CASE REPORT

Obsessive compulsive disorder and giant rectal prolapse
Shalan Joodah


INTRODUCTION

Risks of physical health problems are increased with psychiatric illnesses (1). Individuals with depression (2), anxiety (3), and schizophrenia (4) were of high risk for physical illness than the general population. Obsessive Compulsive Disorder (OCD) is a common chronic psychiatric disorder affecting up to 3% of adults and children (5), characterized with obsessions and compulsions. Rectal prolapse can be observed secondary to OCD (6). OCD is associated with decreased quality of life, and functional impairment (7,8). Most OCD patients can be treated (9). Despite treatment small subgroup develops chronic illnesses (10). Even these chronically ill can respond to psychological and psychopharmaceutical treatments in varying degree (11). There is little research examining the physical health of patients with OCD (7). Measures of quality of life in OCD have suggested that more physical symptoms than the general population (12,13).

Rectal prolapse is a protruding of the rectal wall through the anus, female to male ratio of 6:1. Risk factors include fixation of the rectum to the sacrum, musculature of the pelvic floor and the anus, history of chronic constipation excessive abdominal pressure, and pelvic and obstetric surgeries (14).

Giant rectal prolapse is a rare entity of unknown incidence (15). Full anorectal examination is important. A patulous anus with diminished sphincter tone is usually identified. In the event that the prolapse is still elusive, patients can be asked to photograph the prolapse at home (16). Rectal prolapse is a rare but severe possible complication of OCD (5).

CASE PRESENTATION

A 38 year old married woman consults the outpatient psychiatric clinic due to compulsive washing, frequent checking, and fear from contamination. She lived with her husband, not reporting related marital and family stressful situations. She had no conflict with her sisters and brothers. She had not been smoking, misusing drugs or alcohol. Her history dated back to nine years when she gradually started to experience obsessive compulsive symptoms (mainly the fear of contamination from touching various things she considered dirty). She was diagnosed with OCD at the age of 29, during her first visit to a private psychiatrist.

At time of our first consultation, her symptoms included ritual washing of hands and cleaning and evacuation of bowel in response to contamination obsessions as well as checking compulsions. The condition was associated with sever constipation and urine incontinence. At age 31 years she was started noticing unexpected release of mucus from anus, anal pain and irritation, feeling of full bowels and urgent need to have a bowel movement, and bright red tissue that protrudes from the anus.

These symptoms were severe, as evidenced by the fact that she was complaining from having a severe tenesmus with feeling of incomplete defecation, sensation of inability or difficulty to empty the bowel at defecation, even if the bowel contents have already been excreted.

Tenesmus indicates the feeling of a residue, and is not always correlated with the actual presence of residual fecal matter in the rectum. It is frequently painful and accompanied by involuntary straining and trails of use her fingers to evacuate bowel. The patient reported the need to severely "strain" to try and pass stool but in doing so, had experienced a rectal prolapse. The patient informed her husband of the prolapse. The length of the prolapsing segment was increased gradually. The last measure was about 27-30 cm according to her husband. The patient was able to correct the prolapse manually without issue. These obsessive-compulsive behaviors caused her to spend considerable time at the bathroom and energy that severely interfered with her daily activities and working status. The husband was asked to photograph the prolapse at home. He was sent me the images by Bluetooth. Moreover, she reported difficulty of sleeping as a consequence to the need to perform washing during night or scheduled times. She reported no personal or family history of neither neurological nor mental disorders. Insight was present.

Prior to our clinical assessment, she had been treated by several private psychiatrists first with Fluoxetine up to 60 mg/day Noc, 2008- Aug, 2009 then added Olanzapine 10 mg/day till Aug 2012. She was not compliant with medications. The period Feb, 2013 - May, 2014 she was put on Paroxetine up to 40 mg/day and Respridine 2 mg/day. From Dec, 2016 she was started Respridine 2 mg/day and Clomipramine 25 mg/day. During 2017 she was started regular monthly visits. Now she is stable on Respridine 4 mg/day and clomipramine 250 mg/day. She reported several treatment-related side effects, including weight gain (mainly with Olanzapine), sexual dysfunctions (mainly with Fluoxetine), severe sedation (Paroxetine), and a relative lack of efficacy (all drugs). Based on DSMV criteria, she was diagnosed with obsessive-compulsive disorder. Laboratory results, brain CT, electroencephalogram (EEG), electrocardiogram (ECG), and chest radiograph did not show any problem. Plan for surgery was put with Prof of surgery.

DISCUSSION

The case report describes a patient who meets diagnostic criteria for OCD, according to the DSM-5 (17). Women are six times as likely as men to have rectal prolapse. A consensus among experts in regards to a theory detailing the exact pathophysiology of rectal prolapse remains elusive. However, it has been proposed that the anatomical basis for rectal prolapse involves pelvic floor muscle weakness allowing the rectum to herniate through (18).

Figure 1) The exact pathophysiology of rectal prolapse

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In the case of our patient, in response to the obsessions, she was engaged in repetitive frequent washing, cleaning, manual manipulation of rectum, aggressive evacuation of rectum due to feeling of incomplete emptying, and excessive finger evacuation to induce defecation.

Associated symptoms of rectal prolapse can be particularly worrisome as they include reducible protruding mass with bowel movements, mucous discharge, feeling of incomplete evacuation, rectal bleeding, change in bowel habits and fecal and/or urinary incontinence (19).

In case of our patient, with chronic constipation and tenesmus, she noticed mucus discharge, anal pain, irritation, bleeding, feeling of incomplete emptying rectum, and feeling of full bowel. These symptoms consider as the prodromal symptoms preceding the full blown picture of rectal prolapse in our OCD patient.

Research has suggested that OCD patients experience more physical symptoms; however, few studies have looked at the physical complication of rectal prolapse in individuals with OCD (5). Drummond M (2012) was studied patients with profound OCD during 2004 to 2010. Two cases of rectal prolapse out of 104 were found (20). Stambo U (2016) was carried out a retrospective analysis of OCD patients recorded from 2011 to 2014 to identify those with rectal prolapse. Three cases of rectal prolapse were noted from the 774 cases (5).

CONCLUSION

OCD patients experience more physical symptoms. Rectal prolapse is a severe complication of OCD. Contamination obsessions, constipation, manual evacuation with feeling of incomplete emptying bowel predisposed to prolapsed rectum. Treatment is medical and surgical.

RECOMMENDATION

Obsessive-compulsive disorder should be considered when patients present with uncommon physical complaints.

CONSENT

Written informed consent was obtained from the patient and her husband for publication of this case report. Accompanying images and a copy of the written consent are available for review by the Editor-in-Chief of this journal.

ABBREVIATIONS

OCD Obsessive-compulsive disorder; DSM Diagnostic and statistical manual of mental disorders.

COMPETING INTERESTS

The author declares no competing interests.

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