Gilles de la Tourette syndrome (TS), characterized by chronic multiple motor tics and one or more vocal tics, has not been well recognized in adults. There are many studies in the literature that provide evidence of bipolar disorder being one of the comorbid disorders in adult patients with TS. Treatment of TS in adults with bipolar disorder is very challenging and has not been exclusively studied.

**CASE REPORT**

RS was a 41-year-old single, white male who lived alone in an apartment and assisted his father in his plumbing business. RS had a history of type one bipolar disorder for more than 3 years, alcohol dependence with physiological dependence in early partial remission, sedative-hypnotic abuse, and TS. He was last evaluated in an outpatient department during a regular follow-up session. He was very satisfied and compliant with the medications, and he had been regularly following up in the outpatient clinic.

The patient’s medication included pimozide 1 mg orally twice daily, quetiapine 100 mg orally twice daily, trazadone 100 mg orally at bedtime, lamotrigine 50 mg, and clonazepam 1 mg three times daily. His psychiatric history included TS since childhood with predominantly motor and intermittently vocal tics. He has been treated with propranolol, gabapentin, and pimozide for the tics but the best response had been with the pimozide. He had a documented history of legal charges. These included three instances of drunk driving, assaultive behavior with family, and more than five inpatient psychiatric hospitalizations. The last hospitalization was 4 months prior for aggressive and agitated behavior toward family members. He reported conflicting relationships with family members and no psychiatric history in other family members. He also had a history of two suicide attempts, the last one being 3 years ago when he tried to cut his neck with a knife. His substance use history included alcohol (drinking almost a pint daily for the past 2 years, with his longest period of abstinence being about 2 months) and sedative-hypnotics (he has taken more than the prescribed dose of clonazepam) for 2 years. He had no history delirium tremens, detoxifications, or rehabilitations.

**DISCUSSION**

Treatment of TS in this patient has been very challenging because of co-occurring bipolar disorder and substance use. He was on pimozide, one of the drugs approved by the U.S. Food and Drug Administration (FDA) for TS. The co-occurring bipolar disorder necessitated the adding of quetiapine. Clonazepam and lamotrigine were prescribed for additional relief of his motor tics and bipolar...
disorder-depressive type, respectively. The patient had a very good compliance with the regimen and it had been very effective for him.

The problem and challenge for this treatment was that pimozide can interact with quetiapine to increases the risk for prolonged QT syndrome. The other challenge was that the lamotrigine (FDA-approved for bipolar disorder-depressive type), according to a case study, could provoke symptoms of TS. The third challenge developed when patient started abusing clonazepam.

Follow-up was performed after 2 months on the same regimen with regular monitoring. He remained compliant with his medications, with no exacerbation of symptoms and no hospitalizations reported. The plan was made to closely monitor the QT prolongation by following up with regular electrocardiograms. Lamotrigine did not provoke any symptoms of TS after 2 months, but the plan is to keep a regular watch on any exacerbation of symptoms. The patient was given education regarding clonazepam abuse and will be monitored for any further abuse. He will be following up in an outpatient clinic once every month.

This case is a reminder of the complications and challenges we face in an adult patient with TS with co-occurring bipolar disorder and substance abuse.

REFERENCES