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Research paper

Pharmacotherapy for obsessive compulsive disorder in clinical practice – Data of 842 inpatients from the International AMSP Project between 1994 and 2012

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ABSTRACT

Background: Specific treatment of obsessive compulsive disorder (OCD) is based on cognitive-behavioral therapy, serotonin reuptake inhibitors (SRIs) or their combination. Treatment strategies do not always follow evidence-based guidelines in outpatient settings. Data on pharmacotherapy in inpatient settings are lacking.

Methods: Prescription data for inpatients suffering from OCD in the time period 1994–2012 were obtained from the database of the Drug Safety Program in Psychiatry (AMSP). Data were collected on two index dates per year; the prescription patterns and changes over time were analysed.

Results: Of 842 patients 89.9% received at least one psychotropic drug and 67.6% a combination of at least two psychotropic drugs. The drug groups prescribed most often were antidepressants (78.0%), antipsychotics (46.7%), and tranquilizers (19.7%). In 58.0% of all cases selective serotonin reuptake inhibitors (SSRIs) were used as antidepressants, followed by tricyclic antidepressants (TCAs, 17.8%), mainly clomipramine (10.9%). Second-generation antipsychotics (SGAs) were administered in 37.8% of all cases, first-generation antipsychotics (FGAs) in 13.7%. While the use over time significantly increased for psychotropic drugs, antidepressants, antipsychotics, tranquilizers, SSRIs and SGAs, it remained stable for FGAs and decreased for TCAs.

Limitations: Observational cross-sectional study without follow-up or additional information.

Conclusions: In clinical practice, most OCD patients received pharmacological treatment. The high prescription rate of SSRIs and their preference over clomipramine as well as the augmentation of this therapy with SGAs comply with the guidelines. Administration of tranquilizers as well as sedative FGAs and the choice of single SGAs are not in line with expert recommendations.

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1. Introduction

Obsessive compulsive disorder (OCD) is a severe and disabling mental disorder with an estimated lifetime prevalence of 1.0–2.3% and a 12-month prevalence of 0.7–1.2% in adults (Adam et al., 2012; Hauschildt et al., 2010; Ruscio et al., 2010). The clinical picture of OCD is characterized by obsessions and/or compulsions. Obsessions are defined as recurrent, persistent and intrusive thoughts, images or urges that cause anxiety. Compulsions are defined as repetitive behaviors or mental acts that the patient feels driven to perform in order to reduce the obsession-related anxiety (DSM-IV; ICD-10; American Psychiatric Assosication, 1994; World Health Organisation, 1994).

Treatment guidelines recommend cognitive behavioral therapy (CBT), serotonin reuptake inhibitors (SRIs), or their combination as first-line treatments (Cuijpers et al., 2013; Fineberg et al., 2015; Katzman et al., 2014; Rosa-Alcázar et al., 2008; Hohagen et al., 2015). Cognitive behavioral therapy with exposure exercises can be considered superior to medication for acute treatment and over the long run (Cuijpers et al., 2013; Fineberg et al., 2015; Katzman et al., 2014; Rosa-Alcázar et al., 2008; Hohagen et al., 2015). The pharmacological management of OCD is regarded as second-line treatment except in the case of comorbid depression or predominant obsessions (Hohagen et al., 1998). There is a large body of evidence for the efficacy of SRIs, i.e., selective serotonin reuptake inhibitors (SSRIs) and the tricyclic antidepressant (TCA) clomipramine in high dosages (Bloch et al., 2010; Foa et al., 2005;

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Soomro et al., 2008). A reduction of OCD symptomatology by 20–40% can be expected after 6–8 weeks. The SRI clomipramine – in contrast to other TCA (non-SRI)-has an efficacy similar to that of SSRI, but it is generally less tolerated. Therefore, primarily SSRIs are recommended in accordance with the guidelines (Cuijpers et al., 2013; Fineberg et al., 2015; Katzman et al., 2014; Rosa-Alcázar et al., 2008; Hohagen et al., 2015).

A substantial number of OCD patients (25–60%) either do not respond to a first treatment trial with an SSRI or show only partial response despite an adequate dosage or length of treatment (Bloch et al., 2010; Soomro et al., 2008). Different strategies are generally taken in such cases, such as switching from one SSRI to another or to clomipramine, or vice versa (Hohagen et al., 2015), augmenting the medication with another class of agents (Bloch et al., 2006; Komossa et al., 2010) or with CBT (Anand et al., 2011). Antipsychotics are not effective as monotherapy in OCD, but meta-analyses have demonstrated that adding various second-generation antipsychotics (SGAs) achieved a significant efficacy compared to placebo. The highest efficacy was shown for risperidone and aripiprazole as well as for the first generation antipsychotic (FGA) haloperidol (Bloch et al., 2006; Dold et al., 2015; Komossa et al., 2010; Pessina et al. 2009; Sayah et al. 2012).

