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Case report

Clinical management of comorbid bipolar disorder and obsessive-compulsive disorder: A case series

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Summary.*Background:* Apparent comorbidity between bipolar disorder (BD) and obsessive-compulsive disorder (OCD) is a common condition in psychiatry and it has important nosological and therapeutic implications. Although antidepressants are the first line treatment for OCD, they can induce mood instability in BD. An optimal treatment approach remains to be defined. *Methods:* Longitudinal clinical observation of three severe OCD patients who developed a manic episode during treatment with different classes of antidepressants. *Results:* In our cases, three features support the hypothesis of an underlying bipolarity unmasked by the antidepressant used to treat OCD: positive family history for affective disorders, manic switch induced by antidepressant and improvement of affective and obsessive-compulsive symptoms with mood stabilizers and atypical antipsychotics. *Conclusions:* Osler's view that medicine should be treatment of diseases, not of symptoms, is consistent with the approach of mood stabilization as a first objective in BD-OCD patients, as opposed to immediate treatment with antidepressants. Only persistent OCD patients should be prescribed antidepressants in as low a dose as feasible. (www.actabiomedica.it)

Key words:bipolar, obsessive-compulsive, comorbidity, treatment

Introduction

Apparent comorbidity between bipolar disorder (BD) and obsessive-compulsive disorder (OCD) is a common condition in psychiatry with higher prevalence rates in youths compared to adults (1). The meaning of this comorbidity has not been clarified yet (2).

In a standard 1969 psychiatry textbook, Mayer-Gross and colleagues included patients with BD-OCD comorbidity in the manic-depressive disorders (3). Considering course of illness as a key diagnostic validator (4), the evidence so far on BD-OCD nosology supports the view that the majority of comorbid OCD cases appeared to be related to mood episodes (5).

However, an optimal BD-OCD treatment approach remains to be defined since the gold standard for one disease (6) – according to the American Psychiatric Association – can worsen the other (7). Several published case reports describe OCD patients who developed manic episodes induced by different serotonin reuptake inhibitors (SRIs) (8): this raises the question of comorbidity between BD and OCD.

We present a longitudinal clinical observation of three severe OCD patients who developed a manic episode during treatment with different classes of antidepressants.

Case reports

Case 1

The patient is a 56 year-old Caucasian unmarried woman with positive family history for major depres-

sive disorder. From the age of 20, she had presented fear of contamination, leading to elaborate washing and cleaning rituals that had partially impaired her functional capacity. These symptoms met DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) criteria for OCD and were untreated for 34 years. No history of manic or depressive episodes was reported.

At the age of 54, a few months after leaving her parents' home, the obsessions and compulsions increased and she presented with depressed mood and feelings of worthlessness. She was admitted to the inpatient service and treated with sertraline 200 mg/day; obsessive-compulsive and affective symptoms were well controlled and satisfactory quality of life was regained.

After eight months on sertraline 250 mg/day, she developed a manic episode. Her therapy was modified to valproate 1000 mg/day and olanzapine 10 mg/day. Olanzapine was gradually decreased and valproate was continued for the next five months with remission of obsessive-compulsive symptoms and mood stabilization.

After her father's death, compulsive rituals increased prominently. Sertraline 75 mg/day was added to valproate and again complete remission of bipolar and obsessive-compulsive symptoms for the following months was reported.

Case 2

The patient is a 32 year-old Caucasian man with positive family history for recurrent depression. From the age of 21, he had presented recurrent, intrusive, ego-dystonic thoughts having sexual and aggressive content that led him to compulsive mental acts (specifically, praying). These symptoms met DSM-IV criteria for OCD. No history of manic or depressive episodes was reported.

He was admitted to the inpatient service and treated with citalopram 60 mg/day with satisfactory control of obsessive-compulsive symptoms.

After three months on citalopram 60 mg/day, he developed a manic episode. His therapy was modified to valproate 800 mg/day and olanzapine 20 mg/day. Olanzapine was gradually decreased and valproate was continued with remission of obsessive-compulsive symptoms and mood stabilization.

After eight months he decided to stop valproate and compulsive rituals increased prominently. Citalopram 20mg/day was added to valproate with improvement of OC symptoms and mood stabilization.

Case 3

The patient is a 24 year-old Caucasian woman with positive family history for recurrent depression. At 19 years of age, two weeks after delivery, she presented a major depressive episode that improved in the next few weeks with fluvoxamine 100 mg/day.

From the age of 22, she had gradually presented fear of contamination with hand washing more than ten times per day, pathological doubts about daily events, and compulsive checking of light switches. These symptoms met DSM-IV criteria for OCD. No history of manic episodes was reported.

She was admitted to the inpatient service and initially treated with fluvoxamine 200 mg/day without satisfactory control of obsessive-compulsive symptoms. Her therapy was modified to clomipramine 150 mg/day.

After four weeks she developed a manic episode. Her therapy was modified to lithium 900 mg/day and aripiprazole 30 mg/day. Aripiprazole was gradually decreased and lithium was continued with mood stabilization and remission of obsessive-compulsive symptoms.

After three months washing and checking rituals increased prominently. Aripiprazole 10 mg/day was added to lithium and affective and obsessive-compulsive symptoms were well controlled for the following twelve months.

Discussion

In our cases, three features support the hypothesis of an underlying bipolarity unmasked by the antidepressant used to treat OCD: positive family history for affective disorders (9), manic switch induced by antidepressant (7) and improvement of affective and obsessive-compulsive symptoms with mood stabilizers and atypical antipsychotics (10).

The co-occurrence of symptoms of BD and OCD was noted 150 years ago by Morel (11), but the topic remains insufficiently studied. However, given the available scientific evidence, some observations can be made.

Apparent BD-OCD comorbidity is a common condition in psychiatry with higher prevalence rates in youths compared to adults (12). In particular, as reported by recent studies, obsessive-compulsive symptoms in childhood and adolescence increase the risk of a later BD diagnosis (13). Considering course of illness as a key diagnostic validator, especially among patients with a primary diagnosis of BD, the majority of comorbid OCD cases appeared to be related to mood episodes (4). Obsessive-compulsive symptoms in comorbid patients appeared more often - and sometimes exclusively - during depressive episodes, and comorbid BD and OCD cycled together, with obsessive-compulsive symptoms often remitting during manic/hypomanic episodes. The clinical features of comorbid BD-OCD patients would explain why OCD and BD symptoms respond to adequate mood stabilizers and atypical antipsychotics (10). Only in a minority of comorbid patients with persistent OCD, despite improvement in mood episodes, addition of low doses of antidepressants could be considered while strictly monitoring emerging symptoms of mania or mixed states.

Progress in this area would serve to shed light on the best clinical management of BD-OCD comorbidity. Considering the important nosological, clinical and therapeutic implications, future research efforts may lead to more grounded guidelines, which are greatly needed in patients with comorbid BD-OCD.

Clinical implications

Osler's view that medicine should be treatment of diseases, not of symptoms (14), is consistent with the approach of mood stabilization as the primary goal in treating apparent BD-OCD patients, as opposed to immediate treatment with antidepressants that seemed to be less effective and more harmful in BD-OCD than in non-comorbid patients.

Authors' contributions: AA and MT have contributed to data acquisition. AA, MT and AO have been involved in data interpretation and drafting the manuscript. Our manuscript has been approved by all authors.

Consent: Written informed consent was obtained from the patients for publication of this Case report. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

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