Late-Onset Obsessive-Compulsive Disorder Comprising Somatic Obsessions:

Is This a Distinct and Overlooked Phenotypic Subtype?

Joana Regala, MD, MS, and João Reis, MD

Although late-onset obsessive-compulsive disorder (OCD) should prompt the investigation of secondary causes, most patients do not evidence an underlying medical illness or a structural brain abnormality, thus constituting presumable idiopathic cases.[1,2] A subset of patients manifests somatic obsessions, bringing about diagnostic challenges. Somatic obsessions comprise hyperawareness of autonomic processes, distressing body-focused preoccupations raised by interoceptive stimuli, and overestimation of threatening consequences.[3–8] Notably, somatically focused OCD has a considerable phenomenological overlap with hypochondriasis.[8,9] Furthermore, given that OCD is a heterogeneous nosologic entity with different symptom-based dimensions, as well as frequent comorbid psychiatric disorders including hypochondriasis, it is not uncommon for a transdiagnostic evolution from OCD to hypochondriasis to occur during the clinical course. Therefore, it might be quite challenging to differentiate somatically focused OCD from hypochondriasis.

Case Report

A 73-year-old man was hospitalized for a psychopathologic picture characterized initially by religious obsessive mental images and thoughts preceded by mild depressive symptoms related to financial hardships. Being unable to acknowledge its senseless nature, he developed mystical and guilty delusion-like ideas, modulated by the pathoplastic effect of core religious beliefs, and a dysfunctional inflated sense of responsibility. Those intrusive and ego-dystonic mental images and thoughts had occurred in the past several years, however, not in a recurrent or uncontrollable manner or causing significant distress or interference with psychosocial functioning. His Yale-Brown Obsessive-Compulsive Scale (YBOCS)[10] score was 25. Ancillary tests were unremarkable. Transglutaminase antibodies were negative, ruling out the hypothesis of celiac disease, which could account for an impairment of tryptophan-serotonin metabolism, secondary to malabsorption.[11] Neuroimaging revealed no brain alterations that could disrupt frontostriatal circuitry.

The patient's therapeutic regimen comprised the selective serotonin reuptake inhibitor antidepressant sertraline 200 mg/d, augmented with mirtazapine 45 mg/d and aripiprazole 15 mg/d. Additionally, lamotrigine, trazodone, buspirone, gabapentin, and benzodiazepines were added with a significant improvement (60% YBOCS score reduction at the seventh week of treatment). Delusion-like ideas subsided as religious obsessions ameliorated. Nevertheless, somatic obsessions became noticeable. He developed an obsessive fear of choking/dying by asphyxiation triggered by posterior rhinorrhea, with neutralizing strategies, namely consecutive and day-long rituals of swallowing (motor compulsions) and avoidance of cold exposure. Obsessive fear also stemmed from visceral sensations, with an underlying hyperawareness of interoceptive stimuli, intrusive preoccupations about nonspecific catastrophic consequences, and intolerance of uncertainty, resulting in avoidance of nutritional intake and occasional panic.

Discussion

This case is in accordance with previous studies that found that in comparison to early onset counterparts, patients with late-onset OCD most commonly exhibit preceding long periods of subclinical OCD and stressful events before the full-blown clinical picture of OCD emerges.[2] Regarding the differential diagnostic considerations, hypochondriasis shares with OCD the high degree of harm avoidance, anxiety, catastrophic cognitions, and repetitive checking behaviors resembling compulsions as patients search for signs of illness.[8,9,12] Conversely, different than the typical ego-dystonic and resistant pattern observed in somatic obsessions, in which patients fear getting an illness or the occurrence of catastrophic imaginary events, hypochondriacal

worries are ego-syntonic beliefs of having an illness, accompanied by somatic sensations on which irrational fears are superimposed.[12,13] Additional disorder-specific clinical clues that point to OCD comprise ritualized neutralizing strategies and the co-occurrence of other classic obsessions unrelated to illness concerns. Although these signs are helpful, they fall short when considering those patients with OCD who have poor insight into the irrationality of their fears. It is noteworthy that poor insight is associated with reduced ego-dystonia regarding obsessive-compulsive symptoms.[5] Therefore, whenever insight is poor, somatic obsessions can be hardly distinguishable from hypochondriacal worries.

We hypothesize that somatic obsessions constitute a distinct phenotype of OCD, stemming from a complex interplay of neurobiological and environmental factors shared with hypochondriasis. However, further research is warranted to clarify this issue.

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Author Affiliations: Department of Geriatric Psychiatry, Centro Hospitalar Psiquiátrico de Lisboa, Lisbon, Portugal.

Corresponding Author: Joana Regala, MD, Centro Hospitalar Psiquiátrico de Lisboa, Av. Do Brasil, nº 53, 1749-002 Lisboa (joanaregala@gmail.com).

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ORCID: Joana Regala: https://orcid.org/0000-0001-5534-0326; João Reis: https://orcid.org/0009-0002-3462-3030.

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