Νέες θεραπευτικές προσεγγίσεις στην ΙΨΔ και τις συνδεόμενες με αυτήν διαταραχές

Δημήτρης Ρούκας
Ψυχίατρος
Σάμος, 03 Μαΐου 2019

Περίγραμμα παρουσίασης…

- Ιδεοψυχαναγκαστική διαταραχή (ΙΨΔ)
- Αυτοκτονικότητα και αλεξιθυμία στην ΙΨΔ
- Θεραπεία ΙΨΔ
- PANDAS και PANS
- ΙΨΔ και συναισθηματικές διαταραχές
- Τριχοτιλλομανία
- Σωματοδυσμορφοφοβική διαταραχή
- Παρασυσσώρευση
- Δερματιλλομανία (skin picking)
- Συμπεράσματα…

ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

ΙΨΔ ΚΑΙ ΣΧΕΤΙΖΟΜΕΝΕΣ Δ/ΧΕΣ

- Ιδεοψυχαναγκαστική διαταραχή
- Παρασυσσώρευση
- Σωματοδυσμορφοφοβική διαταραχή
- Τριχοτιλλομανία
- Δερματιλλομανία (skin picking)

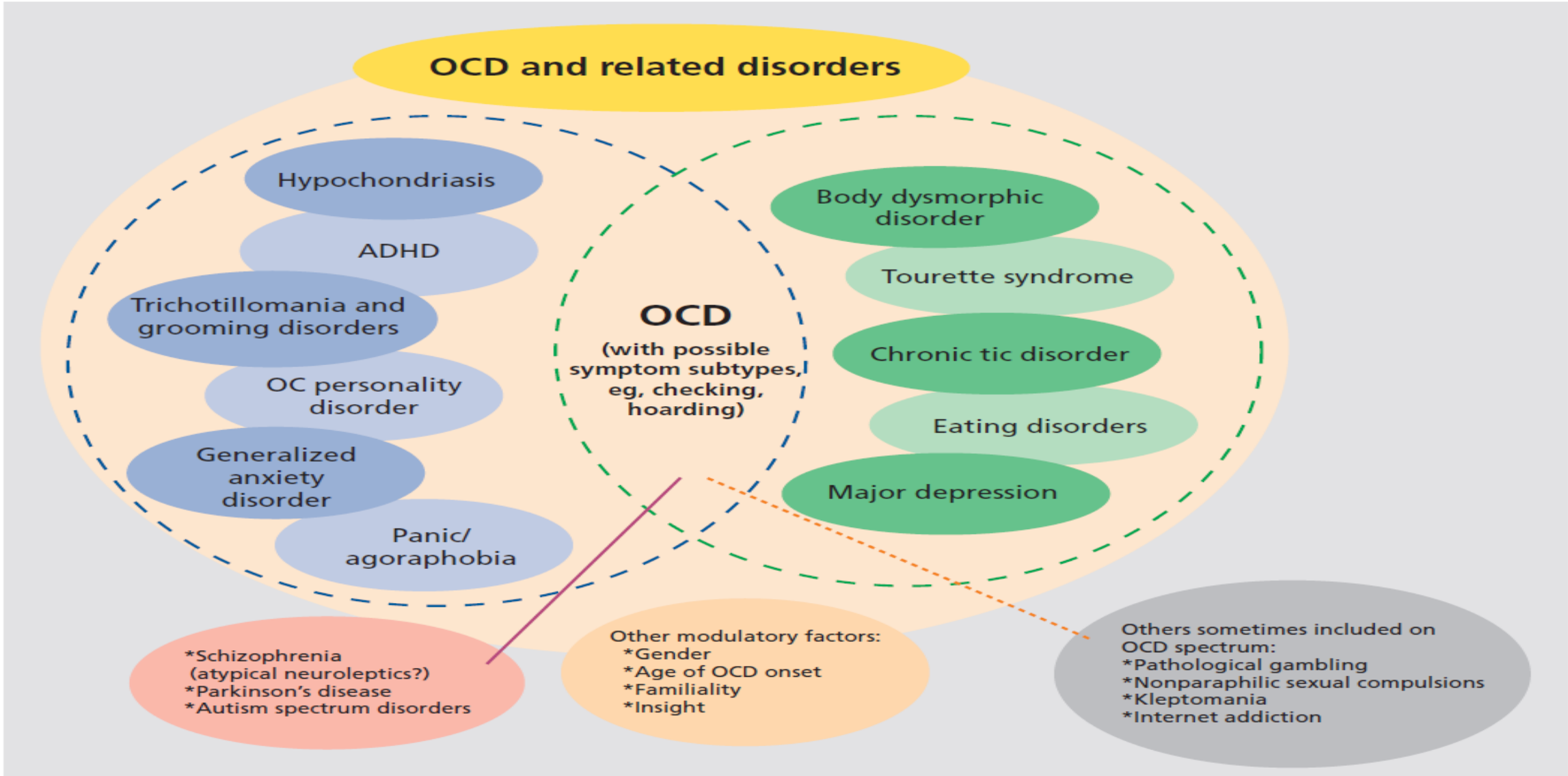

Figure 2. OCD and disorders comorbid with OCD.
Adapted from ref 12: Hollander E, Kim S, Braun A, Simeon D, Zohar J. Cross-cutting issues and future directions for the OCD spectrum. *Psychiatry Res*. 2009;170:3-6. Copyright © Elsevier/North-Holland Biomedical Press 2009, ref 19: Mataix-Cols D, Rosario-Campos MC, Leckman JF. A multidimensional model of obsessive-compulsive disorder. *Am J Psychiatry*. 2005;162:228-238. Copyright © American Psychiatric Association 2005, and ref 76: Murphy DL, Timpano KR, Wendland JR. Genetic contributions to obsessive-compulsive disorder (OCD) and OCD-related disorders. In: Nurnberger J, Berrettini W, eds. *Principles of Psychiatric Genetics*. Cambridge, UK: Cambridge University Press; 2010. Copyright © Cambridge University Press, 2010

ΕΠΙΔΗΜΙΟΛΟΓΙΑ ΙΨΔ

- 2% στο γενικό πληθυσμό
- Μέση ηλικία έναρξης 19.5 έτη
- 25% έναρξη στα 14 έτη
- Άνδρες έναρξη σε μικρότερη ηλικία
- Άνδρες : γυναίκες 1:1

ΕΠΙΔΗΜΙΟΛΟΓΙΑ

- **Ανεργία 15 – 41% ασθενών με ΙΨΔ**

  (Eisen et al 2006 , Pinto et al 2006)

- **Κατάθλιψη 17 – 60% ασθενών με ΙΨΔ**

  (Abramowitz, 2004, Frare et al 2004)

- **Απόπειρα αυτοκτονίας 11 – 27% ασθενών με ΙΨΔ**

  (Kamath et al 2007, Torres et al 2011)

ΣΥΝΥΠΑΡΞΗ ΜΕ ΑΛΛΕΣ ΨΥΧΙΚΕΣ ΔΙΑΤΑΡΑΧΕΣ

- Κατάθλιψη 60-80%
- Διπολική διαταραχή 21.5%
- Διαταραχή γενικευμένου άγχους 30%
- Ειδική φοβία 22%
- Κοινωνική φοβία 18%
- Διαταραχές πρόσληψης τροφής 17%
- Κατάχρηση αλκοόλ 14%
- Διαταραχή πανικού 12%
- Διαταραχή Tourette 7%

(Fineberg et al 2012)

ΔΙΑΣΤΑΤΙΚΗ ΠΡΟΣΕΓΓΙΣΗ ΤΗΣ ΣΥΜΠΤΩΜΑΤΟΛΟΓΙΑΣ

- «Απαγορευμένες» σκέψεις
  (επιθετικές, σεξουαλικές, θρησκευτικές)
- Αμφιβολία/έλεγχος (over responsibility for harm)
- Συμμετρία/τακτοποίηση
- Μόλυνση/καθαρμοί
- Παρασυσσώρευση

(Hasler, 2007)

ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

- **ΙΔΕΟΛΗΨΙΕΣ**
- **Μόλυνσης 45%**
- **Αμφιβολίας 42%**
- **Σωματικού τύπου 36%**
- **Συμμετρίας 31%**
- **Επιθετικότητας 28%**
- **Σεξουαλικού περιεχομένου 26%**

(Fullana et al, Am J Psych, 2009)

ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

- **ΚΑΤΑΝΑΓΚΑΣΜΟΙ**
- **Ελέγχου 60%**
- **Καθαριότητας 50%**
- **Καταμέτρησης 36%**
- **Ανάγκης εξομολόγησης/παράκλησης 31%**
- **Συμμετρίας 28%**
- **Παρασυσσώρευσης 18%**

(Fullana et al, Am J Psych, 2009)

Obsessive-Compulsive Disorder
Advances in Diagnosis and Treatment

Matthew E. Hirschtritt, MD, MPH; Michael H. Bloch, MD, MS; Carol A. Mathews, MD

Table 1. Common Obsessions and Corresponding Compulsions in Obsessive-Compulsive Disorder

