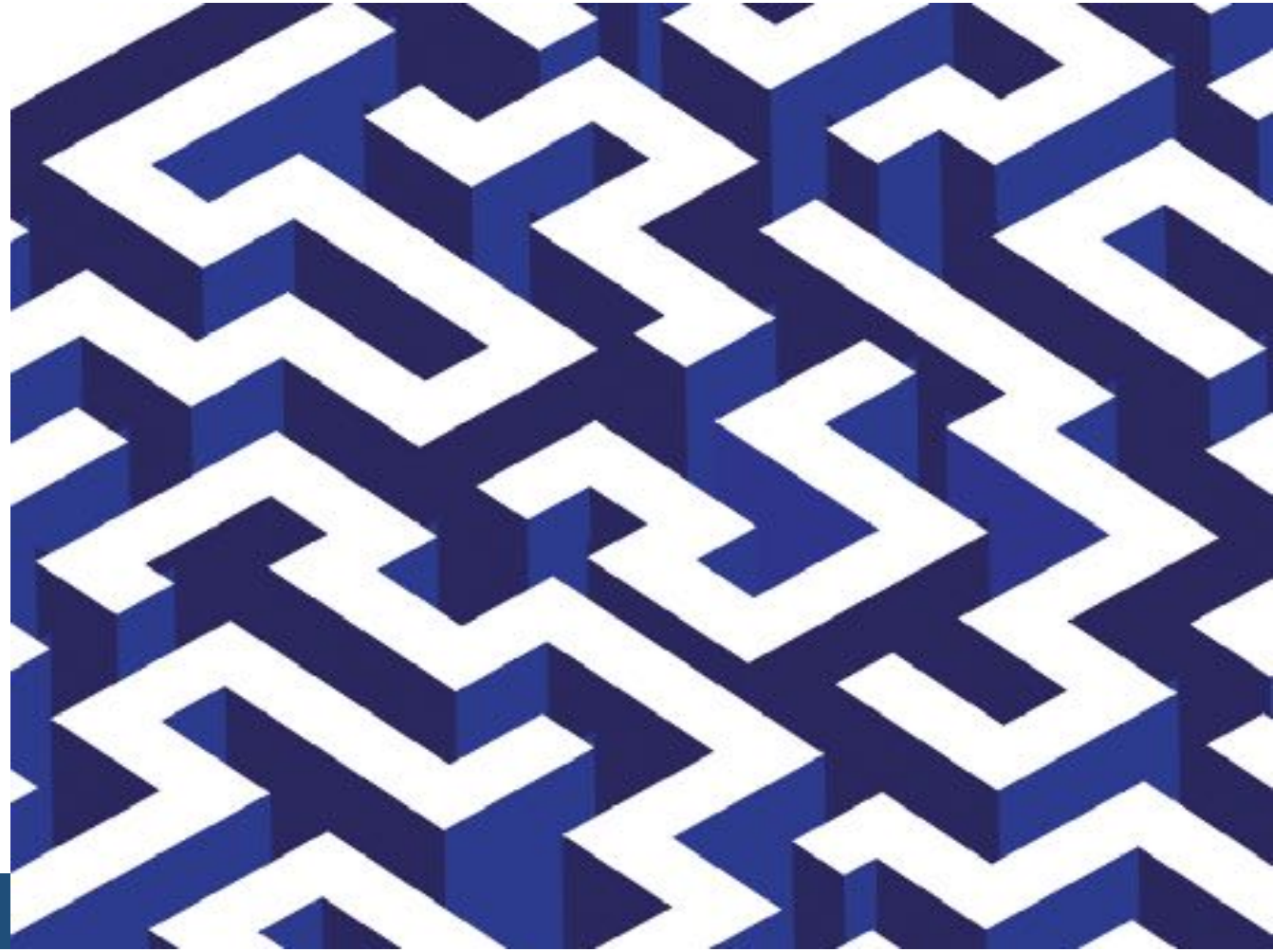
DISTURBO OSSESSIVO COMPULSIVO



Dall'infanzia all'età adulta.

