

A DIFFICULT CASE OF AN ANXIETY DISORDER

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A young man was referred by his external psychiatrist for inpatient treatment with a history of significant obsessive-compulsive symptoms over a number of years, with hand washing, checking rituals, opening and closing cupboards a certain number of times, time-consuming shower rituals, repeated picking of scabs on his skin, ritualistic posturing of standing on one leg whenever he had to struggle with doing anything new, including trying on fresh clothes. He had a compulsive ritual of jumping down flights of stairs and this had resulted in the need for knee reconstruction surgery a year ago. He has been seeing his highly regarded psychiatrist and respected senior clinical psychologist as an outpatient for a long time. This is the first time he has agreed to inpatient care despite many such recommendations over the years because of poor treatment gains as an outpatient for a variety of reasons.

As he continued to pick on his scabs before and after his admission into the ward, his scabs worsened and he required antibiotics. However, he felt anxious about taking anything new. A tiny portion of the antibiotic tablet contents went onto the skin of his index and middle fingers of his right hand as he fiddled and sweated, whilst ruminating and debating internally whether he should ingest the new tablet. He reluctantly took the tablet but after returning to his room, he made repeated attempts to rub off and wash away the supposedly still remaining antibiotic contents on the skin of his fingers. In a panic state and within the next hour, he proceeded frenetically to rub the "new things" on his fingers with a towel and he sustained second-degree skin thickness burns in the process. It appeared that obsessions over contamination fears served to trigger the compulsive skin rubbing episode. A skin graft was recommended following review by the hand surgeon who saw him in the general hospital.

He was treated and monitored closely to prevent any further picking. A plaster cast was put in place as a precaution. His treatment consisted of a significant dose of clomipramine, as he experienced sub-optimal response to a number of SSRI (specific serotonin reuptake inhibitors) antidepressants such as sertraline and fluoxetine over the years for a number of reasons. Clomipramine is considered a more potent agent. He saw his clinical psychologist to address a very tailored individualized gradual exposure response prevention program. Nursing staff members soon learned to be especially vigilant of his adherence to medications, after discovering his attempts to avoid taking them. A sedating atypical antipsychotic medication at an adequate dose was also given to ease his anxious state. Over a number of weeks, he made significant partial improvement in terms of his physical recovery from the damage to his hand as well as his symptoms such that he was discharged from inpatient care to continue day patient and outpatient treatment.

General Treatment Considerations for Obsessive-Compulsive Disorder

The above is certainly not a typical case of OCD by any means. Professionals involved in his treatment before his admission confided that he was certainly the most challenging of the numerous cases of OCD they had treated in their experience.

OCD was previously thought to be relatively rare in the general population but more recent community studies have estimated a lifetime prevalence of 2.5%. It can be associated with significant debility and much suffering not only to the patient but also to their families.

The cognitive-behaviour therapy (CBT) technique of exposure and response prevention, as well as serotonin reuptake inhibitors (SRIs include clomipramine as well as SSRIs such as fluvoxamine, fluoxetine, sertraline, paroxetine, citalopram and escitalopram) are widely accepted as first-line treatments. Antipsychotic medications may enhance treatment response in some cases. Some uncomplicated cases may respond to just CBT or SRIs.

For those very much considered treatment resistant, after much effort with combined psychological and pharmacological treatments, the options are limited with novel treatments including transcranial magnetic stimulation, deep brain stimulation, vagus nerve stimulation and psychosurgery in some other places.

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