CASE REPORT

Co-morbid obsessive compulsive and hypochondriac disorders complicated by tardive dyskinesia in a Nigerian man

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Abstract

The objective was to report a case of obsessive-compulsive disorder (OCD) with comorbid somatic symptoms that was complicated by movement disorders. A literature search on related issues was done online with Google Scholar, followed by a chronological report of the index case. This case presents a 52-year-old man who presented with intrusive, disturbing, and unreasonable thoughts at the mid adolescent time. Following these were complaints of multiple somatic symptoms which the patient labeled with different disease terms. The illness affected his academic, occupational, social, and marital role obligations. And lately, in the illness due to underlying predispositions, developed drug-related movement problems that worsened his state of handicap. This case attempts to point out the importance of early detection and cautious use of medications in patients, who present with OCDs with or without other psychiatric co-morbidities.

Key words: Hypochondriasis, obsessive compulsive disorder, tardive dyskinesia

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Introduction

Obsessive compulsive disorder (OCD) is a group of disorders that may present repetitive unwanted urges, thoughts, imageries, ruminations, and or behaviors/acts as the core clinical expressions in the sufferer. It occurs between childhood and early adulthood with a lifetime prevalence of 2–3%, and runs a protracted course in the sick.[1] The symptom presentations may vary with different patients, and whether OCD is called an anxiety disorder[2] or is classified as a separate entity under the OCD and related disorders;[3] obsessive preoccupations with or without repetitive behaviors or acts remain the basic psychopathological presentations in the sufferer. These are present on most days for at least 2 weeks[2] or for certainty of diagnosis, a period of 6 months.[3] Furthermore, there is a significant distress or impairment in the person's social, occupational or other important areas of functioning even if he/she does not see it as so. The International Classification of Diseases-10 notes that the obsessional thoughts or ruminations are sometimes futile, involving an endless and quasi-philosophical considerations.[2] Somatic concerns in persons with OCD are not as common as that of contamination, as a result, such patients with bodily focused concerns are more often seen in nonpsychiatric health care settings.[4] The fear of coming down with a disease may lead people with somatic obsessions to repeatedly check with health care providers for reassurances about their state of health. OCD was generally associated with serotonergic/dopaminergic problems in mainly the nondominant lateral orbital frontal loop, basal ganglia, thalamus and failures with cognitive, and behavioral inhibition.[5] The somatic type has been associated with other disorders in which ruminations and rituals that center on health and appearance are their hallmarks. Hypochondriasis

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was linked to OCD due to a high prevalence of the earlier in relations of OCD probands.[6] Patients with OCD usually have other past or current classic OCD obsessions, are more likely to engage in classic OCD compulsions, and generally do not experience somatic and visceral symptoms of illness. Somatic obsessions are more easily distinguished from somatization disorder in that patients with somatic obsessions usually focus on one illness at a time and are not preoccupied with a diverse, apparently unrelated array of somatic symptoms.[7] Studies of adults with OCD have shown that 40–60% have a poor response to 3-month trial of serotonin-reuptake inhibitors (SRIs) and these also have severe disabilities such as, poor quality-of-life, impairments in academic, work, and social functioning.[1] This further implicates OCD as a heterogeneous illness, hence difficulties identifying good predictors of treatment outcome.[1] Antipsychotics when taken with SRI's sometimes in OCDs can modestly reduce the symptoms.[8] Unfortunately, the use of these antipsychotics for many months or years could cause involuntary movements called "tardive dyskinesia (TD)". Even the newer antipsychotics that have a lesser propensity to TD have limited benefits in OCD.[8] However, augmenting SRIs with other drugs such as antipsychotics, and cognitive behavioral therapy was generally recommended as an alternative in the OCD treatment-resistant situations.[8]

This is a concise narration of an uncommon type of protracted OCD co-existing with convictions of physical illnesses in a Nigerian man with a later onset movement disorder. He was initially inappropriately managed with various antipsychotics. Literature review of OCD in Nigeria did not reveal previous similar cases. This case also highlights the morbid risk of TD when augmenting with antipsychotics in people with OCD.

