated with the use of escitalopram1,2. Here, we report a postmenopausal woman who developed euprolactinemic galactorrhea while on escitalopram.

A 32-year-old, married woman presented to our outpatient clinic with a complaint of galactorrhea from both breasts, occurring for one month. She had begun treatment for depression with escitalopram 10 mg/day four months earlier; she reported improvement in the depressive symptoms at four weeks of treatment. However, she had developed galactorrhea, which had lasted for a month. Six years prior to this event, the patient had undergone total abdominal hysterectomy and bilateral salpingo-oophorectomy due to ovarian cysts; she was not on hormone replacement or any other medications. She did not have any family history of psychiatric disorders. A mental status examination revealed mild depressed affect and sleep disturbance. The patient was diagnosed with major depressive disorder partly in remission and galactorrhea associated with escitalopram. Her physical and neurological examinations were normal, except for the galactorrhea. Her serum prolactin level was normal (10.03 ng/ml). Serum prolactin levels were normal in repeated measurements at the same time of day. Laboratory tests were normal except for FSH and LH, which were high due to post-oophorectomy status. MRI of the brain and hypophysis, breast ultrasonography, and cytological examination were normal. As a result, we concluded that the galactorrhea was associated with escitalopram, and therefore escitalopram treatment was discontinued. The patient was advised to avoid coitus and breast stimulation for one week. Four days after stopping the escitalopram, the galactorrhea diminished. Serum prolactin level was checked again at ten days and at four weeks after discontinuation of escitalopram, and it was still normal. According to the Naranjo causality scale (which showed a score of 7)3, the adverse effect was probably caused by escitalopram. Later, the patient was prescribed sertraline 50 mg/day for depression treatment. The six-month follow-ups indicated that the patient maintained well on sertraline, her serum prolactin level was normal, and there was no galactorrhea.

There are the reports of galactorrhea induced by selective serotonin reuptake inhibitors, including escitalopram, in the literature4. Mahasuar et al. reported a case of euprolactinemic galactorrhea in a postmenopausal woman induced by imipramine and escitalopram. The patient was also treated with glibenclamide for type II diabetes. The authors suggested that the combined use of antidepressants and glibenclamide could have caused the euprolactinemic galactorrhea2. Our report, however, is of a patient developing galactorrhea when using only escitalopram. To the best of our knowledge, this is the first case report to document that escitalopram alone induced

Euprolactinemic Galactorrhea Associated with Escitalopram in a Postmenopausal Woman

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Euprolactinemic galactorrhea associated with escitalopram in a postmenopausal woman.

The causal mechanism for galactorrhea induced by antidepressants is not clear. It has been suggested that hyper-responsiveness of thyrotropin-releasing hormone (TRH) is the probable reason for euprolactinemic galactorrhea⁵, although study findings are inadequate. Consequently, this case demonstrates that clinicians should consider escitalopram as a possible cause of euprolactinemic galactorrhea in postmenopausal women.

References:

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