Case Report

Obsessive-Compulsive Disorder Presenting with Compulsions to Urinate Frequently

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ABSTRACT

Obsessive compulsive disorder (OCD) is a common psychiatric disorder which is easily recognized. However, sometimes patients of OCD present in such an atypical presentation of symptoms and a pathway to care involving multiple specialities. We report a case of a girl who had consulted several physicians and a urologist for frequent micturition, who was treated as a case of OCD after clarifying the compulsive nature of her symptom. There was significant improvement in her condition following 8 weeks of treatment with 200 mg of Sertraline and behaviour therapy.

Key words: *Compulsive urination, frequent micturition, obsessive-compulsive disorder*

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a common psychiatric disorder (2-3% of the general population), which is diagnosed easily most of the time by a psychiatrist or even a physician.[1] It is sometimes very difficult to properly diagnose a person for OCD based only on a routine interview.[2] The presentation of OCD may be so atypical or unusual that the patients may be referred to different specialties before the actual diagnosis can be made. Neuropsychological studies have consistently found cognitive impairment in the domains of memory and attention in patients of OCD. Anxiety, lack of confidence, indecisiveness, and associated clinical symptoms of OCD along with impaired memory and attention, may further complicate or interfere in the delivery of information.[3,4] This is the first case to report a compulsion of frequent micturition as a part of OCD. It is also unique because it presented as a predominant symptom, not at the onset of illness but rather at a later stage.

CASE REPORT

An 18-year-old girl presented with frequent micturition for the past 2 years causing severe personal and social impairment. She was evaluated by several physicians and urologists, who could not attribute any organic cause to her symptom. The patient was finally referred to the Department of Psychiatry for further evaluation.

On careful review of the history, it was found that she had severe compulsion to urinate frequently. The compulsive urge was secondary to an underlying obsession of something going wrong if she would not go

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to the toilet. The compulsions had gradually increased which led to increased frequency of micturition. This was in the absence of polydipsia, dysuria, hesitancy, or any other features of organicity. Mental state examination revealed her to be very anxious and at times agitated. She had sexual and contamination obsessions. However, her main distress was the compulsion to frequently urinate. These symptoms made her feel dysphoric. Baseline Yale-Brown Obsessive-Compulsive Scale (YBOCS) score was 29 indicating severe OCD. She was referred to the Department of Urology to rule out organicity beyond any doubt. Urodynamic studies revealed an underactive detrusor, which was the result of frequently emptying the bladder causing a decrease in the bladder capacity. She was advised of only psychological management by the urologists.

She was started on fluoxetine with which she had improved partially with a dose of 40 mg/day. She was unable to tolerate higher doses due to gastrointestinal side effects. She was later started on tab sertraline up to 200 mg daily after gradual titration.[5] Aripiprazole was added as an augmentation agent considering severe agitation, dysphoria, and insomnia. Aripiprazole was gradually built up to 7.5 mg at bedtime.[6,7]

Patient and relatives were not willing for inpatient admission for a full trial of cognitive behavior therapy, so she was treated as an outpatient. Good rapport was established with the patient. She received three sessions of exposure response prevention after her dysphoria and agitation settled. She showed dramatic improvement in the severity of anxiety and ability to resist compulsion. Aripiprazole was gradually tapered and stopped after 6 weeks. Her YBOCS score at the end of 8 weeks was zero indicating complete remission. She had improved in her personal and social functioning.

DISCUSSION

Compulsive behaviors in OCD can sometimes present in atypical ways. In this case, the compulsion to urinate frequently was a dominant compulsion which brought her to clinical attention. Even though other obsessive-compulsive symptoms had a longer course, they did not elicit any health seeking due to lesser distress and interference. This symptom of compulsive urination also started later in the course of her illness when some of the commonly occurring obsessions or compulsions as found in the YBOCS checklist had already settled spontaneously.

This is the first case according to the best of our knowledge where the frequent micturition is part of the obsessive-compulsive psychopathology, although it has been reported in certain depressive, anxiety, and psychotic disorders.

The anxiety levels of patient and family members regarding physical health and their relative lack of knowledge regarding mental health led them to seek general health services rather than psychiatric care despite the patient having psychopathology consistent with OCD for many years. This case highlights the possibility of atypical symptom presentation in OCD and the need to enquire about past obsessions and compulsions in routine psychiatric interviews.

CONCLUSION

OCD can present with symptom of frequent micturition. It may present to specialists in other branches. It highlights the need for physicians to promptly refer patients who present with symptoms which are not explained physically for psychotherapeutic work. It also highlights the need for specific enquiry of current and past obsessive compulsive symptoms. Even rare symptoms can be recognized and treated effectively like other cases of OCD with careful history taking and evaluation.

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Conflicts of interest
There are no conflicts of interest.

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