Despite the disabling character of OCD, community-based studies in western countries have reported help-seeking rates of only 10–40% among OCD patients, depending on the total number of OCD symptoms and the presence of severe and violent obsessions (Ruscio et al., 2010; Schwartz et al., 2013; Torres et al., 2007). Apparently the tolerance of obsessive compulsive problems might be relatively high as long as distress and impairment in private relationships and work are not too disruptive. Even when patients contact the health system, OCD often remains undetected and OCD target therapy is rarely induced (Wahl et al., 2010; Ruscio et al., 2010). In outpatient settings, about 43–65% of all OCD patients receive pharmacological treatment consisting of an SRI, but only half of them at a dosage that is effective for OCD (Denys et al., 2002; Van Ameringen et al., 2014). Augmentation therapy is common, mostly with SGAs, followed by benzodiazepines, and antidepressants (Van Ameringen et al., 2014).

Until now, the existing studies on treatment practice in OCD were all based on self-reports from relatively small samples of patients in secondary or tertiary outpatient centers (Denys et al., 2002; Ruscio et al., 2010; Schwartz et al., 2013; Van Ameringen et al., 2014). Little is known about treatment practice in primary care centers and inpatient settings. This study analysed the actual prescription patterns of pharmacotherapy for OCD in a large psychiatric inpatient population treated during routine clinical practice between 1994 and 2012. We used prescription data based on medical records, examined prescription patterns over time, and compared the results with the guideline recommendations.

2. Methods

2.1. Data source

For the present study prescription data were used that had been collected through the International Drug Safety Program in Psychiatry (Arzneimittelsicherheit in der Psychiatrie, AMSP). AMSP is an ongoing international multicenter drug safety program which has collected data on psychopharmacotherapy and adverse drug reactions from psychiatric hospitals in a naturalistic setting since 1993. Its methods have been described in detail elsewhere (Engel et al., 2004; Grohmann et al., 2004). Briefly, AMSP consists of two principal data collections from 109 hospitals in Germany, Switzerland, and Austria, and for some time also data from one hospital each in Belgium and Hungary. The number of participating hospitals increased from nine in 1994–56 by 2012. In a cross-sectional approach all participating hospitals assess drug prescriptions for all inpatients under surveillance on two reference days per year. All drugs administered on these days are recorded along with the patient's age, gender, and leading psychiatric diagnosis. Comorbid psychiatric diagnoses are not recorded. Furthermore, severe adverse drug reactions that occur at these hospitals in association with psychopharmacological treatment are continuously reported and collected. For the current study only the cross-sectional AMSP dataset with prescriptions from 84,607 patients surveyed between 1994 and 2012 was used. In this time period 78 hospitals provided data on OCD patients.

2.2. Study population and design

Within the AMSP dataset all patients with a current diagnosis of OCD based on ICD-10 diagnostic codes F42.0, F42.1, F42.2, F42.8, F42.9 and F42.*, i.e., subclassification was missing, were selected. It is important to note that the recorded ICD codes did not in all cases differentiate between the diagnostic subgroups within the category F42: F42.0 obsessions, F42.1 compulsions, or F42.2 mixed obsessions and compulsions. Therefore, a differential analysis of the psychopharmacological prescription habits between the diagnostic subgroups was not possible. For the study population (n=842) all demographic information and prescriptions were analysed on the day of data collection.

The Ethics Committee of the Ludwig Maximilian University of Munich, where the AMSP main data center is located, approved such analyses of the AMSP data by a waiver of authorization.

2.3. Data analysis

The study was mainly descriptive. Tables and figures demonstrate the mode and development of the prescription practice during the observation period. One exception to the descriptive approach was the use of binary logistic regression to detect time trends. The year was often a significant predictor of the number of prescribed drugs. Except for TCAs, all the significant trends were positive, i.e., prescriptions increased over time. The lower limit of the 95% confidence intervals (CI) of the odds ratio indicates a significant, positive trend, if greater than 1. For TCAs the upper limit of the 95% CI was below 1, thus showing a decrease of prescriptions.

3. Results

3.1. Characteristics of study population

Characteristics of the study population are presented in Table 1. A total of 842 patients with a leading admission diagnosis of OCD based on ICD-10 codes were identified. Most cases showed a mixed symptomatology with obsessions and compulsions (50.5%). According to the clinical picture, obsessions dominated in 13.9% of the cases, compulsions in 13.5%. In 16.5% of the cases further information was missing which would have allowed differentiation between these subgroups. More patients were included during the second half of the 18-year observation period, which corresponded to the increasing number of hospitals participating in AMSP over time, and there were as many females (51.2%) as males.

3.2. Psychotropic drug groups

The majority of all patients treated for OCD took at least one psychotropic drug (89.8%). The probability of receiving any psychotropic drug significantly increased during the observation

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