•Forum•

Comorbid bipolar disorder and obsessive-compulsive disorder

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Summary: Obsessive-compulsive symptoms are common in patients with bipolar disorders. This comorbid condition complicates the clinical treatment of the two disorders, so identifying these individuals is important. We discuss the comorbid occurrence of obsessive-compulsive disorder and bipolar disorder, introduce possible etiological mechanisms that could result in this common comorbid condition, discuss recent research advances in the area, and propose some clinical principles for managing such patients.

Key words: obsessive-compulsive disorder; bipolar disorder; comorbidity

[*Shanghai Arch Psychiatry*. 2015, **27**(4): 246-248. doi: http://dx.doi.org/10.11919/j.issn.1002-0829.215009]

Previous studies have documented high rates of comorbidity of other psychiatric conditions among individuals with bipolar disorders (BD).[1] One study estimated that obsessive-compulsive disorders (OCD) accounted for 21% of all comorbidities in BD.[2] There is continuing debate about whether (a) these are two independent conditions that can co-occur or (b) OCD is a specific subtype of BD. Regardless of the inter-relationship of the two conditions, the comorbid occurrence of these two types of symptoms can cause a clinical dilemma because selective serotonin reuptake inhibitors (SSRIs) – which are quite commonly used to treat OCD – increases the risk of precipitating manic symptoms. [3-6]

The OCD symptoms that occur in individuals with BD often occur during the depressive episodes or during the intervals between episodes of depressive or manic symptoms.[7,8] This timing of OCD symptoms during BD is consistent with the cyclic nature of BD and suggests shared biological mechanisms between the two disorders. In support of this hypothesis, a study using Positron Emission Tomography (PET) found that in untreated persons with BD the serotonin-transporter binding potential in the insular and dorsal cingulate cortex was higher among BD patients with pathological obsessions and compulsions than among BD patients without such symptoms.[9] Moreover, a linkage study found that compared to OCD patients without comorbid BD, patients with comorbid OCD and BD were more likely to have a family history of mood disorders but less likely to have a family history of OCD.[10] However, another study found no significant difference in the rates of a positive family history of OCD between patients with OCD alone and those with comorbid OCD and BD.[11] Further support for the hypothesized common etiology comes from a preliminary molecular genetic study which found that hyperpolarization activated cyclic nucleotide-gated channel 4 (HCN4) is a common susceptible locus for both mood disorders and OCD, but further studies with larger sample sizes are needed to replicate this finding.[12]

The presence of OCD in BD complicates the clinical presentation. Compared to patients with BD without comorbid OCD, those that have comorbid BD and OCD often have a more severe form of BD, have more prolonged episodes, are less adherent to medication, and are less responsive to medication. Recent studies about comorbid BD and OCD have reported the following:

(a) Temporal relationship. Some studies suggest that OCD is an antecedent of BD,[10] but others report concurrent onset of OCD and BD.[13,14]

(b) Course of disease. In 44% of patients with comorbid BD and OCD the episodes are cyclic.[15] The course of disease is more chronic among BD patients with OCD compared to those without comorbid OCD.[16,17] OCD is more commonly observed in patients with Type II BD, among whom the prevalence of OCD has been reported to be as high as 75%.[18]

(c) Compulsive behaviors. The most commonly reported compulsions among patients with comorbid OCD and BD are compulsive sorting,[14,19,20,21] controlling or checking,[20] repeating behaviors,[13,22] excessive washing,[20] and counting.[19] Obsessive reassurance-seeking is also commonly reported in these patients.[23] In children and adolescents with BD, compulsive hoarding, impulsiveness,[24] and sorting[25] are more common.

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A full-text Chinese translation of this article will be available at http://dx.doi.org/10.11919/j.issn.1002-0829.215009 on October 26, 2015.

(d) Substance and alcohol abuse. A study found a higher prevalence of sedative, nicotine, alcohol, and caffeine use among individuals with comorbid OCD and BD compared to those with BD without OCD.[14] Similarly, compared to OCD patients without comorbid mood disorders, those with a comorbid mood disorder were more likely to have a substance abuse diagnosis (OR=3.18, 95%CI=1.81–5.58) or alcohol abuse diagnosis (OR=2.21, 95%CI=1.34–3.65).[11,13,26,27,28]

(e) Suicidal behaviors. Compared to BD patients without OCD, a greater proportion of patients with both disorders had a lifetime history of suicidal ideation and suicide attempts.[2,11,13,29,30]

The clinical management of comorbid OCD and BD requires first focusing on stabilizing the patient's mood, which requires the combined use of multiple medications such as the use of lithium with anticonvulsants or atypical antipsychotic medications such as quetiapine;[31-33] adjunctive treatment with aripiprazole may be effective for the comorbid OCD symptoms.[4] In the case of OCD comorbid with type II BD, after full treatment of the mood symptoms with mood stabilizers the clinician can, while monitoring for potential drug interactions, cautiously try adjunctive treatment with antidepressants that are effective for both depressive symptoms and OCD symptoms and that have a low risk of inducing a full manic episode, including the selective serotonin reuptake inhibitors (SSRIs): fluoxetine, fluvoxamine, paroxetine, and sertraline.[32,35]

In summary, BD comorbid with OCD may be etiologically distinct from either of the disorders. Clinicians should pay attention to its complex clinical manifestations and carefully consider the treatment principles outlined above.

Conflict of Interest

The authors declare no conflict of interest related to this manuscript.

Funding

There was no funding support provided for the preparation of this report.

双相障碍与强迫症的共病

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概述：在双相障碍患者中强迫症状是常见的。因为双相障碍和强迫症的共病状态会令这两种障碍的临床治疗复杂化，所以确定这些共病的患者是很重要的。我们讨论了强迫症和双相障碍的共病，介绍了可能导致这种常见共病状态的发病机制，也讨论了该领域最新的研究进展，并提出一些管理这些患者的临床原则。

关键词：强迫症；双相障碍；共病

本文全文中文版从 2015 年 10 月 26 日起在 http://dx.doi.org/10.11919/j.issn.1002-0829.215009 可供免费阅览下载

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(received, 2015-03-03; accepted, 2015-05-26)

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