CASE REPORT

OBSESSIVE COMPULSIVE SCHIZOPHRENIA (OCS) REVISITED: A FIVE-YEAR CASE REPORT

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ABSTRACT

Objective: **This is a case report discussing the comorbidity of obsessive compulsive disorder (OCD) and schizophrenia. 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 obsessive-compulsive disorder over five 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 difficulties in his rehabilitation were highlighted.**

Keywords: obsessive compulsive disorder (OCD), schizophrenia spectrum

Introduction

Dual diagnosis of OCD and schizophrenia is of great interest to clinicians as it poses multiple clinical challenges. Increasingly, evidence showed that obsessive compulsive schizophrenia is clinically distinctive as it has a grave clinical course, poor treatment response, worse functional impairment [1], worse overall psychopathology, prominent negative symptoms and possibly greater prefrontal pathology [2].

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 obsessive compulsive schizophrenia 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 [3]. The presence of tics in particular, indicates the involvement of dopamine system [4].

Diagnosing this subgroup of patients is difficult. Recent findings suggest that obsessive-compulsive symptoms may warrant a new diagnostic entity within the OCD-Schizoprenia spectrum [2,5].

Case report

A 29 year-old Chinese single man had his first contact with us in 2002 at the age of 23. Although he had obsessive-compulsive symptoms since adolescence, he was

irregular with treatment sought from several private psychiatric clinics. He presented with anger outbursts and low mood caused by distressing obsessive thoughts (about contamination and orderliness) together with compulsive rituals (e.g. bathing and other tasks). His medical history revealed presence of simple motor tics. There was no family history of psychiatric disorder. Physically, he was aesthenic built and had occasional head and neck motor tics. The rest of systemic examinations were unremarkable.

A diagnosis of Obsessive Compulsive Disorder with depression was made. At this point, diagnoses of schizophrenia and Gilles de le Tourrette were also considered. We adopted a holistic approach including neuromedical assessment, pharmacotherapy and behavioural therapy (graded exposure response prevention). Medications were titrated to an eventual regime of fluoxetine 80 mg daily, haloperidol 2.5mg twice daily (started primarily to control his tics) and clonazepam 1mg thrice daily. Significant positive response on obsessive-compulsive symptoms was seen after about 6 weeks in the ward. However, as the patient progressed, he had spells of relapses observed during a few trials of home leave. During these short periods of home stay, his family complained that he continued to have anger outbursts in response to his obsessive thoughts although his compulsion has significantly reduced. Subsequently, a few family sessions were conducted with the emphasis on psychoeducation and behavioural techniques to be employed at home. He was finally discharged in early 2003 and maintained well until mid 2005. During this period, he was compliant with treatment and came for the follow-up regularly while attending a day care centre daily for occupational therapy.

Then, in early 2006, he developed psychosis in the form of third person auditory hallucination (derogatory in nature), persecutory delusions and delusions of reference. His obsessive-compulsive symptoms were relatively well controlled. His diagnosis was reviewed and changed to schizophrenia. He developed oculogyric crisis when haloperidol dose was increased. Quetiapine was then introduced, to which he responded well. However, as its dose was titrated higher, it unmasked his obsessive-compulsive symptoms and the illness took a worsening turn. A few trials of atypical antipsychotics (including risperidone and olanzapine) followed but failed to achieve symptoms remission. While the psychosis improved, the patient continued to experience distressing obsessive-compulsive symptoms. Fluoxetine then was switched to clomipramine. Clozapine was finally introduced with the condition deemed as treatment resistant. The response of the patient to clozapine and clomipramine combination therapy was positive.

However, as the symptoms remitted, again we faced difficulty discharging him. We identified high expressed emotion in the family; comprising his parents and two other siblings. This had also contributed to unsuccessful trials of home leave during his prolonged hospitalizations. While his family members were supportive, there were great expectations for him to be fully well. These led to critical interactions and stressful hostile environment at home. Recognizing there is a need to reduce the patient's contact hours with his family as well as considering his psychosocial needs and his family's roles, he was finally discharged to a nursing home that also offers occupational training.

A year has passed since his last admission. He has since become quite well, although occasionally still affiliated with some

residual obsessive-compulsive symptoms. We acknowledged that the treatment pathway has been a roller coaster ride for the patient, his family and clinicians. His progress in the near future is monitored with apprehension as we continue our efforts to understand a baffling illness.

Discussion

The comorbidity of schizophrenia and OCD or Obsessive-compulsive Schizophrenia (OCS) is not as rare as previously believed [2]. The Epidemiologic Catchment Area (ECA) study found that the rate of OCD with schizophrenia was 12.2% [6] while others reported prevalence rates between 7.8% and 25% [5].

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 [2,7]. Lysaker et al. (2000) [7] also found greater positive symptoms and emotional discomfort in these patients. Interestingly, like this patient, half of the patients had OCD before psychosis [8] although at least 2 other clinical variations identified [3], reflecting its heterogeneity and further complicating the diagnosis. Overall, the findings consistently showed a graver clinical picture within the schizophrenia spectrum [1,2]. Regarding treatment, patients with OCS were reported to have poorer response than do neurotic obsessive-compulsive patients [1] and non-OCD schizophrenia [8].

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 [8]. Interestingly, we noted in our case that oral haloperidol did not protect him against the development of 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 obsessive-compulsive symptoms in patients with schizophrenia, as occured in this case [8]. 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 [8] suggested that obsessive-compulsive symptoms in schizophrenia should be targeted secondary to psychosis and only when their severity is clinically significant. Psychosocially, our difficulties in his rehabilitation also highlighted the need for resources that meet these needs.

Overall, we recognized that OCS had poor clinical course, lower functioning and longer hospitalization as demonstrated here. Furthermore, it required an intricate balance of psychopharmacotherapy and psychosocial rehabilitation.

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