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EDITORIAL

Obsessive–compulsive disorder: The usefulness of a pharmacological practice guideline☆

Trastorno obsesivo-compulsivo: utilidad de una guía terapéutica farmacológica

José M. Menchón[a,*], Julio Bobes[b], Jerónimo Saiz-Ruiz[c]

[a] *Departamento de Psiquiatría, Hospital Universitario de Bellvitge-IDIBELL, Departamento de Ciencias Clínicas, Universidad de Barcelona. Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM), L'Hospitalet de Llobregat, Barcelona, Spain*
[b] *Departamento de Psiquiatría, Universidad de Oviedo, Hospital Universitario Central de Asturias, Centro de Investigación Biomédica en Red área de Salud Mental (CIBERSAM), Instituto de Neurociencias del Principado de Asturias (INEUROPA), Oviedo, Spain*
[c] *Departamento de Psiquiatría, Hospital Universitario Ramón y Cajal, CIBERSAM, IRYCIS. Universidad de Alcalá, Alcalá de Henares, Madrid, Spain*

Obsessive–compulsive disorder (OCD) has been considered a rare, infrequent, basically psychological—psychodynamic—disorder, difficult to treat. However, knowledge of this disorder has evolved substantially over the last several decades and many of the classic concepts about it have been modified. We now find ourselves faced with changes in the prevalence of the disorder and greater preponderance of these cases in clinical visits. In addition, the underlying neurobiological findings—mainly from neuroimaging—have provided a fairly specific perspective of the disorder in terms of the brain areas and circuits involved. All of this yields a logical base for drug treatment for OCD. The disorder is complex, with a wide range of varied signs and symptoms. The result is difficulties in identifying, diagnosing and planning therapy for each case.[1] This heterogeneity[2] and the current OCD perspectives give rise to the need to establish the best evidence-based therapeutic drug strategies[3] that help the clinician to choose the most appropriate therapy in each instance.

Prevalence: The prevalence of OCD is now considered to be significantly higher than initially thought. At the beginning of the 1980s, OCD prevalence in the general population was estimated at around 0.05%, a figure that was compatible with the perception that clinicians held as to its prevalence in surgery visits, given that there were infrequent cases of the disorder. However, several post-1984 studies have set OCD prevalence at 2–2.5% of the general population, which translates into high prevalence.[4,5] This difference between OCD prevalence in the general population and the presence of patients with OCD in visits to the doctor stems from the fact that individuals with OCD rarely seek help from mental health professionals. For example, in the Epidemiologic Catchment Area (ECA) study, only 34% of the patients with OCD were found to have ever mentioned their symptoms to a physician, while only 20% of them had sought help from a mental health specialist.[6,7] More recent studies have found a more frequent search for treatment, approximately 37%, mainly associated with the presence of comorbidity.[8] The reasons why the individuals affected by the disorder avoid looking for treatment for these symptoms or do not explain them to their physicians are varied, but they are related to

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* Corresponding author.
E-mail address: jmenchon@bellvitgehospital.cat (J.M. Menchón).

the lack of information about OCD. Some people with the disorder feel embarrassed by the symptoms or feel that if they explain the symptoms, they will be stigmatised as seriously mentally ill; others think that the symptoms may mean that they are 'loosing their minds, while yet another group lacks insight into the symptoms or believes that there is no treatment'. However, the population has greater access to general and specific information about disorders now and there is more widespread dissemination of health-related subjects. That is making it easier for individuals affected by the disorder or for their relatives to identify the obsessions or compulsions as symptoms of a disorder that can be treated with efficacy and that their quality of life can be improved.

Quality of life and the personal and healthcare system burden: The burden, both in personal terms and for the healthcare system, is highly significant. OCD has been considered to be one of the 10 main causes of disability, together with another 4 disorders (major depression, schizophrenia, bipolar disorder and alcoholism).[9] The relevance that OCD has for quality of life is also reflected in the fact that it was explicitly mentioned in the Director General's speech at the 111th session of the Executive Board of the World Health Organisation (WHO).[10] Likewise, more recent estimations also suggest that OCD is linked to severe disability. The WHO[11] has recently published tables for disability-adjusted life years (DALY) for different diseases and conditions, updating the previous 2000 data available for each country. In these tables, it can be seen that mental and behavioural disorders constitute, in Spain, the groups with the heaviest burden (1194.0 DALY) compared with other groups of illnesses at the same level. And, within mental disorders, anxiety disorders (in which OCD is included) make up the second largest group of disorders with greatest disability (134.3 DALY), behind unipolar depressive disorder (538.7 DALY) but ahead of schizophrenia (106.5 DALY) and drug-abuse related disorders (109.7 DALY). Different studies have found data similar to those mentioned. Patients with OCD show poor quality of life. A Spanish study[12] found that the quality of life that these patients had was the same as that of patients with schizophrenia in mental health areas, although better than theirs in areas of physical health; likewise, their quality of life was worse than that of patients with heroine dependency or of depressed patients. In comparison with other neurotic disorders, OCD is associated with greater social and work deterioration and greater emotional impact.[13] In addition to suffering the cost to their quality of life, patients with OCD also present high rates of comorbidity with other disorders: up to 90% of patients with OCD will fulfil criteria for another disorder at some time during their lives, as some epidemiological studies have found.[5]

Delay in diagnosis and delay in treatment: Both clinical experience and studies indicate that not only do the individuals with OCD see doctors less often, they also suffer delays in the identification of the proper diagnosis and in the implementation of disorder-appropriate treatment. A well known study (Brown Longitudinal Obsessive–Compulsive Study [BLOCS]),[14] which involved a follow-up of a large patient sample, found that there was a time lag of approximately 17 years on average from onset of the obsessive symptoms and receiving adequate treatment, and a period of some 11 years from the time that diagnostic criteria for OCD were fulfilled. Such a delay represents a troubling ethical problem,[15] given that, besides the impact of OCD on quality of life, there are data suggesting that a delay in initiating appropriate treatment is associated with worse response to treatment as well as worse evolution.[16]

Treatment choice and resistance: Although it may seem that drug treatment for OCD is well established, some studies have shown that the treatment of these patients is particularly deficient. For example, an epidemiological study led by Torres et al.[17] found that only 9.4% of people with OCD had seen a psychiatrist in the previous year; furthermore, only 4.6% had seen a psychologist, 5% received cognitive-behavioural therapy, 2% were taking a selective serotonin reuptake inhibitor and 10% were on tricyclic antidepressants. Another factor to remember is that first-line drug treatment for OCD has a relatively limited response. It is estimated that 30–40% of the cases given such treatment will show an unsatisfactory response and 10% will remain resistant to any type of therapeutic approach.[18] In the cases that show a lack of response to treatment or have a poor or limited response, it is important to know the specific drug strategies that are backed by the strongest scientific evidence.[19]

In a recent *Manifesto*,[20] OCD-related matters that are key for advancing in knowledge about the disorder and its application in clinical practice were identified. Among the different questions posed, the need for a correct therapeutic approach was stressed[21] for better personalisation of treatment. The aspects mentioned in this brief review are relevant for an adequate drug therapy approach. The high rates of prevalence that the disorder involves and the need to identify the symptoms better, to reduce the delay in OCD diagnosis and treatment and to improve drug prescription guidelines are all factors that will lead to greater efficacy, lower therapeutic resistance and, consequently, a lesser psychological burden and better quality of life. Having drug therapy guidelines available for OCD can be of decisive help in reaching this objective.

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