Kocatepe Tıp Dergisi
Kocatepe Medical Journal
18:157-161/Ekim/2017

OLGU YAZISI / CASE REPORT

SANRI BENZERİ SAPLANTILAR İLE SOMATİK SEMPTOMLARIN EŞLİK ETTİĞİ OBSESİF KOMPULSİF SEMPTOMLARIN AYIRICI TANISI, BİR OLGU SUNUMU

CASE REPORT: DIFFERENTIAL DIAGNOSIS OF OBSESSIVE-COMPULSIVE SYMPTOMS CONFOUNDED BY DELUSION-LIKE FIXATIONS AND SOMATIC SYMPTOMS IN AN ADOLESCENT

Serhat NASIROĞLU[1], Veysi ÇERİ[2]

[1]Sakarya Üniversitesi Tıp Fakültesi, Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları AD,
[2]Marmara Üniversitesi Pendik Eğitim ve Araştırma Hastanesi Çocuk Ergen Psikiyatri Kliniği

ÖZ

Obsesif Kompulsif Semptomlar, özellikle de zorlayıcı nedensiz obsesyonlarını açıklamada güçlük çeken çocuk ve ergenlerde olmak üzere sanrılar ile karışabilmektedir. Obsesyonlar, aşırı zihinsel uğraşlar ve sanrılar ile karışabilmektedir. Psikosomatik semptomlar çocuklar tarafından sıklıkla belirtilen bir durumdur ve sürekli baş ağrıları anksiyete bozukluğu olan kişilerde nadir değildir. Sürekli baş ağrıları terapotik yaklaşımı olumsuz olarak etkileyebilmektedir ve aynı zamanda doğru tedaviye de ulaşmayı güçleştirmektedir. Bu olguda obsesif kompulsif semptoloji ile başvuran bir kız ergendeki tanısal güçlükleri ile bu semptomların psikoeğitim ve farmakoterapi ile başarılı bir şekilde tedavisi tartışılmaktadır. Aynı zamanda obsesif kompulsif bozukluğun (OCD) doğru tanısı ile ergenler ile ailelerine psikoeğitim verilmesinin bu gençlerin öz güvenlerine kavuşmaları ve aileleri ile tekrar yapılandırılmış bir ilişki kurmaları için önemi tartışılacaktır. Bu yaş bireylerde OKB'nin farmakolojik tedavisinde seçilecek ajan Selektif Serotonin Geri Alım İnhibitöreleridir (SSRI). Son olarak bu olgunun anksiyete ile ilişkili bir durum olarak doğru şekilde tanımlanması ve psikolojik yaklaşımı ile farmakolojik yönetimi oldukça önemlidir.

ANAHTAR KELİMELER: Genç, Obsesif Kompulsif Bozukluğu, Selektif Serotonin Geri Alım İnhibitörü, Takıntı, Kuruntu, Tedavi

ABSTRACT

Obsessive-compulsive symptoms can at times be confounded by delusional symptoms, which can be especially challenging to interpret correctly in children and adolescents, who may struggle to articulate the intrusive or unreasonable nature of their obsessions. Obsessions, overvalued ideas and delusions can have an overlap. Persistent headaches are not uncommon amongst patients presenting with anxiety disorders and psychosomatic symptoms are frequently reported by children. Psychosomatic complaints, such as enduring headaches, can also have an undesirable impact on therapeutic approach and delay access to the correct treatment. In this case we discuss diagnostic pitfalls in an adolescent girl presenting with obsessive-compulsive symptomatology and a successful treatment of enduring symptoms with psycho-education and medication. We will argue that psycho-education for young people and their families based on a correct diagnosis of obsessive compulsive disorder (OCD) is essential to provide reassurance, to help young people regain self-confidence and re-establish constructive relationships within the family unit. Selective serotonin re-uptake inhibitors (SSRI) are the drug of choice for pharmacological treatment of OCD in this age group. We conclude that a correct diagnosis of the condition as "anxiety-driven" was of paramount importance for psychological approach and pharmacological management of this case.