Dott.ssa Cecilia Mainardi
Medico Specializzando
U.O. Psichiatria Universitaria

5 MAGGIO 2017

CASO CLINICO

- **Nome**: S.M.
- **Età**: 22
- **Occupazione**: Studente Universitario (Ingegneria)

- Inviato dal mmg per valutazione

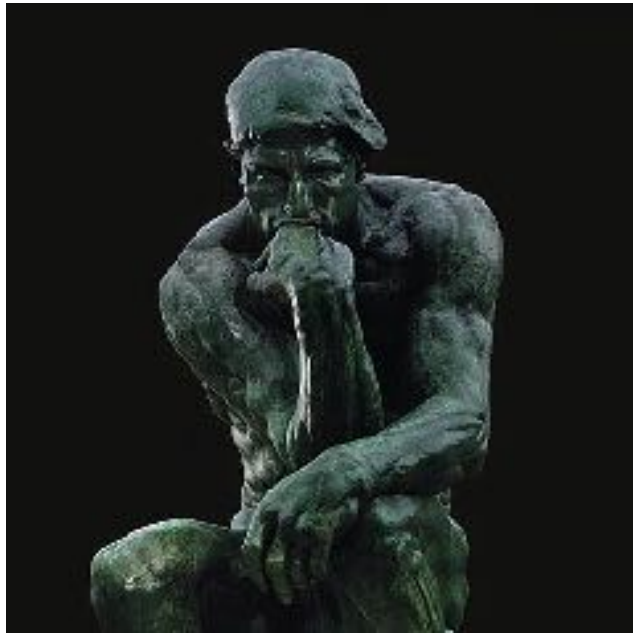
CASO CLINICO

Prima osservazione in ambito specialistico psichiatrico

- Tratti anancastici di personalità, tendente all'ipercontrollo.
- Da qualche mese, in relazione ad EVS in ambito relazionale: netta elevazione della quota ansiosa libera, comparsa rimuginazioni in chiave OC su temi esistenziali e religiosi, tematiche di dubbio sempre più interferenti, ideazione di contrasto.
- Scadimento del funzionamento sociale ed universitario.

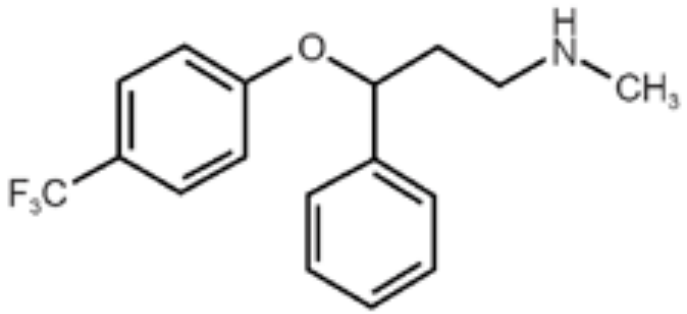
CASO CLINICO

- ✓ **Ruminazioni sulla propria identità sessuale, su temi esistenziali e religiosi**
- ✓ **Dubbio e indecisione, con difficoltà nell' azione**
- ✓ **Ideazione di contrasto, a contenuto sessuale**
- ✓ **Egodistonia**
- ✓ **Interferenza con il normale funzionamento**



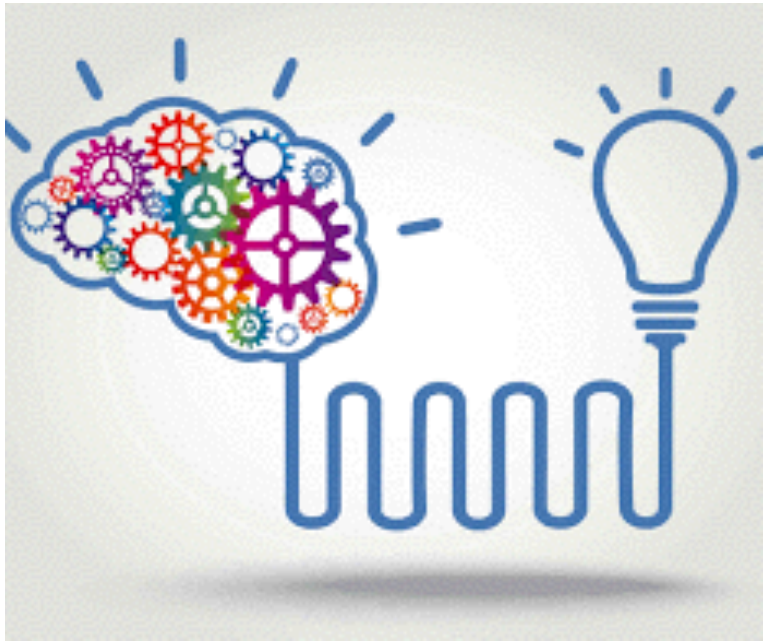
CASO CLINICO

- ✓Valutazione clinica trasversale
- ✓In base all' osservazione clinica, viene posta diagnosi di DOC
- ✓Prescritta terapia a base di SSRI ➔FLUOXETINA 40 mg/



