

### **Paroxetine in a patient with obsessive-compulsive disorder, anorexia nervosa and schizotypal personality disorder**

*Dear Sir:*

Obsessive-compulsive disorder (OCD) is a chronic and crippling illness for which long-term drug therapy is often necessary, since remission is rare and relapse is likely when treatment is discontinued.<sup>1,2</sup> OCD often occurs with other conditions,<sup>3</sup> and relations between OCD and anorexia nervosa<sup>4</sup> and between OCD and schizotypal conditions<sup>5</sup> have been established. We describe the successful treatment of a patient suffering from concomitant OCD, anorexia nervosa and schizotypal personality disorder with a combination of the selective serotonin reuptake inhibitor (SSRI) paroxetine, which has been shown to be effective in treating OCD,<sup>6</sup> and an antipsychotic agent.

#### **Case report**

A 34-year-old woman had been displaying symptoms of OCD, anorexia nervosa and schizotypal personality disorder since she was 14 years old. She first received a formal diagnosis and treatment when she was 29 years old. She had been admitted to hospital 3 times, primarily for the treatment of anorexia nervosa. During these hospitalizations, she refused to eat independently, interfered with catheter-feeding, and showed ex-

cessive compulsive ceremonials with psychomotor retardation and repetitive behaviour. Over the course of these hospitalizations she was treated with the antidepressants amitriptyline (maximum dosage 150 mg per day) and mianserin (120 mg per day), the antipsychotic levomepromazine (400 mg per day), and cognitive-behavioural psychotherapy.

When she was 33 years old, she was readmitted, again primarily because of anorexia nervosa. Psychotherapy was not feasible because of her excessive compulsive rituals. She was given paroxetine (60 mg per day) in combination with the antipsychotic haloperidol (3 mg per day). Within 6 weeks, the symptoms of anorexia and her OCD behaviour, measured using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), had improved. Shortly after she was discharged, however, her medication was discontinued and her symptoms gradually worsened.

Six months later she was readmitted for symptoms of anorexia, OCD behaviours (for which she scored 12 for obsessions and 12 for compulsions on the Y-BOCS scale), a subdepressive mood and sleep disturbances. Following treatment with paroxetine (40 mg per day, increased to 60 mg per day after 1 week), in combination with the antipsychotic risperidone (4 mg per day introduced gradually over 1 week) and doxepin (to treat sleep disturbances, 25 mg per day, increased to 50 mg per day after 1 week), for 8 weeks, her Y-BOCS scores improved to 6 for obsessions and 6 for compulsions.

The patient continued to take paroxetine and antipsychotic medication (changed from risperidone to pimozide, 4 mg per day, because of extrapyramidal side effects associated with risperidone<sup>3</sup>) and received group and individual insight psychotherapy for 6 months; doxepin therapy was discontinued after 5 months. She quickly became more mentally and physically healthy, becoming oriented to the future and euthymic, and she suffered no further anorexia or sleep problems.

The patient is currently being treated with paroxetine (60 mg per day) and pimozide (2 mg per day), which have been given for 9 months. She maintains a stable weight and suffers no psychopathological problems, apart from an insignificant subdepressive mood, a somewhat reduced drive and some minor compulsive symptoms.

#### **Discussion**

Many patients suffer silently with psychiatric problems and consequently have a poor quality of life; this patient suffered with OCD, anorexia nervosa and schizotypal personality disorder for 15 years before receiving a formal diagnosis and treatment.

Relapse after the withdrawal of treatment for psychiatric illnesses can be problematic: even after 3 separate psychological and pharmacological regimens, this patient still exhibited excessive compulsive rituals, continued to lose weight and had low mood.

Paroxetine has established effi-

cacy in the treatment of OCD.<sup>6</sup> In addition to being effective in treating anorexia and schizotypal symptoms, antipsychotics can augment the treatment response to SSRIs in OCD.<sup>7</sup> A rapid alleviation of this patient's OCD, anorexia nervosa and schizotypal personality disorder occurred after she was treated with a combination of paroxetine and an antipsychotic agent.

When treatment was discontinued, however, the patient's behaviour gradually worsened and it became apparent that long-term treatment was necessary. Paroxetine, prescribed with an antipsychotic agent, again achieved rapid results. The patient has been receiving this treatment regimen for more 9 months, with no return of anorexia nervosa, only minor psychological and compulsive symptoms and no unexpected adverse effects. This case study supports further investigation into the use of a combination of paroxetine and an antipsychotic in patients with mixed diagnoses of OCD, anorexia and schizotypal conditions.

## References

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## Depression and cardiovascular disorders

*Dear Sir:*

I read with interest the recent editorial by Swenson entitled "Management of comorbid depression and heart disease: the time has (almost) come."<sup>1</sup> I would like to offer some comments on this paper.

First, many patients with depression have suicidal tendencies.<sup>2</sup> They view suicide as the final solution to their problems. Suicidal behaviour in patients with depression may be conscious, semiconscious or unconscious. It has recently been suggested that patients suffering from depression may "exploit" their immune system for suicide; i.e., the immunological abnormalities in patients with depression are directed by the central nervous system, in a subtle method of suicide.<sup>3</sup> The same idea can be applied to the effects of mood on the cardiovascular system. Depression increases the risk of morbidity and death related to cardiac disorders and may

play an important role in the development of angina, hypertension, myocardial infarction, arrhythmias and sudden cardiac death.<sup>1,4</sup> The brain "destroys" the body.

Second, depression and certain personality traits are associated with disorders of the cardiovascular system.<sup>1,4</sup> The same psychological factors decrease the effectiveness of the immune system, and thereby promote infection.<sup>3,5</sup> Several papers on the association between coronary artery disease and infections have been published over the past decade.<sup>6,7</sup> It has recently been proposed that inflammation is a causative mechanism for coronary artery disease.<sup>6</sup> The development of infection and inflammation in the atherosclerotic plaque may be related to psychological disorders that suppress the immune system. Hence, the immune system may be involved in the effects of psychological factors on the heart and blood vessels.

Third, the effect of depression on the cardiovascular system is an impressive example of the mind-body relation. Better understanding of mind-body interactions may significantly improve treatment of medical and behavioural disorders.

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