Case Report

Mr. Mf is a 52-year-old married, Fulani, Moslem man who had not been regular at work due to an illness that spanned 35 years. He is a University graduate who decided to consult a psychiatrist. His reasons for consultation were due to abnormal body movements, and varying disturbing, sometimes amusing thoughts that he felt were unreasonable most of the time. Thus, in his words, was "too much daydreaming". He was in the mid-adolescent (16 years) period at the onset of illness while preparing for the final secondary education examinations (West African School Certificate Examinations [WASC]). The patient had difficulties concentrating on his studies because of preoccupations with varying thoughts and ideas. The thought intrusions got more interfering in his academic career that he found it difficult to cope with a post basic study. Though MF finds the thoughts unreasonable and disturbing, he could not stop himself from thinking about them and almost acts on detects sometimes. These thoughts could be about his being extremely wealthy and influential, hunted by mercenaries, and seeing himself as the head of state of the country with many accolades, especially from his kinsmen whom he would immensely help solve their problems. At the end of these thoughts that sometimes come with hazy mind imageries, he sees himself toppled and overthrown from power. At other times, compelling thoughts of suicide by jumping from an upstairs "senselessly" hunt the patient's mind, though he never acted on it and has never wished to die at any time. He gets relief from the tension mounted on him by these thoughts by playing basketball in the early days of the illness. The patient also realized the thoughts very rarely occur when he is discussing with people than when he is alone or studying. Though worried about these thoughts that are not within his control, he denied feeling anxious or depressed. He denied any unusual experiences like hearing voices of unseen people, and seeing what others around do not see. He claimed the thoughts were unreasonable and disturbing, but feels incapable of stopping their occurring. The patient said he developed breathing problems which he called "asthma" around the time of the onset of the daydreaming, and different bodily problems that he self-labeled with medical terms like, pile (when he felt pains in the anal area), ulcer (when he felt abdominal pains and rumbling when drinking water), upper respiratory tract infection, when he felt persistent pain in the throat, persistent catarrh, and shaky front upper incisors. These physical complaints did not abate with several years of both conventional and alternative medical treatments by doctors as well as quacks. A recent test of memory with the Folstein's mini-mental state examination did not support his claim of disorder of memory. He had at different times, unconfirmed doses of antipsychotic medications and benzodiazepines like: Haloperidol, fluphenazine decanoate, and trifluoperazine, chlorpromazine and diazepam tablets in a psychiatric health unit few days after the onset of the "daydreaming". Furthermore, he consulted with unorthodox mental healers and general practitioners when this did not seem to abate with the earlier consultation at the psychiatric health unit. He stopped the antipsychotics after 3 years due to the experienced side-effects of the medications. 9 years after stopping orthodox drugs he visited a hospital in Medina where antipsychotics were re-prescribed, but the patient could not continue with the recommended treatment due to drug side-effects. The patient revisited the psychiatric hospital when his problems did not abate with traditional therapy, and antipsychotics with benzhexol tablets to help with drug side-effects were prescribed. Thirty years after, the onset of illness and with prolonged antipsychotics use the patient came down with abnormal involuntary movements around the mouth, neck, shoulders, and hands. He decided to try the mental health care at the Aminu Kano Teaching Hospital 5 years after the onset of the movement problems. Apart from the patient's earlier acclaimed physical

