Prodromal schizophrenia is the initial phase of disturbance prior to the full-blown psychotic picture. It comprises of various and non-specific symptoms such as affective changes, anxiety symptoms, unusual perceptions, obsessions and odd beliefs. These manifestations may last from few weeks to several years. Approximately 80%-90% of schizophrenic patients experience the prodrome. However, only 30%-40% of people with prodromal stage convert to florid manifestations of schizophrenia. Many studies of prodromal stage schizophrenia confirm the value of early psychosis intervention.

The relation between OCD or OCS and schizophrenia is discussed thoroughly across different stages of schizophrenia except for prodromal phase where limited studies were found. The prevalence of this particular association varies largely from 2.7% to 36.9% for OCS and from 1.5 to 30% for OCD. The studies had conflicting results regarding the possible transition to psychosis among the ultra-high-risk population with positive OCD/OCS versus negative counterparts.

The aim of this report is to present a case of OCD with detailed and intrusive mental images, which were resolved with antipsychotic medications.

THE CASE

A sixteen-year-old male student presented with six months history of recurrent intrusive images with disturbing/frightening content associated with fearfulness and decreased socialization. The patient would see himself near a graveyard, trying to run away while being chased by dead people and feeling extremely terrified. These images come episodically daily (4–7 episodes per day) lasting approximately 2–3 minutes each and had increased in frequency. They were occasionally triggered by seeing his home from outside in a dark and quiet environment.

The episodes have the same sequence of images every time. The patient could not stop the flow of images until entering his own home and closing the gate (a relieving ritual) with initial success to abort these intrusive images but failed later. He does not regard these images as irrational. He denied having any other perceptual experiences apart from seeing monsters attacking him, and occasionally an awful girl crawling over the wall shortly before falling asleep (hypnogogic hallucination).

The patient had decreased socialization with his family and the surrounding people. He described his mood as fearful most of the time. No reported change in sleeping or eating pattern. Unremarkable history of headache, loss of consciousness, seizure or any other physical complaints. The patient has no suicidal ideation or plans. No evidence of suspicious or odd beliefs. Past psychiatric and medical history were unremarkable. Family history revealed a schizophrenic mother with frequent relapses, one of these was during her pregnancy with the patient. The developmental history showed substandard school performance. Concerning premorbid history, the family described their son as being aloof, different from other children with few friends and limited hobbies.

Mental state examination revealed a thin young boy, well-kempt and groomed, with an occasional evasive gaze. His speech was mainly induced with reduced rate and volume, noticed aprosody and prolonged speech latency. The mood was euthymic with reactive affect. The patient was preoccupied with his complaint; he did not show evidence of other thinking abnormality. No observed abnormal perceptual experiences.

* Specialist Psychiatrist
Department of Psychiatry
King Khalid University Hospital
Kingdom of Saudi Arabia

** Senior Registrar
Department of Psychiatry
Ministry of Health
Sohar, Oman
E-mail: omanlion84@yahoo.com
He is insightful about possible psychiatric etiologies for his condition.

The initial differential diagnosis was schizophrenia (prodromal phase) versus obsessive-compulsive disorder or temporal lobe epilepsy. Therefore, full investigations were performed including complete blood count, urea and electrolytes, liver, renal and thyroid function tests, ceruloplasmin, ammonia, and lactate dehydrogenase, brain CT scan and electroencephalogram; all were normal. Therefore, his provisional diagnosis was prodromal schizophrenia, and he was prescribed olanzapine 10 mg daily, which resulted in noticeable improvement of the intrusive mental images. During two years of follow-up, the patient started to exhibit marked negative symptoms of schizophrenia including asociality, anhedonia and blunted affect. Therefore, the medication was increased to the maximum dose with no tangible improvement; consequently, aripiprazole was prescribed up to 15 mg daily with modest improvement in his overall condition.

DISCUSSION

This case illustrates the complexity of the diagnosis of an officially established disorder that is OCD with well-defined criteria and controversial labeling prodromal schizophrenia with several presentations including OCD.

Several studies investigated the relationship between schizophrenia and OCD or OCS; several hypotheses were postulated. Some authors considered the early onset of OCS as a subtype of schizophrenia and that they are the first presentation of the disorder while others suggested a separate category of schizophrenia with a new nosology (schizo-obsessive disorder)\(^7\). Recent studies considered both diagnoses as two separate entities with high comorbidity, almost having similar age of onset in adolescence\(^8\). Although all of these theories have their major confounding factors (small sample size and variable participant characteristics), they could not be ruled out in our case.

The impact of OCD/OCS among prodromal schizophrenia or at-risk people for psychosis was revealed in some studies by having a higher clinical impairment, more depressive symptoms and suicidality\(^4,5,10-15\).

CONCLUSION

Our patient was managed as a case of prodromal schizophrenia rather than solely OCD based on the associated features (aloofness, progressive social and academic decline, slowed psychomotor functions and dysprosody). Positive family history of schizophrenia in addition to praecox feeling further confirmed the patient’s condition. The following two years of the patient’s course revealed the necessity of considering the full detailed presentation of prodromal schizophrenia rather than the spot diagnosis of OCD to benefit from early intervention psychosis services and minimize the clinical deterioration.

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