KEYWORDS: Adolescent, Obsessive Compulsive Di-sorder, Selective Serotonin Re-uptake Inhibitor, Ob-session, Delusion, Treatment

Geliş Tarihi / Received: 24.06.2015
Kabul Tarihi / Accepted: 18.12.2015

Yazışma Adresi / Correspondence: Serhat NASIROĞLU
Sakarya Üniversitesi Tıp Fakültesi, Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları AD,
serhatnasiroglu@gmail.com

INTRODUCTION

Obsessive compulsive disorder (OCD) is characterized by intrusive thoughts or images (obsessions) and repetitive behaviors or rituals (compulsions) performed to relieve anxiety (1). OCD often emerges in childhood or adolescence, with approximately a third to a half of adult patients reporting a childhood onset (2). It is a chronic and debilitating condition that can impair social relationships, ability to complete tasks such as schoolwork and personal hygiene, and impact interpersonal/familial relationships (3). Although initially thought to be a rare condition, more recent prevalence rates have been reported to range from 1% to 4% amongst children and adolescents (4, 5). The best documented evidence is in favor of cognitive behavioral therapy (CBT) and pharmacological treatment with selective serotonin re-uptake inhibitors (SSRI) (6). Randomized controlled studies have demonstrated the combination of CBT and SSRIs(7) to be superior to treatment with either of them alone and combined treatment approach can produce better results in more severe cases (8).

OCD and psychosis can present as comorbid conditions however there are publications that have emphasized the difficulty in distinguishing between obsessive-compulsive and delusional symptoms and found that some cases of OCD are confounded by delusional disorders (9). Cognitive dysfunctions in patients with OCD and psychosis have been reported to have the same relationship with overvalued ideas and that thought changes involving obsessions, overvalued ideas and delusions can have an overlap (10).

In this article we report a dramatic response to treatment in an adolescent girl, whose symptoms of OCD had been masked with recurrent headaches and whose obsessional preoccupations had reached proportion of an overvalued idea (if not a delusion) at times.

CASE REPORT

A 16-year-old girl was brought by her mother to the outpatient clinic of our child and adolescent psychiatry department with a complaint of recurrent headaches that had persisted over the past two years despite extensive use of analgesic medications. It was noticed (during consultation) that her thumb was covered with a plaster, which, her mother reported to have been consistently used in the past five years. The young girl was initially reluctant to provide information about the reason for wrapping up her thumb; however the mother said that her daughter had used plasters to ease the pain. The mother also reported that her daughter insisted on wearing tight jeans or stockings, which she changed several times during the day as she complained of them becoming loose. Physical examination was normal but inspection of her thumb revealed significant atrophy. She said she had thought that there was "something wrong" with her thumb however was unable to explain what it could be. A detailed clinical interview revealed that she had started to use plasters to cover a spot on her thumb, which she thought would prevent the infection from contaminating her body and spreading to others. She reported intrusive mental images of her whole body being covered with spots and wounds and that using adhesive bandages had alleviated her distress. She then started using wound dressings on top of the adhesive plasters to ensure that there would not be any leakage from the wound. Although her parents had forcefully removed the bandages at times they eventually gave up due to high levels of distress and aggressive outbursts. She was reported to be a perfectionist and a "control freak" in terms of constantly monitoring the skins of others in the family. Her mother noted that her daughter had always been suspicious of others and always questioning the motives behind seemingly normal daily interactions with others. Although the impact of her symptoms on the family life was reported to be "unbearable", she seemed to have functioned at school relatively well. Otherwise her developmental history was normal and there was no evidence of formal thought disorder, perceptual abnormalities or any other mood or anxiety disorder.

A provisional diagnosis of obsessive compulsive disorder was made and psycho-education was provided. An empathetic approach and reas-

surance that she was not "mad or crazy", which she had been labelled with by her family, helped to establish a therapeutic alliance. She was commenced on sertraline 50 mg/day. In the follow-up appointment in four weeks she reported that her headaches had completely gone and that she felt calmer and less distressed, in general. She was reluctant remove the bandages on her thumb but clearly more amenable to question the validity of her thoughts and beliefs about the need for it. A deadline to remove the bandage in four weeks' time was mutually set. Sertraline was increased to 100 mg and aripiprazole 2.5 mg was added due to persisting complaints of fluctuations in the mood, restlessness and agitation. In the next follow-up she reported to have removed the bandage a week before the deadline and her mother conveyed a relief in the family due to her daughter's controlling behavior having become more manageable.

