ANZJP

Australian & New Zealand Journal of Psychiatry
2016, Vol. 50(6) 594–598

Commentaries

Comorbid bipolar disorder and obsessive–compulsive disorder in children and adolescents: Treatment implications

Andrea Amerio[1,2], Matteo Tonna[3], Anna Odone[4], Brendon Stubbs[5] and S Nassir Ghaemi[2,6]

[1]Department of Clinical and Experimental Medicine, University of Parma, Parma, Italy
[2]Mood Disorders Program, Tufts Medical Center, Boston, MA, USA
[3]Department of Mental Health, Local Health Service, Parma, Italy
[4]Department of Biomedical, Biotechnological and Translational Sciences, Unit of Public Health, University of Parma, Parma, Italy
[5]Institute of Psychiatry, Kings College London, London, UK
[6]Department of Psychiatry and Pharmacology, Tufts University Medical School, Boston, MA, USA

Corresponding author:
Andrea Amerio, Department of Clinical and Experimental Medicine, University of Parma, c/o Ospedale Maggiore, Viale A. Gramsci 14, 43126 Parma, Italy.
Email: andrea.amerio@studenti.unipr.it

DOI: 10.1177/0004867415611235

Apparent comorbidity between bipolar disorder (BD) and obsessive–compulsive disorder (OCD) is a common condition in psychiatry with higher prevalence rates in youths (23.2%, 95% confidence interval [CI] = [11.5%, 41.3%]) compared to adults (13.56%, 95% CI = [10.4%, 16.25%]) (Amerio et al., 2015).

The meaning of this comorbidity has not been clarified yet. The treatment of BD-OCD patients remains a great challenge since the gold standard for one disease (serotonin reuptake inhibitors [SRIs] for OCD) can worsen the other (antidepressants can cause mania and/or more mood episodes in BD; Amerio et al., 2014a).

The literature on pharmacologic or psychotherapeutic approaches especially in pediatric BD-OCD patients is limited. Therefore, we updated our recent systematic review (Amerio et al., 2014b) and focused specifically on the treatment of BD-OCD comorbidity in children and adolescents.

Studies were identified by searching the electronic databases MEDLINE, EMBASE and PsycINFO. We combined the search strategy of free text terms and exploded MeSH headings for the topics of BD, OCD and treatment combined as follows: ((((((‘Therapeutics’[Mesh]) OR treatment*) OR therap*) OR pharmacotherap*) OR psychotherap*)) AND (((((((((‘Bipolar Disorder’[Mesh]) OR Bipolar disorder) OR BD) OR Bipolar) OR Manic depressive disorder) OR Manic depressive) OR Manic)) AND ((((‘Obsessive-Compulsive Disorder’ [Mesh]) OR OCD) OR Obsessive-compulsive) OR Obsessive-compulsive disorder))). Studies published in English through 31 August 2015 were included. Further studies were retrieved from reference listing of relevant articles and consultation with experts in the field.

Seven studies were selected (Table 1). In all selected studies, BD-OCD patients received mood stabilizers (lithium, divalproex sodium). In the largest study, 42.1% of comorbid patients required a combination of multiple mood stabilizers and 10.5% a combination of mood stabilizers with atypical antipsychotics (quetiapine, risperidone, aripiprazole). Addition of antidepressant (clomipramine) to mood stabilizers led to clinical remission of both conditions in only one study. In other cases, antidepressants (escitalopram) seemed prone to cause more manic/hypomanic episodes in BD-OCD than in non-comorbid patients.

The evidence so far on BD-OCD nosology supports the view that the majority of cases of comorbid BD-OCD are in fact BD cases (Amerio et al., 2014a). Osler’s view that medicine should be treatment of diseases, not of symptoms, is consistent with the approach of mood stabilization as a first objective in apparent BD-OCD patients, as opposed to immediate treatment with SRIs.

Authors’ contributions

Authors A.A., M.T., A.O. and B.S. designed the study and wrote the protocol. Studies were identified and independently reviewed for eligibility by two authors (A.A., A.O.) in a two-step based process. Data were extracted by one author (A.A.) and supervised by a second author (S.N.G.) using an ad hoc developed data extraction spreadsheet. The same authors who performed data extraction (A.A., S.N.G.) independently assessed the quality of selected studies using the checklist developed by Downs and Black for both randomized and non-randomized studies. A.A., M.T., A.O. and B.S. have been involved in drafting the manuscript, and S.N.G. revised it critically. S.N.G. has given final approval of the version to be published. All authors read and approved the final manuscript.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Dr Amerio, Dr Tonna, Dr Odone and Dr Stubbs report no conflicts of interest. Dr Ghaemi has provided research consulting to Sunovion and Pfizer and has obtained a

Table 1. Studies that met inclusion/exclusion criteria for systematic review.

