

CO-MORBIDITY OF BIPOLAR AFFECTIVE DISORDER AND OBSESSIVE COMPULSIVE DISORDER IN A BEDFORD COMMUNITY PSYCHIATRY TEAM

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SUMMARY

This is a study of the prevalence and impact of co-existing bipolar affective disorder on patients with OCD, and the effect on their management within a community psychiatric team. We found that 16% of patients who visited psychiatric outpatients with a diagnosis of OCD had co-existing bipolar affective disorder. Of these the majority had bipolar affective disorder II (67%). Co-morbidity raised a number of challenges to patient management. Compared to the control group the patients with co-morbid bipolar affective disorder required a greater number of outpatients appointments, had a greater number of hospital admissions, were more likely to have been allocated a care coordinator and to have received psychological input.

Key words: OCD - bipolar affective disorder – co-morbidity

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BACKGROUND

Current evidence suggests that there is considerable co-morbidity of OCD with Bipolar Affective Disorder. Studies have demonstrated that 7-21% of patients with Bipolar Affective Disorder have an additional diagnosis of OCD (Krüger 2000, Joshi 2010, Magalhães 2010, Chen 1995). This link appears to be most prevalent in men; with a study showing 69% of those with co-morbidity to be male (Zutshi 2007). Studies looking at bipolar in patients with OCD found a prevalence of 15-15.7% (Joshi 2010, Perugi 1997). OCD is most commonly associated with Bipolar Affective Disorder II (Krüger 2000, Perugi 1999).

The significance of this association lies in the possible effects of co-morbidity on the phenotype of each condition and in the implications for treatment. Research suggests that patients with Bipolar Affective disorder experience a more episodic course of OCD. The symptoms of OCD are more severe in the depressive phase of BAD and tend to be less severe or absent during mania/ hypomania (Zutshi 2007). Patients with co-morbid OCD are more likely to have a history of rapidly cycling Bipolar Affective disorder (Magalhães 2010). Increased suicidality and alcohol dependency have also been noted (Krüger 2000, Magalhães 2010, Zutshi 2007, Perugi 2002, Lee 2008). Olanzapine has been demonstrated to be less effective in treatment of Bipolar Affective Disorder in patients with co-morbid OCD (Joshi 2010).

Given the growing evidence of the high rates and complex needs patients with this co-morbidity appear to require, we thought it important to look at the additional burden placed on health care resources. In this study we focused on the prevalence of bipolar disorder in outpatients with OCD. We then explored how the care

needs of patients with bipolar- OCD co-morbidity differed from those with OCD.

METHODS

Data was drawn from a database of outpatient visits to the Bedford East team at Bedford Hospital from 2006-2011. Diagnoses were classified according to ICD-10 criteria. All patients recorded as having a diagnosis of OCD were identified (N=58). We then analyzed the proportion of these patients recorded to have Bipolar Affective disorder I, bipolar affective disorder II or unspecified bipolar affective disorder (total N=9).

To study the effect of bipolar affective disorder on patients with OCD a control group of patients with OCD, without bipolar were randomly selected from the database. The following measures of health care requirements were compared: number of outpatients appointments required; the number of home/ hospital treatment admissions; whether or not a care coordinator was allocated; the number of risk factors listed, medications prescribed, and use of psychotherapy.

RESULTS

16% of the patients with OCD were also diagnosed with bipolar affective disorder. Of these 67% had Bipolar Affective Disorder II (Figure 1).

The group of patients with dual diagnosis attended a greater number of outpatients appointments. In addition 3 patients required hospital/ home admissions whereas no-one in the pure OCD group did. This was the case whether we examined the year 2010, or all years between 2006 and 2010 (Figure 2).

