Comparative simultaneous measurement of cerebrospinal fluid 5-hydroxyindoleacetic acid and blood serotonin levels in delirium tremens and clozapine-induced delirious reaction

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SUMMARY Cerebrospinal fluid 5-hydroxyindoleacetic acid and total blood serotonin levels were measured simultaneously in 11 female patients with delirium tremens and nine schizophrenic women with clozapine-induced acute delirium. Both groups had significantly raised levels of 5HIAA in CSF and significantly reduced blood 5HT levels as compared with normal control subjects, symptom-free alcoholics, or clozapine-treated schizophrenics. The two delirious groups were not distinguishable from each other in respect of their CSF 5HIAA or blood 5HT values. After clinical recovery both values returned to normal levels.

There is strong evidence that acute and chronic ethanol consumption can disturb neurotransmitter, and in particular serotonin (5HT), metabolism (Eccleston et al., 1967; Badawy and Evans, 1974). Acetaldehyde, rather than ethanol itself, has been suggested to divert the indoleamine catabolism from the normal predominating oxidative to a reductive pathway (Feldstein, 1969, 1973), and there are many indications that this metabolic shift may lead to formation of biologically highly active alkaloidlike condensation products (Dajani and Saheb, 1973; Majchrowitz, 1973; Walsh, 1973). During chronic ethanol ingestion, tolerance develops to its effects on the central nervous system. Its underlying biochemical mechanism is, however, still unclear; transmitter turnover studies and measurements of enzymatic activity have yielded controversial results (Redmond and Cohen, 1971; Raskin and Sokoloff, 1974). It seemed useful, therefore, to obtain data about serotonin metabolism in delirium tremens, especially in female patients as there is a very marked increase of alcoholism in women in Hungary. While in the period 1960–69 only a single case of delirium tremens was admitted to hospital, there were two in 1970, and 26 in 1976. In the past seven months of 1977 19 women were hospitalised for delirium tremens.

Clozapine, a special type of neuroleptic drug, has been reported to affect 5HT metabolism (Ackenheil et al., 1974; Bürki et al., 1975); although it has negligible extrapyramidal side effects, a delirious reaction can occur in certain patients (Gabriel et al., 1976). In an earlier study (Banki, 1977b) we demonstrated a transient elevation of 5-hydroxyindoleacetic acid (5HIAA) in the CSF and a progressive increase of blood 5HT content during clozapine administration, where delirious reactions were associated with pronounced indoleamine changes; this prompted us to include clozapine-induced delirium in this study.

Total blood 5HT content corresponds almost totally to platelet 5HT stores (Berstad, 1976) which, in turn, may serve as a peripheral model for central serotonergic neurones (Pletscher, 1968; Murphy and Costa, 1975). Measurement of 5HIAA in the CSF, on the other hand, serves as an index of CNS serotonin turnover. In this way, the simultaneous measurement of these two variables seemed likely to yield more information on 5HT metabolism than the separate determination of either of these metabolites.

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Subjects and methods

Eleven female patients with manifest delirium tremens and nine with clozapine delirium were studied; their ages were similar (average 39.5 and 42.0 years, respectively). The diagnosis of delirium tremens was established according to standard criteria (Reis, 1973) including the requirements for chronic alcoholism (Criteria Committee, 1972). The prominent symptoms were disturbed consciousness, disorientation, perception disorders, gross tremor, ataxia, sweating, anxiety, and agitation (less frequently euphoric-hyperthymic state). Clozapine-induced delirium was in many aspects similar to delirium tremens: hallucinations, confusion, automatic movements, and disorientation were identical, but tremor, vaso-dilatation, hypertension, and so on were absent.

Nine patients with delirium tremens were hospitalised for the first time, and one had her fourth delirium. Symptoms usually started 18 to 48 hours before admission. The last alcohol intake took place between six and 72 hours (average 36 hours) before arriving at the hospital. The patients with clozapine-induced delirium were all schizophrenic, admitted two to five days earlier, and receiving only clozapine in an average daily dose of 200 mg. The examination took place six to 18 hours after delirium had begun.

