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COMORBIDITY IN AUTISM SPECTRUM

Paule Philippe[1], Jean-Marc Scholl[1] & Jessica Jacques[2]

[1]Liege Autism Reference Centre, University Hospital Centre, Université de Liège, Liège, Belgium
[2]University Hospital Centre, Université de Liège, Liège, Belgium

Objectives

We wish to describe the work of the presentation of the Liege Autism Referal Centre, its legal limits and the clinical work of the team. We also wish to discuss the issue of co-morbidity, which constitutes an important part of our work.

Background

The Liege Autism Referal Centre opened in March 2006. More than 300 patients have been examined in the centre so far. It's situated on the eleventh floor of the Brull Building, Liege University's day-clinic, (quai Godefroid Kurth, 35 - 4020 LIEGE).

The legal limits set up by the Belgian National Health Insurance Institute (INAMI) for any Belgian autism reference centre are:

- for patients under 18 years, 8 four-hour-modules are allowed to make the assessment.
- for patients over 18 years, a total of 16 hours are only allowed.

At the end of our work, we have to draw up a report containing our clinical diagnosis as well as the advised orientation and we have to hand it in to the patient. As for patients with Pervasive Developmental Disorders, a follow-up consultation can be arranged to reappraise the diagnosis and orientation value on the basis of 10 hours a year during 5 years, renewable 1 time.

Population of the liege autism reference center

The population of cases who have been assessed at the centre is described in figures 1, 2 and 3.

