Obsessive-Compulsive Disorder as a Part of Prodromal Schizophrenia

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Prodromal schizophrenia presents with a wide variety of psychiatric symptoms including obsessive-compulsive disorder (OCD) or obsessive-compulsive symptoms (OCS). However, this differentiation between a sole diagnosis of OCD and prodromal schizophrenia seems challenging in some settings.

We present a sixteen-year-old male with six-months history of recurrent intrusive images and fearfulness, in addition to decreased socialization. He was managed as a case of prodromal schizophrenia and was treated with antipsychotics. His obsessions decreased but he continued to exhibit negative schizophrenia within two years of follow-up. Acknowledging the diversity of prodromal schizophrenia presentations rather than treating symptoms as a cross-sectional diagnosis (especially in high-risk population for psychosis) is crucial for a better management.

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Prodromal schizophrenia is the initial phase of disturbance prior to the full-blown psychotic picture. It comprises of various and non-specific symptoms such as affective changes anxiety symptoms, unusual perceptions, obsessions and odd beliefs. These manifestations may last from few weeks to several years. Approximately 80%–90% of schizophrenic patients experience the prodrome[1]. However, only 30%-40% of people with prodromal stage convert to florid manifestations of schizophrenia[2]. Many studies of prodromal stage schizophrenia confirm the value of early psychosis intervention.

The relation between OCD or OCS and schizophrenia is discussed thoroughly across different stages of schizophrenia except for prodromal phase where limited studies were found. The prevalence of this particular association varies largely from 2.7% to 36.9% for OCS and from 1.5 to 30% for OCD[3,4,5]. The studies had conflicting results regarding the possible transition to psychosis among the ultra-high-risk population with positive OCD/OCS versus negative counterparts[6].

The aim of this report is to present a case of OCD with detailed and intrusive mental images, which were resolved with antipsychotic medications.

THE CASE

A sixteen-year-old male student presented with six months history of recurrent and intrusive images with disturbing/frightening content associated with fearfulness and decreased socialization. The patient would see himself near a graveyard, trying to run away while being chased by dead people and feeling extremely terrified. These images come episodically daily (4–7 episodes per day) lasting approximately 2–3 minutes each and had increased in frequency. They were occasionally triggered by seeing his home from outside in a dark and quiet environment.

The episodes have the same sequence of images every time. The patient could not stop the flow of images until entering his own home and closing the gate (a relieving ritual) with initial success to abort these intrusive images but failed later. He does not regard these images as irrational. He denied having any other perceptual experiences apart from seeing monsters attacking him, and occasionally an awful girl crawling over the wall shortly before falling asleep (hypnogogic hallucination). The patient had decreased socialization with his family and the surrounding people. He described his mood as fearful most of the time. No reported change in sleeping or eating pattern. Unremarkable history of headache, loss of consciousness, seizure or any other physical complaints. The patient has no suicidal ideation or plans. No evidence of suspicious or odd beliefs. Past psychiatric and medical history were unremarkable. Family history revealed a schizophrenic mother with frequent relapses, one of these was during her pregnancy with the patient. The developmental history showed substandard school performance. Concerning premorbid history, the family described their son as being aloof, different from other children with few friends and limited hobbies.

Mental state examination revealed a thin young boy, well-kempt and groomed, with an occasional evasive gaze. His speech was mainly induced with reduced rate and volume, noticed aprosody and prolonged speech latency. The mood was euthymic with reactive affect. The patient was preoccupied with his complaint; he did not show evidence of other thinking abnormality. No observed abnormal perceptual experiences.

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He is insightful about possible psychiatric etiologies for his condition.

The initial differential diagnosis was schizophrenia (prodromal phase) versus obsessive-compulsive disorder or temporal lobe epilepsy. Therefore, full investigations were performed including complete blood count, urea and electrolytes, liver, renal and thyroid function tests, ceruloplasmin, ammonia, and lactate dehydrogenase, brain CT scan and electroencephalogram; all were normal. Therefore, his provisional diagnosis was prodromal schizophrenia, and he was prescribed olanzapine 10 mg daily, which resulted in noticeable improvement of the intrusive mental images. During two years of follow-up, the patient started to exhibit marked negative symptoms of schizophrenia including asociality, anhedonia and blunted affect. Therefore, the medication was increased to the maximum dose with no tangible improvement; consequently, aripiprazole was prescribed up to 15 mg daily with modest improvement in his overall condition.

DISCUSSION

This case illustrates the complexity of the diagnosis of an officially established disorder that is OCD with well-defined criteria and controversial labeling prodromal schizophrenia with several presentations including OCD.

