17 - 31.8d Persistent (Chronic) Motor or Vocal Tic

31.8d Persistent (Chronic) Motor or Vocal Tic Disorder

Piacentini J, Woods DW, Scahill L, Wilhelm S, Peterson AL, Chang S. Behavior therapy for children with Tourette disorder. A randomized controlled trial. JAMA. 2010;303:1929–1937. Porta M, Sassi M, Cavallazzi M, Fornari M, Brambilla A. Servello D. Tourette's syndrome and the role of tetrabenzine: review and personal experience. Clin Drug Investig. 2008;28:443–459. Roessner V, Plessen KJ, Rothenberger A, Ludolph AG, Rizzo R, Skov L. European clinical guidelines for Tourette syndrome and other tic disorders. Part II: Pharmacologic treatment. Eur Child Adolesc Psychiatry. 2011;20:173–196. Rothenbertger A, Roessner V. Functional neuroimaging investigations of motor networks in Tourette syndrome. Behav Neurol. 2013;27:47–55. Scharf JM, Miller LL, Mathews CA, Ben-Shlomo Y. Prevalence of Tourette syndrome and chronic tics in the populationbased Avon longitudinal study of parents and children cohort. J Am Acad Child Adolesc Psychiatry. 2012;51:192–201. Steeves T, McKinlay BD, Gorman D, Billinghurst L, Day L, Carrol A. Canadian guidelines for the evidence-based treatment of tic disorders: Behavioural therapy, deep brain stimulation and transcranial magnetic stimulation. Can J Psychiatry. 2012;57:144–151. Thomas R, Cavanna AE. The pharmacology of Tourette syndrome. J Neural Transm. 2013;120(4):689–94. Verdellen C, Griendt JVD, Hartmann A, Murphy T, the ESSTS Guidelines Group. European clinical guidelines for Tourette syndrome and other tic disorders. Part III: behavioural and psychosocial interventions. Eur Child Adolesc Psychiatry. 2011;20:97–207. Weisman H, Qureshi IA, Leckman JF, Scahill L, Bloch MH. Systematic review: Pharmacological treatment of tic disorders —Efficacy of antipsychotic and alpha-2 adrenergic agonist agents. Neurosci Biobehav Rev. 2013;37(6):1162–71. Woods DW, Piacentini JC, Scahill L, Peterson AL, Wilhelm S, Chang S. Behavior therapy for tics in children: acute and long-term effects on psychiatric and psychosocial functioning. J Child Neurol. 2011;7:858–865. 31.8d Persistent (Chronic) Motor or Vocal Tic Disorder Chronic motor or vocal tic disorder is defined as the presence of either motor tics or vocal tics, but not both. Tics may wax and wane but must have persisted for more than 1 year since the first tic onset to meet the diagnosis for persistent (chronic) motor or vocal tic disorder. According to the Fifth Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria, this disorder must have its onset before the age of 18 years. Chronic motor or vocal tic disorder cannot be diagnosed if the criteria for Tourette's disorder have ever been met.

EPIDEMIOLOGY The rate of chronic motor or vocal tic disorder has been estimated to be 100 to 1,000 times greater than that of Tourette’s disorder in school-age children. School-age boys are at highest risk. Although the disorder was once believed to be rare, current estimates of the prevalence of chronic motor or vocal tic disorder range from 1 to 2 percent. ETIOLOGY Chronic motor or vocal tic disorder as well as Tourette’s disorder tend to aggregate in the same families. Twin studies have found a high concordance for either Tourette’s

disorder or chronic motor tics in monozygotic twins. This finding supports the importance of hereditary factors in the transmission of tic disorders. DIAGNOSIS AND CLINICAL FEATURES The onset of chronic motor or vocal tic disorder typically occurs in early childhood. Chronic vocal tics are considerably rarer than chronic motor tics. Chronic vocal tics, in the absence of motor tics, are typically less conspicuous than the vocal tics in Tourette’s disorder. The vocal tics are usually not loud or intense and are not primarily produced by the vocal cords; they consist of grunts or other noises caused by thoracic, abdominal, or diaphragmatic contractions. DIFFERENTIAL DIAGNOSIS Chronic motor tics must be differentiated from a variety of other motor movements, including choreiform movements, myoclonus, restless legs syndrome, akathisia, and dystonias. Involuntary vocal utterances can occur in certain neurological disorders, such as Huntington’s disease and Parkinson’s disease. COURSE AND PROGNOSIS Children whose tics emerge between the ages of 6 and 8 years seem to have the best outcomes. Symptoms often last for 4 to 6 years and remit in early adolescence. Children whose tics involve the limbs or trunk may have less prompt remission than those with only facial tics. TREATMENT The treatment of chronic motor or vocal tic disorder depends on several factors including the severity and frequency of the tics; the patient’s subjective distress; the effects of the tics on school or work, job performance, and socialization; and the presence of any other concomitant mental disorder. Psychotherapy may be indicated to minimize the secondary social difficulties caused by severe tics. Behavioral techniques, particularly habit reversal treatments, are effective in treating chronic motor or vocal tic disorder. When severe, tics may be reduced through the use of atypical antipsychotics such as risperidone. If not effective, typical antipsychotics such as pimozide or haloperidol may be helpful. Behavioral interventions are the first line of treatment. REFERENCES Du YS, Li HF, Vance A, Zhong YQ, Jiao FY, Wang HM. Randomized double-blind multicentre placebo-controlled clinical trial of the clonidine adhesive patch for the treatment of tic disorders. Aust NZJ Psychiatry. 2008;42:807–813. Jummani R, Coffey BJ. Tic disorders. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:3609. Knight T, Stevvers T, Day L, Lowerison M, Jette N, Pringsheim T. Prevalence of tic disorders: A systematic review and

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