Case Report

Obsessive Compulsive Disorder with Bipolar Mood Disorder: A Rare Comorbidity in India

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ABSTRACT

Obsessive compulsive features occurring in mania have been well documented. Though there have been some studies on obsessive compulsive disorder (OCD) comorbid with mania in the western countries, there are very few case reports and studies in India. Our aim is to report one such case here, who presented with OC features which are not typical of the symptom cluster of the OCD commonly seen with mania in earlier reports. Also, the comorbidities in OCD should be recognized as this can have important diagnostic and therapeutic implications.

Key words: *Bipolarity, comorbidity, obsessive compulsive disorder*

INTRODUCTION

Psychiatric disorders have been known to have various comorbidities. Obsessive compulsive disorder (OCD) too is one such disorder which can coexist with other anxiety disorders, mood and psychotic disorders. Of these, depressive symptoms are the commonest comorbidity. Mania in OCD can occur either as an independent comorbidity or as a result of an antidepressant-induced switch in a patient on anti-OCD drugs. Whatever the cause may be, this comorbidity implies that there can be a host of differences in the presentation, course, treatment guidelines and prognosis.

CASE REPORT

A 17-year-old first born male patient who was premorbidly of an easy temperament had a strong family history of mental illness. There was depression in the mother and OCD in the maternal uncle and cousin. His intellectual performance was average. He consulted a Psychiatrist for OCD of five years duration and was prescribed clomipramine 75 mg, fluoxetine 20 mg and risperidone 1 mg. A week after this consultation, he presented to our out patient department (OPD) with a history of obsessions of contamination, sexual images, compulsions of washing, checking, repetitions and ritualistic compulsions. It was of an insidious onset and a fluctuating course. There was no history of attention deficit hyperactivity disorder (ADHD) or Tourette's syndrome. He also had depressive symptoms i.e. sadness, suicidal behavior, decreased sleep and delusion of reference, which he said was of one month duration. Patient was admitted as he also had suicidal ideas and plans and was given fluoxetine 40 mg along with clomipramine 75 mg. His Hamilton rating scale for depression (HAM-D) and Y-Brown obsessive compulsive scale (Y-BOCS) scores were 42 and 32 respectively. During the stay in the hospital, he was found to have agitation and aggression, increased speech output, increased psychomotor activity, grandiose ideas about his physical power and sexual imagery regarding the treating staff and the nurses. Young mania rating scale (YMRS) score was 39. His

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OC symptoms persisted with the same severity. He was then started on divalproex sodium and dose built up to 1 500 mg, risperidone gradually increased to 12 mg, clonazepam 1 mg and parenteral antipsychotics. As there was no reduction in symptoms, quetiapine was started and the dose built to 400 mg. Despite the high dose of antipsychotics, there was no extra pyramidal side effects (EPS). Clomipramine and fluoxetine were stopped. Not finding an adequate response and due to the presence of suicidal ideas, he was started on electroconvulsive therapy and after one sitting of modified electro convulsive therapy (ECT), his manic symptoms worsened. His aggression and increased verbal output reduced minimally after increasing the dose of quetiapine to 600 mg and his YMRS scores reduced to 30. He was discharged on request with divalproex sodium 1 500 mg, risperidone 4 mg and quetiapine 600 mg and was advised regular follow-up. During the follow-up, he was found to have prominent symptoms of both mania and OCD, though he reported a 50% reduction of manic symptoms.

There are some differences from the available evidence that were found in above patient. The OC symptom cluster of this patient was not typical of that reported in this comorbidity. The bipolarity was of type I. An interesting finding was that both OCD and mania were prominent in intensity.

DISCUSSION

There is a dearth of studies on OCD comorbid with mania in India. One study was by Reddy *et al*.[1] which was an assessment of psychiatric comorbidity in children and adolescents with OCD. Fifty-four children with OCD were assessed using a structured interview schedule and only one subject had bipolar disorder. Another study by Zutshi *et al*.[2] in NIMHANS on clinical features reported that obsessions and compulsions worsened with the severity of depression and completely disappeared with mania. Kalra *et al*.[3] reported obsessions of contamination and pathological doubts with cleaning and spitting rituals in their case. A case report by Sathyanarayana *et al*.[4] showed that anti-OCD drugs can induce mania.

There are studies and reports from other countries as well. Cosoff and Hafner found that 30% of inpatients with bipolar disorder met criteria for OCD.[5] There is a high rate of comorbidity between OCD and bipolarity, as reported by Chen and Dilsaver too.[6] The epidemiologic catchment area (ECA) study suggested 18 times higher risk for developing OCD in bipolar euthymic patients in comparison with general population.[7] But, Kruger *et al*.[8] and Strakowsky *et al*.[9] found variable rates of comorbidity between bipolar disorder and OCD from 8 to 35% in bipolar inpatients suffering from OCD.

This comorbidity is known to present differently compared with the conventional presentation of OCD. This difference in the presentation may be with regards to the clinical features, course or prognosis of the illness. Patients with OCD comorbid with bipolar mood disorder present early in life compared with pure OCD[10] and the psychopathology of OCD involves more of existential, philosophical, hoarding, sexual obsessions and odd superstitions.[10-12] Youth with comorbid OCD and Bipolar Disorder (BPD) had greater comorbidity, poor functioning and more hospitalization, probably because of the element of bipolarity in them.[10] A study done by Zutshi *et al*. on 28 OCD patients with bipolarity showed a less severe OCD, episodic course, family loading and a greater comorbidity of depression, social phobia and generalized anxiety disorder.[2] There is also a higher incidence of prior suicide attempts.[13]

Obsessions and compulsions worsened with the severity of depression and completely disappeared during mania in a patient with OCD comorbid with bipolarity as reported by Gordon and Rasmussen.[14] A lifetime comorbidity of bipolarity has to be kept in mind if a patient with OCD presents with an episodic course, as opined by Perugi *et al*.[15] His study on 135 patients with episodic OCD showed, in 27% of them, a significantly higher rate of family history of mood disorder and lifetime comorbidity with BP II disorder. Kruger *et al*. found comorbid OCD to be more common in BP II in comparison with BP I.[13] But, Koyuncu *et al*. found no statistically significant difference between the frequency of comorbid OCD in BP I and BP II.[12]

Treatment guidelines may differ as compared with that of pure cases.[1] BPD also responds poorly to mood stabilizing antipsychotics like olanzapine in the presence of OCD.[16] BPD receives preference with regards to treatment.[17] Go *et al*. reported that 30% of patients on selective serotonin reuptake inhibitor (SSRIs) may develop manic or hypomanic symptoms.[18] In the above study, six of 20 patients on SSRIs at doses as low as 10 mg of fluoxetine developed manic or hypomanic symptoms. The authors were unable to explain as to whether mania/hypomania appears in OCD children without comorbid mood disorder. They were also uncertain whether patients on high-dose SSRIs with OCD are more likely to have a switch than those with a mood disorder.

CONCLUSION

This is a complex comorbidity to treat as OCD requires high doses of SSRIs which precipitates mania. A sound

knowledge of etiology and the pathology operating gives an insight into the comorbidity.[2] Hence, the neuropathology is yet to be explored. It is yet to be determined as to which is prudent: treating with only one drug or resorting to complex combination therapy. Though there have been studies on OCD in psychosis, there is a need to thoroughly evaluate for mania/hypomania in OCD. This comorbid disorder requires a systematic exploration as there is not much epidemiological data on its incidence in India.

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