Top 5 Complex Patients with OCD

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Faculty Disclosure

- **Dr. Grant**: Grant/Research Support—Otsuka Pharmaceuticals, Trichotillomania Learning Center, Wellcome Trust.

Disclosure

- The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the US Food and Drug Administration).
  - The off-label use of monotherapy or adjunctive ondansetron, mirtazapine, buspirone, risperidone, aripiprazole, haloperidol, quetiapine, olanzapine, memantine, N-acetylcysteine, topiramate, lamotrigine, riluzole, and ketamine for the treatment of OCD will be discussed.

- Applicable CME staff have no relationships to disclose relating to the subject matter of this activity.

- This activity has been independently reviewed for balance.

Learning Objectives

- Review typical clinical presentation of obsessive-compulsive disorder (OCD) as well as the complex ways it presents
- Identify common comorbidities in OCD as well as the more treatment-interfering co-occurring disorders
- Assess evidence-based approaches to the treatment of OCD and what may be helpful when the more common evidence-based treatments are exhausted

Clinical Features

Characterized by the following:

- **Obsessions** (recurring distressing ideas or images) and
- **Compulsions** (recurring behaviors designed to decrease anxiety caused by obsessions)
- **Prevalence**: 2%
- **Male and females** affected equally

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Clinical Features

- Onset of OCD appears to be bimodal, with onset either during childhood (mean age 10 years) or during adolescence or young adulthood (mean age 21 years)
- Onset is earlier in boys than in girls, and onset after 30 years of age is unusual
- In childhood-onset OCD, boys are more commonly affected than girls

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Subtypes

Common Obsessions

- Contamination
- Pathologic doubt
- Somatic obsessions
- Symmetry
- Taboo

Common Compulsions

- Checking
- Washing
- Counting
- Needing to confess

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Diagnosis

- Patients with OCD should be assessed regarding their conviction that their obsessive beliefs are accurate
- Poor insight, to varying degrees, occurs in 14% to 31% of individuals with OCD and has been associated with worse treatment outcomes
- Up to 30% of individuals with OCD have a tic disorder, the presence of which has been associated with a poor response to pharmacotherapy for OCD in children and adolescents

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Screening Questions

- Have you been bothered by thoughts that didn't make any sense and kept coming back to you even when you didn't want them to, like being exposed to germs or dirt or needing everything lined up in a certain way?

- How about having images pop into your head that you didn't want, like violent or horrible scenes or something sexual?

- How about having urges that kept coming back to you even though you didn't want them to, like harming a loved one?

Screening Questions (cont'd)

- Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, repeating something over and over until it "feels right", counting up to a certain number, or checking something several times to make sure that you'd done it right?

- How much time a day would you spend with these thoughts or doing these behaviors? Did these thoughts or behaviors have an effect on your life or bother you?

- How strongly do you believe these thoughts are true or likely to happen? Are you completely convinced?

Why Treat OCD?

- WHO: OCD is one of the world's top 10 causes of illness-related disability
- Without treatment, remission rates are low (approximately 20%)
- With appropriate treatment, patients report substantially higher rates of symptom response/remission
- Only approximately one-third of patients with OCD receive appropriate pharmacotherapy, and < 10% receive evidence-based psychotherapy

Grant JE. *N Engl J Med*. 2014;371(7):646-653.

Treatment

- Clomipramine – EKG, blood levels, drug interactions
- SSRIs
- Augmentation strategies
- Cognitive-Behavioral Therapy (CBT) / Exposure and Response Prevention (ERP) Therapy

EKG = electrocardiogram; SSRI = selective serotonin reuptake inhibitor.

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FDA-Approved Medications for OCD

- Clomipramine – SRI 150–250 mg/day
- Fluoxetine – SSRI up to 120 mg/day (approved up to 80 mg/day)
- Fluvoxamine – SSRI up to 450 mg/day (approved up to 300 mg/day)
- Paroxetine – SSRI up to 80 mg/day (approved up to 60 mg/day)
- Sertraline – SSRI up to 400 mg/day (approved up to 200 mg/day)

- All except paroxetine approved for ages ≥ 6 to 10 years
- Upper doses are often higher for OCD than used for major depressive disorder

US Food and Drug Administration. Drugs@FDA: FDA Approved Drug Products. www.accessdata.fda.gov/scripts/cder/daf/.
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Augmentation Strategies

- **Serotonergic drugs**
  - Ondansetron (5-HT_3 antagonist) (1–8 mg/day)
  - Clomipramine – add to SSRIs, but caution warranted if added to fluoxetine or paroxetine
  - Negative studies of mirtazapine and buspirone (5-HT_{1A} receptor partial agonist)

- **Antipsychotics**
  - Risperidone (0.5–3 mg/day); response rates 40%–50%
  - Aripiprazole (10–15 mg/day)
  - Haloperidol (2–10 mg/day)
  - Mixed results for quetiapine and olanzapine
  - Metabolic syndrome, hypercholesterolemia, diabetes, obesity

Leppink EW, Grant JE. Pharmacological Augmentations of SRIs for Obsessive Compulsive Disorder. In: Abramowitz JS, et al (Eds). *The Wiley Handbook of Obsessive Compulsive Disorders*. Wiley; 2017.

Augmentation Strategies (cont'd)

- **Glutamatergic drugs**
  - Memantine, an NMDA receptor antagonist (5–20 mg/day)
  - N-acetylcysteine (NAC) (600–2400 mg/day)
  - Topiramate (150–200 mg/day)
  - Lamotrigine (100 mg/day)
  - Negative studies of riluzole and glycine, an NMDA agonist
- **Other agents**
  - Pindolol (pre-synaptic 5-HT_{1A} receptor antagonist) – mixed studies (7.5 mg/day)
  - Once weekly morphine (30–45 mg/week)
  - Lithium, naltrexone, desipramine – negative studies

NMDA = N-methyl-D-aspartate.

