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| **EDITORIAL**  □ **SCHIZO-OBSESSIVE DISORDER; A DIAGNOSTIC MILESTONE IN CLINICAL PSYCHIATRY**  **IMTIAZ AHMAD DOGAR', ANIQA SHAFI'**  'Professor & Chair, Department of Psychiatry and Behavioral Sciences, DHQ/Allied hospitals, FMU, Faisalabad 'Consultant Psychiatrist, Department of Psychiatry and Behavioral Sciences, DHQ/Allied hospitals, FMU, Faisalabad  Schizophrenia is classified as a major psychiatric ailment. Its obsessive disorder can be explained by the implication of Catechol­ presentation is often quite remarkable, and patients usually present O-methyltransferase (COMT) gene polymorphism in patients with unique symptoms. Obsessive compulsive disorder is an other suffering from schizophrenia with obsessive-compulsive features'. mental illness with distinct features and presentation. There are The major neurotransmitters attributable to the underlying multiple things which differentiate schizophrenia from Obsessive pathology of this disorder includes dopamine and serotonin".There Compulsive Disorder (OCD) including clinical features. Some studies are specific neuroanatomic pathologies implicated in patients found that Schizo-obsessive patients have higher education and suffering from schizo-obsessive disorder". Fronto-basal ganglia occupational functioning in comparison with schizophrenic patients circuits dysfunction carries importance in such patients. Gray matter without obsessive-compulsivefeatures'. volume is reduced in patients suffering from schizo-obsessive disorder in specific regions of the brain which includes medial  Yet there are some features which are common to both. These orbitofrontal cortex, medial superior frontal gyrus,anterior cingulate features include both having neurodevelopmental aeteological cortex, rectus gyrus, left thalamus and left inferior semi-lunar lobule factors, and patients suffering from these disorders have family of the cerebellum.Cortical thickness is also reduced in these patients history of affective disorders, OCD and schizophrenia. Obsessive­ particularly in right supplementary motor area, right superior compulsive symptoms are observed to be more prevalent in temporal gyrus, right middle cingulate cortex, right angular gyrus schizophrenics as compared with the general population'. Even the and right middle occipital gyrus. These changes are specific to works of early clinicians like Kraepelin and Bleuler reflect the patients suffering from schizo-obsessive disorder". MRI of patients presence of obsessive-compulsive symptoms in their schizophrenic with schizo-obsessive disorder reveal that with increasing duration patients'·'. This thing has been under the debate for several decades of illness the size of frontal lobe shrinks and this phenomenon is not and quitemany mental health professionals support the formation of seen in patients suffering from schizophrenia without obsessive­ a new entity termed as"Schizo-ObsessiveDisorder". compulsive symptoms. In another study which revolved around  measuring the sizes of anterior horn of lateral ventricle and third  Recently a new entity is introduced in literature termed as schizo­ ventricle using MRI scans of the brain found that these structures are obsessive spectrum disorders which embraces schizo-obsessive enlarged in schizo-obsessive patients in comparison with patients disorder, schizophrenia with Obsessive-Compulsive Disorder (OCD), with only schizophrenia". On functional MRI (fMRI) lower activation schizophrenia with Obsessive-Compulsive Symptoms, Schizotypal of left dorsolateral prefrontal cortex is linked with the increasing Personality Disorder with OCD, OCD with psychotic features, and severity of obsessive-compulsivesymptoms".  OCD with poor insight'.It is often difficult to distinguish among these  entities. To simplify things, patients who fulfil the criteria for both The obsessions and compulsions encountered in patients suffering Schizophrenia and OCD are considered to be suffering from schizo­ from schizophrenia are usually bizarre in nature. The obsessions may obsessive disorder. Although the two major psychiatric classification be of sexual or religious nature. Schizophrenics usually report systems (DSM 5 & ICD 11) broadly used worldwide are not able to obsessive-compulsive symptoms not being egodystonic and acknowledge this disorder as a separate entity. It requires further patients perceive themasarising from within".  data, exploration and research. Even the current editions of major  psychiatric textbooks that are commonly used worldwide by the Results from recent studies conclude that patients with schizo­ psychiatrists and trainees have not highlighted schizo-obsessive obsessive disorder suffer from higher rates of cognitive deficits, disorder. Though the latest edition of Oxford Textbook of Psychiatry depression, suicidal ideation and social dysfunction when compared does mention the term "schizo-obsessive" and accepts it asadisorder with patients who suffer from schizophrenia alone.The presence of that warrants clinical attention'. On the brighter side eminent obsessive-compulsive symptoms in patients with schizophrenia psychiatrist Dr. Michael Poyurovsky authored a book titled "Schizo carry poor prognosis. Schizo-obsessive patients carry an increased Obsessive Disorder" which was published by Cambridge University risk of suicide. There is a strong association between suicide and Press in 2013. This book is dedicated solely to this specific disorder score on Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Higher and covers all aspects of thisuniqueillnessin detail'. scores on Y-BOCS carry an increased risk of suicide'. The patients  diagnosed with schizo-obsessive disorder demonstrated lower It is estimated that around 30% of the patients suffering from neuro-psychological functioning when assessed using Wisconsin schizophrenia also experience comorbid obsessive-compulsive Card Sorting Test in comparison with patients diagnosed with symptoms and 12% of these patients also fulfil the criteria of schizophrenia only specifically in areas like cognitive abilities, non­ Obsessive-Compulsive Disorder (OCD)'. The genetic basis of schizo- verbal memory, visuospatialskillsand executive functions". | |  |
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It is noted that a subset of patients with schizophrenia starts to manifest obsessive-compulsive features after initiation of the treatment with second generation antipsychotics. This phenomenon is more prevalent in patients being treated with Clozapine'. First generation typical antipsychotics have negligible effects on the serotonergic pathways in the brain and that makes them not much effective in schizo-obsessive patients. Among second generation antipsychotics, there is a dilemma of paradoxical effect of some antipsychotics worsening the obsessive-compulsive symptoms. Clozapine and risperidone are notorious for worsening obsessive-compulsive symptoms. Quetiapine is also another second-generation atypical antipsychotic which can cause exacerbation of obsessive compulsive features". Olanzapine and aripiprazole have shown good results in patients suffering from schizo-obsessive disorder. Quite often augmentation with an anti­ obsessional agent like Clomipramine and Selective Serotonin Reuptake Inhibitors (SSRls) e.g. Sertraline, Fluoxetine and Fluvoxamine is required. Non-pharmacological interventions including Cognitive-Behavioural Therapy (CBT) can also be used for obsessive-compulsive symptoms". Treatment resistant patients suffering from schizo-obsessive disorder often show good response to electroconvulsive therapy (ECT)".

