CASE REPORT

Urinary frequency: going beyond the tract

Rahmat R

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Abstract

Obsessive-compulsive disorder (OCD) is a common anxiety disorder which can be chronic and sustained. An OCD sufferer experiences intrusive and repetitive thoughts, impulses, and behaviors, which ultimately cause extreme discomfort. We report a case of a patient that primarily presented with lower urinary tract symptoms who was subsequently treated with antibiotics. Nonetheless, the symptoms persisted.

In subsequent consultations, the patient clarified the compulsive nature of his symptoms and was treated as a case of OCD. Therefore, it is crucial for physicians to correctly identify the nature of the symptoms to manage the disorder properly and to avoid unnecessary consultation and treatment. To the best of our knowledge, this is the first report of other presentations of OCD.

Introduction

In recent years, awareness about obsessive-compulsive disorder (OCD), a mental health condition, has increased. The disorder is clinically characterized by recurrent intrusive thoughts (obsessions) and repetitive behaviors (compulsions) that affect daily routine and impair function, which causes distress.[1] The obsession induces stress and anxiety, while the compulsion serves to reduce anxiety.[2] The presentation of OCD can be confusing and the patient can be misdiagnosed for up to a decade before proper treatment is initiated.[3] Similar to other psychiatric disorders, the patients frequently present to physicians in specialties other than psychiatry. Another treatment barrier can be shame, and people with the illness suffer in silence.[4] The following case report is an example of a patient with OCD symptoms who presented to primary care several times with similar complaints before being diagnosed with OCD. The patient and the treating physician did not expect the patient's lower urinary tract symptoms to indicate an illness beyond the tract. To best of our knowledge, this is the first case report of OCD causing frequent urination.

Case Description

A 20-year-old patient accompanied by his mother was seen at an outpatient clinic at a university hospital with a five-month history of lower urinary tract symptoms. He reported urinary frequency associated with incomplete voiding and terminal urinary dribbling sensation. He had experienced such symptoms previously. He first sought consult on this matter in October 2017 and was seen by a medical officer at that time. During the consultation, nothing of significance was found in the physical examination. Laboratory analyses including full microscopic examination of urine and random blood sugar were found to be within the normal range. At the end of the consultation, he was treated for symptomatic urinary tract infection. He was prescribed with antibiotics, 250 mg of Cefuroxime twice daily for one week, and scheduled for follow-up care in two weeks.

On the second visit, the patient reported persistence of the symptoms despite completing the antibiotics. There was no active treatment at the consultation and he was scheduled for renal function testing in two weeks.

On the third visit, the patient was accompanied by his mother and claimed symptoms had persisted and there was no improvement. The problem created distress for both of them. On further evaluation, he denied taking over-the-counter medications or recreational drugs and seldom consumed caffeinated drinks. On systemic review, there was no fever, dysuria, hematuria, low back pain, or loss of weight or appetite. There was no family history of cancer and no significant issues were found in the HEADSS (home, education, activities, drugs, suicidality, and sex) assessment.

The patient claimed the condition had disturbed his daily routine especially related to religious activities. His mother also felt disturbed by his everyday habit. He needed to go to the toilet repeatedly, rushed to urinate more often before prayer than at other times and frequently changed clothes because he

claimed he had terminal urinary dribble on his pants. When asked, he explained he had a strong feeling or thought of urinary dribble on his pants and the feeling was stronger just before any religious activities such as prayer. To suppress this thought, he frequently went to the toilet to urinate to empty his bladder. Sometimes he would spend half an hour in the toilet to satisfy his need to feel that his bladder was empty and clean of dribble. He considered this practice a waste of his time which was stressful for him and impacted his daily activities. He denied experiencing any other symptoms to suggest delusions or a mood disorder. Based on the symptoms, and the absence of organic cause for his problem, the diagnosis of OCD was discussed with the patient as the criteria based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) were fulfilled. The case was referred to a psychiatric clinic for shared care. He was seen by a psychiatrist and prescribed 20 mg of Fluoxetine every morning and scheduled cognitive behavioral therapy. Currently, the patient is still under follow-up and very much satisfied with the treatment by the psychiatry team.

Discussion

OCD is a highly heterogeneous disorder, presenting with a range of symptoms vary from patient to patient. Based on the DSM-5, the criteria for OCD include the presence of obsessions, compulsions, or both. Commonly, when obsessions arise, sufferers attempt to suppress abrasive thoughts with other thoughts or actions. Both obsessions and compulsions can cause anxiety and distress in the sufferers as well as their families, especially when the symptoms involved are time-consuming, thus affecting their daily routine.[1] Generally, symptoms of OCD include fear of or obsession over contamination by dirt or germs, constant checking compulsions, repetition of intrusive thoughts of a somatic, aggressive, or sexual nature, and excessive concern with order and symmetry.[6] These symptoms can be easily recognized by most physicians. Nonetheless, sufferers of OCD can sometimes present atypical symptoms, hindering proper diagnosis and treatment. For example, Singh et al. (2009) reported OCD presenting with symptoms of hearing difficulties, only recognized after negative test results and multiple consultations to explain the symptoms.[7]

In the present case, the patient fulfilled the criteria of the DSM-5 for OCD. He experienced repetitive thoughts of urine dribbling and staining his pants, and he found it difficult to ignore the thought. To neutralize the obsessions, he manifested repetitive behavior by frequent urination, consistent with compulsion criteria. Previously, Ahn et al. (2016) showed a correlation between overactive bladder syndrome and obsessive-compulsive disorder in Korean women, suggesting the need for further exploration of the association between overactive bladder and OCD[8]. Indeed, the presentation of OCD can be confusing and can be misdiagnosed as other disorders, leading to unnecessary investigations and ineffective treatment. Ultimately, the patient becomes dissatisfied because of non-resolving symptoms. Unrecognized and untreated OCD affects the quality of life and daily activities[9] not only for the patient but also the family members. In this case, the patient was feeling dysphoric over frequent urination which was mistakenly treated as urinary tract problems. This may be because the main symptom presented is rarely reported as a possible presentation in OCD patients. In one similar report, an 18-year-old female was diagnosed with OCD after multiple consultations with physicians on her symptom of frequent micturition.[10] Therefore, it is crucial for primary healthcare professionals to be able to identify symptoms of OCD or to refer any atypical presentation for a second opinion. As with other mental illness, if OCD is suspected, the patient should be managed as per guidelines and referred to a psychiatrist for proper assessment, diagnosis, and treatment.

Conclusion

OCD can manifest with various symptoms and in this present case, urinary frequency. Symptoms unexplained by tests and a physical examination may require further evaluation, including consideration of the possibility of psychiatric illness which can be obscured and frequently missed. This is vital to avoid misdiagnosis, lengthy consultations, and unnecessary investigations and treatment.

Acknowledgement

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