
Letter to the editor

PRODROMAL OBSESSIVE-COMPULSIVE SYMPTOMS IN A CASE OF SCHIZOPHRENIA

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Dear Editor:

The relation between obsessive and/or compulsive symptoms and psychosis has been verified since the XIX century.¹ At present, this relation presents in different ways.^{2,3} In the first place, individuals with psychosis who show obsessive-compulsive symptoms (OCS)⁴ and that can present at the onset of the disease (prodromes).⁵ In the second place, the OCS can occur within the context of a psychosis, and can overlap with psychotic phenomenology, thus representing a "frustrated form of psychosis"⁵ and 3) the OCS induced by neuroleptics.² Finally, the OCS or obsessive-compulsive disorder (OCD)² within an already established schizophrenia (the so-called schizo-obsessive syndrome).⁶

A 19-year old male was referred from the day hospital to the acute hospitalization unit (AHU). He had two previous admissions in the AHU at 13 and 18 years of age and erratic follow-up in child psychiatry outpatient clinics. He has a family background of OCD. His father had "manías" during his childhood and facial motor tics and a bother is diagnosed of OCD.

First contact with the mental services was at 13 years of age due to "depression." At this age, he had an anxiety attack during an examination at school that he could not finish. After that, he experienced intense fear of going to school, so that he had school absenteeism during one year. As a result of this absenteeism, his parents observed counting rituals, hand washing rituals and repeated behaviors such as brushing his teeth up to 15 times, putting on his slippers many times. In the outpatient clinic, he was diagnosed of OCD and treated with sertraline 25 mg, risperidone solution 0.50 mg. and clorazepate dipotassium 5 mg. Shortly after, he was admitted to the child-youth acute unit of psychiatry due to behavior alterations. After, the patient returned to the outpatient children's clinic. During this period, his OCD course was torpid and reflected the psychosocial deterioration of the patient. Within a few months, an amotivation picture began while the obsessions and compulsions abated with

the treatment. At this time, he was diagnosed of "incipient psychosis."

At 18 years, the patient was admitted due to hostility towards his parents. Complementary tests were performed (lab. analysis, magnetic resonance, EEG, ECG, all of which were within normality). The treatment on discharge was fluvoxamine (200 mg/d) and aripiprazole (10 mg/d) and follow-up, preferable in his out-patient clinic.

During his evolution in the Mental Health clinic, where good therapeutic connection was made, he begin his first work as an administrative in a company, with an adequate relation with his peers, so that slow tapering of his medications was initiated. He has mild social withdrawal ("I only go out with my parents") and absence of own fantasies characteristic of his age ("I do not know what I will do with my first paycheck"). He does not have characteristic symptoms of OCD, he has laconic and impoverished speech during the interviews and maintains long silences, lack of spontaneity. The follow-up of the patient, both in the out-patient clinic of child psychiatry, in the AHU and finally in the out-patient clinics as well as the natural history of his symptoms and disappearance of the OCS after treatment at 14 years supports the diagnosis of simple schizophrenia.

Our case shows the variety of symptoms that can present at the onset of schizophrenia. It seems to be that schizophrenic patients with OCS during the prodromic phase are clinically different from those without OCS. This suggests the possibility of the classification of a subtype of schizophrenia.⁷ When the schizophrenia is established, the OCS may appear concurrently or shortly after the psychotic episode and also be related with the severity of the psychosis and the negative symptoms.⁸

Regarding the transition of an established OCD to schizophrenia, some authors have suggested its low frequency.⁹ The frequency of the change of diagnosis from OCD to schizophrenia has been established in already classic studies⁹ in which, however, there are methodological errors. They are generally young patients for whom the clinician always has diagnostic doubts at the onset of the picture, as occurred in our case. Apparently, the obsessive symptoms are shown on the first plane although the critical attitude of the obsessive ideation is generally partial. The change to the schizophrenia diagnosis generally occurs after a torpid evolution of the picture, poor response to treatment and the persistence of the initially obsessive ideation.⁹

Finally, our cases contributes an interesting observation regarding the child-youth backgrounds of children who develop adult schizophrenia. The results of prospective-type epidemiological studies indicate that between 23% and 61% of the children who obtained a diagnosis at a given time had a different diagnosis in subsequent evaluations.¹⁰

It would be necessary, as some authors point out,² to carry out a precise examination of the temporal course of the OCSs in relation to a possible prodromic symptom and thus be able to detect those children with schizophrenia (or even psychopathological factors that predict it) to generate preventive and therapeutic strategies that minimize the impact of this disease.

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