Obsessions[a]	Specific Examples	Compulsions [b]	Specific Examples
Fear of contamination[c]	Preoccupation or disgust with bodily waste; repetitive concern of spreading illness	Cleaning or washing	Excessive hand washing or cleaning of household items (long after they are reasonably clean)
Persistent doubting	Anxiety that the house door is unlocked despite having just locked it, or that the oven is turned off despite having just turned it off	Checking	Repeatedly checking that oven is off, doors are locked; driving back along a road to ensure that no one was injured; excessively checking writing to ensure no error was made
Violent or sexual intrusive thoughts	Intrusive, unwanted violent or horrific images; unwanted sexual images of strangers, family, friends	Repetitive "undoing" thoughts	Repeated, "neutralizing" thoughts (eg, "I am not a violent person," repeated asking for reassurance that one did not commit a violent or unwanted sexual act)
Fears of causing harm	Intrusive fears of dropping an infant one is holding; fear of inadvertently hitting pedestrians when driving	Repeated behaviors, checking	Repeatedly driving past crosswalks to check for injured pedestrians
Symmetry	Excessive worry and distress if items on a bookshelf are not arranged symmetrically	Ordering or arranging	Repeatedly arranging books on a bookshelf so that the spines are exactly aligned
Religious scrupulosity	Excessive concern with "right vs wrong"	Religious compulsions	Excessive prayer or apologies to God; need to tell or confess
Superstitions	"Lucky" or "unlucky" numbers or colors	Superstitious behaviors	Avoiding writing unlucky numbers; repeating activities a certain "lucky" or "right" number of times

[a] Obsessions are unwanted, repetitive thoughts.

[b] Compulsions are repetitive behaviors or thoughts. Often, but not always, performed to address anxiety associated with obsessions. Avoidance behaviors are also common in response to many obsessions. For example, an individual with an obsessive fear of dropping infants may avoid interacting with children altogether.

[c] Individuals with contamination fears may not use public bathrooms or public transportation.

JAMA. 2017;317(13):1358-1367. doi:10.1001/jama.2017.2200

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journal homepage: www.elsevier.com/locate/ynicl

Association between hippocampus volume and symptom profiles in obsessive–compulsive disorder

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ARTICLE INFO

ABSTRACT

medication, disease duration and scanner. The patient group characterized by overall lower symptom scores and without high symptom severity in any specific domain showed the highest hippocampal volume. Finally, the comparison with healthy controls demonstrated significantly lower hippocampal volumes in those patients whose symptom profile was characterized by a high severity of ordering and checking symptoms.

comparison with healthy controls demonstrated significantly lower hippocampal volumes in those patients whose symptom profile was characterized by a high severity of ordering and checking symptoms.

Conclusions: Present results provide further confirmation for alterations in hippocampus structure in OCD and suggest that symptom profiles which take into account the multi-symptomatic character of the disorder should be given greater attention in this context.

ΑΝΤΑΠΟΚΡΙΣΗ ΣΤΗ ΘΕΡΑΠΕΙΑ ΜΕ SRIs

- "…Poor-insight into obsessions, symmetry/hoarding and contamination/washing dimension and the presence of certain personality disorders are associated with poor response to SRIs…"

(Hazari N, Narayanaswamy JC, Arumugham SS)

Expert Rev Neurother. 2016 Oct;16(10):1175-91

ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ ΚΑΙ ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

ΙΨΔ ΚΑΙ ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ

Συσχέτιση με αυξημένη σοβαρότητα:

Ιδεοληψίες σεξουαλικού επιθετικού και θρησκευτικού περιεχομένου

Καταναγκασμοί συμμετρίας - διάταξης

(Velloso et al 2016)

ΙΨΔ ΚΑΙ ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ

Άγχος σε ασθενείς με ΙΨΔ σχετίζεται με αυτοκτονικότητα

(Raines et al 2014, Storch et al 2015)

ΙΨΔ ΚΑΙ ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ

P. Velloso et al./European Psychiatry 38 (2016) 1–7

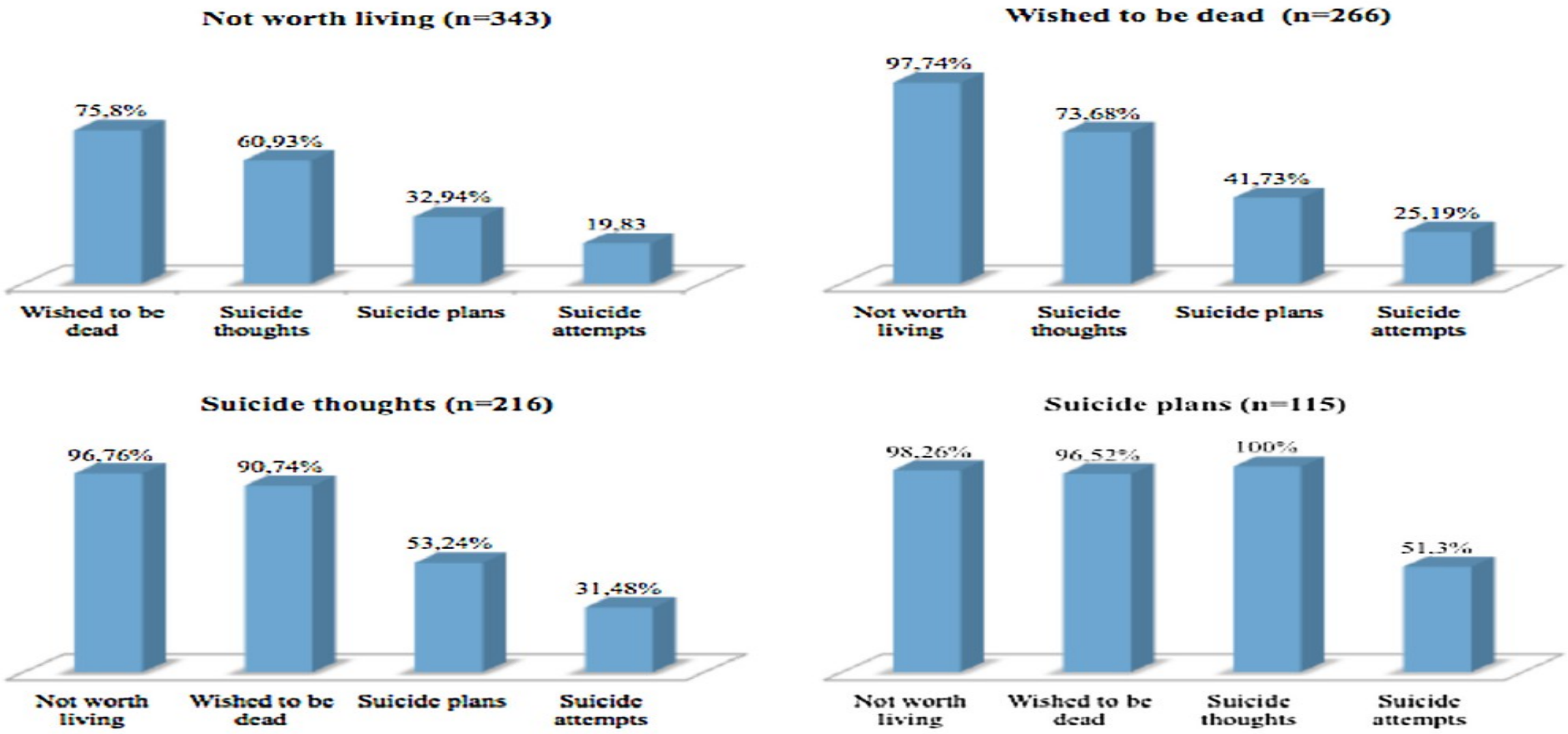


Fig. 1. Co-occurrence rates between the suicidal behaviors.

ΙΨΔ ΚΑΙ ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ

- **Οι ασθενείς με ΙΨΔ και αυτοκτονικότητα εμφανίζουν:**

- **Χαμηλή ποιότητα ζωής**
- **Ιστορικό απόπειρας αυτοκτονίας σε μέλος της οικογένειας τους**
- **Αυξημένα επίπεδα κατάθλιψης και άγχους**

(Velloso et al 2016)

ΑΛΕΞΙΘΥΜΙΑ ΚΑΙ ΙΨΔ

- Αλεξιθυμία εμφανίζεται στο 30 - 40% των ασθενών με ΙΨΔ και σχετίζεται με αυξημένη βαρύτητα συμπτωμάτων και πτωχή εναισθησία
- Η αλεξιθυμία σχετίζεται με αυξημένο κίνδυνο αυτοκτονίας στους ασθενείς με ΙΨΔ
- Η αλεξιθυμία σχετίζεται θετικά με ιστορικό απόπειρας αυτοκτονίας και αυξημένο κίνδυνο αυτοκτονίας ακόμα και όταν δεν αναγνωρίζονται καταθλιπτικής τάξης συμπτώματα

(De Berardis et al 2014)

Revista Brasileira de Psiquiatria. 2014;36:125–130

doi:10.1590/1516-4446-2013-1189

ORIGINAL ARTICLE

Alexithymia, suicidal ideation, and serum lipid levels among drug-naïve outpatients with obsessive-compulsive disorder

