

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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This letter was accepted for publication on December 21, 2015.

Klinik Psikofarmakoloji Bulteni - Bulletin of Clinical Psychopharmacology
2016;26(2):212-3. DOI: 10.5455/bcp.20151221101229

Declaration of interest:

A.S.A.: The author reported no conflict of interest related to this letter.

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 direction¹. 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 disorders². 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 diplopia³. 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.

Worth four-dot test was positive for diplopia. Binocular single vision was achieved by 12 Δ prism base out test prism. Neurologist observations was found to be normal. Meanwhile based on literature search and detailed review of the patient's medical history, sertraline was suspected to be the causal agent for this adverse reaction. Therefore, patient stopped sertraline and there was no reoccurrence of diplopia or any other visual problems.

All psychotropic medications have the potential to induce numerous and diverse unwanted ocular effects, but diplopia is a rare adverse effect of the psychotropic medication use. Diplopia after taking high doses of antidepressants such as bupropion, citalopram and sertraline are also reported³⁻⁵. The specific mechanism causing diplopia is not clear but after taking high doses of antidepressants is expected to cause diplopia by the involvement of ocular serotonergic interneuron fibers⁵.

It seems indeed difficult to relate the mechanisms of action of sertraline to the onset of diplopia. Here, our patient's neurological and ophthalmologic examinations were normal. The blood chemistry analyses were also normal. This information suggests that diplopia could be related to sertraline.

We report a case of diplopia related to sertraline. To the best of our knowledge, this is the second report of sertraline-induced diplopia and first from Turkey³. Thus, it is important for the clinician to recognize these conditions and educate patients about these ocular adverse effects when prescribing sertraline.

Keywords: sertraline, diplopia, adverse effect

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This letter was accepted for publication on January 09, 2016.

Klinik Psikofarmakoloji Bulteni - Bulletin of Clinical Psychopharmacology 2016;26(2):213-4. DOI: 10.5455/bcp.20160109124021

Declaration of interest:

S.E., H.N.U., A.P.V.: *The authors reported no conflict of interest related to this letter.*