CASO CLINICO Decorso (1)

- Miglioramento dei dubbi ossessivi, riduzione delle idee di contrasto
- Miglioramento del funzionamento globale, ripresa dell' università, delle attività sportive e sociali, riduzione dei sentimenti di demoralizzazione.
- Quota ansiosa fluttuante



CASO CLINICO Decorso (2)

- Ridotto bisogno di sonno
- Incremento delle energie e delle attività sociali
- Loquacità (insolita, secondo i familiari), fino a logorrea
- Coinvolgimento in attività a rischio, spese eccessive
- Progettualità incongrua
- Spunti di irritabilità

ALCUNI SPUNTI DI RIFLESSIONE…

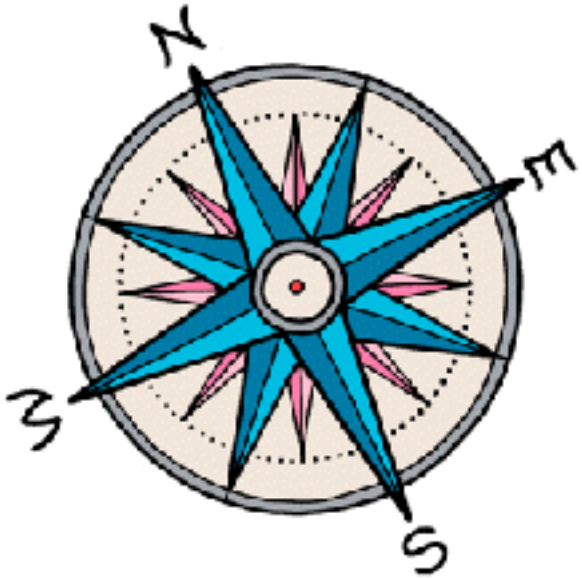
- ✓ Quali sono gli elementi nuovi e le loro implicazioni?
- ✓ Cosa è stato tralasciato nella prima valutazione clinica?
- ✓ Come intervenire?

ALCUNI SPUNTI DI RIFLESSIONE…

- ✓ La diagnosi di Disturbo Bipolare viene misconosciuta, perché è stata fatta una valutazione trasversale e non longitudinale.
- ✓ Non vengono esplorate familiarità e decorso
- ✓ E’ mancata una valutazione delle possibili comorbidità (mediche e psichiatriche)

CASO CLINICO

Si rende necessaria una nuova valutazione psichiatrica, durante la quale vengono esplorate <u>familiarità</u> e <u>decorso,</u> che riorientano la diagnosi, mettendo in luce le comorbidità.



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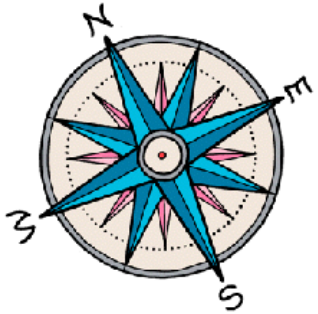
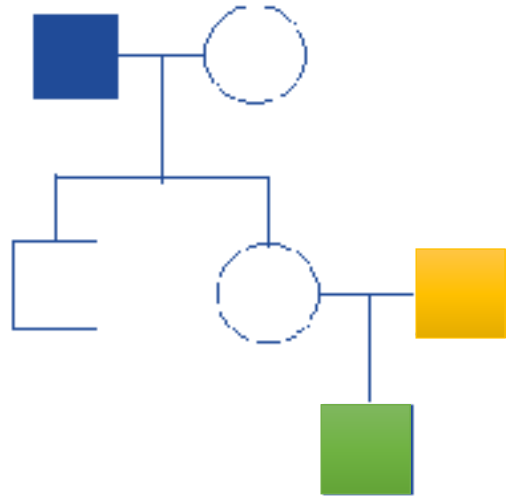
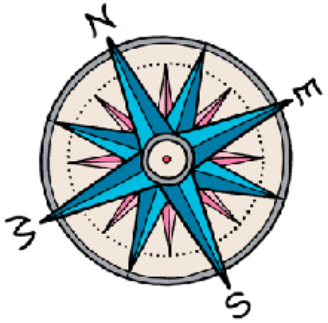


FAMILIARITA': Positiva in entrambe le linee per disturbi di interesse psichiatrico

- Familiarità per disturbo bipolare in linea materna (nonno materno)
- Familiarità per DOC e disturbo d' ansia in linea paterna (padre)



CASO CLINICO



<u>DECORSO:</u>
Precedente fase depressiva(19 aa), che era stata correlata ad un voto basso inaspettato alla maturità. Riduzione delle energie e degli interessi, ritiro sociale, infuturazione pessimistica.