Domenico De Berardis,[1,2] Nicola Serroni,[1] Stefano Marini,[1] Gabriella Rapini,[1] Alessandro Carano,[2] Alessandro Valchera,[3] Felice Iasevoli,[4] Monica Mazza,[5] Maria Signorelli,[6] Eugenio Aguglia,[6] Giampaolo Perna,[7,8,9] Giovanni Martinotti,[3] Paola A. Varasano,[10] Gabriella Lucidi Pressanti,[10] Massimo Di Giannantonio[2]

Table 1 Comparison of Y-BOCS, SSI, and serum lipid levels between individuals with alexithymia (patients with a TAS-20 score ⩾ 61), without alexithymia (patients with a TAS-20 score ⩽ 61), and healthy controls, controlling for age, gender, BMI, and MADRS scores (data expressed as mean ± SD)

	Overall (n=79)	Scores ⩾ 61 on TAS-20 (n=24, 30.4%) (I)	Scores ⩽ 61 on TAS-20 (n=55, 69.6%) (II)	Controls (n=40) (III)	Between groups comparison (ANCOVA) (df = 1.78)	Post-hoc analysis (Bonferroni) p-values	Effect size (Cohen's d), alexithymics vs. non-alexithymics
Y-BOCS							
Total score	26.0±5.4	32.5±4.1	23.2±2.9	-	$F = 138.6$, $p < 0.001$	-	2.61
Obsessive subscale	14.1±2.8	16.9±2.4	12.8±1.9	-	$F = 68.6$, $p < 0.001$	-	1.54
Compulsive subscale	11.9±3.1	15.5±2.3	10.3±1.7	-	$F = 118.7$, $p < 0.001$	-	2.57
SSI	3.3±3.2	7.2±2.9	1.6±1.2	-	$F = 143.8$, $p < 0.001$	-	2.52
TC (mg/dL)	183.4±16.6	172.1±12.2	188.4±12.9	184.3±25.0	$F = 29.3$, $p < 0.001$	0.001 I < II, III	1.30
HDL-C (mg/dL)	51.7±8.6	44.5±3.4	54.8±8.4	53.6±9.4	$F = 45.6$, $p < 0.001$	0.001 I < II, III	1.61
LDL-C (mg/dL)	106.6±14.8	97.6±11.5	110.6±14.4	107.4±17.3	$F = 16.1$, $p < 0.001$	0.001 I < II, III	1.00
VLDL-C (mg/dL)	23.7±5.5	28.1±4.3	21.8±4.8	21.2±5.8	$F = 81.2$, $p < 0.001$	0.001 I > II, III	1.38
TG (mg/dL)	127.7±18.5	140.8±22.7	122.0±12.9	124.4±20.1	$F = 21.2$, $p < 0.001$	0.001 I > II, III	1.02
TC/HDL-C ratio	3.6±0.5	3.9±0.4	3.5±0.5	3.5±0.6	$F = 14.9$, $p < 0.001$	0.001 I > II, III	0.88
LDL-C/HDL-C ratio	2.1±0.4	2.2±0.3	2.1±0.4	2.1±0.5	$F = 3.9$, $p = 0.05$	0.05 I > II, III	0.28

ANCOVA = analyses of covariance; BMI = body mass index; df = degrees of freedom; HDL-C = high-density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol; MADRS = Montgomery-Åsberg Depression Rating Scale; SD = standard deviation; SSI = Scale for Suicide Ideation; TAS-20 = Toronto Alexithymia Scale; TC = total cholesterol; TG = triglyceridemia; VLDL-C = very-low-density lipoprotein cholesterol; Y-BOCS = Yale-Brown Obsessive Compulsive Scale.

ΙΨΔ ΚΑΙ ΑΥΤΟΚΤΟΝΙΚΟΤΗΤΑ

- **Παράγοντες που αυξάνουν τον κίνδυνο αυτοκτονίας σε ασθενείς με ΙΨΔ:**

- **Συνύπαρξη κατάθλιψης**
- **Αυξημένη βαρύτητα καταθλιπτικών συμπτωμάτων**
- **Αυξημένη βαρύτητα ΙΨΔ συμπτωμάτων**

(Balci et al 2010, Torres et al 2011, Fineberg et al 2013, Velloso et al 2016)

ΘΕΡΑΠΕΙΑ
ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗΣ ΔΙΑΤΑΡΑΧΗΣ

ΚΑΤΕΥΘΥΝΤΗΡΙΕΣ ΟΔΗΓΙΕΣ (WFSBP)

- **SSRIs και χλωριμιπραμίνη αποτελούν 1η επιλογή στη θεραπεία της ΙΨΔ**

- **SSRIs (εκτός σιταλοπράμης) Α 1**

- **Χλωριμιπραμίνη Α 2 (λόγω ΑΕ)**

(Kellner 2010)

ΔΟΣΟΛΟΓΙΑ SRIs ΣΤΗΝ ΙΨΔ

Table I. Adult selective serotonin reuptake inhibitor dosing guidelines for obsessive-compulsive disorder

Serotonin reuptake inhibitor	Starting[a]	Usual target	Usual maximum	Occasional[b]
Clomipramine	25	100-250	250	–[c]
Escitalopram	10	20	40	60
Fluoxetine	20	40-60	80	120
Fluvoxamine	50	200	300	450
Paroxetine	20	40-60	60	100
Sertraline[d]	50	200	200	400

ΔΙΑΡΚΕΙΑ ΘΕΡΑΠΕΙΑΣ

- **Συνεχιζόμενη θεραπεία με SSRIs στη μέγιστη αποτελεσματική δόση για διάστημα τουλάχιστον 12-24 μηνών και στη συνέχεια σταδιακή μείωση δόσης 10-20% κάθε 1-2 μήνες**

ΣΤΡΑΤΗΓΙΚΕΣ ΒΕΛΤΙΩΣΗΣ ΚΛΙΝΙΚΗΣ ΑΝΤΑΠΟΚΡΙΣΗΣ ΣΤΗ ΘΕΡΑΠΕΙΑ

- Αύξηση δόσης SSRI
- Αλλαγή SSRI
- Αλλαγή τρόπου χορήγησης SSRI
- Συνδυασμός SRIs

- Προσθήκη αντιψυχωτικού

- Προσθήκη άλλων φαρμάκων

ΠΡΟΣΘΗΚΗ ΑΝΤΙΨΥΧΩΤΙΚΟΥ ΣΤΗ ΘΕΡΑΠΕΙΑ ΤΗΣ ΙΨΔ

- **ΜΕΤΑ - ΑΝΑΛΥΣΗ ΓΙΑ ΑΝΤΙΨΥΧΩΤΙΚΑ**
- **Σημαντική αποτελεσματικότητα για ρισπεριδόνη, αριπιπραζόλη**

(Dold et al 2013, Veale et al 2014)

- **ΤΕΚΜΗΡΙΩΜΕΝΗ ΑΠΟΤΕΛΕΣΜΑΤΙΚΟΤΗΤΑ**
- **Ρισπεριδόνη ++**
- **Αριπιπραζόλη ++?**
- **Ολανζαπίνη + ?**
- **Κουετιαπίνη + ?**
- **Παλιπεριδόνη + ?**

(Maglione et al 2011, Storch et al 2013, Veale et al 2014)

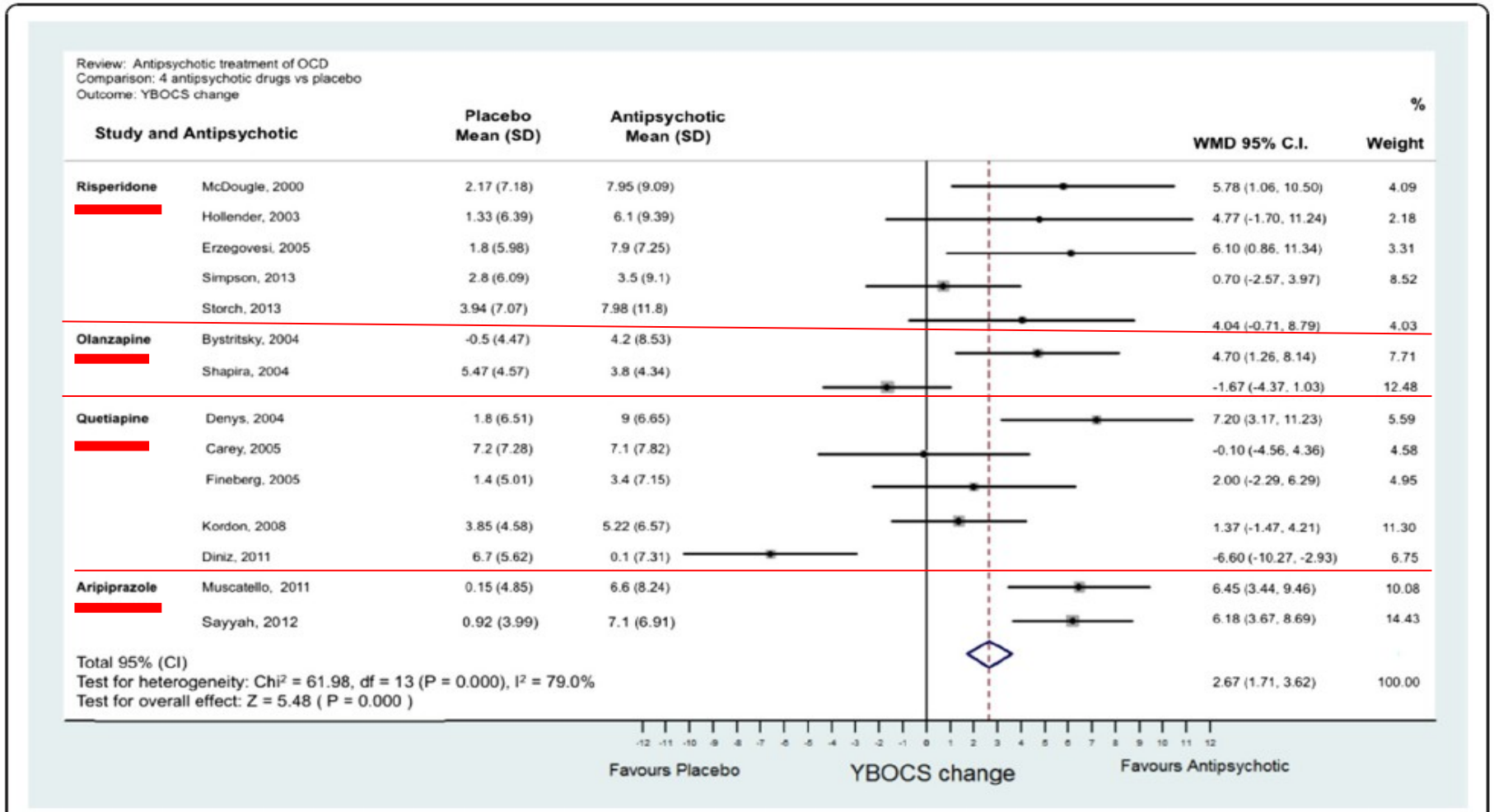
Veale et al. BMC Psychiatry 2014, 14:317
http://www.biomedcentral.com/1471-244X/14/317

