

27 - Treatment refractory OCD and BDD in children

Treatment-refractory OCD and BDD in children

590 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 Treatment-refractory OCD and BDD in children Evidence from randomised trials suggests that up to three-quarters of medicated patients have an adequate response to treatment. About a quarter of children and young people with OCD will therefore fail to respond to an initial SSRI, administered for at least 12 weeks at the maximum tolerated dose, in combination with an adequate trial of CBT and exposure and response prevention (ERP). These children should be reassessed and compliance clarified, and it should be ensured that clinical comorbidities are not being missed. In such cases, children and young people should usually have additional trials of at least one other SSRI. Research suggests that approximately 40% respond to a second SSRI in both OCD and BDD.¹⁹ Following this, if the response is limited, consideration should be given to referral to a specialist centre. In OCD, trials of clomipramine may be considered and/or augmentation with a low dose of risperidone or aripiprazole.^{13,20} Augmentation with antipsychotics is not recommended in the treatment of BDD. The combination of fluvoxamine and clomipramine has been used in refractory cases^{21,22} but, given the dangers of serotonin syndrome, these regimens should be reserved for specialist centres. Improved efficacy seems to be linked to the altering of the metabolism of clomipramine by fluvoxamine. There is evidence that low-dose antipsychotic augmentation of SSRI treatment as an off-label therapy can benefit patients whose response to treatment has been inadequate despite at least 3 months of two maximal tolerated separate SSRIs. There is a more robust evidence base in adult cohorts than in younger people. Only a third of treatment-resistant adult cases of OCD showed a meaningful response to this augmentation strategy. Small studies conducted on children and young people showed a clinical improvement for OCD, with a larger evidence base available for aripiprazole compared with risperidone.^{23–25} A 6–8-week trial of low-dose antipsychotic augmentation is typically sufficient to assess efficacy. In practice, doses no larger than aripiprazole 2.5–5mg daily or risperidone 0.5mg daily should be used. It is important to discontinue the antipsychotic if no response is noted after this trial of SSRI augmentation. Antipsychotics alone are not efficacious treatments for obsessive compulsive disorders. Often children and young people whose OCD or BDD has been difficult to treat have comorbidities such as autism spectrum disorder, ADHD or tic disorders. The response to medication can be differentially affected by these comorbidities. For instance, patients with tic disorders may benefit somewhat more from augmentation with

second- generation antipsychotics.²⁶ Untreated ADHD can also commonly interfere with engagement with CBT due to poor focus. Very often efforts to address ADHD with appropriate treatments including medication can dramatically improve engagement with CBT. However, caution is required with regard to stimulant use, particularly for young people who are not ‘fighting back’ against compulsions. In this group, one can see an increase in compulsions as concentration improves. Careful clinical review and reformulation are important in treatment-resistant OCD and BDD. Comorbidities and wider psychosocial factors need to be considered for their impact on the treatment response overall. The evidence base around systemic factors and their application in OCD is poor. Very often clinical experience shows that it can be vital to support families and carers during treatment. Alternative experimental and adult treatments are given in Tables 5.8 and 5.9.

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