DISCUSSION

Normal/developmental rituals need to be considered in the differential diagnosis of OCD. However such rituals are relatively easy to distinguish as developmental rituals are not a cause of distress and that they do not interfere with functioning (11). Pediatric autoimmune neuropsychiatric diseases upon streptococal infections usually named as Pandas were defined as a new syndrome in 1998 by Swedo and her friends and consistent attention on these diseases were continuing by the time of year. Seen in children; Pandas following the group A haemolytic streptococci infections are evaluated in the obsessive compulsive diseases upon the immunological reactions caused by those haemolytic streptococci infections (12). In order to make diagnosis of obsessive-compulsive disorder (OCD) it is assumed that the patient at some point recognizes the obsessions or compulsions as unreasonable. However, insight into the validity of their "obsessional" beliefs vary amongst the adolescents and this clinical reality is also acknowledged in the DSM-IV. Occasionally, patients with OCD present with psychopathology that could be considered as "psychotic". To illustrate this, O'Dwyer and Marks (2000) presented five relevant case vignettes and suggested that such cases were best regarded as severe "atypical" OCD with delusions (13). They reported that as the rituals in such cases are all cued by intrusive thoughts, the patient feels compelled to carry them out to relieve associated distress, and they are all carried out "ritualistically". The patient being severely disabled by the illness but being otherwise intact in addition to the absence of other forms of thought disorder were noted to be the key factor to group the illness as anxiety driven. None of the patients in their case series had made significant improvement with antipsychotic drugs, although several had improved on SSRIs or noradrenergic medications.

In the case of the young girl we presented here, we provided family education based on our formulation of OCD. We aimed to modify the parental attitude to the young person whose seemingly "odd" behavior, rigidity in her beliefs and attitudes had alienated her from her family. For pharmacological management, we chose to start with an SSRI instead of an antipsychotic medication. Her obsessional "fixation" about the need for using plasters had already lessened prior to commencing aripiprazole and she was more amenable to question the validity of her beliefs and change her ritualistic behavior in the review in four weeks. Explaining discontinuation of her compulsive behavior only by adding aripiprazole at such a low dose in such a short period would not be convincing in our view. The same argument can surely be debated for the pharmacological benefit of sertraline too. In resisted OCD cases antipsychotic aripiprazole was used in a lot of clinical trials as an elevator agent. The agonistic effect on 5-HT1A receptors of aripiprazole was found to be relevant to its anti OCD properties. The studies also showed that aripiprazole was also efficant in monotherapy also in tic disorders and schizophrenia; aripiprazole found to be effective in treating the symptoms of obsessive compulsive situations(14). Whether her obsessional fixation reached strength of an "overvalued idea", similar to that of an anorexic fixation on the body weight and shape or body dysmorphic disor-der, could also be contended (15). In terms of the recurrent headaches that the young person had presented with, it was not possible to as-

certain whether they were migraine headaches. Non-migraine headaches are not uncommon amongst patients presenting with anxiety disorders and psychosomatic symptoms are frequently reported by children, who struggle to articulate their chief complaints.

Citing the study by Hudson et al. Who suggested that "migraine headache syndrome" and OCD were "affective spectrum disorders", which might share heritable pathophysiological features, Dinn et al, noted that their findings supported the contention that headache phenomena were associated with obsessive-compulsive (OC) and depressive symptoms (16-17). They suggested that clinicians might consider screening patients with migraine for OC symptoms. In our view, dramatic disappearance of headaches in the young person we reported here needs further and more convincing explanation. To our knowledge, there is no evidence for the benefits of SSRIs in patients with migraine (although tricyclic antidepressants and serotonin agonists are used) however discontinuation of headaches in parallel to alleviation of OCD symptoms with an SSRI agent is certainly worthwhile to be further evaluated.

Hypochondriasis known as the disease of being sick is a characterized by the consistent mis-thoughts of the people upon the wrong evaluation of people's self conditions thinking that they will be suffering serious diseases although given guarantee and sufficient professional awareness and help to those people. It is seen from the very beggining of life. The symptoms can be seen in any age but more often these are seen around 20-30ies of age. (18)

People with hypochondriasis usually refer themselves having a vital organ disease such as heart or brain failures. The linkageand similar sides of hypochondiasis with depressions are well known for many years. Masochistic tendencies are related to guilt and pessimism. Agression through inside can be related to those guilt and pessimism. In our case the diagnosis was far from this point because there was no frequent request to see a doctor nor thoughts of having serious disease was mentioned (19).

