CASE

Clinical profile of "schizo-obsessive" disorder: a case report

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Abstract

Objective: This is a case report discussing the comorbidity of obsessive-compulsive disorder (OCD) and schizophrenia. Greater prevalence rate of obsessive compulsive symptoms in schizophrenia are found and poor outcome reported. Such clinical phenomenon merits recognition as a distinct subgroup of schizophrenia with unique challenges and treatment needs.

Method: A case report presenting schizophrenia with preceding OCD over two years.

Results: This report describes the clinical course and treatment challenges of a patient with obsessive compulsive schizophrenia (OCS).

Conclusion: This case illustrates that OCS is a complex disorder with atypical clinical characteristics. In managing this patient, several clinical dilemmas including diagnostic ambiguity, problems with pharmacotherapy and stigma towards modified electroconvulsive therapy were highlighted.

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Introduction

Obsessive compulsive (OC) symptoms in schizophrenia have been described in various forms as a part of the schizophrenic phenomena and the clinical phenomenon of OC symptoms coexistent with schizophrenia has intrigued clinicians for over a century.[1,2]

Increasingly, evidence showed that obsessive compulsive schizophrenia (OCS) is clinically distinctive as it has a grave clinical course, poor treatment response, worse functional impairment,[3] worse overall psychopathology, prominent negative symptoms and possibly greater prefrontal pathology.[4]

At present, it remains controversial whether it is part of a spectrum of schizophrenia or there is overlap in psychopathology between the disorders. The pathogenesis of OCS remains vague. It possibly arises from substantial overlap of the proposed functional circuits involving complex interactions between the systems of the neurotransmitters (particularly serotonin and dopamine) and their dysfunctions.[5]

There is growing evidence that patients with comorbid obsessive-compulsive disorder (OCD) and schizophrenia (recently termed "schizo-obsessive")[6,7] may represent a special category of the schizophrenia population.[8] Considering the above points the following case was considered for illustration so as to show the occurrence of OCD in schizophrenia and its response to treatment.

Case report

Mr K a 19 years old male patient studying in XIIth class has been increasingly complaining of lack of interest and poor concentration in studies for two years due to which he had frequent absenteeism. He had repetitive, intrusive, distressing and unwanted thought that his face was continuously changing shape. As a compulsion he used to ask his family members to check if his face was normal although he knew were no such abnormalities. Patient attempted to ignore such thoughts by pushing his chin upwards or to the contra-lateral side apparently trying to reshape it. He also used to put himself in manneristic posture for extended period of time like putting his head down on the floor and feet up. Two years later along with the OC symptoms patient developed bizarre delusions. Patient had the fixed, firm and false belief that the face of other people with whom he was talking was appearing over his face. He became hopeless, helpless and felt that life is not worth living anymore. Sleep was also disturbed and appetite was markedly decreased. Self-care was poor. Patient became distressed and fearful due to the above thought and he started contemplating about suicide. Patient was repeatedly asking his parents to help him commit suicide and on two occasions he also attempted suicide.

Mental status examination revealed a poorly established rapport; coherent speech; depressed mood; anxious, stable and restricted affect; obsessional thought and compulsion to check his face in mirror or get it checked by some family members; bizarre delusion; suicidal ideas; partial impairment of abstract thinking and judgement. Insight was grade II.

Patient met the text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) criteria for undifferentiated schizophrenia and OCD and was thus diagnosed as a case of schizo-obssesion.

Patient was started on trifluperazine at a dose of 20 mg/day and the dose was gradually titrated up to 30 mg/day within seven days. Patient didn't show any response and subsequently fluoxetine was added and titrated to an eventual regime of 80mg/day. As patient didn't show any response and he kept on seriously contemplating about sui-

cide, he was advised for modified electroconvulsive therapy (MECT) but the parents denied MECT. Parents declared that they will not in any case opt for MECT due to the traditional stigma associated with it.

Finally clozapine was introduced with the condition deemed as treatment resistant. The response of the patient on fluoxetine and clozapine will be followed and if there is still no response then fluoxetine will be switched to clomipramine.

Discussion

The comorbidity of schizophrenia and OCD or OCS is not as rare as previously believed.[4] The Epidemiologic Catchment Area (ECA) study found that the rate of OCD with schizophrenia was 12.2%[9] while others reported prevalence rates between 7.8% and 25%.[10] Clinically, patients with OCS have characteristics distinctive from patients with non-OCD schizophrenia. These are described as greater negative symptoms, worse overall psychopathology and significantly more impaired executive functioning.[4,11] Interestingly, like this patient, half of the patients had OCD before psychosis[12] although at least two other clinical variations identified,[5] reflecting its heterogeneity and further complicating the diagnosis. Overall, the findings consistently showed a graver clinical picture within the schizophrenia spectrum.[3,4] Regarding treatment, patients with OCS were reported to have poorer response than do neurotic obsessive-compulsive patients[3] and non-OCD schizophrenia.[12]

The data on pharmacotherapy are limited; mostly based on case reports and uncontrolled clinical trials. Generally, conventional antipsychotics are not recommended as they have poor serotonergic effect.[12] This case illustrate the onset of both schizophrenia and OCD almost simultaneously and at a comparatively young age who didn't respond well to the combination of conventional antipsychotic (trifluperazine) and the selective serotonin reuptake inhibitor (SSRI), fluoxetine.

In this case we noted that oral trifluperazine did not protect the patient against the psychosis despite his good compliance. One important issue of pharmacotherapy in patients with OCS is the contradicting reports in the usefulness of atypical antipsychotics. Atypical antipsychotics have been implicated to induce or exacerbate preexisting OC symptoms in patients with schizophrenia.[12] In contrast, there is early evidence to indicate favourable responses with clozapine either alone or in combination. For combination therapy, either with SSRIs or clomipramine, Poyurovsky[12] suggested that OC symptoms in schizophrenia should be targeted secondary to psychosis and only when their severity is clinically significant.

Overall, we recognised that OCS had poor clinical course, lower functioning and longer hospitalisation. The progress of this patient in the near future is monitored with apprehension as we continue our efforts to understand a baffling illness.

Further reading

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