BMC Psychiatry

RESEARCH ARTICLE Open Access

Atypical antipsychotic augmentation in SSRI treatment refractory obsessive-compulsive disorder: a systematic review and meta-analysis

David Veale[1,4*], Sarah Miles[1], Nicola Smallcombe[2], Haben Ghezai[1], Ben Goldacre[3] and John Hodsoll[1]



Antipsychotic augmentation in the treatment of obsessive-compulsive disorder

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Department of Psychiatry, OCD Clinic, NIMHANS, Bengaluru, Karnataka, India

Table 1: Antipsychotic augmentation in obsessive-compulsive disorder (taken with permission from the Indian Psychiatric Society guidelines for the management of obsessive-compulsive disorder, 2017)

Drug	Recommended dose (mg/day)	Strength of recommendation
Aripiprazole	5-10	A
Risperidone	1-3	A
Haloperidol	2.5-10	B

A – Consistent, good quality patient-oriented evidence, i.e., meta-analysis of RCT with consistent findings or high-quality individual RCT; B – Inconsistent or limited-quality clinical trials or studies with inconsistent findings/lower quality clinical trial/cohort study/case–control study. RCT – Randomized controlled trials

CONCLUSIONS AND RECOMMENDATIONS

Antipsychotics are currently the first-line pharmacological augmenting agents for OCD. Current evidence suggests that among patients augmented with antipsychotics, one in three SSRI-resistant OCD patients will show a response. Among antipsychotics, risperidone, and aripiprazole have the best evidence, with haloperidol to be considered as second-line owing to its unfavorable side-effect profile. Antipsychotics should be administered in low-to-medium doses and should be discontinued if there is an unsatisfactory response after an adequate trial not longer than 3 months. Long-term use should be considered only after weighing the risks and benefits.

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DOI: 10.1002/hup.2686

RESEARCH ARTICLE

WILEY

Treatments used for obsessive–compulsive disorder—An international perspective

Vlasios Brakoulias[1] | Vladan Starcevic[1] | Umberto Albert[2,3] | Shyam Sundar Arumugham[4] |

Results: The study surveyed 19 expert centres from 15 countries (Argentina, Australia, Brazil, China, Germany, Greece, India, Italy, Japan, Mexico, Portugal, South Africa, Spain, the United Kingdom, and the United States) providing a total sample of 7,340 participants. Fluoxetine (n = 972; 13.2%) and fluvoxamine (n = 913; 12.4%) were the most commonly used selective serotonin reuptake inhibitor medications. Risperidone (n = 428; 7.3%) and aripiprazole (n = 415; 7.1%) were the most commonly used antipsychotic agents. Neurostimulation techniques such as transcranial magnetic stimulation, deep brain stimulation, gamma knife surgery, and psychosurgery were used in less than 1% of the sample. There was significant variation in the use and accessibility of exposure and response prevention for OCD.

Conclusions: The variation between countries in treatments used for OCD needs further evaluation. Exposure and response prevention is not used as frequently as guidelines suggest and appears difficult to access in most countries. Updated treatment guidelines are recommended.

Obsessive-Compulsive Disorder
Advances in Diagnosis and Treatment

Matthew E. Hirschtritt, MD, MPH; Michael H. Bloch, MD, MS; Carol A. Mathews, MD

Table 3. First-Line Behavioral and Pharmacologic Treatment Options for Obsessive-Compulsive Disorder in Adults[a]

Modality	Description	Frequency and Duration	SMD (95% CI)	NNT (95% CI)
Psychotherapy				
Exposure-response prevention	Controlled, repeated, and prolonged exposure to obsession-triggering stimuli with instructions to avoid compulsive behavior	13-20 weekly sessions or weekday daily sessions for 3 wk; periodic "booster" sessions may be offered within 3-6 mo after initial treatment	1.33 (0.91-2.57)[b,40]	3 (2-5)[b,40]
Cognitive therapy	Identifying maladaptive/illogical beliefs about obsessions that drive behavior (eg, compulsions) and developing more useful schemas to counter erroneous appraisals/valuation of obsessions			
Medication				
	Starting Dose, mg/d	**Target Dose, mg/d**		
SSRIs[c]			0.61 (0.44-0.92) [d,e,44]	5 (3-8)[d,f,44]
Fluoxetine	20	80		
Fluvoxamine	50	300		
Sertraline	50	200		
Paroxetine	20	60		
Citalopram	20	40[g]		
Escitalopram	10	40		
Tricyclic				
Clomipramine	25	250[h]	0.95 (0.68-1.25)[i,45]	

Abbreviations: NNT, number needed to treat; SMD, standardized mean difference; SSRI, selective serotonin reuptake inhibitor.

[a] The treatment modalities described are associated with an "A" Grading of Recommendations Assessment, Development and Evaluation level of evidence. The references represent systematic reviews or meta-analyses.

[b] Comparators consisted of unblinded control conditions (n = 37 trials). There is insufficient evidence to support the superiority of cognitive therapy vs exposure-response prevention.

[c] Assess adequate response to SSRI therapy 8-12 weeks after initiation, with 4-6 weeks at maximal tolerable dose.[36,37] There is insufficient evidence to support the superiority of any particular SSRI over any other. All appear to have similar efficacies.

[d] Comparators consisted of blinded, placebo-control conditions (n = 17 trials).

[e] Assuming SD = 8.65 for the Yale-Brown Obsessive-Compulsive Scale.

[f] NNT may differ by dose.

[g] The Food and Drug Administration has issued a recommendation not to exceed a daily dose of 40 mg because of increased risk of QT-segment prolongation, and not to exceed 20 mg among certain populations (eg, >60 years, coadministration of cytochrome P450 2C19 inhibitors such as cimetidine).[46]

[h] Trough (≥12 h postdose) combined serum concentration of clomipramine and desmethylclomipramine should remain <500 ng/mL to reduce risk of seizure and cardiac-conduction delay.

[i] Comparators consisted of blinded, placebo-controlled conditions (n = 7 trials), fluvoxamine (n = 1 trial), and desipramine (n = 1 trial). There is insufficient evidence to support the superiority of clomipramine vs any of the SSRIs.

JAMA. 2017;317(13):1358-1367. doi:10.1001/jama.2017.2200

JAMA | Review

Obsessive-Compulsive Disorder
Advances in Diagnosis and Treatment

Matthew E. Hirschtritt, MD, MPH; Michael H. Bloch, MD, MS; Carol A. Mathews, MD

Deep-brain stimulation, which was initially piloted for the relief of movement disorders such as those found in Parkinson disease and has since expanded to include neuropsychiatric disorders, involves the surgical implantation of electrodes and the introduction of targeted electrical stimulation to specific brain regions. Deep-brain stimulation for OCD typically targets the anterior limb of the internal capsule/nucleus accumbens or thalamus/subthalamic nucleus.[75] Crossover trials comparing OCD symptomatology and severity when the implanted electrodes are on compared with when they are off demonstrate the efficacy of deep-brain stimulation for both brain regions,[75] and recent studies have further refined the brain regions of interest, improving treatment outcomes.[76] A meta-analysis of 31 studies involving 116 participants with OCD who underwent deep-brain stimulation estimated a 45.1% decrease in post-treatment Y-BOCS total score and a 60.0% response rate (defined as >35% reduction in post-treatment Y-BOCS score).[75] Although nonsurgical neuromodulation techniques, such as electroconvulsive therapy and repetitive transcranial magnetic stimulation, both of which have demonstrated efficacy in specific mood disorders, have been investigated in the treatment of OCD, the current body of evidence is too limited to comment meaningfully on their effectiveness in OCD.[77,78]

There are also several promising pharmacologic augmentation strategies for treatment-resistant OCD whose efficacy has not yet been clearly demonstrated. In particular, specific agents with adequate safety profiles and preliminary evidence of OCD symptom reduction in open-label or small RCTs include ketamine,[58,59] riluzole,[60,61] *N*-acetylcysteine,[62] memantine,[63] lamotrigine,[64] celecoxib,[65] and ondansetron.[66] There is also interest in the use of nutraceuticals such as myoinositol, glycine, milk thistle, and serotonin (5-hydroxytrypophan),[67] although there is insufficient evidence to support the routine use of any of these agents in treating OCD.