Literature contains ample evidence that supports the reality of schizo-obsessive disorder, yet psychiatrists are quite often reluctant to make this diagnosis. Consultants and supervisors exhibit reservations on this diagnosis, especially for their trainees to avoid the term in examination settings where this particular diagnosis can land a trainee into difficulties. This can partly be explained by the fact that more research is required in this field to clear out the nosological dilemma of placement of this disorder as it is in no man's land.It may be classified either along with schizophrenia or as a variety of OCD. Psychiatrists need to share their experience regarding this entity, its presentation in clinical settings and response to different treatment options on different forums. Patients presenting with features of schizo-obsessive disorders are rising, probably due to increased recognition of this entity among psychiatrists. Supervisors also need to acknowledge this entity and guide their trainees in the early recognition and ample treatment of this disorder. They should be encouraging the psychiatrists of the future to accept and diagnose schizo-obsessivedisorder.

The aim of this discussion is to highlight the significance of schizo­ obsessive disorder as a separate entity and to warrant special attention of psychiatrists along with specific treatment guidelines for this illness. It is the need of the hour to recognize this disorder and impart the due attention it deserves asthe patients with this disorder carry greater morbidity and distress. It requires treatment strategies that are not possible while disregarding the existence of this entity using conventional mindset. We see recognition of schizo-obsessive disorder as the up coming milestone to achieve in the near future.

