

Risperidone as Monotherapy for a Patient With Obsessive Compulsive Disorder Comorbid With Schizoaffective Disorder: A Case Report

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Abstract: Data on the efficacy of antipsychotics as monotherapy for obsessive-compulsive disorder (OCD) are inadequate. This report presents the case of a patient with OCD that was successfully treated with risperidone as monotherapy. Assessments revealed significant reductions in OCD symptoms after risperidone treatment (4 mg/d). This report suggests the beneficial effect of risperidone for a patient with OCD comorbid with schizoaffective disorder.

Key Words: risperidone, obsessive compulsive disorder

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The pharmacotherapy of patients with manic episodes comorbid with obsessive compulsive disorder (OCD) is a noteworthy problem because antidepressants that are effective for OCD may precipitate manic/hypomanic or mixed episodes.¹ Therefore, we usually prescribe antipsychotics for patients with OCD who have concomitant manic symptoms and avoid the use of antidepressants. Herein, we present the case of a patient with OCD comorbid with schizoaffective disorder with manic episodes who benefited from risperidone as monotherapy for OCD.

CASE REPORT

Mr. B, a 44-year-old single male with a middle-class socioeconomic status and living with his parents, had suffered from irritable mood, an increase in goal-directed activity, talkativeness, psychomotor agitation, distractibility, and grandiosity and was diagnosed as having a bipolar I disorder, single episode, at age 17 years. He was hospitalized and received mood stabilizer treatment. After discharge, he was regularly followed up at the psychiatric outpatient clinic. However, the symptoms, including persistent delusion of reference and disorganized behaviors, were noted to be without prominent mood disorder after the manic episode remitted at age 30 years. The diagnosis then was changed to schizoaffective disorder. He was hospitalized several times from age 17 to 44 years because of either manic episodes or psychotic symptoms. Occupational functioning impairment was elicited. He had taken clozapine 200 to 300 mg/d for the last 10 years.

In August 2013, he was admitted to our acute psychiatric ward with complaints including obsessive thoughts and compulsive behaviors for 1 month before admission. The obsessive doubts included the names of strangers on the bus, the details of television programs, and the things in other people's bags. The compulsions included asking the stranger's name, writing down

the words he saw on TV, as well as opening and skimming through other people's bags. His Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)² total score was 37 on the first day of admission. He denied suicidal or violent ideation; he had no significant medical disease; and he denied previous illicit drug use. There were neither active manic nor psychotic symptoms of schizoaffective disorder upon admission. He had taken clozapine (225 mg/d), lithium (600 mg/d), carbamazepine (600 mg/d), and escitalopram (up to 30 mg/d) for OCD during the 20 days before admission.

We cross-titrated the medication from clozapine to aripiprazole and shifted from escitalopram to paroxetine to treat the OCD after admission (Fig. 1). Paroxetine was started from 40 mg/d. Aripiprazole was started at 5 mg/d and elevated to 10 mg/d after 5 days. Twenty days later, his obsessive compulsive symptoms (Y-BOCS score, 21) had improved a lot. However, he reported hands tremor, manic symptoms including irritability, talkativeness, and distractibility, as well as an increase in goal-directed activity.

Because of hands tremor and manic symptoms, we discontinued paroxetine, aripiprazole, and lithium and prescribed clozapine 100 mg/d and valproic acid. The manic symptoms improved, but the OCD exacerbated (Y-BOCS score, 36). We continued using valproic acid 1200 mg/d and carbamazepine 600 mg/d and changed medication from clozapine to olanzapine using the cross-titration strategy. However, the OCD persisted after using olanzapine 15 mg/d (Y-BOCS score, 36). He also described marked sedation, lower leg weakness, and falling down at midnight with olanzapine use.

We changed olanzapine to risperidone because of the above adverse effects. Risperidone was titrated steadily to 4 mg/d. He was discharged 16 days later and reported a decrease in OCD severity (Y-BOCS score, 7) without the emergence of a mood episode. He was regularly followed up at our psychiatric outpatient department, and the Y-BOCS score was 5 at 8 weeks after discharge. No other drug-related adverse effects were noticed.

DISCUSSION

In the present case, the OCD could have occurred naturally or been induced by clozapine. We observed that the OCD symptoms of this patient dramatically improved after a switch from olanzapine to risperidone (Y-BOCS scores, 36–7). There are no reports supporting the use of valproate or carbamazepine for OCD.³ Therefore, our data suggest that risperidone monotherapy may be efficacious for monotherapy of a patient with OCD comorbid with schizoaffective disorder.

