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OBSESSIVE COMPULSIVE DISORDER:CO-MORBIDITY IN MANIC PHASE OF BIPOLAR AFFECTIVE DISORDER

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ABSTRACT

Comorbidity is known to occur among various psychiatric disorders. About the third of the patients with Obsessive Compulsive Disorder have major depressive disorder and anxiety disorder but coexistence of Obsessive Compulsive Disorder with mania is rare to see. Here we report a case of Obsessive Compulsive Disorder where manic phase was accompanied by obsessions of contamination and pathological doubts along with cleaning rituals and spitting rituals.

Key words: Obsessive Compulsive Disorder, co-morbidity, bipolar affective disorder, mania

The co-occurrence of bipolar affective disorder with other medical and psychiatric disorders has been little studied. Several psychiatric disorder appear to occur with rates higher than expected including OCD (Obsessive Compulsive Disorder), bulimia nervosa, panic disorder , impulse control disorder and substance abuse (Strakowski et al.,1994). A psychiatric research study done at Material Sciences Institute, University of Texas, showed life time rates of comorbidity of obsessive compulsive disorder to be 21% and 12.2% among bipolar and unipolar patients respectively (Chen & Dilsaver,1995).Also described is social phobia followed by hypomania, as well as bipolar disorder manifesting as episodic OCD. In another work, studying the course of OCD co-occuring with bipolar disorder demonstrated an interval course that frequently mirrored the course of the bipolar disorder. Thus obsessive compulsive syndrome may represent an alternative expression of the bipolar disorder in same patients (Strakowski et al.,1998).

It is however unusual to see a case of bipolar affective disorder in which patient had OCD in manic phase which disappears in depressive phase. We are reporting a case which highlights this pattern of disorder.

Mr.JPS is a 25 year old unmarried male. He is farmer by occupation and a resident of Barabanki (UP).

CASE REPORT

Mr. JPS was brought to the psychiatric hospital by his relatives after he was found to have rigidity in all his four limbs, generalised fine tremors, drooling of saliva and difficulty in speaking. Six months prior to admission he had begun to talk a lot, although not about anything in particular. The talktiveness was combind with inappropriate behaviour, that was very embarrassing to the rest of his family. He would sing songs and dance and tell obscene jokes. Not only was such behaviour completely out of character for him, but he also did these things with complete disregard to the circumstances He began walking excessively. He seemed unable to remain still for a second. His condition developed

insidiously. Along with these symptoms he started washing his hands excessively and would avoid walking behind the girls. He would say that he gets contaminated with dirt and pathogenes and required repeated washing. He would also admit that is wrong to do so but could not help it. Regarding avoiding walking behind the girls he would say that when he see them from behind, he would say that he had irresistible thought he would have anal sex with them and also people would abuse him when he walks behind the girls. He would spit again and again to avoid such thoughts. With these complaints he was shown to a psychiatrist who prescribed him antipsychotics after which he developed parkinsonian features

History: Mr.JPS had a normal birth and infancy. He had no problems in childhood and early adolescence and he did well at primary school and at middle school. He was a gentle and quite boy and was rather introverted. He liked to work in fields and to watch movies. He did not have a very active social life. At the time of patient's referral, there was no history of neuropsychiatric illness in the family.

Seven years previouosly JPS had has short lived episode of 3 weeks of elation, increased activity, talkativeness and decreased sleep. Then another similar episode with symptoms of successive and repetitive cleaning and washing in addition to manic features. The patient then switched into the episode of sadness, decreased talkativeness, lethargy and pessimistic talks. In this episode features of excessive and repetitive cleaning and washing were not present. Then there was similar episode of depression one year after this.

Findings:

Physical Examination: Fine tremors were present in fingers on extension, tongue tremors were also present. Cog wheel rigidity was present in all four limbs. Shoulder dropping was slow and glabeller tap reflex was present Speech was slurred.

Mental State Examination. Mr.JPS was of an average built, tidily and smartly dressed. He was talking incessantly in a slurred voice. There was pressure of speech and lost track of his thoughts several times by noises or minor details in surroundings.

His mood fluctuated between irritability and elation. His thought content had grandiosity and obsession of contamination and pathological doubts. No perceptual abnormality was observed. He did not show any impairment in memory judgement was impaired.

Investigations: All lab investigations were within normal limits.

Course: The patient was treated with injection promethazine I.V and trihexyphenydyl 2 mg TDS and lorazepam 2 mg TDS initially for one week. At the end of this period, his extrapyramidal symptoms disappeared. His grandiosity became more apparent and flow of speech increased. Then he was put on lithium 300mg TDS and dose of lorazepam was increased to 10mg, day. His psychomotor activity, grandiosity and pressure of speech decreased after 10 days. Simultaneously his behaviour therapy was started. The patient finally recovered completely after four weeks of treatment and was discharged from the hospital.

DISCUSSION

It is well known that obsessive compusive symptoms occur commonly during episodes of depression both unipolar as well as bipolar. Several studies (Krager et al.,1995,2000; Strakowsk et al.,1998) have found variable rates of comorbidity between bipolar disorder and OCD from 8% to 35%. ECA study suggested 18 times higher risk for devolping OCD in bipolar euthymic patients in comparison to general population (Boyd et al.,1984). Appearance of obsessive compulsive disorder in manic phase in our patient is contrary to the findings of Gorden & Rasmussen(1986) & Keck et al.(1986) who have found inverse relation between mania and obsessive compulsive disorder. Recent study by Kruger et al.(2000) has found comorbid OCD to be more common in Bipolar II disorder in comparison to bipolar I however our case is a typical example of bipolar I disorder.

This case report brings in light the possible hidden association between bipolar disorder and

obsessive compulsive disorder. One should also remain cautious about the use of SSRI in treating OCD in bipolar patient because of risk switch.However in our patient the patient's obsessive compulsive symptomatology disappeared after the resolution of manic phase with lithium. So one may not need antiobsessional agents in treating OCD with comorbid Bipolar disorder.

This case report alert the clinician to see for obsessive compulsive symptoms in patients of Bipolar disorder.Future studies are needed to look for possible cause of association between two conditions and their implications.

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