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Short Communication

Successful treatment of comorbid obsessive–compulsive disorder with aripiprazole in three patients with bipolar disorder

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Abstract

Data on the efficacy of aripiprazole in obsessive–compulsive disorder (OCD), compared to data on the efficacy of other atypical antipsychotics, are inadequate. This report presents the successful treatment of concurrent OCD with aripiprazole in three patients with bipolar disorder (BD). Assessments performed with the Yale–Brown Obsessive–Compulsive Scale revealed significant reductions in OCD symptoms. Aripiprazole may be a beneficial psychotropic agent for the treatment of BD and OCD comorbidity, which is an important problem in clinical practice.

Keywords: Aripiprazole; Obsessive–compulsive disorder; Bipolar disorder

1. Introduction

Obsessive–compulsive disorder (OCD) is one of the most common psychiatric disorders that negatively affects quality of life and leads to disability in occupational and social functioning [1,2]. Nonetheless, OCD could be associated with mood disorders, including bipolar disorder (BD). Studies suggest a relatively high lifetime OCD and BD comorbidity rate ranging from 9% to 39% [3–6]. OCD comorbidity is not only frequently seen but also associated with a significantly worse antimanic response and a more chronic course of BD [6,7]. In addition, the treatment of comorbid OCD is a notable problem in clinical practice because antidepressants that are effective for OCD may precipitate manic/hypomanic or mixed episodes.

In the past years, reports have pointed out a potential role for atypical antipsychotics in the treatment of OCD that is resistant to serotonin reuptake inhibitors. Aripiprazole is an atypical antipsychotic with a high-affinity partial agonistic activity on D_2 and $5HT_{1A}$ receptors and $5HT_{2A}$ antagonism [8]. Review and meta-analyses of randomized controlled trials suggest the efficacy of aripiprazole in the acute treatment and maintenance treatment of manic episodes [9,10]. Moreover, adjunctive aripiprazole seems to be effective in improving response rate in patients with major depressive disorder [9]. New data in the literature suggest a role for aripiprazole in the treatment of OCD. These reports include aripiprazole augmentation of serotonin reuptake inhibitors in treatment-resistant OCD, or aripiprazole in the treatment of comorbid obsessive–compulsive symptoms in patients with schizophrenia [11–13]. This report presents the successful treatment of OCD comorbid with BD with aripiprazole in three cases.

2. Case presentations

The patients were examined at the Psychiatry Outpatient Clinic of the Meram Faculty of Medicine at Selcuk University. All of the cases were diagnosed with BD (BD I in Cases 1 and 3, and BD not otherwise specified in Case 2) and OCD according to *The Structured Clinical Interview for DSM-IV Axis I Disorders* [14]. The severity and type of obsessive–compulsive symptoms were assessed using the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) [15]. All patients reported that obsessive–compulsive symptoms negatively affected their social functioning and quality of life, in turn causing marked distress and anxiety. None of the

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patients had any other psychiatric diagnoses. All patients gave written informed consent for the publication of data.

2.1. Case 1

A 23-year-old single male was admitted to the outpatient clinic with complaints including inappropriate thoughts and repetitive behaviors during the last 8 months. He had a history of manic episode 18 months ago. There were no active symptoms of BD episode upon admission. Y-BOCS showed the existence of contamination obsessions and cleaning/washing and checking compulsions. The Y-BOCS total score was 30. The patient was taking only lithium (900 mg/day), with a serum level of 0.88 mEq/L at the time of admission. There was no history of treatment with any antiobsessional or antidepressant drugs. In addition, he stated that he had not taken any antipsychotic medication within the last year.

After the psychiatric evaluation, aripiprazole was added to lithium. Aripiprazole was started at 10 mg/day and elevated to 15 mg/day after 7 days. Four weeks later, he reported a decrease in OCD symptom severity without the emergence of any mood episode. During this interview, the Y-BOCS total score was 21. The same score was 12 at the end of 8 weeks. He reported no significant side effects.

2.2. Case 2

A 24-year-old single male presented to the outpatient clinic due to hypomanic symptoms, including elevated mood, decreased need for sleep, being more talkative than usual, distractibility and an increase in goal-directed social activity that did not cause marked impairment in functioning since 2 weeks ago. He had no previous history of any mood episode. Lithium (1200 mg/day) and olanzapine (10 mg/day) were administered. The hypomanic symptoms were resolved within the following 4 weeks. During the second interview performed at 4 weeks, he also described obsessive–compulsive symptoms, including religious and sexual obsessions, and checking and miscellaneous compulsions, according to Y-BOCS. He reported that these symptoms had existed for approximately 3 years, and that the severity of the symptoms did not change throughout the treatment period of the hypomanic episode. The Y-BOCS total score was 27.

