Fluvoxamine in the treatment of trichotillomania, obsessive compulsive disorder and major depression — a case report

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Trichotillomania (TTM), an impulse control disorder, and obsessive compulsive disorder (OCD) have been studied as variants of the same spectrum of disorders.[1,2] Arguments for and against this have been published.[3] Other common problems that OCD and TTM share are high co-morbidity rates with other disorders[4-6] and the treatment resistance experienced when TTM occurs as a single entity or in conjunction with OCD.[4,7]

Multiple treatment regimens for TTM and augmentation strategies have been postulated and researched, leading to no conclusive evidence of a fixed treatment regimen. The majority of studies have been single case reports, on a limited number of patients, or have lacked sufficient controls.

Pharmacotherapy used in the treatment of TTM includes: amitriptyline,[8] isocarboxide,[9] clomipramine,[4,10] lithium,[11] fluoxetine,[4,12,13] buspirone,[14] paroxetine,[4] pimozide augmentation,[15] trazodone,[16] sertraline,[17] fluvoxamine,[4,18] naltrexone,[4] citalopram,[4] venlafaxine[4] and inositol.[4,19]

In the treatment of TTM, one study of fluvoxamine found that dosages of less than 300 mg/day had limited efficacy in the treatment of 21 patients over a 12-week period.[18]

This case study highlights the difficulties experienced by a patient with OCD, TTM and major depression, and indicates the effectiveness of fluvoxamine in the treatment of such a combination.

Case study

A 19-year-old law student presented with the complaint of excessive hair pulling leading to extensive hair loss. This behaviour started at the age of 10 years with the pulling of his eyebrows. It subsided at the age of 13 years, only to resurface at the age of 15 years (pulling of scalp hair). This behaviour occurs when he is under pressure from psychosocial problems and even when he is in a subjectively relaxed state. Coinciding with this behaviour the patient complained of an irritable and dysphoric mood, decreased energy and drive, initial insomnia, loss of appetite and weight (approximately 10 kg in the past 6 months), lack of concentration and forgetfulness, social withdrawal, and suicide ideation (no plans or attempts), over the previous 6 months.

On further questioning the patient had obsessions concerning contamination, aggression, hoarding, pathological doubt and a need for symmetry and exactness. His compulsions included cleaning/washing, checking, repeating rituals and ordering/arranging. For the patient the washing and ordering were the most disturbing, influencing his daily activities and leading to increased anxiety. The Yale Brown Obsessive Compulsive Scale (Y-BOCS) Checklist was used to monitor the severity and progress of these obsessions and compulsions.

The diagnosis of TTM and OCD with a co-morbid major depression (moderate to severe) was made. The patient was placed on fluvoxamine (Luvox) at a starting dose of 50 mg *nocte* and subsequently increased to 100 mg *nocte* after 1 week and then to 150 mg *nocte* the following week. He also received supportive psychotherapy. The patient was followed up at regular intervals and the Hamilton Depression Rating Scale (HAMD) and the Y-BOCS Checklist were used to monitor his progress.

The patient had improved scores on the HAMD after 2 weeks on the maintenance dose of 150 mg, with the biggest improvement in symptoms after 4 weeks of treatment. He continued to improve until remission of the depression was achieved after 8 weeks of treatment. The OCD symptoms prevailed for a longer period of time but lessened in severity. After 12 weeks of treatment only mild obsessions and compulsions (washing and ordering) prevailed that were no longer bothersome to the patient. The TTM symptoms increased in severity for the first 4 weeks of treatment and subsided after 12 weeks of treatment. Full remission of the OCD and TTM could not be commented on, as the patient discontinued his follow-up visits.

Discussion

This case illustrates the early onset of TTM (before the age of 12 years), its waxing and waning course through life with episodes of remission, and the pulling of hair from different sites. The definite increase in severity of hair pulling after the initiation of treatment was a negative finding and the reason for this is currently unknown. This case further highlights the importance of questioning the patient on symptoms of OCD and the exclusion of co-morbid conditions (like depression) when evaluating patients with TTM.

The choice of medication was made largely because of the prominent OCD symptoms and co-morbid depressive symptoms for which fluvoxamine has been proved to be effective. The medication was prescribed as a *nocte* dosage to help the patient with the insomnia he was experiencing and to prevent daytime sedation that might have influenced his studies and working capacity (therefore the morning dose was omitted). The dosage was taken to a level where the patient experienced clinical benefit, continued improvement in his symptoms and no side-effects.

The patient did not report any side-effects on the medication. It is therefore unlikely that side-effects contributed to his discontinuation of follow-up visits.

As illustrated, the combination of fluvoxamine and supportive psychotherapy was beneficial in the treatment of this patient's illness. Although it was not possible to determine whether full remission was obtained, sufficient and significant improvement was made.

Conclusion

Further research into the aetiology of TTM, sufficient treatment protocols for these disorders (TTM as a single entity and in combination with other disorders like OCD and major depressive episode), as well as the long-term treatment options available, are warranted.

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