Early- versus late-onset obsessive-compulsive disorder:

Report of two cases and literature review

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Case 1

S.G., a **15-year-old male**, with no past personal or familial history of psychiatric illness took consultation from a child and adolescent psychiatrist for obsessive ideas mainly about dirt associated with compulsive washing:

- At the **age of 14**, after a hockey practice, he came home and noticed a brownish spot on his training shorts. Since then, the **thoughts** that he is **dirty (feces)** were **intruding** his mind repeatedly, which made him feel **uneasy** and **distressed**
- Those thoughts led him to perform **showering and toileting rituals**, increasingly **time-consuming** and with a **significant impact on his life**, to the point of not being able to go to hockey practice and have members of his family involved
- He recognized the **irrational nature** of his obsessive concerns but could not bring himself to ignore them

Diagnosis:
Early-onset Obsessive-Compulsive Disorder (EOCD) with good or fair insight

Treatment:
a) Psychoeducation
b) Psychotherapy
c) Pharmacological treatment (Fluvoxamine, starting dose of 50 mg/day)

Case 2

M.J., a **41-year-old woman**, with no past history of psychiatric illness had been suffering from **obsessive-compulsive disorder (OCD)** for **5 years** (main complaint – **compulsive checking**). Her **medication** had been **gradually withdrawn** at her request because of her desire to become pregnant. A few months later, she was referred to a new psychiatric assessment:

- After a **termination of pregnancy** for fetal anomaly at 19 weeks, she described a **worsening of her checking rituals** as well as **intrusive thoughts** of **accidental harm** to her older son
- Her symptoms were **time-consuming** and caused **clinically significant distress** and impairment
- She recognized that her fears were **absurd and irrational** but claimed to be powerless in stopping them

Diagnosis:
Late-Onset Obsessive-Compulsive Disorder (LOCD) with good or fair insight

Treatment:
a) Psychoeducation
b) Psychotherapy
c) Pharmacological treatment (Sertraline, starting dose of 50 mg/day)

Recent studies support the idea that OCD is clinically and etiologically heterogeneous and that there are two distinguishable groups according to the age at onset: EOCD (mean onset 11 years) and LOCD (mean onset 23 years)

EOCD (vs. LOCD)

Male gender predominance	More likely to be comorbid with tics and other obsessive-compulsive spectrum disorders
Greater OCD global severity	Possibly no more likely to be comorbid with anxiety and mood disorders, or attention-deficit/hyperactivity disorder (ADHD)
Higher frequency of clinically significant obsessions and compulsions of most types	Higher prevalence of OCD in first-degree relatives

e.g., religious, sexual, and aggressive obsessions

Requires further investigation

Conclusions: Results support the view that **EOCD** and **LOCD** are **distinct subtypes of OCD** and that EOCD may represent a more severe one. Further studies with prospective designs are needed to improve our understanding of EOCD and LOCD.