JAMA. 2017;317(13):1358-1367. doi:10.1001/jama.2017.2200

Glutamatergic augmentation strategies in obsessive–compulsive disorder

Indian J Psychiatry 2019;61:S58-65.

Karthik Sheshachala, Janardhanan C. Narayanaswamy

Table 2: Summary of Glutamatergic medications used in treatment of obsessive-compulsive disorder

Drug	Dose/day	Level of evidence	Adverse effects
Memantine	20 mg	2	Headache, somnolence, confusion (rare)
N-acetyl cysteine	2400 mg	2	Nausea, vomiting, flushing of skin (rare)
Lamotrigine	100 mg	2	Rash, SJS
Topiramate	≤200 mg	2	Renal stones
Riluzole	100 mg	2	Nausea, vomiting, fatigue, elevated LFT (rare)
Glycine	60 g	No evidence	Nausea, disagreeable taste, constipation
D-cycloserine	125 mg/infusion	No evidence	Headache, somnolence, vertigo, tremors, convulsions (at higher doses)

Level 2 evidence: Lesser quality RCT; prospective comparative study; retrospective study; untreated controls from an RCT. SJS – Steven–Johnson syndrome; LFT – Liver function test, RCT – Randomized controlled trial

These agents represent a viable alternative in treatment refractory patients, where better-proven strategies have been exhausted. Among these, memantine appears to be more promising in terms of the number of good quality positive trials. Ketamine for OCD is still in experimental stages, unlike in treatment of depression where encouraging results are obtained. However, there is a need to further evaluate its efficacy, given the rapid onset of action. It may lend itself as a molecule to examine the glutamatergic hypothesis of the disorder. Anticonvulsant medications – topiramate and lamotrigine – have demonstrated only a modest benefit. However, they may work in a small subset of patients. NAC has large RCT with positive results and some recent RCTs with negative findings. NAC may be considered as

Journal of
Clinical Pharmacy and Therapeutics

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N-acetylcysteine augmentation therapy for moderate-to-severe obsessive–compulsive disorder: randomized, double-blind, placebo-controlled trial

K. Paydary, A. Akamaloo, A. Ahmadipour, F. Pishgar, S. Emamzadehfard and S. Akhondzadeh

SUMMARY

What is known and objective: N-acetylcysteine (NAC) has been proposed as a potential therapy for obsessive–compulsive disorder (OCD) as it may regulate the exchange of glutamate and prevent its pre-oxidant effects. The aim of the present double-blind, placebo-controlled trial was to assess the efficacy and tolerability of NAC augmentation in moderate-to-severe (OCD) treatment.

Methods: In this randomized, double-blind, two-centre, placebo-controlled, 10-week trial, patients with moderate-to-severe OCD were enrolled. Patients were randomized into two parallel groups to receive fluvoxamine (200 mg daily) plus placebo or fluvoxamine (200 mg daily) plus NAC (2000 mg daily). A total of 44 patients (22 in each group) were visited to evaluate response to therapy using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) at baseline, and at weeks 4, 8 and 10. Side effects were recorded using predesigned checklists upon each visit.

Results and discussion: Repeated-measures ANOVA showed a significant effect for time × treatment interaction (Greenhouse–Geisser corrected: $F = 5{\cdot}14$, d.f. = 1·64, $P = 0{\cdot}012$) in the Y-BOCS total score and a significant effect for time × treatment interaction (Greenhouse–Geisser corrected: $F = 5{\cdot}44$, d.f. = 1·54, $P = 0{\cdot}011$) in the Y-BOCS obsession subscale between the two groups.

What is new and conclusion: Our results showed that NAC might be effective as an augmentative agent in the treatment of moderate-to-severe OCD.

PANDAS KAI PANS

Neuroscience and Biobehavioral Reviews 86 (2018) 51–65

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Neuroscience and Biobehavioral Reviews

journal homepage: www.elsevier.com/locate/neubiorev

Treatment of PANDAS and PANS: a systematic review

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Successful treatment of any medical disorder depends on careful diagnostic workup, identification of pathogeneses, appropriate treatment, and valid evaluation of response. In the field of PANDAS, PANS, CANS, and PITAND, all of these steps are problematic. Our findings indicate that there is no strong evidence to recommend treatment of PANDAS, PANS, CANS, and PITAND with antibiotics, tonsillectomy, immunomodulation, CBT, SSRIs, or neuroleptics. Nevertheless, in many case reports, authors note remarkable improvement after treatment with IVIG, antibiotics, and TPE and it is possible that flare duration may be shortened by NSAID or corticosteroids.

In the era of personalized medicine, symptoms of PANDAS, PANS, and PITAND and related disorders should be treated on a case-by-case basis. Careful collection of etiological clues and treatment outcomes can be beneficial to patients and the research field alike. While awaiting valid and well-designed RCTs, treatment of PANDAS and PANS with antibiotics, IVIG, TPE, and/or corticosteroids – in addition to SSRIs and CBT– can be defended in clinical practice if treatment response can be expected. For instance, the use of antibiotics and tonsillectomy may prevent recurring strep infections (Burton et al., 2014), and treatments with IVIG, TPE, NSAIDs, and corticosteroids should be considered in cases with clinical evidence of neuroinflammation. Our findings should encourage further evaluations of potential treatments for these disabling disorders.

Antibiotics for PANDAS?

Limited Evidence: Review and Putative Mechanisms of Action

Elisabetta Burchi, MD,[a,b,*] and Stefano Pallanti, MD, PhD[a,c,d]

Table 2. Neuroimmune Activities of Antibiotics and SSRIs

Activity	β-Lactams	Macrolides	SSRIs
Modulation of neurotrasmitter signaling	↑GLT1 ↑5-HT, DA ×GABA-A receptors ×Action on microbiota	×GABA-A receptors ×Action on macrobiota	
Immunomodulating effects	↓ROS, IL-1, IL-6, IFN-γ, TNF-α ↓Astroglial and microglial modulation	↓IL-6, IL-8, IL-12, TNF-α, TLR4, iNOS ↑IL-10 ↑Activated neutrophils	↓IFN-γ, IL-β, IL-2, IL-6, TNF-α ↓T cell proliferation ↑Lymphocyte apoptosis
Neurogenesis	↓Apoptosis		↑Hyppocampal neurogenesis

Abbreviations: DA = dopamine, 5-HT = 5-hydroxytryptamine (serotonin), GABA-A = γ-aminobutyric acid type A, GLT1 = glutamate transporter 1, IFN = interferon; IL = interleukin; iNOS = inducible nitric oxide synthase; ROS = reactive oxygen species, SSRI = selective serotonin reuptake inhibitor, TLR4 = toll-like receptor 4; TNF-α = tumor necrosis factor α.
Symbols: ↑ = increase, ↓ = decrease × = antagonism.

https://www.psychiatrist.com/_layouts/PPP.Psych.Controls/ArticleViewer.ashx?ArticleURL=/PCC/article/Pages/2018/v20n03/17r02232.aspx

ΚΑΤΑΘΛΙΨΗ ΚΑΙ ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

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Journal of Anxiety Disorders

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A network perspective on comorbid depression in adolescents with obsessive-compulsive disorder

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ARTICLE INFO

Keywords:
Obsessive-compulsive disorder
Depression
Network analysis
Comorbidity
Adolescent psychopathology

ABSTRACT

People with obsessive-compulsive disord
with greater symptom severit
symptoms in 87
direct
separate
obsessional pro-
the depression syndrome. A
ecede depression symptoms. Concentration
be distinctive to adolescents. We conclude that the
des a new way to understand the etiology and maintenance of
work analysis can improve research and treatment of mental disorder co-
ding hypotheses concerning potential causal symptom structures and by identifying
that may bridge disorders.

syndromes linked by bridge symptoms. Bridges between the two disorders emerged between obsessional problems in the OCD syndrome, and guilt, concentration problems, and sadness in the depression syndrome. A directed network indicated that OCD symptoms directionally precede depression symptoms. Concentration

Factors Associated with Depression in Obsessive-Compulsive Disorder: A Cross-Sectional Study

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[2]Department of Psychiatry, Başkent University, Faculty of Medicine, Ankara, Turkey

ABSTRACT

Conclusion: Our study suggests that many factors are strongly associated with depression in OCD. Positive correlations between poor insight, severity of obsession and compulsion, and stressful life events during the last six months increased the risk of depression in OCD. Our study suggests that high level of avoidance, instability and retardation, history of suicidal attempt, and delayed treatment are other notable factors associated with the development of depression in OCD.

depression (OCD–MDD, n=77) were included in the study. All patients were diagnosed with OCD using the Structured Clinical Interview for DSM-IV. The Yale–Brown Obsessive-Compulsive Scale, Beck Anxiety Scale, and Beck Depression Scale were administered to all patients. After the socio-demographic and clinical variables and scales were accomplished, the OCD patients divided into two groups as OCD with or without depression and we compared their mean scores of the variables and scales. Univariate analyses were followed by logistic regression.

with depression in OCD. Positive correlations between poor insight, severity of obsession and compulsion, and stressful life events during the last six months increased the risk of depression in OCD. Our study suggests that high level of avoidance, instability and retardation, history of suicidal attempt, and delayed treatment are other notable factors associated with the development of depression in OCD.

