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Case Report

Withdrawal Emergent Dyskinesia After Discontinuation of Aripiprazole

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Abstract

Atypical antipsychotics are widely used not only to treat psychotic symptoms but also as a mood stabilizer in bipolar disorder and for augmentation in patients with unipolar depression. Withdrawal dyskinesia cases had been described in cases with sudden discontinuation of an antipsychotic that was prescribed in higher doses. In the presented case of a 36-year-old female, Aripiprazole was prescribed and taken at a low dose of 5mg over a period of 4 years resulting in withdrawal emergent dyskinesia upon discontinuation.

This case report demonstrates the importance of patient education and physician awareness of the risk of extrapyramidal symptoms not only while the patient is taking the antipsychotic but also after discontinuation especially as Aripiprazole is also given to children and adolescents. The article might serve to guide future treatment and medication management choices.

Keywords: Withdrawal emergent dyskinesia; Adverse reaction to atypical antipsychotic; Extrapyramidal symptoms after discontinuation of atypical antipsychotic

Introduction

Atypical antipsychotics are a widely used medication group that are considered better tolerated medications than typical antipsychotics. Aripiprazole acts as a partial agonist at the dopamine receptor [1]. The medication is used not only to treat psychosis but also for mood stabilization, augmentation for depression, and for conduct or disruptive behavior disorders as well as behavior control in children with autism spectrum disorder. The medications in that group of atypical antipsychotics have many potential side effects, with tardive dyskinesia being the most severe [2].

Withdrawal syndromes after discontinuation of antipsychotics have previously been described. Given that antipsychotics act on the dopaminergic pathways, long term treatment with such agents can potentially lead to an increase in dopamine response after discontinuation [3]. This is particularly true for typical antipsychotics. Aripiprazole and its active metabolite, dehydro-aripiprazole, have very long half-lives, about 75-90 hours, which pharmacologically would make an acute withdrawal appear less likely [4].

Withdrawal emergent dyskinesia is considered a subtype of tardive dyskinesia. This syndrome can include abnormal movements in the face, neck, tongue, and trunk as well as extremities with the onset after discontinuation of the antipsychotic. Also, somatic symptoms have been described including vomiting, tachycardia, hypertension, insomnia, tachycardia, or dizziness [5,6].

While tardive dyskinesia has a low rate of remission, improvements in symptoms in withdrawal emergent dyskinesia have been described [7].

Case reports have been published in context of discontinuation of ziprasidone, risperidone olanzapine and clozapine and high doses of Aripiprazole (15mg or higher) [8-16]. There is one report of withdrawal dyskinesias of 5mg dose in an 81-year-old woman [17].

Methods

Literature review of Embase, Medline, and PsycINFO for articles and case reports discussing withdrawal dyskinesia in context of discontinuation of Aripiprazole or other antipsychotics.

Case Presentation

Pt is a 36-year-old female with a history of depression and anxiety who was managed by her primary care provider with an initial medication regimen of Sertraline 50mg daily and Buspirone 5mg daily. She was admitted to psychiatric inpatient care from 03/10/2021 to 03/15/2021 due to worsening depression and suicidal ideation in the context of psychosocial stressors. The patient had endorsed the feeling of intermittent hopelessness along with some erratic sleep and appetite patterns. There was no reported history of hypomanic or manic symptoms, nor has there been a reported history of psychosis. The patient also engaged in alcohol use, reporting consumption of 4-8 drinks daily in the weeks prior to admission. No other substance use was reported.

During the hospitalization, her Sertraline was increased to 100mg daily dose, Buspirone was discontinued, and Aripiprazole was added at 5mg dose for augmentation. The patient had reported some initial sedation as side effects from the Aripiprazole which subsided after switching the medication to nighttime administration.

The patient showed improvements in mood and affect, participated in groups and socialized with peers. The patient felt well throughout 2021, remained abstinent from alcohol use, and continued on the same medication regimen. She became pregnant in September of 2021 and followed her Obstetrician-Gynecologist's recommendation to hold the Aripiprazole. However, she consecutively developed worsening depressive symptoms, including feeling of hopelessness, had reduced appetite, and reduced oral intake. She switched psychiatrists and was restarted on Abilify 5mg at 10 weeks pregnant and Sertraline was increased to 150mg daily dose with positive therapeutic benefit. She started to eat more regularly and was more positive, and her depressive thoughts resolved.

Throughout the follow up visits in 2022-2024, she remained stable on this medication regimen consistent of Abilify 5mg and Sertraline 150mg daily dose. In the beginning of 2024, she again switched providers and endorsed mood instability and a new medication Vilazodone 40mg daily was added to the regimen and Sertraline was gradually tapered off. Bupropion was started as a new antidepressant in August 2024 in combination with Aripiprazole 5mg and Vilazodone 40mg daily. However, the patient did not improve and started to express that she would like to taper off her medications. In August 2024, Vilazodone was decreased to 10mg daily dose and stopped in October 2024. Pt then was maintained on Aripiprazole 5mg and Bupropion 150mg daily and Zoloft was restarted at 12.5mg. In December 2024, the patient started to taper off her medications, taking Zoloft 12.5mg and Abilify 2mg every other day. She stopped taking any psychiatric medication on 01/11/2025.

On 01/16/2025, the patient was seen by me as new provider endorsing involuntary movements in her jaw, tongue, and facial muscles which was new to her as she never had experienced any extra-pyramidal symptoms. She reported pain in her teeth at night and recurrent headaches. She was seen by her dentist and neurologist who did not find any organic abnormalities.

I offered to order Benztropine 02/10/25 which she declined to take after reviewing the side effects. She took a supplement consistent of ginkgo, vitamin E and zinc and started to wear a mouth guard. She reported on 02/27/2025 that her symptoms were about 90% better. On 03/27/2025 she reported that her symptoms had worsened greatly with the onset of her menses. A trial of Benztropine 0.5mg BID did not provide improvement and the patient's symptoms continued to bother and significantly interfere with her life during her 3 month follow up. At this point, I ordered Ingrezza 40mg daily which was not approved by her insurance. The patient continued to report ongoing withdrawal- dyskinesia symptoms up to her 8 months follow-up visit after discontinuation of the atypical antipsychotic. In the following months, her involuntary movements improved significantly.

Discussion

Atypical antipsychotics should be started after careful consideration of risks and benefits.

Atypical antipsychotics, with a lower rate of drug-induced movement disorders such as parkinsonism and dyskinesia, are believed to be better tolerated and less likely prone to cause extrapyramidal side effects. However, the risk of such disabling side effects exists.

While the use of atypical antipsychotics often leads to clinical benefits in the treatment of several psychiatric diagnoses, the use is nevertheless associated with the risk of such disabling side effects.

If withdrawal from an antipsychotic is suspected, reinstatement of previous medication dose is likely to produce resolution of withdrawal symptoms. Gradual reduction of dose and tapering to cease is recommended to avoid the possibility of and lessen the severity of somatic withdrawal symptoms.

Many times, dyskinetic movements can be self-limited; however, in cases they persist, the quality of life of the patient can be substantially decreased.

Conclusion

While Aripiprazole and other atypical antipsychotics have a wide range of clinical indications, physicians need to be cautious when prescribing Aripiprazole or any other atypical antipsychotic.

Thorough education of the patient needs to occur to monitor possible side effects while taking atypical antipsychotics and upon discontinuation.

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