The patient was maintained on the same treatment (lithium, 1200 mg/day; olanzapine, 10 mg/day) that he had been taking for the hypomanic episode for 8 weeks. At the end of this period, there was no indication of an active episode of BD, and the Y-BOCS total score was 28. Olanzapine was gradually discontinued, and aripiprazole (15 mg/day) was initiated. Coadministration of the antipsychotics lasted for 14 days. The Y-BOCS total scores were 22 at 4 weeks following the initiation of aripiprazole, and 16 at 8 weeks following the initiation of aripiprazole. There was no evidence of a mood episode throughout the follow-up period. In addition, no significant side effects of aripiprazole were observed.

2.3. Case 3

The third patient was a 29-year-old married female who was referred to the outpatient clinic due to severe obsessive–compulsive symptoms. She reported that these symptoms had been present for approximately the past 7 years and had greatly exacerbated within the past 1 year. She had also been diagnosed with BD 4 years ago and had a history of one depressive episode and one manic episode. Three months previously, while she was on remission, paroxetine (20 mg/day) — in addition to the valproate (750 mg/day) that she had been taking prophylactically on the advice of a psychiatrist — was started because of severe obsessive–compulsive symptoms. Two weeks later, the patient was hospitalized in another hospital for manic episode symptoms for a total duration of 3 weeks. After the manic episode had been controlled, the patient was referred to the current outpatient clinic.

The patient was taking olanzapine (20 mg/day) and valproate (1000 mg/day), with a serum level of 85 μg/ml upon admission, and she had no significant mood symptoms. The present OCD symptoms included contamination and religious obsessions, and cleaning/washing, checking and miscellaneous compulsions. The patient had 34 points on Y-BOCS. She also described marked sedation due to olanzapine. The current antipsychotic medication was gradually switched to aripiprazole (25 mg/day). The intensity and frequency of the obsessive–compulsive symptoms diminished dramatically within 4 weeks. The Y-BOCS total scores were 18 and 12, respectively, at 4 and 8 weeks after the initiation of treatment with aripiprazole. This antipsychotic agent was well tolerated by the patient. Additionally, the patient was on remission during the observation period.

3. Discussion

To date, this appears to be the first report on the efficacy of aripiprazole in the treatment of OCD accompanying BD. According to the results of previous studies, this antipsychotic agent is useful in the treatment of OCD. A small open-label study by Connor et al. [16] suggested that 43% of patients with OCD responded to aripiprazole as monotherapy. Recently, Pessina et al. [12] noted that nine patients with treatment-resistant OCD showed significant improvement during the study period when aripiprazole was added to serotonin reuptake inhibitors. Moreover, Glick et al. [11] examined aripiprazole monotherapy in schizophrenia comorbid with OCD. They reported an improvement of greater than 35% on Y-BOCS in six of seven patients. The present cases suggest considerable effects of aripiprazole on OCD symptoms in these patients. According to Y-BOCS, the mean symptom reduction was 56.5% after the administration of aripiprazole in the cases.

Mood stabilization is the first objective in BD comorbid with OCD. After the stabilization, low doses of serotonin reuptake inhibitors could be considered in case OCD

continues [17]. However, in this situation, it is necessary to monitor the emergence of hypomanic/manic or mixed states [17]. In the present report, aripiprazole was administered to patients without an active mood episode.

Whether the improvement in symptoms is due to aripiprazole is unclear in these cases. However, aripiprazole was only an adjunctive drug in one case, and OCD symptoms dramatically decreased following a switch from olanzapine to aripiprazole in the other two cases. These findings suggest the therapeutic efficacy of aripiprazole in OCD accompanying BD. There data indicate successful aripiprazole monotherapy in pure OCD or in OCD comorbid with schizophrenia [11,16]. Moreover, different pharmacodynamic properties, including dopamine–serotonin stabilization of aripiprazole, may explain its effectivity [12,18].

A meta-analysis suggested that, compared to placebo, augmentation of serotonin reuptake inhibitors with standard or high doses of antipsychotics for the treatment of OCD appeared to be more effective than augmentation with low doses [19]. It is unclear whether the dose of aripiprazole could play a pivotal role in therapeutic response. In previous reports, aripiprazole monotherapy and augmentation doses were reported as 10–30 and 5–20 mg/day, respectively [11–13,16]. Similarly, in the cases described in the current report, the operative doses of aripiprazole were 15 and 25 mg/day. The effects of different aripiprazole doses were not evaluated in these cases.

In conclusion, the present report suggests the beneficial effects of aripiprazole in OCD comorbid with BD. If this report is confirmed by further controlled studies, aripiprazole may contribute to the resolution of an important problem in clinical practice.

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