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Escitalopram Efficacy in Obsessive-Compulsive Disorder Comorbid with Bipolar Disorder

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To the Editor,

Bipolar disorder with comorbid obsessive-compulsive disorder (OCD) rates vary between 7 to 39%. Inversely, 15% of OCD patients present with bipolar disorder (BPD) comorbidity. Little is known on the efficacy and safety of pharmacotherapy in BPD comorbid with OCD. Registered indications for OCD and BPD do not cover comorbidity and no guidelines for the one exist (1-3).

We demonstrated a case of obsessive-compulsive-bipolar comorbidity that responded to divalproex plus high doses of escitalopram along with psychoeducation with behavioral intervention achieving functional remission of both Axis I disorders.

A 43-year-old Caucasian male with a 5-year history of psychiatric treatment was admitted to psychiatric ward with severe OCD with BPD in remission.

The psychiatric history revealed course of BPD with non-compliance and predominance of manic and mixed episodes. The patient had been diagnosed with BPD at the age of 38 and had been hospitalised three times. He had a good response to divalproex mood-stabilizing treatment resulting in full remissions lasting up to 2 years. The episodes of non-compliance resulted from lack of psychoeducation for BPD. OCD had started at the age of 22 and was associated with the functional impairment from that time on. The patient never reported his OCD symptoms up to the moment of the current admission because their content was unacceptable for him as they were related to compulsive behaviours focused on hand and whole body washing along with safety behaviours focused on avoidance strategies fixed on the risk of contamination with dirt. Thus, no OCD treatment had been started at any time and no remission periods had been observed with gradual increase in the OCD intensity.

Physical examination along with neurological evaluation and laboratory tests were normal. He was the only child and family history was negative for mental disorders. EEG revealed a normal pattern. He received divalproex with no concomitant medications. On admission the patient was euthymic. No psychomotor drive disturbances were noticed. He presented no psychotic symptoms. His consciousness was clear. No suicidality was present. The patient presented with numerous intrusive thoughts and actions lasting cumulatively up to 6 hours per day (score 31 points in Yale-Brown Obsessive Compulsive Scale [Y-BOCS]) (4).

In the course of the hospitalisation, mood-stabilizing treatment was maintained with divalproex 1000 mg pro die (serum level 80 µg/mL) and lithium 750 mg pro die (serum level 0.30 mmol/l). Escitalopram was started and tapered up to the dose of 40 mg pro die. Therapeutic response and tolerability of escitalopram were good.

Mild gastrointestinal symptoms appeared at initiation of escitalopram and moderate sexual dysfunction appeared afterwards and was present in course of the whole SSRI treatment period. Behavioural therapy for OCD and psychoeducation for BPD were performed. He obtained gradual and steady improvement in OCD symptomatology with good remission for BPD. On discharge, patient's Y-BOCS score was 16. During six-month-long follow up, his OCD symptomatology further reduced below and he remained in remission for both BPD and OCD. The treatment was kept with no changes from the moment of the discharge from the hospital. Valproate serum level was 76 µg/mL at that time.

For those with comorbid BPD and OCD, a combination pharmacological treatment of mood stabilizers and antidepressants is recommended and/or behavioural therapy is to be considered (5). Perugi and Toni (6) suggest divalproex is a preferable mood stabilizer for BPD patients with comorbid anxiety disorders. They note that antidepressants commonly used for OCD, such as SSRIs, may worsen BPD and atypical antipsychotics, commonly used for BPD, and may worsen OCD (7).

The patient described responded well to the treatment with escitalopram at the dose of 40 mg pro die resulting in functional OCD remission on discharge and in follow-up. As the patient presented stable BPD remission, we decided to keep the mood stabilizers doses at the levels applied prior to the current admission albeit subtherapeutic lithium level. Moreover, as we intended introducing escitalopram, we were cautious about the increase in the serotonergic transmission and the risk of serotonin syndrome as well as the risk of switch. The combined treatment with escitalopram and mood stabilizers was well tolerated and proved to be safe.

Clearly one must proceed with caution when attempting to treat the common occurrence of comorbid OCD and BPD. However, our case demonstrates efficacy and safety along with a good tolerance of the combination of divalproex and high doses of escitalopram in an OCD patient in the course of BPD.

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