From all patients 5 ml heparinised blood and 5 ml CSF were taken (the latter by lumbar puncture) simultaneously, after careful medical examination. Delirium tremens patients were investigated immediately after admission, clozapine-delirium patients at the time when symptoms developed fully. At this time the interval since the last alcohol intake was between six and 12 hours. The delirium tremens patients were drug-free at this first sample taking.

Both kinds of delirium were treated with intravenous chlorpromazine (Heminevrin Astra), followed when necessary by oral medication, and supplemented with antibiotics, fluid therapy, vitamins, magnesium, and potassium (Hudolin et al., 1973; Sattes, 1973). All patients with delirium tremens recovered substantially within three to six days. Clozapine-induced delirium never lasted for longer than 24 hours; these schizophrenic patients were then treated with other neuroleptics or ECT or both.

Blood and CSF samples were mixed with 0.05 ml 0.3% ascorbic acid and immediately frozen to −20°C. Laboratory assay took place within six days by the O-phthalaldehyde fluorescent method (Curzon and Green, 1970; Geeraerts et al., 1974).

After clinical recovery (usually 18–22 days) further simultaneous blood and CSF samples were taken from all patients. Results were compared with the blood 5HT and CSF 5HIAA data obtained from groups of symptom-free alcoholic women, schizophrenic women under clozapine-treatment, and female patients without major psychiatric illness who were hospitalised for hysteria, neurotic, or other conflict behaviour, character disturbance, or other personality problems. Average age was similar in all the groups (44 years for alcoholics, 37 years for schizophrenics, and 41.4 years for control subjects).

Statistical analysis was done using analysis of variance and Student’s t test (two-tailed).

Results

Table 1 shows 5HIAA levels in CSF in the patient groups. Alcoholics had the same average levels as control subjects, but the delirium tremens and clozapine-delirium groups both had significantly higher values though they did not differ statistically from each other. Clozapine-treated schizophrenic patients who had no delirium also showed slightly but significantly raised average 5HIAA levels.

<table>
<thead>
<tr>
<th>5HIAA levels in CSF of patients with delirium tremens, clozapine-induced delirium, and alcoholism, and in control subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>5HIAA ng/ml</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1 Delirium tremens</td>
</tr>
<tr>
<td>2 Clozapine-delirium</td>
</tr>
<tr>
<td>3 Clozapine-treated*</td>
</tr>
<tr>
<td>4 Control</td>
</tr>
<tr>
<td>5 Alcoholic</td>
</tr>
</tbody>
</table>

*Schizophrenic patients without delirious reaction.

Blood serotonin content showed a different pattern (Table 2). Here both delirious groups had marked lower average values as compared with either control subjects, alcoholics, or schizophrenics under clozapine; in addition, this last group had higher blood 5HT levels as compared with controls—that is, changes were in the opposite direction. However, this increase in blood 5HT was not statistically significant. Delirium tremens and clozapine-delirium patients had practically identical average levels; symptom-free alcoholics also tended to have a lower blood 5HT content, but this was not statistically significantly different from control subjects.

Three weeks later, after clinical recovery, all
Table 2. Total blood serotonin content in the patient subgroups

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Number</th>
<th>Mean ± SEM</th>
<th>Range</th>
<th>Analysis of variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Delirium tremens</td>
<td>11</td>
<td>80 ± 6.9</td>
<td>49–130</td>
<td></td>
</tr>
<tr>
<td>2 Clozapine-delirium</td>
<td>9</td>
<td>81 ± 7.5</td>
<td>50–113</td>
<td>F = 10.13</td>
</tr>
<tr>
<td>3 Clozapine-treated*</td>
<td>8</td>
<td>207 ± 17.0</td>
<td>114–284</td>
<td>p &lt; 0.01</td>
</tr>
<tr>
<td>4 Alcoholic</td>
<td>16</td>
<td>143 ± 16.2</td>
<td>66–302</td>
<td></td>
</tr>
<tr>
<td>5 Control</td>
<td>12</td>
<td>178 ± 12.5</td>
<td>128–266</td>
<td></td>
</tr>
</tbody>
</table>

*As in Table 1. Groups 1 and 2 do not differ statistically from one another, but both are significantly lower as compared with groups 3, 4, or 5. None of the latter differ statistically.

values showed a clear tendency toward the normal: clozapine-delirium patients had both CSF 5HIAA and blood 5HT values within the normal range, delirium tremens patients approached the levels found in alcoholics—that is, a lower blood 5HT content and a tendency toward elevated CSF 5HIAA (Table 3).