Leppink EW, Grant JE. Pharmacological Augmentations of SRIs for Obsessive Compulsive Disorder. In: Abramowitz JS, et al (Eds). *The Wiley Handbook of Obsessive Compulsive Disorders*. Wiley; 2017.

Cognitive-Behavioral Therapy

Exposure and Response Prevention Therapy

- ERP consists of repeated and prolonged exposures to fear-eliciting stimuli or situations, combined with instructions for strict abstinence from compulsive behaviors
- Fear-eliciting stimuli or situations are presented in a hierarchical manner
- Therapist instructs patient to abstain from the compulsive behavior that the patient believes will prevent the feared outcome or reduce the distress

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Exposure and Response Prevention Therapy (cont'd)

- 60% to 85% of patients report a considerable reduction in symptoms with ERP and improvement is maintained for up to 5 years
- ERP can be delivered in multiple formats, including by telephone or by Internet with minimal therapist support, with similar efficacy
- ERP should be delivered weekly or twice weekly, for approximately 20 to 30 total hours of therapy
- After the short-term treatment, exposure therapy should be delivered as monthly "booster" sessions for 3 to 6 months to maintain gains

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Cognitive-Behavioral Therapy

Cognitive Therapy

- Cognitive therapy focuses on teaching patients to identify and correct their dysfunctional belief about feared situations
- Cognitive therapy assists patients in reducing anxiety and compulsions by identifying these automatic unrealistic thoughts and changing their interpretations
- When undergoing cognitive therapy, the patient keeps a daily diary of obsessions and interpretations associated with the obsessions
- Using Socratic questioning, the therapist challenges the unrealistic belief and helps the patient identify the cognitive distortion

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Cognitive Therapy (cont'd)

- Cognitive therapy has shown improvement in 60% to 80% of patients, with effect sizes almost as large as those with ERP
- As with ERP, dropping out of cognitive therapy prematurely is common (20%–30% of patients)
- Although cognitive therapy may be a viable alternative for patients who are reluctant to participate in ERP, ERP is supported by a larger body of empirical data and is therefore recommended as the first-line psychotherapy treatment for OCD

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Other Treatments?

- Exercise
- Transcranial magnetic stimulation (TMS) – just received FDA approval
- Ketamine
- Ablative surgeries
  - Anterior Cingulotomy: Success rate of 56%

Alonso P, et al. *PLoS One*. 2015;10(7):e0133591.

Top 5 Complex Patients

Patient #1

- 30-year-old woman who reports obsessions of contamination; will not touch anything outside of her home; takes her clothes off when returns from outside and keeps her apartment sealed off from the world
- Bathes upon returning home for about 5 hours, has rituals of washing in a particular order; if interrupted or it does not feel correct, she does it over and over
- Worsening over the last 2 years, leaving her completely housebound
- Calls daily, but cannot leave home to come for appointment
- How should this patient be evaluated and treated?

Treatment: *Patient #1*

- Skype or house call?
- If medication contaminated, then what?
- CBT/ERP

Patient #2

- 45-year-old male with harm OCD
- 20 years of OCD with limited improvement from previous treatments (trials of 5 SSRIs); currently on fluoxetine 80 mg
- Obsessions of harm to others – fears he has killed people from actions, goes to police and turns himself in weekly, bothers neighbors to see if they are OK

Treatment: *Patient #2*

- Get a clear history of all medication trials, doses, and durations of those doses
- Get history of therapy and whether he did exposures
- Consider augmentation with clomipramine; get EKG and start 50 mg/qhs; blood levels and follow-up EKG
- Consider memantine 10 mg/qam if clomipramine not effective

Patient #3

- 48-year-old man seeking treatment for obsessions regarding sacrilegious obsessions
- 2 years ago received opioids for back pain, worked for his obsessions; comes seeking treatment for his dual diagnosis
- What to treat first? How?

Treatment: *Patient #3*

- Educate about opioids and OCD
- Consider buprenorphine/naloxone for opioids (possibly OCD)
- CBT for addiction
- SSRI
- ERP for OCD

Patient #4

- 23-year-old male found in a grocery store
- Standing in the aisle for 8 hours
- Mumbling to himself
- Saying that there were bad foods, thought to be psychotic
- Taken to ED
- Had contamination issues and would bleach food before eating it

Treatment: *Patient #4*

- Get a clear history of all medication trials, doses, and durations of those doses and therapy history
- Had tried all SSRIs at high doses for at least 8 to 10 weeks and had done > 30 hours of ERP and cognitive therapy
- We started trial of clomipramine (250 mg/day)
- Limited benefit; added memantine (no benefit), then risperidone (no benefit), then aripiprazole (no benefit); another trial of ERP (no benefit)
- Consider ethical review for surgery

Patient #5

- 26-year-old male with obsessions about doing things “just right”
- OCD started when he was 19 years old; spending 3 hours/day with obsessive thoughts
- ERP was not helpful when he tried it 2 years earlier
- Presents to the Emergency Department with mania after 4 weeks on high dose of fluoxetine (80 mg/day)

Treatment: *Patient #5*

- Role of anti-epileptics?
- Suicide assessment
- Start SSRI – when and what dose?
- Start ERP again?

Practical Take-Aways

- OCD is a common, disabling psychiatric disorder
- OCD commonly co-occurs with other disorders
- Standard treatments of SSRIs and ERP may not be enough