An Atypical Presentation of Obsessive Compulsive Disorder with Difficulty in Hearing

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ABSTRACT

Obsessive compulsive disorder (OCD) is a common psychiatric disorder which is easily recognized. However, sometimes patients of OCD present in such an atypical or bizarre way that their problem comes to notice as being a psychiatric disorder after multiple consultations in different specialties. We are reporting a case of a man who had first sought opinion in the Department of Ear, Nose and Throat (ENT) for hearing impairment. He was then referred to a neurologist and a general physician for evaluation of neurological cause of his symptom. As no pathology related to ENT or neurology could be detected, he was referred to the Department of Psychiatry. The patient’s chief complaints were difficulty in hearing and inability to understand at once. He could be diagnosed as a case of OCD after meticulous evaluation and studying his response to treatment. There was significant improvement in all the presenting symptoms over a period of 6 weeks on 60 mg of fluoxetine.

Key words: Atypical presentation, hearing impairment, obsessive compulsive disorder

INTRODUCTION

Obsessive compulsive disorder (OCD) is a common psychiatric disorder (2% - 3% of the general population) which is diagnosed easily most of the time by the psychiatrist or even the physician. It is sometimes very difficult to properly diagnose a person for OCD based only on an interview. The presentation of OCD may be so atypical or unusual that the patients may be referred to different specialties before the actual diagnosis can be made. Neuropsychological studies have consistently found cognitive impairment in the domains of memory and attention in patients of OCD. Anxiety, lack of confidence, indecisiveness, associated clinical symptoms of OCD, along with impaired memory and attention, may further complicate or interfere in the delivery of information.

CASE REPORT

A 36-year-old man used to request multiple repetitions of spoken words in order to understand what was said. Relatives and family members advised him to consult an ENT surgeon for hearing impairment. No organic cause of hearing impairment was found. He was then referred to a neurologist and a general physician for evaluation of neurological cause of his symptoms. Even after multiple consultations with the ENT, neurology and medicine specialists, no organic pathology to explain his symptoms could be detected. The patient lost considerable time and money because of delay in diagnosis caused by the atypical presentation to specialties other than Psychiatry. At last, the patient was referred to the Department of Psychiatry for further evaluation. The patient’s chief complaints were difficulty in hearing, grasping or comprehending the components of conversations, interactions or clinical interviews at once. He had this problem for the last 6 months. During the interview, almost every question or the instruction had to be repeated slowly 2 to 3 times or more to make him understand. He was anxious and expressed regret repeatedly for the inconvenience caused to the doctor because of his disability. Initially the patient was put on mirtazapine 15 mg/day and clonazepam 0.75 mg/day, keeping in mind the possibility of anxiety disorder NOS (not otherwise specified). There was no significant improvement even after 4 weeks of
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therapy. The case was reviewed from the diagnosis point of view. Mental state examination of the patient revealed impaired attention and concentration with depressive and anxiety symptoms. Detailed evaluation of the patient revealed that his mind remained full of unnecessary thoughts. However, the patient could not express further details to enable definite diagnosis. The possibility of OCD, predominantly obsessive type, was kept on the basis of answers of leading questions, and he was put on fluoxetine 60 mg/day (titrated from 40 to 60 mg) and clonazepam 0.5 mg/day. There was drastic improvement in all the presenting symptoms, including his ability to grasp and comprehend conversation, along with improvement in anxiety symptoms and clarity in thinking over a period of 6 weeks. The patient was then able to report his pre-treatment problem and the level of improvement comprehensively. He accepted that he was unable to understand or express his own problem before treatment. According to him, there were thoughts keeping his mind busy all the time, to the extent that he was unable to think or communicate his problem effectively. According to him, initially he used to make frequent unsuccessful attempts to get rid of these excessive and unnecessary thoughts. According to the wife of the patient, after treatment the patient was able to hear clearly. The diagnosis could be confirmed as OCD on the basis of patient’s spontaneous elaboration of symptoms and the level of improvement.

DISCUSSION

In this case, the presentation of OCD is atypical, as the chief complaint was problem in hearing. He was able to hear on normal volume of sound, but the sentences needed to be repeated multiple times. He was not hard of hearing. Moreover, no ENT-related or neurological cause of hearing impairment was found in the patient. Though hearing difficulty was not his chief subjective problem, he consulted the ENT doctor only after repeated and forced advice by his wife and relatives. The hearing problem as perceived by the patient’s friends and relatives was basically a misinterpretation of the patient’s problem secondary to his psychiatric illness. Also the patient was unable to express his actual problem at the time of presentation.

The patient used to ask for repetition of the spoken sentences multiple times in order to grasp the components of interaction because of his significantly impaired attention. However, there could be the other possibility that this behavior could be a compulsive act of the patient to confirm his doubts. The patient could not confirm the latter. The patient could not express his problem elaborately, which was one of the reasons for not being able to make an early diagnosis. There were multiple factors that had complicated and hindered the narration of history by the patient. Lack of clarity of thoughts and associated clinical symptoms of OCD (especially predominantly obsessive type), indecisiveness, anxiety, lack of confidence, along with impaired memory and attention, were the possible factors in this case, as also reported in different studies. The patient could express details of his illness comprehensively once his above-mentioned signs and symptoms improved significantly. His wife and relatives also reported improvement in his hearing, which was actually the improvement in his attention and OCD symptoms.

Such an atypical presentation may lead to misdiagnosis, delay in diagnosis, loss of time and money as the patient may present to other specialties instead of Psychiatry. High suspicion for diagnosis of OCD and response to treatment may help in managing such cases.

CONCLUSION

Obsessive compulsive disorder is usually easily recognized, but sometimes its presentation is so atypical or bizarre that the problem comes to notice as being a psychiatric disorder after multiple consultations in different specialties. But if proper evaluation is done, such cases can easily be recognized and treated effectively.

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