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Case Report Open Access

Very Early Onset Obsessive-Compulsive Disorder: A Case Report

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Abstract

In this case report we present a case of obsessive-compulsive disorder in a 3-year-2-month old girl. It is aimed to describe a very early onset case of obsessive-compulsive disorder, which was treated with fluoxetine and had benefited from treatment. The case had massive crying, yelling and tantrum attacks in the foreground. She had her first compulsions at 2 years of age, and after that, her compulsions were increased day by day. These symptoms were just like not bathing and not changing other clothes or dirty diapers. The case was obsessive-compulsive disorder based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, diagnostic criteria. It has been started selective serotonin reuptake inhibitors. Her compulsions have been decreased during the first month of therapy. This case highlights the issue that obsessive-compulsive disorder should may start very early in the lifetime and if severe, early onset OCD can seriously affect the quality of life of the patient and her family.

Keywords: Compulsion; Obsession; Very early onset obsessive-compulsive disorder

Introduction

Obsessive-compulsive disorder (OCD) is a common, chronic, neuropsychiatric disorder, that frequently begins during childhood and adolescence, with an estimated lifetime prevalence of 2–3% in the general population [1,2]. It is reported that selective serotonin reuptake inhibitors (SSRIs) are more effective than placebo in the treatment of pediatric OCD [3].

Early onset OCD is a rare entity and associated with worse prognosis [4]. Therefore, effectively treating the disorder at an early stage is critical for the patient. We report a case of very early onset OCD that showed good response to pharmacotherapy.

Case

The present case is about 3-year and 2-month old female child whom had nuclear family and middle socioeconomic status. She was not going to school. She had not any past medical and psychiatric illness and history of OCD. Her symptoms were presenting after stopping breastfeeding. She had one-year history of insidious onset and progressively deteriorating symptoms characterized by repeated crying, yelling, hitting her feet onto the ground until it was bleeding. She was also hitting her family members and she had ten or fifteen times tantrum attacks till half to one hour long in a day. She did not want to go out of the house and didn't want to accept the neighbors, relatives or friends to her house. She avoided playing with peers. She did not want to have bath, and also didn't want to change her clothes or dirty diapers. After she had bath she wanted to wear her dirty clothes, which she gets out before the bath and she wanted to have her dirty diapers again. If it wasn't happening, she was getting anxious, and after that she was crying, yelling and hitting around. She was putting her toy box or pencil box into the right place but nobody had any knowledge about the right place for the boxes, and also she couldn't describe the right place for them. If her mother couldn't find the right place she was starting to get anxious, and she was crying, yelling and hitting around. She didn't like her 13 years old sister; she would not let her to touch her or her stuffs. When her sister touched inadvertently, she was reacting by crying. She didn't want her sister to come home from school or let her for watching TV. If her sister did these things she was yelling and crying a while. She only wanted to eat from her dish, not from another and was drinking only from straw, not from a cup. She was wearing the same dresses and shoes every day. She didn't want to buy new dresses or shoes. She was not using the toilets which were outside the house, why she was thinking that they were very dirty so that she was making her toilet into her clothes. Her crying, yelling and hitting behaviors were repetitive, unwanted, and functionally impairing overt behavior without adaptive function, performed a stereotyped fashion. The mental status examination revealed crying, yelling and refuse a communication and negativistic attitude. She was diagnosed as a case of OCD based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, diagnostic criteria. It was planned to manage her as outpatient with pharmacological treatment. Her symptoms were severe and cause significant distress which was affecting her relationships and daily routine. She was started on fluoxetine 10 mg/day. The routine activities were planned with the therapist for every day. Exposure and response prevention planned in the routine activities with her mother just like buying clothes, shoes, having a bath, going outside of the house and also accepting neighbors, relatives or friends to home. It was difficult to get her involved into the treatment and following instructions because of why she had negativistic attitude. It was decided to make sessions with her family. Psycho-education for the family members had been started. Initially, the parents had difficulty in accepting the fact of their kid's problems were because of a psychiatric illness, and as they believed that the problem of their kids were due to maladaptive and oppositional behavior and she did it on purpose to provoke them. However, after the psycho-education, her mother understood the nature of her illness. It was preferred to her that she joined activities appropriate for a child of her age, and to attend kindergarten. After the fluoxetine 10 mg/day has begun, she started showing improvement almost in all the problem areas. No drug-related side-effects were observed during

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the treatment period. After 1 month, a lot of improvements just like going to toilet at outside the home, changing her clothes, eating from the other dishes, drinking from cups, buying new clothes or shoes had been seen. Her rigid rules like putting her toy or pencil box into the right place has been stopped. The hostility that against her sister has been decreased. One hundred percent of recovery was seen according to her parents. Clinical Global Impression Scale-Severity (CGI-S) was assessed as 5; Global Assessment Scale (GAS) was assessed as 41-50 before the treatment. After 1-month Clinical Global Impression Scale-Improvement (CGI-I) was assessed as 2 (much improved), GAS was assessed as 91-100.

Her improvement has been going on till 7 months. In our opinion, the treatment of the illness at the early stage made our treatment successful. At the end of the treatment, both of the patient and her family's quality of life has been improved.

This case is being continued to be follow-up in our clinic and her treatment has been planning to sustain about one year more.

Discussion

In this case report, a very early onset OCD was treated by using fluoxetine, and her clinical follow-up was discussed. OCD is seldom diagnosed in children younger than six years of age. There were few cases which were reported as early onset OCD [3,5-7]. In our case, OCD had started at 2-3 years of age with irritability, crying and tantrum attacks. The symptoms which were irritability, crying and tantrum periods can easily cause a misdiagnose and can interpretable as developmental specific problems. In the foreground, there were repetitive and stereotypic compulsions. It was decided to initiate pharmacological treatment why the OCD symptoms of our patient impaired functionality of herself and her family, and caused significant distress in her own daily life, SSRIs are recommended as the first-line pharmacologic treatment for OCD [8]. In Turkey, SSRI molecules are only present in liquid form, which are fluoxetine and escitalopram. Therefore, as the first choice we decided to initiate fluoxetine treatment for the patient. SSRI response is thought to be delayed in OCD, even more so than in major depression. According a meta-analysis, which included 17 trials of SSRIs including 3,276 subjects, a statistically significant benefit of SSRIs compared to placebo was seen within 2 weeks after the start of treatment [9]. Our case has responded to the treatment in one month, which the treatment was with fluoxetine, and exposure-response prevention directed for the repetitive behavior that includes her mother's help. The parents must be counseled intensively and they must be included into the therapeutic process for very early onset OCD.

This case is very important for better understanding very early onset OCD. Because of being awareness of the clinicians in these symptoms for the diagnosis of illnesses, it may lead to a renewed emphasis on early detection and intervention strategies. It is clear that very early onset OCD may remain undiagnosed and untreated for many years. Thus, if early detection and early effective treatment is possible, full recovery for OCD patients could become a reality. As mental health professionals for early detection and intervention strategies and prevent OCD becoming debilitating, chronic, and lifelong the awareness of very early onset OCD is important.

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