Trattato con un ciclo di psicoterapia imprecisata, con remissione dei sintomi.

CASO CLINICO Gestione Farmacologica

Cosa si fa a questo punto?

- Impostazione di terapia con Timoregolatori (Acido Vaproico, fino a 750 mg/die)
- Revisione della terapia antidepressiva (Sospensione di fluoxetina, reinserimento successivo di Sertralina)
- BDZ in fase acuta, per ridurre lo stato ansioso e migliorare il pattern ipnico. Successivo scalaggio in 15 gg circa.

The clinical impact of bipolar and unipolar affective comorbidity on obsessive–compulsive disorder

Giulio Perugi[a,*], Hagop S. Akiskal[b], Chiara Pfanner[a], Silvio Presta[a], Alfredo Gemignani[a], Alessandro Milanfranchi[a], Patrizia Lensi[a], Susanna Ravagli[a], Giovanni B. Cassano[a]

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Received 7 November 1996; accepted 8 April 1997

Abstract

Previous studies on the comorbidity of Obsessive–Compulsive Disorder (OCD) have largely focused on comorbidity with major depressive and anxiety disorders. The present investigation deals with a more complex pattern of comorbidity involving bipolarity. Indeed, in a consecutive series of 315 OCD outpatients, 15.7% had such comorbidity (mostly with bipolar II disorder). Unlike non-bipolar OCD patients, these had a more gradual onset of their OCD which, nonetheless, pursued a more episodic course with a greater number of concurrent major depressive episodes. These bipolar OCD patients had a significantly higher rate of sexual and religious obsessions, and a significantly lower rate of checking rituals. OCD probands with non-bipolar major depressive comorbidity (34.8%) were then compared with the remainder of OCD. These 'unipolar' OCD were older, had a more chronic course with hospitalizations and suicide attempts, had greater comorbidity with generalized anxiety disorder and caffeine abuse; finally, they were more likely to have aggressive obsessions and those with a philosophical, superstitious or bizarre content. Our data suggest that when comorbidity occurs with bipolar and unipolar affective disorders it has a differential impact on the clinical characteristics, comorbidity and course of OCD. We submit that the presence of major depression in OCD is incidental, as OCD in such cases dominates the course and dictates treatment choice. By contrast, when bipolar and obsessive–compulsive disorders co-exist, bipolarity should take precedence in diagnosis, course and treatment considerations.

Keywords: Obsessive–compulsive disorder; Bipolar II; Unipolar depression; Comorbidity

"Disturbo ossessivo compulsivo"

DISTURBO BIPOLARE e DOC

- Maggior frequenza di ossessioni a contenuto sessuale e religioso
- Minor frequenza di rituali di ordine o di check
- Comorbidità maggiore con Disturbo di Panico- agorafobia
- Comorbidità con Fobia Sociale
- Comorbidità maggiore con abuso di sostanze (alcool, sedativi, nicotina, caffeina)
- I trattamenti con TCA e SSRI sono associati ad un più elevato rischio di switch, specialmente se non in associazione a timoregolatori

"Disturbo ossessivo compulsivo"

Obsessive-Compulsive–Bipolar Comorbidity: A Systematic Exploration of Clinical Features and Treatment Outcome

Giulio Perugi, M.D.; Cristina Toni, M.D.; Franco Frare, M.D.; Maria Chiara Travierso, M.D.; Elie Hantouche, M.D.; and Hagop S. Akiskal, M.D.

Background: Notwithstanding the emerging literature on comorbidity between obsessive-compulsive disorder (OCD) and bipolar disorder, relatively few systematic data exist on the clinical characteristics of this interface and its treatment. The aim of the present study is to address this challenge as it appears in a setting of routine clinical practice.