Atypical antipsychotics have a curious relationship with OCD symptoms. While they are effective as an augmentation strategy in OCD, they also have been shown to give rise to de novo OCD symptoms in people with psychosis.^{4,5} Atypical antipsychotics block 5HT receptors at low doses, and the D2 blockade increases as the dose increases.⁶ 5HT blockade at low doses may aggravate OCD symptoms, and dopamine blockade at higher doses may explain the improvement of OCD symptoms at higher

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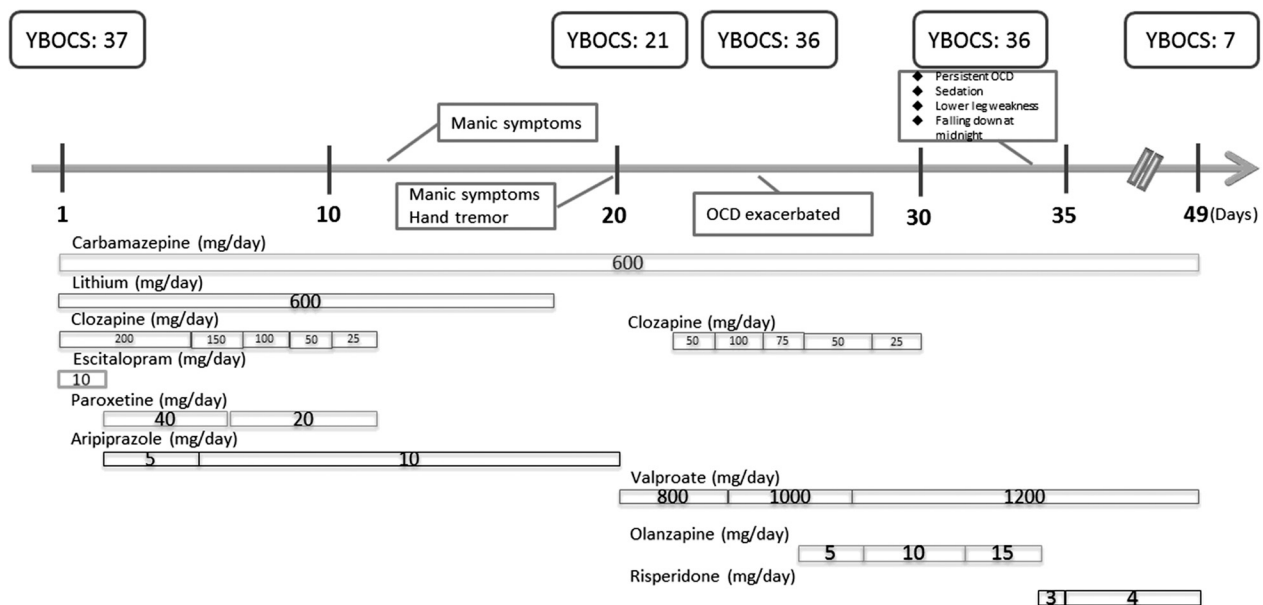


FIGURE 1. Medications record during the last hospitalization of Mr. B.

doses. Some clinical evidence supports this dose-response relationship.⁷

Risperidone is an antagonist of the serotonin 5-HT_{2A}, dopamine D₂, α_1 - and α_2 -adrenergic, and histamine H₁ receptors. Its affinity in vitro is 20× higher for 5-HT_{2A} than for D₂ receptors; in vivo, it occupies 5-HT_{2A} receptors at a dose 10× lower than it does in D₂ receptors.⁸ Distinct from haloperidol, risperidone has been shown to dose-dependently increase extracellular concentrations of 5-HT in rat frontal cortex.⁹

In a previous study, an increase in 5-HT_{2A} receptor binding was noted in the caudate nuclei of untreated patients with OCD.¹⁰ The up-regulation in 5-HT_{2A} receptors might be compensatory for decreased serotonin in the feedback loop between the thalamus and orbito-frontal cortex, the caudate nuclei, and the globus pallidus. This explains the effectiveness of risperidone, which has a high affinity for 5HT_{2A} receptors.

Based on previous studies, risperidone^{6,11–13} is the only antipsychotic that is consistently effective as an augmentation treatment for OCD when compared with placebo. Three placebo-controlled randomized controlled trials^{14–16} have shown that risperidone is effective as an augmentation strategy. Furthermore, risperidone is the first choice when an antipsychotic is considered for augmentation in OCD, followed by aripiprazole and haloperidol, whereas olanzapine and quetiapine require further study.³

CONCLUSIONS

To our knowledge, this is the first report of risperidone used for monotherapy of OCD in clinical practice. The present report suggests the beneficial effects of risperidone in OCD comorbid with schizoaffective disorder.

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