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Comorbid bipolar affective disorder and obsessive compulsive disorder in childhood: A case study and brief review

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Abstract: Obsessive compulsive disorder and bipolar affective disorder in the pediatric population show a bidirectional overlap. Few studies that have addressed this issue show that the prevalence of obsessive compulsive disorder in bipolar affective disorder patients ranges from 0 to 54%, and 1.85 to 36% of the obsessive compulsive disorder patients have a comorbid bipolar affective disorder. We report a case of a patient with an onset of obsessive compulsive disorder at two-and-a-half years of age, who developed mania after exposure to escitalopram. We suggest that in pediatric obsessive compulsive disorder cases, antidepressants be used with caution, especially in cases with a positive family history of bipolar affective disorder.

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Full text: Introduction

Childhood mental disorders are known for their associated comorbidities; childhood bipolar affective disorder and obsessive compulsive disorder are no different. They are marked with multiple comorbid anxiety disorders, mood disorders, and disruptive behavior disorders. It was once considered that bipolar comorbidity in obsessive compulsive disorder was rare and a systematic investigation in this area was not done until recently. [1] Even today, there is a dearth of literature in this area, when childhood population is considered. We report the case of a child presenting with obsessive compulsive disorder and bipolar disorder at a very young age. A review of the relevant literature has been undertaken, to compile the information on comorbidity of bipolar disorder and obsessive compulsive disorder in childhood. A Pubmed search was done using the keywords, 'childhood', 'adolescent', 'obsessive compulsive disorder', 'bipolar disorder', 'antidepressant-induced mania / hypomania,' and relevant articles were retrieved supplemented with a manual search of cross-references.

Case Report

The index patient, a four-year-old male, from a rural background of eastern India, presented with irritability for 18 months. He would frequently gesticulate as if he was brushing something off his clothes. He would say, "chhiya gaya hai" (local dialect of Hindi, meaning: "there's filth on my clothes and body") whenever someone would touch him and would be irritated. In the seven months prior to presentation he used to urge his family members to wash his dresses with detergent repeatedly. After being touched by someone he would insist on getting bathed, using an unusually excessive amount of water, and taking a long time before he would let the attendant take him out of the bathroom. He would also repeatedly touch the private parts of the female members of the family. Another noted feature was his habit of repeatedly hitting himself or biting his body parts. On asking about these he would not provide any explanation, but would say that he did not like doing these. There was a family history of bipolar disorder in the maternal grandfather. However, the birth, prenatal, postnatal, and developmental history was unremarkable. When admitted in hospital, there were few occasions of tearfulness. He would often demand that the bed sheets and linens be washed several times a day, as they were not satisfactorily clean. The self-injurious behaviors also continued. Entertaining a diagnosis of obsessive compulsive disorder he was started on escitalopram 5 mg per day and behavioral intervention was done for the self-injurious behaviors. He showed improvement in his overall condition and was discharged on that regime. At follow-up after four months, he showed increased goal-directed behaviors, an unusual cheerful mood, and the

parents reported increased socialization. The diagnosis of obsessive compulsive disorder with mania was made; he was re-admitted, escitalopram was stopped and tablet lithium 600 mg per day was started, and was increased to 750 mg (serum level 0.92 mmol / l) along with tablet risperidone 1 mg per day. On this regime the manic symptoms improved significantly. Risperidone was reduced to 0.5 mg for increased sedation. He was discharged on lithium 750 mg and risperidone 0.5 mg per day.

Discussion

Childhood bipolar affective disorder is different from the adult counterpart for its different clinical presentation (protracted irritability with frequent violent outbursts, confusing the picture with disruptive behavior disorder) and course (chronic and continuous rather than acute and episodic). It is also marked with frequent comorbidities and anxiety disorders, it often shows a bidirectional overlap. [2] There have been few studies investigating the comorbidities of anxiety disorder in childhood and adolescent bipolar disorder, which are summarized in [Table 1]. [1],[3],[4],[5],[6],[7],[8] These studies show that the prevalence of obsessive compulsive disorder in bipolar affective disorder cohorts, range from 0 to 54%. Among other comorbidities, separation anxiety disorder, generalized anxiety disorder, and attention deficit/hyperactivity disorder figure, prominently. However, most of the studies were flawed by the selection and referral bias and the recall bias of patients and their guardians. Also, there have been studies in pediatric obsessive compulsive disorder patients, where comorbid bipolar disorder has been assessed, which are summarized in [Table 2]. [9],[10],[11],[12],[13],[14] Among the primary obsessive compulsive disorder cases, bipolarity has been seen in 1.85 - 36% of the patients, and in those patients, the overall severity is higher, they respond poorly to medications, and in them, the age of onset of obsessive compulsive disorder is earlier than in the cases of pure obsessive compulsive disorder patients. {Table 1}{Table 2}

Antidepressant-induced manic / hypomanic switches in primary obsessive compulsive disorder cases have been very rare, especially in the pediatric population. [15],[16] The selective serotonin reuptake inhibitors (SSRIs) impose a lower risk in inducing a manic / hypomanic switch, compared to other antidepressants. [17] Cyclothymic and episodic variants of obsessive compulsive disorder have been described in adults, which are pointers toward latent bipolarity. [18],[19],[20],[21] However, there has been no study addressing these issues in children or in the adolescent population. In our case the age of onset of obsessive compulsive disorder was two-and-a-half years. To the best of the authors' knowledge this is one of the youngest patients with obsessive compulsive disorder ever reported. He also developed mania around four months after exposure to escitalopram. A positive family history of bipolar disorder has been seen in our case, which might have paved the way for the onset of bipolarity in this case of a child who initially presented with obsessive compulsive disorder.

Bipolar affective disorder and obsessive compulsive disorder comorbidity is not uncommon in children or the adolescent population, although studies addressing this issue have been scarce. In our opinion, an index of suspicion for bipolarity is always required in childhood obsessive compulsive disorder cases with a family history of bipolar disorder, and the use of antidepressants in these cases has to be judicious.

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