Method: The sample comprised 68 patients with comorbid DSM-IV diagnoses of OCD and major depressive episode admitted and treated at the day-hospital in the Department of Psychiatry at the University of Pisa (Pisa, Italy) during a 3-year period (January 1995–December 1998). Thirty-eight patients (55.8%) showed lifetime comorbid bipolar disorder (12 [31.6%] bipolar I and 26 [68.4%] bipolar II). Diagnoses and clinical features were collected by means of structured (Structured Clinical Interview for DSM-IV) and semistructured interviews (OCD-Interview). Assessments of drug treatments, clinical outcome, and adverse effects were made prospectively as part of routine clinical care throughout the course of their day-hospitalization.

Results: In contrast with non-bipolar OCD patients, OCD-bipolar patients showed a more episodic course with a greater number of concurrent major depressive episodes. They reported a significantly higher rate of sexual obsessions and significantly lower rate of ordering rituals. Furthermore, they reported more frequent current comorbidity with panic disorder-agoraphobia and abuse of different substances (alcohol, sedatives, nicotine, and coffee). Drug treatment with clomipramine and, to a lesser extent, with selective serotonin reuptake inhibitors was associated with hypomanic switches in OCD-bipolar patients, especially in those not concomitantly treated with mood stabilizers. A combination of multiple mood stabilizers was necessary in 16 OCD-bipolar patients (42.1%) and a combination of mood stabilizers with atypical antipsychotics was required in 4 cases (10.5%). OCD-bipolar patients tended to show a less positive outcome for mood symptomatology and general functioning. Three patients required hospitalization for severe mixed episode.

Conclusion: In a tertiary care center, comorbidity between OCD and bipolar disorder is a significant clinical problem affecting a large number of patients and has a substantial impact on the clinical characteristics and treatment outcome of both disorders.

(J Clin Psychiatry 2002;63:1129–1134)

Received July 25, 2001; accepted April 4, 2002. From the Department of Psychiatry, Neurobiology, Pharmacology, and Biotechnologies, University of Pisa, Pisa, Italy (Drs. Perugi and Travierso); Institute of Behavioral Sciences "G. De Lisio," Carrara-Pisa, Italy (Drs. Perugi, Toni, and Frare); Adults Mental Health Unit, Pistoia Zone, Pistoia, Italy (Dr. Frare); Mood Center, Pitié-Salpêtrière Hospital, Paris, France (Dr. Hantouche); and the International Mood Center, Department of Psychiatry, University of California at San Diego and Veterans Administration Medical Center, La Jolla, Calif. (Dr. Akiskal).

In the spirit of full disclosure and in compliance with all ACCME Essential Areas and Policies, the faculty for this CME activity were asked to complete a full disclosure statement. The information received is as follows: Dr. Akiskal is a consultant for Lilly and is on the speaker/advisory board for Lilly and Janssen.

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Major depression has been considered the most common complication of obsessive-compulsive disorder (OCD), ranging from 13% to 75%.[1–5] Less attention has been devoted to the comorbidity between OCD and bipolar disorder, despite numerous reports based on a nonsystematic search for such an association.[6,7] The development of mania or hypomania in response to treatment with tricyclic antidepressants or selective serotonin reuptake inhibitors (SSRIs) has been described widely in OCD case series and reports.[8–14] Lifetime comorbidity between OCD, panic disorder, and social phobia on the one hand, and mood disorder on the other, has been systematically investigated by means of standardized assessment in a recent Pisa-San Diego collaborative study.[15] Major depression was the most common comorbid disorder, and the rate of comorbid major depression was significantly higher in the social phobia (52.1%) and OCD (38%) groups than in the panic disorder (29.4%) group. Even bipolar II disorder was more frequently associated with social phobia (21.1%) and OCD (17.7%) than with panic disorder (5.0%). These findings contradict a common perception that the relationship between anxiety and mood disorders is largely limited to unipolar depression and dysthymia. Epidemiologic studies in the community support the significant relationship between bipolar disorder and OCD,[16–18] suggesting that such comorbidity is not simply a result of clinical center bias.

Clinical data regarding the comorbidity between bipolar disorder and OCD have also been reported in both

"Keeping in mind scantiness and heterogeneity of the available literature, the best interpretation of the available evidence appears to be that mood stabilization should be the primary goal in treating BD-OCD patients."

(Amerio A., Odone A., Marchesi C., Ghaemi SNJ Affect Disord. 2014.)

GRAZIE PER L'ATTENZIONE