References	Study design	Country	Study population	Diagnosis assessment	Results	Quality[a]
Annigeri et al. (2011)[1]	Case report	India	OCD Pt. ($n=1$, age = 17 years)	HAM-D, Y-BOCS, YMRS; DSM-IV	Divalproex sodium 1500 mg/day, risperidone 4 mg/day and quetiapine 600 mg/day with partial remission of OC symptoms and mood stabilization	18/31
Cop (2014)[2]	Case report	Turkey	OCD Pt. ($n=1$, age = 15 years)	NS; DSM-IV	Manic switch induced by chlorpromazine. Lithium 20 mg/kg for BD; aripiprazole and clonazepam combined with CBT for OCD with partial remission of OC symptoms and mood stabilization	18/31
Fuchs (1994)[3]	Case report	United States	BD Pt. ($n=1$, age = 9 years)	NS; DSM-IV	Four hospitalizations and two partial hospitalizations due to inadequate responses to combinations of neuroleptics and traditional treatments for BD (divalproex sodium, lamotrigine). Clozapine 200 mg/day, lithium 900 mg/day, clomipramine 75 mg/day, OC and affective symptoms well controlled	18/31
Jana et al. (2012)[4]	Case report	India	OCD Pt. (n = 1, age = 4 years)	NS; DSM-IV	Manic switch induced by escitalopram. Lithium 750 mg/day and risperidone 0.5 mg/day; OC and affective symptoms well controlled	18/31
Joshi et al. (2010)[5]	Clinical trial	United States	BD Pt. ($n=52$, mean age = 8.4 ± 3.1 years)	K-SADS-E, YMRS, CGI; DSM-IV	Antimanic response in OCD-BD Pt. significantly lower as compared to non-OCD-BD Pt. (YMRS mean $\downarrow$: -5.9 ± 13.1 vs -13.7 ± 18.8; $\downarrow \geqslant 30\%$: 25% vs 63%; CGI-S Improvement score $\leqslant 2$: 25% vs 68%)	20/31
Masi et al. (2007)[6]	Cross-sectional study	Italy	OCD Pt. ($n=120$, mean age = 13.7 ± 2.8 years)	K-SADS-PL, DICA-R, Y-BOCS, CGI, C-GAS; DSM-IV	BD-OCD Pt. received more mood stabilizers as compared to non-BD-OCD Pt. (86.0% vs 10.4%); 69.8% of BD-OCD Pt. were treated with SRIs; the rate of non responders to pharmacological treatment compared to responders was higher in BD-OCD Pt. than in non-BD-OCD Pt. (54.7% vs 25.6%)	21/31
Masi et al. (2009)[7]	Cross-sectional study	Italy	OCD Pt. ($n=257$, mean age = 13.6 ± 2.7 years)	K-SADS-PL, Y-BOCS, CGI, C-GAS; DSM-IV	BD-OCD Pt. more frequently received polypharmacy than taking SRIs alone (51.1% vs 5.6%)	22/31

BD: bipolar disorder; OCD: obsessive–compulsive disorder; OC: obsessive–compulsive; Pt.: patients; DSM: *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition*; DICA-R: Diagnostic Interview for Children and Adolescents–Revised; K-SADS-E: Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children–Epidemiologic Version; K-SADS-PL: Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime Version. Y-BOCS: Yale–Brown Obsessive–Compulsive Scale; YMRS: Young Mania Rating Scale; CGI: Clinical Global Impression; C-GAS: Children's Global Assessment Scale; HAM-D: The Hamilton Rating Scale for Depression; NS: Not specified; SRIs: serotonin reuptake inhibitors; CBT: cognitive behavioral therapy; $\downarrow$: decrease.

Differences statistically significant ($p < 0.05$).

[a]Checklist for measuring study quality developed by Downs and Black.

[1]Annigeri B, Raman R and Appaji R (2011) Obsessivecompulsive disorder with bipolar mood disorder: A rare comorbidity in India. *Indian Journal of Psychological Medicine* 33: 83–85.

[2]Cop E (2014) An adolescent with obsessive-compulsive disorder and bipolar disorder: A case report. *Bulletin of Clinical Psychopharmacology* 24: S46.

[3]Fuchs DC (1994) Clozapine treatment of bipolar disorder in a young adolescent. *Journal of the American Academy of Child & Adolescent Psychiatry* 33: 1299–302.

[4]Jana AK, Praharaj SK and Sinha VK (2012) Comorbid bipolar affective disorder and obsessive-compulsive disorder in childhood: A case study and brief review. *Indian Journal of Psychological Medicine* 34: 279–282.

[5]Joshi G, Mick E, Wozniak J, et al. (2010) Impact of obsessive-compulsive disorder on the antimanic response to olanzapine therapy in youth with bipolar disorder. *Bipolar Disorders* 12: 196–204.