**REFERENCES**

1. Focseneanu BE, Dobrescu I, Marian G, Rusanu V. Neurological soft signs in early stage of schizophrenia associated with obsessive-compulsivedisorder.JMed Life.2015;8:74-81.
2. Resnik I, Mester R, Kotler M, Weisman A. Obsessive-compulsive

schiziphrenia: a new diagnostic entity? J Neuropsychiatry Clin Neurosci. 2001Winter; 13(1): 115-6.

1. Bleuler E. Dementia praecox, or the group of schizophrenias. New York.International University Press.1956.
2. Karaepelin E. Dementia Praecox and paraphrenia. Edinburg, Livingstone. 1919.
3. Scotti-Muzzi E, Saide OL. Schizo-obsessive spectrum disorders: anupdate.CNS Spectr. 2017 Jun;22(3):258-272.
4. Gelder M, Andreasen NC, Lopez-lbor JJ, Geddes J. New Oxford Textbook of Psychiatry, 2nd Edition. Oxford, UK: Oxford University Press.
5. Poyurovsky M. Schizo-Obsessive Disorder. Cambridge, UK. Cambridge University Press. 2013.
6. Szmulewicz AG, Smith JM, Valerio MP. Suicidality in clozapine­ treated patients with schizophrenia: role of obsessive­ compulsivesymptoms. Psychiatry Res.2015 Nov 30;230(1):50-5.
7. ZinkstokJ, van Nimwegen L,van AmelsvoortT, et al.Catechol-O­ methyltransferase gene and obsessive-compulsive symptoms in patients with recent-onset schizophrenia:preliminary results. Psychiatry Res. 2008;157:1-8.
8. Bottas A, Cooke RG, Richter MA. Comorbidity and pathophysiology of obsessive-compulsive disorder in schizophrenia:is there evidence for a schizo-obsessivesubtype of schizophrenia?J Psychiatry Neurosci.2005;30:187-193.
9. Attademo L, Bernardini F, Quartesan R. Schizo-Obsessive

Disorder: A Brief Report of Neuroimaging Findings. Psychopathology. 2016;49(1):1-4.

1. Wang YM, Zou LQ, Xie WL, Yang ZY, Zhu XZ, Cheung EFC,

S0rensen TA, M0ller A, Chan RCK. Altered grey matter volume and cortical thickness in patients with schizo-obsessive comorbidity. Psychiatry Res Neuroimaging. 2018 Jun 30;275:65- 72.

1. Iida J, Matumura K,Aoyama F. Cerebral MRI findings in childhood-onset schizophrenia, comparison of patients with prodromal obsessive-compulsive symptoms and those without symptoms. Recent ProgChild Adolesc Psychiatry. 1998;2:75-83.
2. Levine JB, Gruber SA, Baird AA,Yurgelun-Todd D. Obsessive­ compulsive disorder among schizophrenic patients: an exploratory study using functional magnetic resonance imaging data.Compr Psychiatry.1998;39:308-311.
3. Schirmbeck F, Zink M. Comorbid obsessive-compulsive symptoms in schizophrenia: contributions of pharmacological andgenetic factors.Front pharmacol. 2013;4:99.
4. Whitney KA, Fastenau PS, Evans JD, Lysaker PH. Comparative neuropsychological function in obsessive- compulsive disorder and schizophrenia with and without obsessive-compulsive symptoms. Schizophr Res.2004;69:75-83.
5. TranulisC, Potvin S,Gourgue M,Leblanc G,Mancini-Marie A,Stip

E. The paradox of quetiapine in obsessive-compulsive disorder.CNS Spectr. 2005 May;l0(5):356-61.

1. Zhou T, Baytunca B, Yu X et al. Schizo-Obsessive Disorder: the Epidemiology, Diagnosis, and Treatment of Comorbid Schizophrenia and OCD.CurrTreat Options Psych.2016;3:235.
2. Johnson E, Peglow S, Patel S, DeFilippo C. Refractory schizo­

obsessive disorder responsive to electroconvulsive therapy. J NeuropsychiatryClinNeurosci. 2014Fall;26(4):E15.



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