A Rare Presentation of a Case of Obsessive–compulsive Disorder Comorbid with Bipolar Affective Disorder

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ABSTRACT

Obsessive–compulsive disorder (OCD) is a chronic illness with waxing and waning course. OCD is not uncommonly found to be comorbid with bipolar affective disorder (BPAD). The course and prognosis of OCD have distinctive features in such cases. Only rarely symptoms of OCD emerge during mania in such individuals. We hereby report a very unusual case of OCD comorbid with BPAD in which obsession and compulsion symptoms occurred only during manic episodes with complete remission during periods between manic episodes (including during depressive episodes).

Key words: Bipolar affective disorder, bipolar disorders, obsessive–compulsive disorder

INTRODUCTION

Obsessive–compulsive disorder (OCD) is a chronic illness with waxing and waning course. Mood disorders are commonly found to be comorbid with OCD, with unipolar depression (in up to 75% of cases) being the most common comorbid condition. Comorbidity with bipolar affective disorder (BPAD) is not very uncommon with prevalence rates ranging from 10% to 20% (Amerio et al., 2015). OCD is known to have an episodic course when associated with comorbid BPAD. One important clinical finding is worsening of obsession and compulsion (OC) symptoms during depression and improvement with mania.[1] Hereby, we report a very unusual case of OCD comorbid with BPAD (BPAD-OCD), in which OC symptoms occurred only during manic episodes with complete remission during periods between manic episodes (including during depressive episodes).

CASE REPORT

Mr. S, a 36-year-old married male with a family history of suicide in brother and depressive illness in the mother, presented to us with an episodic illness of 10 years duration. His current episode started around 3 months back. The episode initially started with a decreased need for sleep and increased activity level during night time. He started remaining irritable most of the time, with frequent anger outbursts.
toward his family members, unlike his previous self. He started demanding more money from them. Within a few days, he started expressing ideas that he was a great person and could do anything. He would also brag about his position and money. However, these ideas would be fleeting and would not remain fixed. He also developed persecutory ideas toward his in-laws and would say that they were doing so out of jealousy. He would be found talking to strangers on streets and had to be brought back home against his wish. During the same time of emergence of these symptoms, he also developed another set of symptoms. He would have repeated doubts that his hands and legs were dirty even after washing them properly. These would lead to repeated cleaning/washing of his legs/hands. Although he would try to resist such thoughts considering them to be excessive, he would almost always yield to the act of cleaning due to associated anxiety if he would not wash them. By 2–3 months, he started spending 6–8 h a day on such repetitive acts of cleaning/washing his hands/feet.

Patient’s history suggested three previous episodes of mania. During all these episodes, OC symptoms would always appear with the emergence of mania and remit as soon as the patient recovered from mania. He had four episodes of depression lasting for 3–4 months each, but OC symptoms did not emerge during any of these episodes. He would be completely symptom-free in between the episodes. Current mental status examination revealed increased speech output, ideas of grandiosity, and obsessive thoughts related to dirt/contamination.

Based on the history and examination, a clinical diagnosis of BPAD, current episode Mania with comorbid OCD was considered. All routine investigations were found to be normal. As he was already prescribed risperidone (up to 4 mg) by his previous psychiatrist for adequate duration, he was treated with olanzapine (up to 15 mg) and lithium (up to 900 mg). With therapy, there was a significant improvement in mania and obsessive-compulsive symptoms in around 4 weeks, with remission of all symptoms by 7 weeks. Last contact (telephonic) with the patient was 15 days back, and the patient was maintaining well with no manic or OC symptoms.

**DISCUSSION**

Our patient suffered from obsessive-compulsive disorder comorbid with bipolar affective disorders (BPAD-OCD). The previous reports suggest that BPAD-OCD has distinct clinical features which include episodic course, more depressive episodes, and higher suicidality.[1] This is evident in our case, in which complete remission of OC symptoms occurred during inter-episodic periods.

The age of onset of OCD usually coincides with that of BPAD in these cases. In addition, they usually have higher rates of sexual, religious and symmetry obsessions, and repeating, counting, and ordering/arranging compulsions as compared to nonbipolar OCD patients.[2] However, obsessions related to contamination are less commonly found in such patients according to the previous reports, unlike our case where predominant obsession was related to dirt and contamination.

One very unusual finding in our case is the emergence of obsessive–compulsive symptoms only during manic episodes. With remission of manic episodes, obsessive–compulsive symptoms would resolve completely. These occurred during all manic episodes. Although patient suffered from four distinct depressive episodes during this period, obsessive–compulsive symptoms did not emerge during any of these. This is contrary to the previous studies/reports which suggest OC symptoms’ improvement with mania and worsening during depressive episodes.[3] Till date, only a few cases have been reported, in which mania was associated with the emergence of OC symptoms.[2] One study reported persistence of obsessive-compulsive symptoms in hypomanic episodes in nearly half of their sample.[3] However, the primary diagnosis in this study was OCD, and none of the patients reported the emergence of these symptoms during (hypo) mania. Such a presentation might suggest obsessive–compulsive symptoms to be a nonspecific symptom of mania. This might represent Kraepelin’s consideration of anxiety symptoms (including obsessions and compulsions) as symptoms of mania and not a distinct entity.[4] It is possible that cases of BPAD-OCD are a heterogeneous group of patients with differing clinical presentations, but they may share a common pathophysiology. Affective dysregulation has been hypothesized as a basic abnormality in both of these illnesses.[5] One important problem also faced in our case is whether to consider OC symptoms a part of BPAD or do they need a separate diagnosis. The hierarchical approach, especially adopted in classic European psychopathology, suggests that anxiety symptoms (including OC symptoms) are not diagnosed as a separate entity when they co-occur with mood disorders.[6] Nevertheless, the course of illness in our patient might support the possibility of OC symptoms being a part of BPAD and not a separate diagnosis.

Certain management issues related to such cases are also worth considering here. The previous studies suggest
that BPAD-OCD patients are at a higher risk of switching to mania induced by antiobsessional medications (for, e.g., selective serotonin reuptake inhibitors). This is especially the case in patients who do not receive the concomitant mood stabilizer. On the other hand, atypical antipsychotics (such as clozapine and olanzapine) have been known to cause/worsen the OC symptoms. Among the antipsychotics, olanzapine has been found to be less effective in the treatment of BPAD-OCD. However, this was not the case in our patient who responded well to olanzapine leading to complete remission of mania. OC symptoms also responded to olanzapine treatment with no further need to add any antiobsessional medication, which supports the possibility of such symptoms to be a part of BPAD.

In conclusion, our case is among the very few reported cases, in which OC symptoms were present/emerged only during manic episodes. Awareness of such an illness and clinical judgment is required for successful management of the case.

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**Conflicts of interest**
There are no conflicts of interest.

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