[6]Masi G, Millepiedi S, Perugi G, et al. (2009) Pharmacotherapy in pediatric obsessivecompulsive disorder: a naturalistic, retrospective study. *CNS Drugs* 23: 241–52.

[7]Masi G, Perugi G, Millepiedi S, et al. (2007) Bipolar comorbidity in pediatric obsessivecompulsive disorder: clinical and treatment implications. *Journal of Child and Adolescent Psychopharmacology* 17: 475–86.

research grant from Takeda Pharmaceuticals. Neither he nor his family holds equity positions in pharmaceutical corporations.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

References

Amerio A, Odone A, Marchesi C, et al. (2014a) Do antidepressant-induced manic episodes in obsessive-compulsive disorder patients represent the clinical expression of an underlying bipolarity? *Australian and New Zealand Journal of Psychiatry* 48: 957.

Amerio A, Odone A, Marchesi C, et al. (2014b) Treatment of comorbid bipolar disorder and obsessive-compulsive disorder: A systematic review. *Journal of Affective Disorders* 166: 258–263.

Amerio A, Stubbs B, Odone A, et al. (2015) The prevalence and predictors of comorbid bipolar disorder and obsessive-compulsive disorder: A systematic review and meta-analysis. *Journal of Affective Disorders* 186: 99–109.

DSM-5 and the RANZCP training requirements

Graham Mellsop[1] and Peter Ellis[2]

[1]Psychological Medicine, Waikato Clinical Campus, University of Auckland, Auckland, New Zealand
[2]Psychological Medicine, University of Otago – Wellington, Wellington, New Zealand

Corresponding author:
Graham Mellsop, Peter Rothwell Academic Centre, Waikato Hospital, Hamilton, New Zealand.
Email: graham.mellsop@waikatodhb.health.nz

DOI: 10.1177/0004867415625818

The Committee for Examinations (CFE) have recently advised that

> *as from 2016, DSM-5 will be used across all summative assessments (Psychotherapy Written Case, Written Examinations and OSCE). The CFE also supported the use of the ICD classificatory system ...*

We are concerned that this effectively mandates the use of *Diagnostic and Statistical Manual of Mental Disorders* 5 (DSM 5) in clinical work, postgraduate teaching and examinations, with only a sop to International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

Given the extent of criticism of the 947 page DSM 5 by eminent psychiatrists in terms of its classificatory approach (Frances, 2014; Krueger and Eaton, 2015), of specific sections (Malhi and Berk, 2015), of the needs of the world's clinicians (Reed et al., 2011) and of psychiatric research (Insel, 2014), this is surprising. Furthermore, both the Australian and New Zealand governments are committed to recording and reporting health data in terms of ICD-10.

What is to be gained from early adoption of a contentious classification designed primarily to serve the needs of US psychiatrists? Are we still hung up on an 'All the way with LBJ' philosophy? Or could we adopt an international perspective and use ICD-10 until some nations and/or the WHO change their diagnostic recording requirements?

Presumably the College is committed to evidence based practice and training psychiatrists to be work-ready – expert in the classification system expected by our two governments? We suggest the CFE reconsider their decision.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

References

Frances A (2014) ICD, DSM and the Tower of Babel. *Australian and New Zealand Journal of Psychiatry* 48: 371–373.

Insel TR (2014) The NIMH Research Domain Criteria (RDoC) Project: Precision medicine for psychiatry. *American Journal of Psychiatry* 171: 395–397.

Krueger RF and Eaton NR (2015) Transdiagnostic factors of mental disorders. *World Psychiatry* 14: 27–29.

Malhi G and Berk M (2015) Depolarising bipolarity: Clinical considerations. *Australian and New Zealand Journal of Psychiatry* 49: 767–769.

Reed GM, Mendonca Correia J, Esparza P, et al. (2011) The WPA-WHO global survey of psychiatrists' attitudes towards mental disorders classification. *World Psychiatry* 10: 118–131.

Psychotropic pharmacogenetics

Ajeet B Singh

IMPACT SRC, School of Medicine, Deakin University, Geelong, VIC, Australia

Corresponding author:
Ajeet B Singh, IMPACT SRC, School of Medicine, Deakin University, PO Box 9148, Geelong, VIC 3219, Australia.
Email: a.singh@deakin.edu.au

DOI: 10.1177/0004867416649443

Genetically guided prescribing (pharmacogenetics) in psychiatry is both promising and controversial. The premise – it may reduce trial and error to find the optimal medication by matching the pharmacological profile of the medication to the associated DNA profile of the patient. But the evidence for psychotropic pharmacogenetics is not at replicated randomized control trial (RCT) level. So, the jury remains out. Yet, such reports are increasingly being advertised and sold.

Due to the pace of technological advances in DNA sequencing, regulators have been caught somewhat flat footed, genetic guidance reports not