Keywords: Obsessive-compulsive disorder, depression, symptom, factor

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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Patients with OCD report lower quality of life after controlling for expert-rated symptoms of depression and anxiety

Leila Jahangard[a], Vahid Fadaei[a], Arezoo Sajadi[a], Mohammad Haghighi[a], Mohammad Ahmadpanah[a], Nasrin Matinnia[b], Hafez Bajoghli[c], Dena Sadeghi Bahmani[d], Undine Lang[d], Edith Holsboer-Trachsler[d], Serge Brand[d,e,f,*]

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ARTICLE INFO

Keywords:
Obsessive-compulsive disorders
Comorbidities
Quality of life
Gender

ABSTRACT

Background: One to three percent of the a
Previous studies have also shown th
associated with self-rated
quality of life of
pressi

Results: Compared to healthy controls, patients with OCD reported a lower QoL, and had higher symptoms of depression and anxiety. This pattern was particularly pronounced among female patients with OCD. QoL was lower in patients with OCD, even when controlling for depression and anxiety. Results from binary logistic regressions showed that female gender, low QoL and higher symptoms of OCD, depression and anxiety together predicted status as patient with OCD.

ensions of
anxiety (Hamilton

QoL, and had higher symptoms of
among female patients with OCD. QoL was
depression and anxiety. Results from binary logistic
and higher symptoms of OCD, depression and anxiety together

ealthy controls, patients with OCD have a poorer quality of life and this is in-
ssion or anxiety, and is particularly pronounced among female patients. Thus, treatment of
take into account patients' comorbidities and gender.

Journal of Affective Disorders 235 (2018) 448–455

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Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

The role of eveningness in obsessive-compulsive symptoms: Cross-sectional and prospective approaches

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ARTICLE INFO

Keywords:
Eveningness
Chronotype
Circadian
Sleep
OCD

ABSTRACT

Background: Eveningness may be defined as th
Previous research has linked evening
highlighted circadian dysregulati
order (OCD). However, li
symptoms. Two st
toms, whil

Results: Results indicated that depression better accounts for the cross-sectional association between eveningness and OC symptoms. However, eveningness was found to be a more robust prospective predictor of change in OC symptoms in Study 2. Furthermore, sleep disturbance, but not total sleep time, partially mediated the relationship between eveningness and OC symptoms.

d OC
nd OC symp-

tween eveningness and OC
a prospective approach to examine
nge in OC symptoms over 4 months is
when controlling for depression symptoms.
counts for the cross-sectional association between even-
ss was found to be a more robust prospective predictor of change
re, sleep disturbance, but not total sleep time, partially mediated the
ss and OC symptoms.
thod self-report approach, unselected sample, and lack of experimental manipulation.
ese findings suggest that eveningness may contribute to the development of OC symptoms over
art due to its effect on sleep disturbance. Future research examining the role of circadian dysregulation
OCD may uncover novel physiological mechanisms.

ΔΙΠΟΛΙΚΗ ΚΑΙ ΙΔΕΟΨΥΧΑΝΑΓΚΑΣΤΙΚΗ ΔΙΑΤΑΡΑΧΗ

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ACTA PSYCHIATRICA SCANDINAVICA

Review

Diagnostic validity of comorbid bipolar disorder and obsessive–compulsive disorder: a systematic review

- ''Comorbid OCD in BD patients. Three population based studies conducted in Italy and USA, reported lifetime prevalence rates of comorbid OCD in BD patients ranging between 11.1% and 21% ''

- ''Comorbid BD in OCD patients. Two population based studies conducted, respectively, in USA and Germany, reported 6% and 10% of lifetime prevalence of comorbid BD in OCD adults''

A. Amerio[1,2], A. Odone[3,4],
C. C. Liapis[2,5], S. N. Ghaemi[6]

Journal of Affective Disorders 225 (2018) 227–233

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

Exploration of comorbid obsessive-compulsive disorder in patients with bipolar disorder: The clinic-based prevalence rate, symptoms nature and clinical correlates

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ARTICLE INFO

Keywords:
Bipolar disorder
Obsessive-compulsive disorder
Comorbidity

ABSTRACT

Background: Comorbidity ... ical attention ...

Results: OCD was found in 15.9% of patients. Earlier age at onset, more frequent pharmacological (hypo)manic switch and a higher rate of comorbid panic disorder were associated with comorbid OCD. In two-thirds (65.4%) of the OCD-BD subjects, obsessive-compulsive symptoms worsened or were confined to depressive episodes. Contamination obsession and checking compulsion were the most common types of obsessive-compulsive symptoms. Drug-induced (hypo)manic switch was observed in more than 60% of the OCD-BD subjects who were previously exposed to antidepressants. None of the OCD-BD subjects were taking antidepressants for OCD in the current specialty clinics.

...were ...ants for OCD in the ... and cross-sectional evaluation, and diffi- ... Korean BD patients was comparable to that of Caucasian patients. ...ore often linked to depressive episodes, a heterogeneous nosologic relationship ...ty of drug-mediated induction is suggested.

WILEY BIPOLAR DISORDERS

Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder

Obsessive compulsive disorder

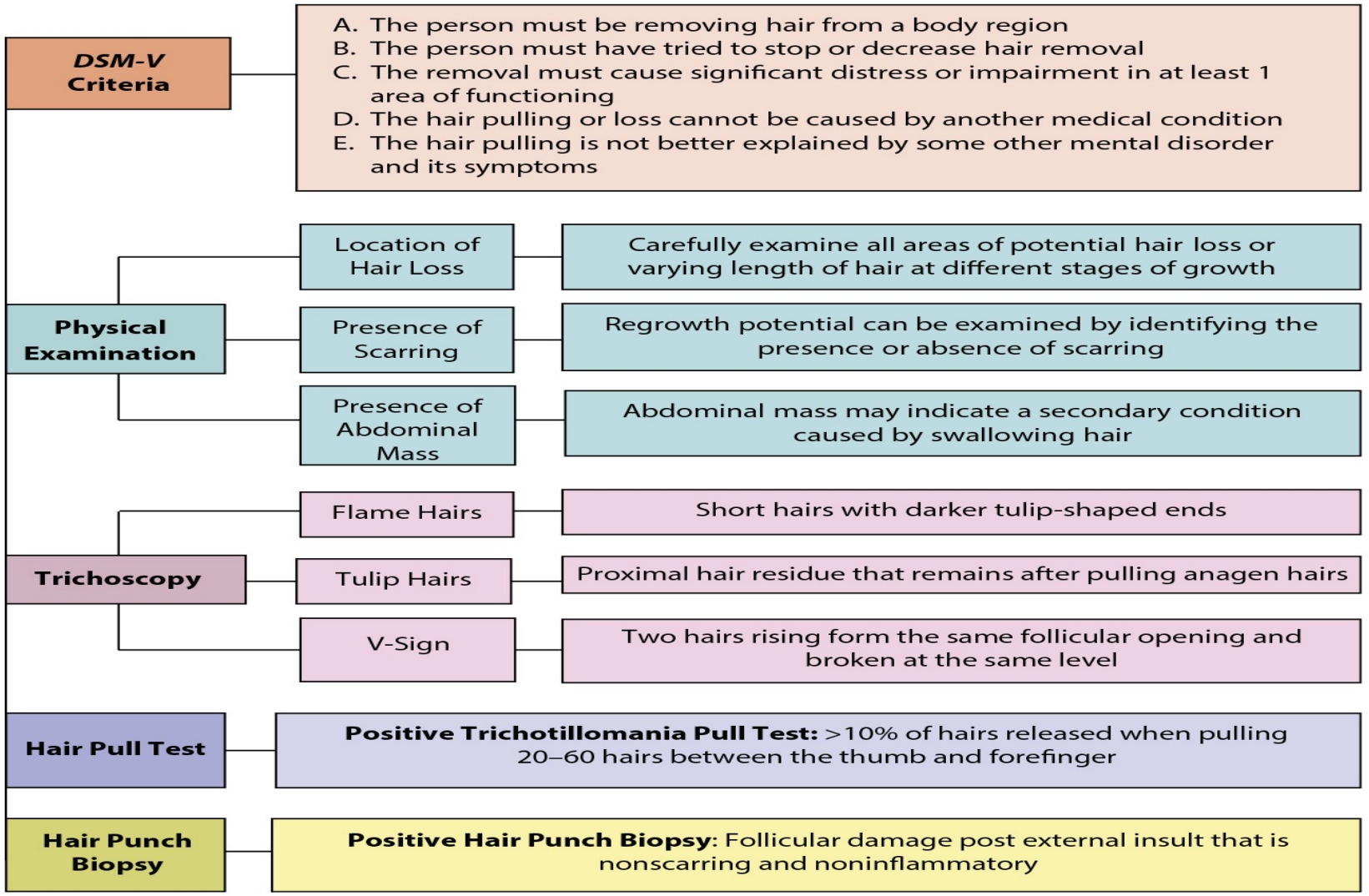
Obsessive compulsive disorder was re-categorized in DSM-5 and is no longer characterized as an anxiety disorder; however, anxiety is a cardinal feature. OCD is a comorbid condition in 10%-20% of patients with BD[730-733] compared with 2%-3% in the general population.[734] However, the prevalence appears to vary widely, depending on the clinical setting and bipolar subtype.[731] Comorbid OCD may be more common in children and adolescents with BD than in adults[731] and has timize prophylactic antimanic agents before initiation. The CANMAT Task Force 2012 report included several small case reports indicating the potential benefit of lithium,[743] anticonvulsants,[743,746] olanzapine,[747,748] risperidone,[749,750] quetiapine[751] and aripiprazole [752] for the treatment of comorbid OCD (all level 4 evidence).