illnesses, he has not been diagnosed with serious medical or surgical problems in the past. The patient denied any history of a similar problem or other psychiatric illnesses in other family members. He was born 52 years ago, and claimed the childhood was uneventful. He was doing well in school, never repeated a class until the start of the illness toward the final examinations (WASC). Despite the illness interfering with his preparation for the examinations, he came out with an upper credit; credit in chemistry, alpha in mathematics (A3), and passes in other subjects. He performed very badly at the school of basic studies, failing all the subjects he took in the examinations. Subsequently, he went in for electrical engineering in one of the polytechnic schools in the North central part of the country. He opted for the electrical electronics after the first session because the illness would not let him cope with the stress of his earlier choice of course. By the next academic session, he continued with the same course at Bayero University, Kano, Nigeria. The daydreams and presumed physical illnesses hampered his academic progress, having several resists and graduating with a pass 2 years later than the duration of 5 years of the course. After a 1-year compulsory National Youth Service Corps duty, he taught Mathematics for 3 years in one of his State's Senior Government Secondary School, but had to abandon teaching for a job in the National population commission, census, and survey division. Mr. MF enjoys his work, but difficulties concentrating on issues, especially during office meetings make it difficult for him to interact as he would have wished with his colleagues. Though he claimed, he had a cordial relationship with other co-workers despite not having been promoted for the past 12 years while on the job. He was not regular at work and it has been 7 months since the patient last went to work. The patient married 23 years ago, 13 years after the first episode of daydreaming, the spouse is 40 years old, formerly a clinical assistant in a general hospital but now in her 1st year in a community health program. Has two male children, the eldest is 13 years old and the second boy is 10 years old. The patient, spouse, and the children have cordial relationships. The illness, especially problems with body movement often affect the sexual relationship between the patient and the spouse. He did smoke cigarette and drank alcohol on occasion, but claimed he stopped for over 10 years now. The forensic history is uneventful and patient presently resides with his wife and children in a 2 bedroom apartment within his extended family home. He claimed he was easy-going, had friends who socially admired him, fairly religious and loved studying before the onset of the illness. Examination showed a dark-complexioned middle-aged, slim and tall man with disorganized dentition who appeared worried, but maintained a good rapport with affable social manners. He walked in normally, but was unable to sit still, repeatedly swinging the trunk from right to left and pushing the chest upwards while sitting. He alternately shrugged each shoulder, and repetitively protruded and retracted his tongue. The jaws moved from side to side with gnashing of the teeth, smacking and pursing of lips, and rapid blinking of the eyes. The speech was of normal rate and quantity, the volume, tone and flow were normal, but the rhythm was slightly muffled. Though worried, his affect was congruent to the prevailing situation. The thought contents were: Obsessed ruminations of grandiosity of being, aggressive obsessions about fear of harming himself by jumping from an upstairs. And somatic preoccupations about having asthma, ulcer, pile, and other physical illnesses despite contrary opinions from doctors. He denied perceptual disturbances. He was conscious and well-oriented to place, person, and time. He managed to repeat five digits forward and backward. However, did not bother attempting the serial seven tests, (100-7) claiming he was too mentally tried to concentrate. The immediate, short and long-term memories were intact and he showed a good understanding of issues both within the state and the country, in general. He showed a good understanding of some local idioms and both social and test judgments were good. The patient felt his problems which he wished for a cure, were both physical and psychological. However, that he was more concerned about the movement problems. Apart from the earlier noted movement abnormalities in the patient, the physical examination revealed no further significant findings. The diagnosis was of an (OCD-predominantly obsessive ruminations and thoughts; F 42.0) with co-morbid hypochondriasis and TD, because of the irrational ruminations and imageries that the patient is unable to resist. A co-existing hypochondriasis in MF is due to his conviction of physical illnesses because of the multiple somatic complaints that he discretely identified as symptoms of these, followed by repeated doctor shopping behavior for treatments. The history of long-term antipsychotic drugs use and the belated onset of involuntary, repetitive, purposeless body movements support a co-morbid TD in the patient. Though the illness started early in the patient, premorbid personality traits that should have predisposed him to OCD were not elicited, neither were there associated familial factors that can explain both OCD and hypochondriasis in him. The stress of preparing for his WASC examinations may have precipitated the illness. A delayed diagnosis that prevented an early good intervention, a co-morbid hypochondriasis and TD were likely the perpetuating factors in the illness. However, despite the chronicity of the illness, the presence of a supportive family, being married to a caring wife, and being employed; should serve as possible protective factors on MF. Schizophrenia disorder should have been an alternative diagnosis, but the thoughts were neither delusional in which the patient should have firmly held to it as his authentic ideas, nor a thought insertion in which MF should have seen it as an enforced idea from someone else. The intrusive and repetitive ego-alien thoughts, roles out an obsessive personality disorder. A somatic type of OCD should have been a diagnosis in MF because he did display obvious obsessive ruminations and imageries with thoughts,