Several studies investigated the relationship between schizophrenia and OCD or OCS; several hypotheses were postulated. Some authors considered the early onset of OCS as a subtype of schizophrenia and that they are the first presentation of the disorder while others suggested a separate category of schizophrenia with a new nosology (schizo-obsessive disorder)[7,8]. Recent studies considered both diagnoses as two separate entities with high comorbidity, almost having similar age of onset in adolescence[9]. Although all of these theories have their major confounding factors (small sample size and variable participant characteristics), they could not be ruled out in our case.

The impact of OCD/OCS among prodromal schizophrenia or at-risk people for psychosis was revealed in some studies by having a higher clinical impairment, more depressive symptoms and suicidality[4,5,10-15].

CONCLUSION

Our patient was managed as a case of prodromal schizophrenia rather than solely OCD based on the associated features (aloofness, progressive social and academic decline, slowed psychomotor functions and dysprosody). Positive family history of schizophrenia in addition to praecox feeling further confirmed the patient's condition. The following two years of the patient's course revealed the necessity of considering the full detailed presentation of prodromal schizophrenia rather than the spot diagnosis of OCD to benefit from early intervention psychosis services and minimize the clinical deterioration.

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REFERENCES

1. Addington J. The Prodromal Stage of Psychotic Illness: Observation, Detection or Intervention? J Psychiatry Neurosci 2003; 28(2):93-7.
2. Gee DG, Cannon TD. Prediction of Conversion to Psychosis: Review and Future Directions. Rev Bras Psiquiatr 2011; 33 Suppl 2:s129-42.
3. Shioiri T, Shinada K, Kuwabara H, et al. Early Prodromal Symptoms and Diagnoses Before First Psychotic Episode in 219 Inpatients with Schizophrenia. Psychiatry Clin Neurosci 2007; 61(4):348-54.
4. Hur JW, Shin NY, Jang JH, et al. Clinical and Neurocognitive Profiles of Subjects at High Risk for Psychosis with and Without Obsessive-Compulsive Symptoms. Aust N Z J Psychiatry 2012; 46(2):161-9.
5. DeVylder JE, Oh AJ, Ben-David S, et al. Obsessive-Compulsive Symptoms in Individuals at Clinical Risk for Psychosis: Association with Depressive Symptoms and Suicidal Ideation. Schizophr Res 2012; 140(1-3):110-3.
6. Zink M, Schirmbeck F, Rausch F, et al. Obsessive-Compulsive Symptoms in At-Risk Mental States for Psychosis: Associations with Clinical Impairment and Cognitive Function. Acta Psychiatr Scand 2014; 130(3):214-26.
7. Fenton WS, McGlashan TH. The Prognostic Significance of Obsessive-Compulsive Symptoms in Schizophrenia. Am J Psychiatry 1986; 143(4):437-41.
8. Zohar, J. Is There Room for a New Diagnostic Subtype: The Schizo-Obsessive Subtype? CNS Spectrums 1997; 2:49-50.
9. Cunill R, Castells X, Simeon D. Relationships between Obsessive-Compulsive Symptomatology and Severity of Psychosis in Schizophrenia: A Systematic Review and Meta-Analysis. J Clin Psychiatry 2009; 70(1):70-82.
10. de Haan L, Sterk B, van der Valk R. Presence of Obsessive-Compulsive Symptoms in First-Episode Schizophrenia or Related Disorders is Associated with Subjective Well-Being and Quality of Life. Early Interv Psychiatry 2013; 7(3):285-90.
11. Fusar-Poli P, Nelson B, Valmaggia L, et al. Comorbid Depressive and Anxiety Disorders in 509 Individuals with an At-Risk Mental State: Impact on Psychopathology and Transition to Psychosis. Schizophr Bull 2014; 40(1):120-31.
12. Poyurovsky M, Fuchs C, Weizman A. Obsessive-Compulsive Disorder in Patients with First-Episode Schizophrenia. Am J Psychiatry 1999; 156(12):1998-2000.
13. Fontenelle LF, Lin A, Pantelis C, et al. A Longitudinal Study of Obsessive-Compulsive Disorder in Individuals at Ultra-High Risk for Psychosis. J Psychiatr Res 2011; 45(9):1140-5.
14. Niendam TA, Berzak J, Cannon TD, et al. Obsessive-Compulsive Symptoms in the Psychosis Prodrome: Correlates of Clinical and Functional Outcome. Schizophr Res 2009; 108(1-3):170-5.
15. Fontenelle LF, Lin A, Pantelis C, et al. Markers of Vulnerability to Obsessive-Compulsive Disorder in an Ultra-High Risk Sample of Patients Who Developed Psychosis. Early Interv Psychiatry 2012; 6(2):201-6.