Since the 2012 CANMAT publication, there has been very limited new evidence regarding the treatment of comorbid BD and OCD. Two published case reports described successfully employing aripiprazole once monthly[753] and orally[754] for patients with intractable bipolar and OCD symptoms. Another case report described benefits of ECT,[755] and a small trial also found benefits with adjunctive topiramate (level 3).[756]

ΤΡΙΧΟΤΙΛΛΟΜΑΝΙΑ

ΤΡΙΧΟΤΙΛΛΟΜΑΝΙΑ

Figure 2. Diagnosis of Trichotillomania



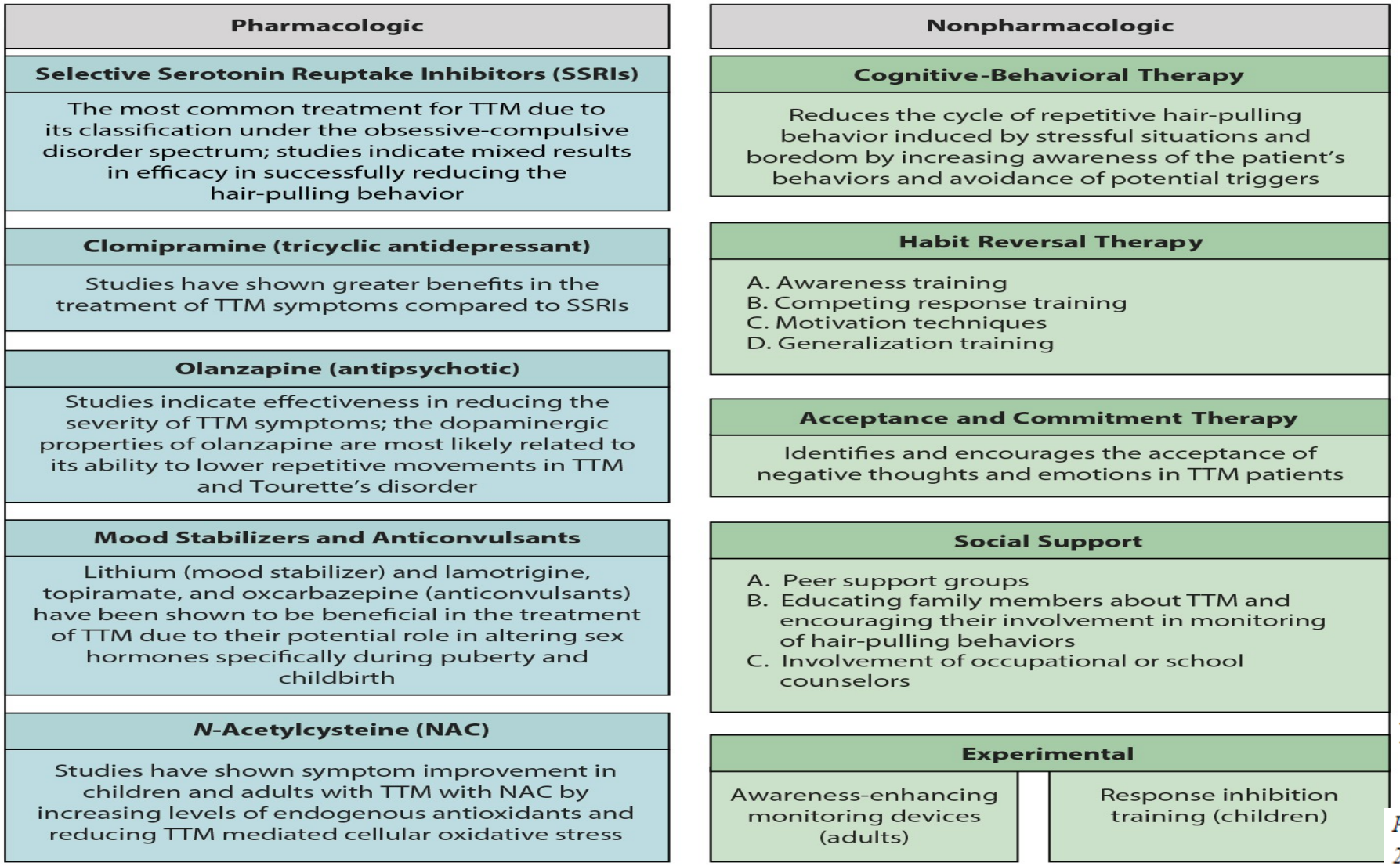
Mohammad Jafferany

Arsh Patel, MS[a]

Prim Care Companion CNS Disord 2018;20(6):18nr02344

ΤΡΙΧΟΤΙΛΛΟΜΑΝΙΑ

Figure 3. Treatment of Trichotillomania (TTM)



Mohammad Jafferany
Arsh Patel, MS[a]
Prim Care Companion CNS Disord
2018;20(6):18nr02344

Trichotillomania: a good response to treatment with N-acetylcysteine*

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Flavia Sternberg[1]
Gisele Jacobino de Barros Nunes[1]

DOI: http://dx.doi.org/10.1590/abd1806-4841.20175435

Abstract: Trichotillomania is considered a behavioral disorder and is characterized by the recurring habit of pulling one's hair, resulting in secondary alopecia. It affects 1% of the adult population, and 2 to 4.4% of psychiatric patients meet the diagnostic criteria. It can occur at any age and is more prevalent in adolescents and females. Its occurrence in childhood is not uncommon and tends to have a more favorable clinical course. The scalp, eyebrows and eyelashes are the most commonly affected sites. Glutamate modulating agents, such as N-acetylcysteine, have been shown to be a promising treatment. N-acetylcysteine acts by reducing oxidative stress and normalizing glutaminergic transmission. In this paper, we report a case of trichotillomania with an excellent response to N-acetylcysteine.

Keywords: Acetylcysteine; Alopecia; Glutamates; Trichotillomania

ΣΩΜΑΤΟΔΥΣΜΟΡΦΟΦΟΒΙΚΗ ΔΙΑΤΑΡΑΧΗ

ΣΩΜΑΤΟΔΥΣΜΟΡΦΟΦΟΒΙΚΗ ΔΙΑΤΑΡΑΧΗ

- Η σωματοδυσμορφοφοφική διαταραχή χαρακτηρίζεται από έντονη ενασχόληση του ατόμου με ένα ή περισσότερα φανταστικά ελαττώματα ή ατέλειες στην εξωτερική του εμφάνιση, που δεν είναι εμφανή ή εκτιμώνται ως ελάχιστα από άλλους.
- Σύμφωνα με το DSM-5 για να δοθεί διάγνωση σωματοδυσμορφοφοφικής διαταραχής, θα πρέπει κάποια στιγμή κατά τη διάρκεια της διαταραχής το άτομο να εκτελέσει επαναλαμβανόμενες συμπεριφορές (πχ. έλεγχος μπροστά σε καθρέφτη, αναζήτηση επιβεβαίωσης) ή νοητικές πράξεις (σύγκριση της εμφάνισης του ατόμου σε σχέση με κάποιον άλλον) ως απάντηση σε δικές του ανησυχίες σε σχέση με την εμφάνιση.

Recent advances in understanding and managing body dysmorphic disorder

Georgina Krebs,[1,2] Lorena Fernández de la Cruz,[3] David Mataix-Cols[2,3,4]

HOW COMMON IS BDD?