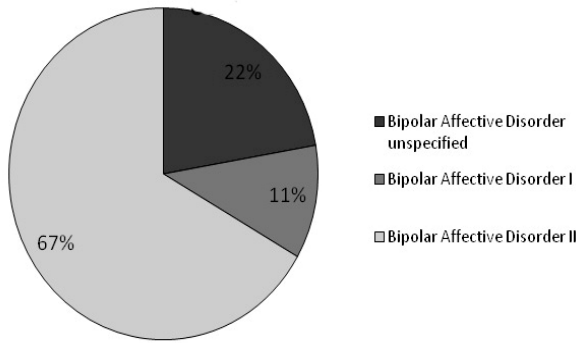


Figure 1. Which form of Bipolar Affective disorder is co-morbid with OCD

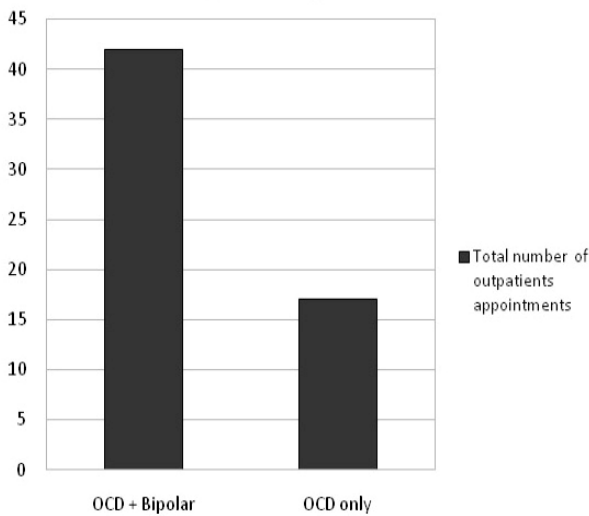


Figure 2. Number of outpatient appointments in 2010

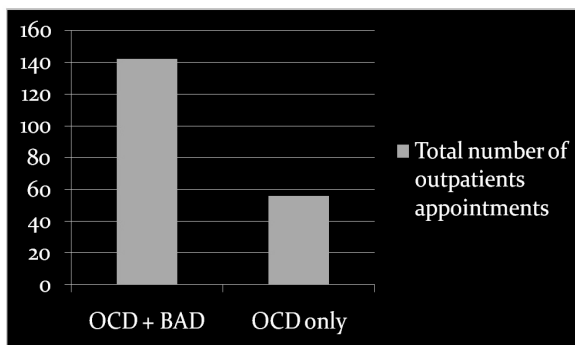


Figure 3. Number of outpatient appointments 2006-2010

Another measure of care needs is the allocation of a care coordinator. Only patients with more complex needs are assigned one. In this sample 78% of patients with co-morbid bipolar were either currently or had previously had a care coordinator; in comparison with 55% of patients in the control group (Figure 4a, Figure 4b).

Regarding risk factors, including suicide and self harm risk, there were more risk factors recorded in the self harm group than in the control group (Figure 5).

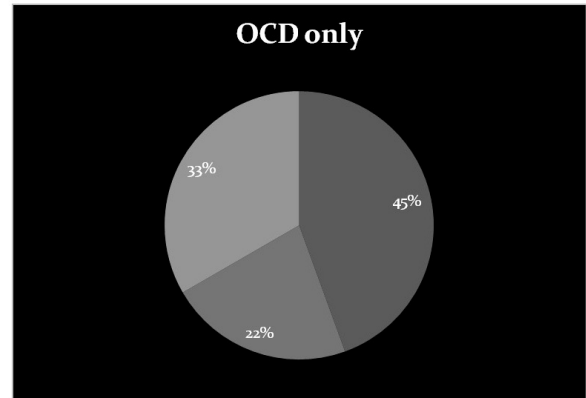


Figure 4a. Number of patients allocated a care co-ordinator in OCD only group

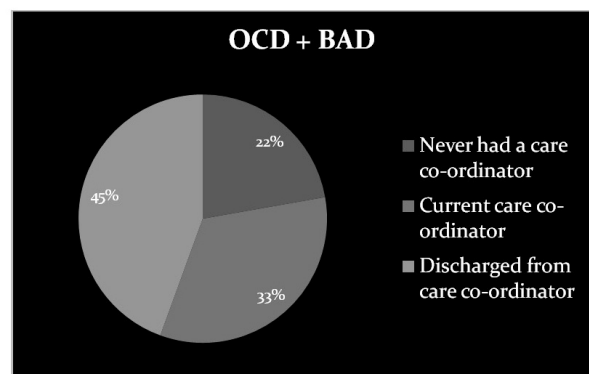


Figure 4b. Number of patients allocated a care co-ordinator in OCD+BAD group

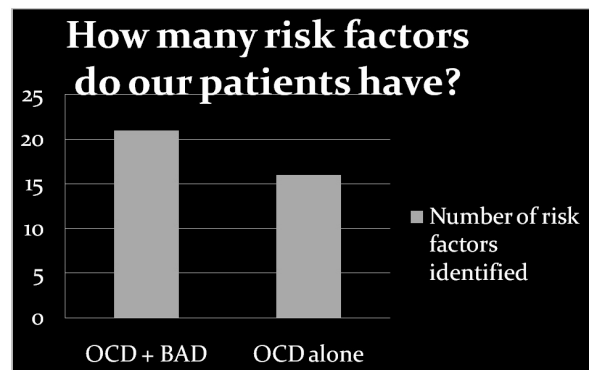


Figure 5. Number of risk factors logged in the two groups

MEDICATIONS

It is difficult to compare the use of medication. 44% of the patients with co-morbid bipolar were receiving the maximum dose of the antidepressant compared to 22% of those in the control group. However the drugs used were different so direct comparison is of limited use. An atypical anti-psychotic was prescribed to 78% of those with bipolar and 55% of the controls. Use of mood stabilizers was limited to the co-morbid group (55%).

