Case Report Of OCD Worsening When Methadone Tapered Below 7.5 mg

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Abstract

A wealthy professional who suffered from a severe obsessive compulsive disorder since age 17, and later also from severe depression and anxiety resistant to antidepressants and antipsychotics, attempted to self-medicate with oxycodone, and became addicted. While in methadone maintenance program he experienced the resurgence of his severe psychiatric symptoms whenever methadone was tapered below 7.5 mg.

INTRODUCTION

Methadone tapering below very low levels occasionally leads to a worsening of obsessive-compulsive symptoms, as in the present clinical case report. Khazaal et al. [1, 2] described cases of a worsening of obsessive compulsive symptoms during methadone tapering. It seems that methadone may suppress certain pre-existing psychiatric symptoms. Antipsychotic effects of methadone were documented in a placebo-controlled study by Brizer et al [3]: patients with treatment-resistant chronic paranoid schizophrenia who received methadone plus neuroleptic showed significant improvement. Maremmani et al. [4] found that stabilization dosages are higher in patients with Axis I psychiatric diagnosis than in those free of such diagnosis and that they take longer to reach stabilization phase and need more attention from clinicians during the tapering of methadone than the patients without Axis I psychiatric diagnosis. However, a psychotic illness is rarely seen during methadone withdrawal, except in rare cases such as those published in Levinson et al [5] and OCD symptoms are rarely noted.

CASE REPORT

Our patient is known within our urban community as a successful professional with an extensive university education. He suffered from severe OCD since age 17 and eventually also developed severe depression and anxiety. He reported that his father also suffered from these symptoms. Our patient unsuccessfully strived to cope with his symptoms in various ways in order to complete the university education and later on to continue functioning within his profession. At one point, he attempted to self-medicate with oxycodone and became addicted. He experienced major depressive symptoms, also a manic episode, and, while diagnosed by various other psychiatrists with the bipolar mood disorder he underwent unsuccessful psychiatric treatments by these specialists with numerous antidepressant and antipsychotic medications, including also sertraline, paroxetine, epival, olanzapine, and fluvoxamine. Atypical neuroleptics may, in some cases, induce or exacerbate obsessive compulsive symptoms. This has been documented with quietapine [6], olanzapine [7], and clozapine [8].

Our patient found a major and continuous relief from OCD and other psychopathology after finally being admitted as outpatient to our methadone maintenance clinic due to his addiction to opiates, and placed on methadone about 3 years ago. During our attempts at methadone tapering, it has been repeatedly determined that his OCD, depression, and anxiety markedly intensified whenever methadone was reduced below 7.5 mg.

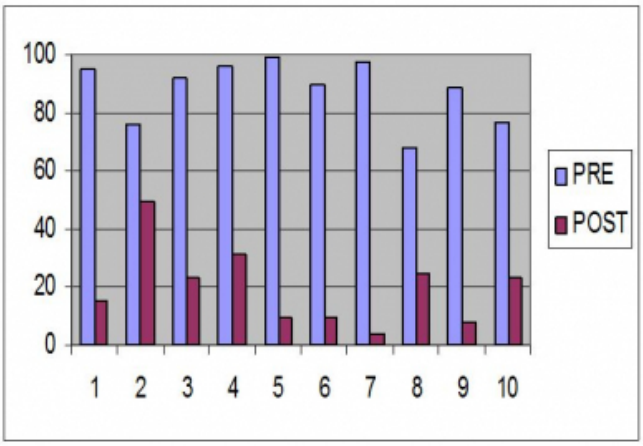
Independently of medical advice, he also used St.John's Wort (a herbal antidepressant [9]) and Inositol (myo-Inositol has been found in a double-blind study to be an effective treatment for OCD [10]). Since the initiation of methadone maintenance and the discontinuation of any other psychiatric medication (except for his independent consume of non-prescription St.John's Wort and Inositol), he found his professional activity less stressful and reported that his financial status has improved accordingly, as shown by his purchases of several expensive buildings.

Our patient was administered the Symptom Checklist-90 Revised (SCL-90-R), i.e., a standardized measure of anxiety, depression, obsessive-compulsive symptoms, paranoid ideation, anger, as well as of phobic and of other psychiatric symptoms (developed by Derogatis [11]). He was instructed to complete this questionnaire to retrospectively describe his symptoms as they were prior to his methadone treatment. Then, he was asked to again complete the same questionnaire to describe his current symptoms.

According to this patient's scores on SCL-90-R, his depressive and obsessive-compulsive symptoms as well as his anxiety and anger prior to methadone were above 90th percentile for male outpatient psychiatric population. These same SCL-90-R scales were below the 32nd percentile while he was on methadone (minimally 7.5 mg, jointly with Inositol and St.John's Wort). In fact, his scores on any of the standard SCL90 scales were above the 60th percentile before methadone and all below the 32nd percentile while on methadone except for his somatization score which was at the 55th percentile even while on methadone.

Figure 1

SCL-90-R profile prior methadone maintenance and during the maintenance (7.5mg)



Legend:

The vertical axis on the left is a scale from 0 to 100 to denote percentile ranks as standardized

on outpatient psychiatric population.

The horizontal axis consists of the following scales of psychopathology:

1 = total score, 2 = somatization, 3 = obsessive-compulsive symptoms,

4 = interpersonal sensitivity, 5 = depression, 6 = anxiety, 7 = anger/hostility,

8 = phobic anxiety, 9 = paranoid ideation, 10 = psychotic symptoms.

The patient suggested that we publish his case study so persons with similar conditions could be helped.

However, eventually, as per strong recommendations of external international experts in the field of addiction treatment, we exhorted again this patient to reduce the methadone dose below 7.5 mg. He agreed, initially seemed comfortable, but then suddenly broke off the contact with our clinic without providing an explanation. Given his clinical history, it is not impossible that he avoided the contact with us due to his unmet need for a higher dose of methadone and a related exacerbation of his psychiatric symptoms.

DISCUSSION

Our case is consistent with clinical studies that show the efficacy of opiate drugs for treatment-refractory OCD. Thus Koran et al [12] found in a placebo-controlled, double-blind trial that once-weekly oral morphine was effective in SRI-resistant OCD. Goldsmith [13] and Shapira [14] reported a major reduction in OCD symptoms in patients treated with tramadol hydrochloride (an atypical opioid). Warnecke [15] described cases of severe chronic OCD in which various other therapies were unsuccessfully attempted and psychosurgery was considered: the patients extensively recovered when treated with morphine.

It is possible that patients who suffered from OCD already before exposure to exogenous opiates may be particularly at risk for the re-activation of OCD symptoms during methadone tapering and need a more intensive clinical monitoring. Empirical data on methadone's impact on psychopathology, at the least in the form of quantitative single case studies, as in this article, are much needed. Hopefully this report will stimulate the interest in prospective longitudinal studies and provide the answer to the therapeutic dilemma of whether or not pressuring patients with treatment resistant OCD, depression, and anxiety to reduce the methadone dose beyond very minimal levels is an optimal psychiatric strategy.

CONCLUSION

Methadone may suppress certain pre-existing psychiatric symptoms and these may re-emerge during tapering of

methadone below very minimal levels.

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