**Discussion**

Although every biochemical measurement carried out in either blood or CSF can give only indirect information about changes in the CNS and must, therefore, be interpreted with caution, the above data seem to indicate that indoleamine metabolism is altered profoundly in both types of delirious states. The concurrent decrease of the stored 5HT in the blood platelets together with the 2.5 fold increase in its metabolite 5HIAA in the CSF would suggest an increased release and turnover of the transmitter amine. However, some of the following points may also be relevant. Firstly, hepatic insufficiency, a common finding in delirium tremens which has also been speculated on as a copathogenetic factor (Wilson, 1973), may be associated with raised 5HIAA levels in CSF (Young et al., 1974) or in brain (Knott and Curzon, 1975). This, however, would not account for the high values in clozapine-induced delirium. Secondly, delirious patients usually have excessive motor activity which may influence their CSF amine metabolite levels (Post et al., 1973). We also found a positive correlation between HVA (but not 5HIAA) levels in CSF and psychomotor activity (Banki, 1977a). This possibility has still to be elucidated. Thirdly, ethanol may impair the removal process of 5HIAA from the CNS, probably by inhibiting Na+K+-activated ATPase in the choroid plexus membrane (Tabakoff and Bogdan, 1974; Tabakoff et al., 1975). This possibility can be tested by the probenecid technique, and deserves special attention. Finally, blood serotonin content reflects peripheral changes which are not necessarily parallel to central processes; in addition, a decreased 5HT storage may also be due to nonspecific stress-response.

The most interesting result of this study is that, in clozapine-induced delirium, indoleamine changes were virtually identical to those observed in delirium tenses. Clozapine causes elevation of CSF 5HIAA in patients, and of brain 5HT and 5HIAA in animals (Ackenheil et al., 1975; Stralendorff et al., 1976), either by increasing 5HT synthesis or by indirect raphe depression (Gallagher and Aghajanian, 1976a, b). In psychiatric patients Banki (1977b) showed that elevation of 5HIAA in the CSF is only transient, while increased 5HT storage—as reflected by the total blood 5HT content—develops gradually but is prolonged. At present we cannot explain why in certain patients indoleamine metabolism responds in a different way, and whether this difference may be related to the clinical picture of delirium. However, the clinical observation that alcoholics are particularly sensitive to the delirium-inducing potency of clozapine (Banki, 1976; Gabriel et al., 1976) suggests a link between delirium tremens and clozapine-induced delirium. Both states are characterised by excessive activation, while withdrawal from chronic ethanol intoxication leads to greatly enhanced release of noradrenaline (Carlsson and Haeggen, 1967) and altered noradrenaline-receptor sensitivity; at the same

Table 3. 5HIAA levels in CSF and blood serotonin levels in delirium tremens and clozapine-delirium before and after clinical recovery

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Before recovery</th>
<th>After recovery</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSF 5HIAA (ng/ml)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium tremens</td>
<td>67 ± 3.6</td>
<td>36 ± 3.4*</td>
<td>31 ± 5.6†</td>
</tr>
<tr>
<td>Clozapine-induced delirium</td>
<td>71 ± 2.8</td>
<td>30 ± 3.0*</td>
<td>41 ± 5.4‡</td>
</tr>
<tr>
<td>Blood 5HT (ng/ml)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium tremens</td>
<td>80 ± 6.9</td>
<td>133 ± 10.2*</td>
<td>53 ± 17.6§</td>
</tr>
<tr>
<td>Clozapine-induced delirium</td>
<td>81 ± 7.5</td>
<td>156 ± 14.4†</td>
<td>75 ± 18.8‖</td>
</tr>
</tbody>
</table>

Values expressed as x ± SEM.

*Not significant versus alcoholics, significant versus normal control subjects (p < 0.02 and < 0.01 for CSF 5HIAA and blood 5HT, respectively).
†Not significant versus normal controls.
‡(p < 0.001).
§(p < 0.02).
‖(p < 0.01).
time clozapine has been found to act primarily at these receptors (Gallagher and Aghajanian, 1976). Our further studies will be aimed at investigating these possibilities.

References