Overall management of this case can be argued against due to several reasons. We did not use any symptom checklist to get a wider view of the problem areas and diagnosis was made by clinical interview based on DSM-IV criteria. No objective measures were used to evaluate response to treatment, which was based on clinical observation and the information provided by the patient and her family. Diagnosis and overall treatment approach was discussed in professional consultations amongst the authors of this paper.

CONCLUSIONS

This case report demonstrates that obsessive-compulsive symptoms can have an atypical presentation and be masked with somatic complaints, which can delay access to the treatment. Diagnosis of presentation as "anxiety driven" rather than "psychotic" is important for determining therapeutic approach, and the choice of pharmacological agents, hence can have a major impact on the outcome.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth ed. rev. Washington DC, American Psychiatric Association, 2000.

2. Rasmussen SA, Eisen JL. Epidemiology of obsessive compulsive disorder. Journal of Clinical Psychiatry. 1990;53:10–14.

3. Piacentini J, Bergman RL, Keller M, McCracken J. Functional impairment in children and adolescents with obsessive-compulsive disorder. Journal of Child and Adolescent Psychopharmacology. 2003;13:61–69.

4. Ruscio AM, Stein DJ, Chiu WT, Kessler RC. The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. Molecular Psychiatry. 2010;15:53–63.

5. Zohar AH. The epidemiology of obsessive-compulsive disorder in children and adolescents. Child AdolescPsychiatrClin N Am. 1999;8:445-460.

6. Thomsen PH. Obsessivecompulsive disorder: Pharmacological treatment. Eur Child Adolsc Psychiatry 2000;9 Suppl 1:/I/7684.

7. The Pediatric OCD Treatment Team. Cognitivebehaviour therapy, sertraline, and their combination for children and adolescents with obsessivecompulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. JAMA. 2004;292:1969-76.

8. March JS, Frances A, Carpenter D, Kahn DA. The expert consensus guidelines series: Treatment of obsessivecompulsive disorder. J Clin Psychiatry. 1997;58:172.

9. Aardema F, O'Connor KP, Emmelkamp PM, Marchand A, Todorov C. Behavinferencial confusion in obsessive-compulsive disorder: the inferencial confusion questionnaire. Res Ther. 2005;43(3):293-308.

10. Kitis A, Akdede BB, Alptekin K, Akvardar Y, Arkar H, Erol A, et al. Cognitive dysfunctions in patients with obsessive-compulsive disorder compared to the patients with schizophrenia patients: relation to overvalued ideas. ProgNeuropsychopharmacolBiol Psychiatry. 2007;31(1):254-61.

11. Rapaport JL, Inoff G. Practitioner review: Treatment of obsessive-compulsive disorder in children and adolescents. J. Child PsycholPsychiat. 2000;41:419-431.

12. Singer, H. S. (2015). PANDAS: The need to use definitive diagnostic criteria.Tremor and Other Hyperkinetic Movements 2015;5:327.

13. O'Dwyer AM, Marks I. Obsessive-compulsive disorder and delusions revisited. Br J Psychiatry. 2000;176:281-4.

14. Ercan E. S, Ardic UA, Ercan E, Yuce D, Durak S. A Promising Preliminary Study of Aripiprazole for Treatment-Resistant Childhood Obsessive-Compulsive Disorder. Journal of child and adolescent psychopharmacology. 2015;25(7):580-584.

15. McKenna PJ. Disorders with overvalued ideas. British Journal of Psychiatry. 1984;145:579 -585.

16. Hudson JI, Mangweth B, Pope HG Jr, Hausmann A, De Col C, Laird NM, Beibl W, Tsuang MT. Family study of affective spectrum disorder. Arch Gen Psychiatry 2003;60:170-177

17. Dinn WM, Aycicegi-Dinn A, Robbins NC, Harris CL. Migraine Headache and Obsessive-Compulsive Symptoms in a Student Sample. Bulletin of Clinical Psychopharmacology. 2005; 15:174-181

18. Scarella TM, Laferton JA, Ahern DK, Fallon BA, Barsky A. The Relationship of Hypochondriasis to Anxiety, Depressive, and Somatoform Disorders. Psychosomatics. 2016;57(2):200-207.

19. Hocaoğlu Ç. Farklı Bir Hipokondriyazis: Bir Vaka Sunumu. Journal of Mood Disorders. 2015;5(1):36-9.