but these were not followed by typical obsessive-compulsive (OC) acts. In addition, the somatic symptoms were not mere thought expressions in the patient, but were experienced visceral manifestations that he mistook for somatic illness symptoms. Both hypochondriasis and somatization disorder relate to multiple psychogenic somatic presentations, but with the conviction that those were signs of physical illness in the earlier. He was educated in the ways the various physical illnesses he claimed to have may manifest. This easily swayed him into doubts about actually having the acclaimed illnesses that were not supported by medical findings. Routine laboratory investigations like full blood count, urinalysis, urea, and electrolytes were unremarkable. A clinical psychologist who reviewed Mr. MF instituted self-management control and cognitive behavioral therapy sessions. The patient tolerated clomipramine up to 300 mg daily than when given the selective SRIs, of which he complained worsening of the movement problems and seeing strange images in white. He was prescribed clonazepam for the TD while awaiting the purchase of tetrabenazine overseas by the relations. Some other adjunctive drugs for the TD as Vitamin E, B-6, and sodium valproate were prescribed for the patient.

Discussion

This case highlights the protracted course of a complex OCD with coexisting multiple hypochondriac complaints in a Nigerian man. The span of the illness in this patient from mid adolescent period to middle-age caused handicapping issues in fulfilling academic, occupational and social responsibilities, and recently sexual with an added on TD. Despite haven sought an orthodox help early at the start of illness, delay instituting an appropriate care in the patient was likely a problem of proper illness identification as observed in earlier studies.[9,10] This is more difficult when typical manifestations of OCD are absent or complicated by comorbid psychiatric disorders.[11] Such delayed identification may cause an inappropriate management care with possible iatrogenic complications as noted in MF. A 2-year longitudinal study by Rahman and Kamal revealed that patients with OCD suffer for a long time, have impaired social and occupational functioning and majority of them also suffer from co-morbid psychiatric disorders.[11] This case supports the neurodevelopmental hypothesis of OCD by the mid adolescent time of onset of the obsessional thoughts in MF.[12] However, associated early tics and soft neurological signs were not ascertained, although to antipsychotic use, some movement disorders came on later in the illness. His cultural and social background likely influenced the obsessional thoughts and ruminations that centered on leadership. This is because politics and leadership roles hold a strong part in the future ambitions of the young men from that part of the country. This supports the earlier finding that the phenomenological observations in OCD are dependent upon cultural and social factors,[13] hence the need for culture-specific tools when planning OCD researches.

Hypochondriasis as an OCD spectrum disorder is not well-supported by the few reports on comorbidity between both disorders despite some patients' hypochondriacal concerns being of similar quality to the obsessional thoughts. Although relations of patients with OCD have high rates of hypochondriasis, available data suggest a closer relationship between hypochondriasis and somatization than with OCD.[6,7] Hence, co-morbid diagnosis of hypochondriasis should sway in this index case with multiple illness convictions.

Some movement disorders such as choreas were linked to dysfunctional frontal-striatal circuits as are found in OCD/OC symptoms.[14] Motor symptoms as akathisia and other abnormal involuntary movements that relate to abnormal frontal-striatal circuitry have also been strongly linked with neuroleptic exposed schizophrenic patients with OCD than those without OCD. Although the pathogenesis is not well-understood, it seems likely that schizophrenics with OCD are more vulnerable to developing medication-induced neurological, motor side effects, and medication unrelated motor side effects.[15] Hence, strengthening an association between OCD, schizophrenia, and movement disorders. In other words, the OCD in MF was likely the vulnerable catalyst that led to a neuroleptic-induced type of TD. Some SRI resistant OCDs improved with low dose conventional or atypical antipsychotic augmentation, but the mechanism of this action is not well-understood.[8] All antipsychotics that have anti-obsessional effect act on 5HT2A, D2, and alpha 1 or 2 receptors with a postulation on the differential blockade of 5HT2A and non 5HT2A receptors as the possible mode of impact.[8]

Conclusion

It is important that for patients to receive good care, clinicians should detect OCD early. Adjuvant therapy with antipsychotics should be used with great caution in situations where the OCD is resistant to the first-line drugs, because such patients are more likely to have complicated drug-induced movement disorders. The sociocultural influence on the phenomenological presentation of OCD in patients is an important consideration when preparing such research protocols.

This study is limited by not assessing the severity of dyskinesia in MF with structured tools such as the Simpson-Angus Rating Scale, Barnes Akathisia Rating Scale, and the Abnormal Involuntary Movement Scale. Despite this, the clinical descriptions of the abnormal movements should support dyskinesia in the earlier.

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