First-onset Non-neurocognitive Obsessive-compulsive Disorder after a Stressful Life Event in Late Life: A Patient with an 11-Year Follow-up

Late-onset obsessive-compulsive disorder (OCD) is rare. Prevalence of patients with OCD among the elderly is much lower than that in general population [1]. Most reports on late-life first-onset OCD have been related to neurocognitive conditions. Only one Caucasian patient with first-onset non-neurocognitive OCD in late life has been reported in a PubMed search [2]. We report here one Taiwanese case in an elderly patient with first-onset non-neurocognitive OCD in late life.

Case Report

A 77-year-old female patient without significant medical, psychiatric, or substance use history had her first onset of OCD at the age 66 years with a potential predisposing stressor two months before the onset. She was cleaning the body of a deceased Buddhist master, whom the patient knew well and had lived with since she was 29 years of age. Patient denied any other stress-related symptoms then. Initial clinical presentations included repetitive cleaning, anxiety, and insomnia, followed by depressive symptoms for more than one month. Her compulsive symptoms were daily repetitive and excessive hand-washing 10 to 20 times with skin lesion, and time-consuming bathing over half an hour. She then came to our clinic for help at the age 66 years. She was diagnosed with OCD with full remission of compulsive and depressive symptoms after her regularly taking a selective serotonin reuptake inhibitor (SSRI), citalopram. Recurrence of OCD without depressive symptoms was noted after SSRI discontinuation twice. Patient had no complaint about worsen memory until she was 76 years old.

The results of laboratory examinations during the treatment and one brain computed tomography at the age 76 years revealed no significant abnormalities. Scores of Cognitive Ability Screening Instrument and Mini-Mental State Examination both were dropped significantly between the age 69 and 76 years. But Clinical Dementia Rating Scale score was increased from 0 to 1. She had a regular clinic follow-up, and lived an independently active life without admission during the 11-year treatment.

Comment

Patients with first-onset OCD in late-life have widely been recognized as the presentation of a potential neurocognitive disorder or neuropathy [3]. According to stress-diathesis model, our patient might have the vulnerability to the stress, the common cause of all kinds of anxiety spectrum disorders. The interplay of the stressful event and the nature of susceptibility of the case resulted in the presentation of mental disorder. It is hypothesized that dementia might be the end-point...
of some forms of primary, late-onset obsessional illness, or may share a common pathophysiologic cause with OCD [4]. Possible explanation was that elevated concentration of glucocorticoids in the brain secondary to stress, leading to the dropped concentration of brain-derived neurotrophic factor (BDNF), finally resulted in having neurotoxicity, apoptosis, and atrophy of the brain, especially in hippocampus [5]. We hypothesize that patients with late-life first-onset non-neurocognitive OCD may have better outcome than those who are elder with untreated OCD since their early stage of life, because the former may have less damage to the nervous system, better coping skills and social support system, and a more “resourceful” brain [6].

In summary, detailed and thorough history, physical examination, and neurocognitive survey must be obtained in late-life first-onset OCD to rule out reversible and treatable neurocognitive focus. Possible stressful event before the onset of OCD may be an entrance to the collaborative alliance and sustainable recovery. (Two authors declare no potential conflicts of interest in writing this report.)

References