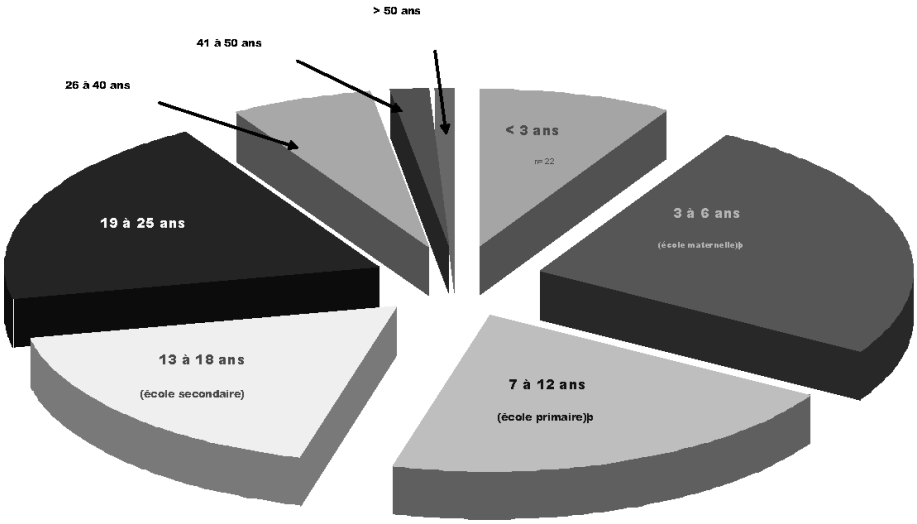

Figure 1. Distribution by age

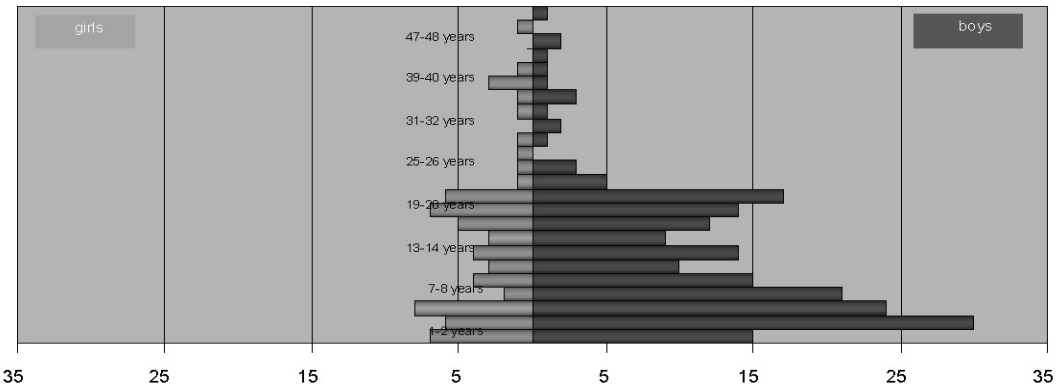

Figure 2. Distribution by age and by sex

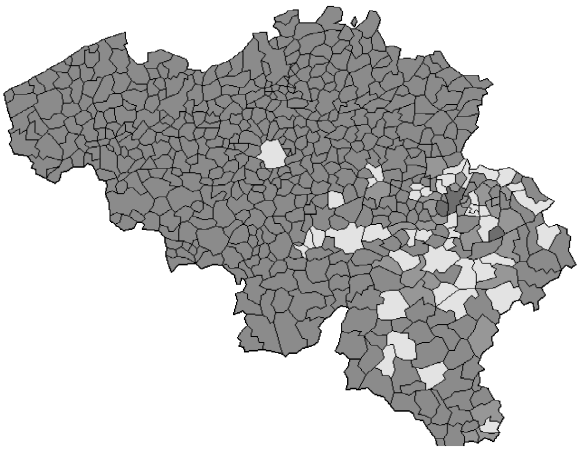

Figure 3. Sector of recruitment

Clinical activity

Our multidisciplinary team includes an orthophonist, a psychomotor therapist, 2 neuropsychologists, 3 psychologists, 1 secretary, 1 social worker and 3 medical doctors: 1 neuropaediatrician and 2 childpsychiatrists. *Our clinical diagnostic work of assessment* includes detailed anamneses and a range of scales and questionnaires, variable according to patients and situations. We can carry out direct observations at home or at school. We also collect all the patient's previous reports. We use a number of standardised scales and tests in our work: CARS (Childhood Autism Rating Scale), ADI-R (Autism Diagnostic Interview-Revised), PEP-R (Psycho-Educational Profile), The Vineland Adaptive Behavior Scale, neuropsychological assessment, IQ (WISC 4)

Here we describe further the issues of co-morbidity which is an important part of our work.

Comorbidity in the autism spectrum

Pervasive development disorders diagnosis tools are now universally used and validated. But nowadays comorbidity is usually neither searched for, nor diagnosed nor treated whereas comorbidity is the rule rather than the exception in PDD. Scientific articles describe at least one associated psychiatric pathology in 70 % of PDD and two or more diseases in 40 %.

Comorbidity consists of temporal coexistence of two or more disorders. But the pathologies are not simply concomitant; they are nested into one another and can arise at different moments in the child's development, each one evolving on their own behalf and interfering with the patient's symptomatology.

Comorbidity must be distinguished from differential diagnoses where the presence of one particular pathology rules out further diagnoses (the rule in the DSM IV R).

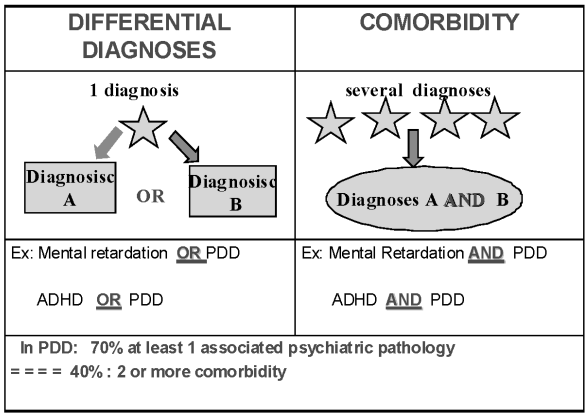

Figure 4. Diagram to show the difference between assessing a differential diagnosis and two co-morbid conditions.

Methods

Here we list the main PDD comorbidity found in literature; (percentages, which will vary according to the different research studies).

Results

Mental retardation and epilepsy are 2 forms of comorbidity that appear to have the most negative influence on the evolution of a child with PDD/Visual or auditivo sensory deficit/Sensory Peculiarities: (hyper or hypo sensibility)/Morphological abnormalities

Table 1. Comorbidity

As described in the literature	as revealed in our center
Mental Retardation	+
Epilepsy	+
Visual or auditivo sensory deficit	+
Sensory Peculiarities: (hyper or hypo sensibility)	+
Morphological abnormalities (MRI)	+
Genetic Syndromes	+
Sleep disorders	+
ADHD	+
Mood disorders: depression, hypomania	+
Anxiety disorders	+
OCD	+
Schizophrenia	+
Dysphasia	+
Dyspraxia	+
Developmental Coordination Disorder	+
Medical history: prematurity	+
Reactive Attachment Disorder of Early Chilhood	+

MRI/ Genetic Syndromes / Sleep disorders / ADHD / Mood disorders: depression, hypomania / Anxiety disorders / OCD / Schizophrenia / Dysphasia / Developmental Coordination Disorder / Medical history: prematurity / Reactive Attachment Disorder of Early Chilhood.

In addition to psychotherapy and support to relatives, some of the comorbid disorders hold out the possibility of specific care and some others can respond to an accurate pharmacological treatment.

Conclusion

Comorbidity is the rule in PDD diagnosis; it is VERY important to look for comorbidies, to diagnose all of them and finally to best treat them.

References

1. *Le diagnostic d'autisme, quoi de neuf?» revue ENFANCE, janvier-mars 2009, édition PUF*
2. *L'Autisme: une autre intelligence» Laurent Mottron édition Mardaga, 2006.*
3. *Leyter O, Folstein S et al: Psychiatric Disorders in Children with Autism: Interview development and rates of disorders» J Autism Dev Disord, 2006.*
4. *Richtal AL, Schreck KA: Sleep problems in autism spectrum disorders: Prevalence, nature, and possible biopsychosocial aetiologies. in Sleep Medicine Reviews 2009.*

Correspondence:
Paule Philippe, MD
Autism Reference Centre, University Hospital Centre, Université de Liège, Liège
Addresses: policlinique Brull, quai G Kurth 45 4020 Liège; Belgium
E-mail: paule.philippe@chu.ulg.ac.be