Table 1. Medications used in the OCD+BAD group

Diagnosis (+ OCD)	Anti-psychotic	Anti-depressant	Anti-Manic
BAD I	Aripiprazole 30mg daily	Fluvoxamine 150mg bd,	Semisodium Valproate 1000mg bd
BAD II			
BAD II, GAD	Quetiapine 400mg daily	Paroxetine 60mg daily	
BAD II, Borderline PD	Quetiapine 200mg bd	Citalopram 40mg daily	Lithium Carbonate [priadel] 400mg daily
BAD II	Risperidone 2mg daily	Sertraline 200mg daily	
BAD II			Depakote 250mg bd
BAD II	Risperidone 3mg mane	Citalopram 60mg daily	Carbamazepine 400mg mane, 600mg nocte
BAD	Risperidone 2mg nocte	Clomipramine 150mg nocte	
BAD, anxiety, panic attacks	Quetiapine XL 300mg daily	Sertraline 50mg daily	Lithium carbonate 1200mg daily

Table 2. Medications used in the OCD only group

Diagnosis	Anti-psychotic	Anti-depressant
OCD		
OCD, mixed obsessional thoughts and acts		Sertraline 200mg daily
OCD		Citalopram 30mg daily
OCD	Aripiprazole 5mg mane	Fluoxetine 60mg daily
OCD	Risperidone 0.5mg bd	Venlafaxine XL 225 mg daily, Mirtazepine 15mg daily
Specific Phobia, OCD	Risperidone 1mg daily	Venlafaxine XL 225mg daily
OCD, Depressive episode		Mirtazepine 45mg daily, Clomipramine 60mg daily
Perinatal Depression, OCD	Stelazine 1mg bd	Venlafaxine 150mg daily
Generalised Anxiety Disorder, OCD	Stelazine 2mg bd	

The proportion of patients that had received psychotherapy was greater in the co-morbid group (67% vs 44%).

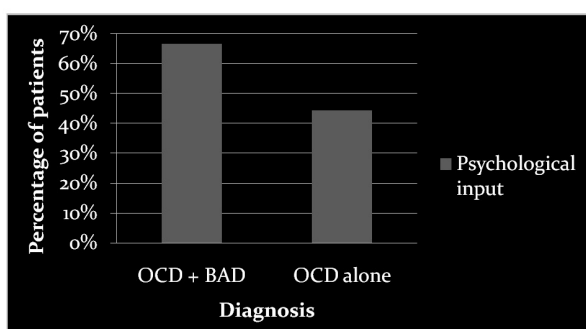


Figure 6. Patients who received psychotherapy in both groups

DISCUSSION

A substantial proportion of OCD patients seen by the team also had bipolar affective disorder. This is consistent with previous literature. We found that the patients with co-morbid OCD and Bipolar had more complex needs and drew more mental health care

resources than the control group. This is important to consider when planning resource allocation.

Treatment of co-morbid patients poses an interesting challenge. One of the first line treatments for OCD is use of SSRIs (selective serotonin re-uptake inhibitors). There is a significant risk of inducing mania or rapid cycling in patients with bipolar affective disorder (Perugi 2002, Go 1998). Prescription of medications for relief of the symptoms of OCD must be carefully balanced against the potential interaction with bipolar. Some suggest preferential use of non-pharmacological treatments for OCD such as CBT. If drug therapy is necessary SSRIs are thought preferable to tricyclic antidepressants and cover with a mood stabiliser may be important (Sasson 2003). Of our patients only 55% were on mood stabilizers, which is an area of possible concern. Another area to explore is only prescribing anti-depressants in the depressive/ euthymic phase of bipolar if OCD asymptomatic in hypomania/ mania.

Given that bipolar affective disorder may not be overt at the time of diagnosis of OCD it is important to carefully monitor all patients for signs of development of mania/ hypomania. This is vital if starting a patient of antidepressant medication. Further identification and understanding of the pattern of OCD in patients with

Bipolar will allow more effective therapy. Potential warning signs suggested include young age at presentation, hoarding type OCD (Perugi 1997, Lee 2008).

CONCLUSION

Further research is needed into link between obsessive compulsive disorder and bipolar affective disorder. Given the evidence for increased morbidity in co-morbid patients it will be important to find methods for early identification in order to provide appropriate care and support.

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