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Case Report Open Access

Worsening of Anxiety Symptoms with Antipsychotic Treatment in a Patient Misdiagnosed with Schizoaffective Disorder

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Abstract

Obsessive compulsive symptoms (OCS) can easily mimic psychosis, which raises the risk for misdiagnosis of obsessive compulsive disorder (OCD) with a primary psychotic disorder, such as schizoaffective disorder. Although both OCD and schizoaffective disorder can be effectively treated with psychotropic medications, a misdiagnosis can result in an inappropriate pharmacotherapy. Here we describe a case of a young patient, who was misdiagnosed with schizoaffective disorder and was treated with multiple second-generation antipsychotic medications (SGAMs) with significant adverse effects, further worsening of OCS and no improvement in psychosis. Patient exhibited remarkable improvement in his OCS, adverse effects and psychosis after he was switched from his SGAM to sertraline, an approved treatment for OCD.

Keywords: Worsening; Anxiety; Antipsychotic; Misdiagnosis; Schizoaffective

Introduction

We report a case of a young Caucasian patient, who was admitted to a state hospital with a diagnosis of schizoaffective disorder, bipolar type. A comprehensive review of patient's history revealed a lack of antipsychotic response with worsening of preexisting obsessive-compulsive symptoms (OCS) despite several trials with second-generation antipsychotic medications (SGAMs). However, when patient was gradually cross-titrated from his SGAM to a selective serotonin reuptake inhibitor (SSRI), he not only showed remarkable improvement in his OCS, but also a complete resolution of his psychosis and extrapyramidal symptoms (EPS).

Case Presentation

A 24-year-old Caucasian male previously diagnosed with schizoaffective disorder, bipolar type and with a history of a traumatic brain injury, cannabis use disorder, and excessive caffeine use, was transferred from a community hospital to a state hospital for treatment-refractory aggression, Capgras delusions, grandiosity, ideas of reference, and lack of insight into his illness. He was trialed on several SGAMs, including olanzapine, risperidone, and aripiprazole without any improvement in his symptoms. On the contrary, his OCS worsened, which was misattributed to lack of response to SGAMs. He also experienced EPS with SGAMs, including metabolic disturbances, tremor, bradykinesia, and cogwheel rigidity. His OCS included wearing several layers of clothing despite summer, using tissues to touch any object, avoiding public situations, and sanitizing any surfaces he came into contact with. Medical records documented behaviors such as collecting his urine/feces in containers, shaving down his teeth, and repeatedly washing his clothing. This presentation along with worsening of OCS with SGAMs suggested a diagnosis of obsessive compulsive disorder (OCD), which prompted gradual discontinuation of aripiprazole and initiation of an SSRI. A two-week cross titration from 20mg/day of aripiprazole to 50mg/day of sertraline resulted in a dramatic improvement in patient's OCS, including less preoccupation with contamination, increased participation in groups, and less psychosis. There were no observations of changes in his sleep or energy, or signs of dysphoria or intolerability to sertraline. Ultimately, the patient was discharged within 4 weeks of this treatment change without any psychotic relapse or bipolarity despite aripiprazole discontinuation.

Discussion

Although it is not uncommon to misdiagnose a primary psychotic disorder in patients with severe OCD [1], the lack of response to several SGAMs, worsening of OCS and increased sensitivity to develop EPS questioned a diagnosis of schizoaffective disorder. Moreover, predominance of OCS over delusional behavior in this patient supported a diagnosis of obsessive-compulsive disorder with lack of insight and comorbid psychosis.

Since OCS respond to serotonergic drugs, such as lysergic acid diethylamide [2] and SSRIs [3], any drug that blocks serotonergic receptors has the potential to worsen OCS [4]. Thus, 5HT2A receptor-blockade by SGAMs provides a plausible explanation for worsening of OCS in this patient. While higher doses of SGAMs may improve treatment-refractory OCS [5] lower doses may also be useful to lower risk of worsening OCS due to less 5HT2A blockade. Regardless, this patient was not treatment-refractory as he responded remarkably well to sertraline monotherapy. However, sertraline-induced improvement in psychosis and/or affective component of OCD cannot be ruled out. Although our patient did not show any signs of hypomania or mania after sertraline treatment, long-term risk of bipolar symptoms cannot be completely ruled out in this patient.

Conclusion

OCD is a complex and heterogeneous disorder with different etiobiological underpinnings requiring diagnostic clarifications in order to employ appropriate treatment strategies. It is important to consider all clinically-relevant symptom domains and their management to prevent undue suffering from a misdiagnosis and inappropriate pharmacotherapy,

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which is frequently associated with cumbersome adverse effects and a compromise in quality of life as occurred in this patient.

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