EPV1330

Clozapine-induced myoclonus in a patient with treatment-resistant schizophrenia: A case report

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Introduction: Clozapine is widely used for treatment-resistant schizophrenia but can cause neurological adverse effects, including myoclonus, that may challenge long-term treatment adherence and effectiveness.
Objectives: To describe clozapine-associated myoclonus and examine the relationship between dose, plasma level, and symptom onset.
Methods: Single-patient case report conducted in the "B" psychiatric department, Hedi Chaker University Hospital, Sfax, Tunisia. The patient was hospitalized in July 2025. Clinical observations, routine laboratories, dosing history, and a clozapine plasma level at symptom onset were extracted from the medical record. Data was de-identified.
Results: We present the case of a 44-year-old woman with treatment-resistant schizophrenia was involuntarily admitted for behavioral disturbances. This was her second psychiatric hospitalization. The symptomatology was dominated by a persecutory delusion directed toward her family. After non-response to multiple antipsychotics, clozapine was initiated and titrated over two months to 300 mg/day with standard monitoring. Shortly after reaching this dose, involuntary myoclonic jerks appeared. At onset, the plasma clozapine level was 349 ng/mL, near the lower therapeutic range. The clozapine dose was reduced to 250 mg/day and clonazepam 1 mg was added, leading to complete resolution of myoclonus.
Conclusions: Clozapine can precipitate myoclonus even at plasma levels within or near the lower therapeutic range.
Plasma monitoring and treatment adjustment should be considered when neurological adverse effects emerge to balance efficacy and tolerability.

Disclosure of Interest: None Declared

EPV1331

Transient transaminitis during an olanzapine to risperidone switch

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Introduction: Olanzapine and risperidone are second generation antipsychotics, which are very commonly used to treat schizophrenia. Whereas both antipsychotics may rarely cause elevation of aspartate (AST) and alanine (ALT) transaminase, evidence suggests that is relatively more common with olanzapine than with risperidone. However, it is also known that the incidence of adverse drug reactions is further increased by polypharmacy.
Objectives: We report a case of an adult male patient treated with olanzapine and unremarkable baseline AST and ALT levels while treated with olanzapine monotherapy, who developed transaminitis while his treatment was cross-titrated to risperidone.
Methods: A 23-years-old male patient with a diagnosis of schizophrenia was involuntary admitted due to an exacerbation of the disease after the patient discontinued his previous antipsychotic treatment (olanzapine 20mg daily). Upon admission, treatment with olanzapine was promptly recommenced, at the previously established dose. However, 15 days later, there was no response to this antipsychotic treatment, therefore a switch to another antipsychotic (risperidone) was decided.
Results: A cross-titration strategy was implemented, as it was thought the safest strategy, and it is depicted in Table 1. Already from the fist days of olanzapine-risperidone co-administration, an AST and ALT elevation was progressively observed, that culminated between the 22nd and 25th day of hospitalization. Although olanzapine was more propable to cause transaminitis, in this case the co-administration of both olanzapine and risperidone was deemed responsible. Therefore, an accelerated cross-titration was implemented towards tha target dose of 6-8 mg risperidone daily (equivalent to 20 mg olanzapine). Remarkably, upon withdrawal of olanzapine, AST and ALT levels normalized rapidly, further confirming that the co-administration was the culprit of the transaminitis. The patient responded well to risperidone treatment, and was discharged a few days later.

Table 1. Timeline, antipsychotic dosing and AST/ALT blood levels

Time	Olanzapine (mg daily)	Risperidone (mg daily)	AST (U/L)	ALT (U/L)
Day 1	20	0	26	25
Day 15	20	2	28	40
Day 22	10	4	57	147
Day 25	5	5	54	149
Day 29	0	6	20	62
Day 32	0	6	18	35
Day 39	0	6	15	22

Conclusions: Antipsychotic switching is commonly needed when a patient does not respond adequately. Broadly three switching strategies are used, "direct switch", "cross-titration", and "titration and discontinuation". A cross-titration strategy, with the first drug gradually discontinued and the second drug gradually introduced, is intuitively perceived by many psychiatrists as the safest. However, as evidenced in this case, a direct switch may prevent adverse reactions that are caused or facilitated by the co-administration of two antipsychotic agents.

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