In a recent systematic review, the weighted prevalence of BDD was estimated to be 1.9% in community samples of adults and 5.8%–7.4% in psychiatric settings, highlighting the importance of clinical vigilance for the disorder.[12] Comparable rates have been found for adolescents, with prevalence estimates ranging from 1.7%–2.2%[12 13] in the commu-

as comorbidity and genetic factors. Nevertheless, a range of environmental factors have been suggested to influence the development of BDD, including childhood abuse, peer teasing and peer victimisation. Studies have shown that adults with BDD report high levels of childhood maltreatment, with up to 79% of patients reporting abuse.[23] Furthermore, retrospectively reported rates of abuse are elevated in patients with BDD compared with healthy controls[24] and patients with OCD,[25]

A range of SRIs have been used in the treatment of BDD, including fluoxetine,[42] fluvoxamine,[43] citalopram,[44] escitalopram[45] and clomipramine.[46] Most evidence for the efficacy of pharmacotherapies in BDD comes from open trials, and only four RCTs of pharmacotherapy have been conducted to date,[42 45–47] which have found response rates ranging from 53%–70%.[42 46] The most recent RCT conducted was a

Further research is needed to establish the relative efficacy of different SRIs and to compare pharmacotherapy to CBT in RCTs and meta-analytic studies. There is also a need to further evaluate potential augmentation strategies for BDD patients who do not respond to SRIs. To date, research on augmentation strategies in BDD is limited to one small open trial and one RCT which evaluated pimozide and olanzapine augmentation of fluoxetine, respectively.[47 50] These studies did not find beneficial effects of augmentation, but this warrants investigation as clinical experience and guidelines suggest that SRI augmentation with an atypical antipsychotic can be beneficial.[31]

ΠΑΡΑΣΥΣΣΩΡΕΥΣΗ

ΠΑΡΑΣΥΣΣΩΡΕΥΣΗ

- Στο DSM-5, η παρασυσσώρευση / αποθησαυρισμός ορίζεται ως επίμονη δυσκολία απόρριψης ή αποχωρισμού υπαρχόντων, ανεξαρτήτου της πραγματικής τους αξίας (Κριτήριο Α).
- Αυτή η δυσκολία συμβαίνει λόγω έντονων παρορμήσεων για αποθήκευση αντικειμένων και/ή υποκειμενικής ενόχλησης σχετιζόμενη με την απόρριψη (Κριτήριο Β).
- Επομένως, η δυσκολία απόρριψης έχει ως αποτέλεσμα την συσσώρευση πολλών υπαρχόντων σε χώρους σπιτιού ή εργασιακούς χώρους, όπου η αρχική χρήση αυτών δεν είναι πλέον επιτρεπτή (Κριτήριο Γ).

ΠΑΡΑΣΥΣΣΩΡΕΥΣΗ

- Curr Neuropharmacol. 2019 Jan 24. doi: 10.2174/1570159X17666190124153048. [Epub ahead of print]
- **Pharmacotherapy for hoarding disorder: How did the picture change since its excision from OCD?**
- Piacentino D1, Pasquini M1, Sani G1, Chetoni C1, Cappelletti S2, Kotzalidis GD1
- This brief review deals with the various issues that contributed to the creation of the new Diagnostic and Statistical Manual condition of hoarding disorder (HD) and attempts at reviewing its pharmacotherapy. It appears that after the newly founded diagnosis appeared in the literature as an autonomous entity, distinct from obsessive-compulsive disorder, **drug trials are not being conducted** and the disorder is left in the hands of psychotherapists, who on their part, report fair results in some core dimensions of HD. The **few trials** on HD specifically regard the serotonin-noradrenaline reuptake inhibitor **venlafaxine**, and, possibly due to the suggestion of a common biological background of HD with attention deficit/hyperactivity disorder, the psychostimulant **methylphenidate** and the noradrenaline reuptake inhibitor **atomoxetine**. For all these drugs, positive results have been reported, **but the evidence level of these studies is low,** due to small samples and non-blind designs. Regretfully, there are currently no future studies aiming at seriously testing drugs in HD.

ΔΕΡΜΑΤΙΛΛΟΜΑΝΙΑ
(SKIN PICKING)

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REVIEW

Excoriation (skin-picking) disorder: a systematic review of treatment options

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Conclusion

ED is often a chronic disorder associated with substantial morbidity and comorbidity. Fortunately, a number of treatment modalities are effective in reducing skin-picking behaviors. The literature systematically reviewed here, and previous meta-analyses, emphasize the relatively sparse evidence base, but also point to the benefit of behavioral treatments.[17,18] SSRIs have been a mainstay of pharmacotherapy, but there is now evidence from a RCT that NAC should also be considered as a potential intervention. There is a need for consensus on the optimal symptom severity measures, and for additional controlled trials, using both explanatory and pragmatic designs. In the interim, there is also a need to improve accessibility to efficacious treatments.

ΣΥΜΠΕΡΑΣΜΑΤΙΚΑ…

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REVIEW ARTICLE

Critical Review of the Use of Second-Generation Antipsychotics in Obsessive–Compulsive and Related Disorders

Dongmi Kim[1] · Nicole L. Ryba[1] · Julie Kalabalik[1] · Ligia Westrich[1]

Table 1 Review process and publication selection

Drug names	Initial screening	Included in this review
Aripiprazole	110	35
Asenapine	4	0
Brexpiprazole	1	0
Cariprazine	0	0
Clozapine	299	4
Iloperidone	5	0
Lurasidone	1	0
Olanzapine	282	43
Paliperidone	10	1
Pimavanserin	0	0
Quetiapine	102	24
Risperidone	212	28
Ziprasidone	23	2
TOTAL	1049	136

Key Points

Obsessive–compulsive disorder, body dysmorphic disorder, trichotillomania, hoarding disorder, and excoriation are characterized by preoccupation and repetitive behavior, and are classified under 'obsessive–compulsive and related disorders' (OCRDs) in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

A trial of second-generation antipsychotics is reserved as a third-line option for patients with treatment-refractory obsessive–compulsive disorder and body dysmorphic disorder. There is no consensus on the trial of these agents in trichotillomania, hoarding disorder, and excoriation.

Aripiprazole and risperidone may confer the most benefit across all the treatment-refractory OCRDs. The metabolic adverse effects of the second-generation antipsychotics, notably olanzapine, may outweigh the benefit of symptom improvement in OCRDs. Well designed studies are needed to inform evidence-based therapy in OCRDs.

Augmentation strategies may help patients who don't respond to first-line treatments

Table 3

Mechanism of action and common uses for alternative agents

Agent	Mechanism	Common uses
N-acetylcysteine	Role in the release of glutamate by modulating the cysteine-glutamate antiporter	Antioxidant to treat acetaminophen overdose
Memantine	Low-affinity antagonist of extrasynaptic NMDA glutamate receptors	Delay cognitive decline in patients with Alzheimer's disease
Ketamine	More potent noncompetitive antagonist of the NMDA receptor than memantine	Anesthetic. Drug of abuse
Topiramate	Directly inhibits AMPA/kainate glutamate receptors	Prevent seizures and headaches
Lamotrigine	Reduce glutamate outflow through inhibition of certain presynaptic voltage-gated sodium channels	Antiepileptic and mood stabilizer
D-cycloserine	Agonist at the glycine site on the NMDA receptor	Animal studies on learning, eg, fear extinction

AMPA: α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid; NMDA: *N*-methyl-D-aspartate

Elana Harris, MD, PhD **Sergio V. Delgado, MD**

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Augmentation strategies may help patients who don't respond to first-line treatments

Table 4

Literature summary of augmentation strategies

Beneficial as augmentation to SSRI	Mixed results	Not beneficial as augmentation or monotherapy	Helpful early in treatment
Memantine	*N*-acetylcysteine	Benzodiazepines	D-cycloserine
Lamotrigine	Topiramate		
	Ketamine		

SSRI: selective serotonin reuptake inhibitor

Recent advances in obsessive compulsive and related disorders

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and related disorders (OCRDs). First, in a major paradigm shift, obsessive–compulsive disorder (OCD) has been moved from the anxiety disorder section to the newly created section on OCRDs in the latest version of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Second, in the last decade, considerable progress has been made in understanding of the neuroanatomical correlates of OCD. While the role of cortico-striato-thalamo-cortical circuits in OCD is now well recognized, the role of other areas such as parietal cortex and cerebellum is being recognized. Global collaborative efforts are being made

OCD. Third, landmark studies have been published on the role of the cognitive-behavioral therapy (CBT) in treating OCD. Fourth, research on brain stimulation in OCD, in particular, role of deep brain stimulation (DBS), repetitive transcranial magnetic stimulation (rTMS), and transcranial direct cortical stimulation (tDCS) has accumulated. The US Food and Drug Administration (FDA) has approved DBS to treat refractory OCD under humanitarian device exemption.

Recently, the US FDA has also approved deep TMS for the treatment of OCD. Finally, there is a great interest in OCRDs other than OCD.

“As λένε και as γράφουν ό,τι θέλουν.
Έρχεται, όμως, ο καιρός που οι άνθρωποι κρίνονται όχι για όσα είπαν
ή έγραψαν για τις πράξεις τους,
αλλά για όσα μαρτυρούν οι ίδιες οι πράξεις τους.
Με τη δύναμη που μου δίνει αυτό το αξίωμα,
έζησα στον κόσμο μέχρι τη δύση της ζωής μου, όπως ακριβώς επιθυμούσα.
Είναι αδύνατον να αλλάξω σήμερα, αλλά θα κάνω ό,τι πρέπει,
και as γίνει ό,τι γίνει.”

Ναύπλιο, 14 Σεπτεμβρίου 1831

Απόσπασμα επιστολής του Κυβερνήτη Ι. Καποδίστρια
προς τον Εϋνάρδο, λίγες μέρες πριν τη δολοφονία του.

Ευχαριστώ για το χρόνο και την προσοχή σας!