

TWELVE MONTH TREATMENT OUTCOMES FOR INTENSIVE PSYCHOLOGICAL THERAPY VS ANTERIOR CINGULOTOMY FOR OCD

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Objectives

Approximately 70% of patients receiving treatment for Obsessive-Compulsive Disorder (OCD) either do not respond or only show a partial response.

For some patients with severe and chronic OCD, a trial of intensive (often inpatient) treatment is necessary before proceeding to neurosurgical treatment but the comparative benefits of these two treatments isn't known.

We compared 12 month outcomes for a naturalistic sample of patients undergoing intensive behavioural treatment with a group who were undergoing bilateral anterior cingulotomy.

Methods

Six patients completing an intensive treatment programme (ITP) were compared retrospectively with 5 patients undergoing neurosurgery (ACING).

Both groups were naturalistic samples of the most recent patients receiving each treatment. All neurosurgical patients had previously failed to show a sustained improvement from an intensive treatment programme.

The primary outcome measure was the score on the self-report Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). Severity categories on the Y-BOCS are as follows:

Y-BOCS Score	Severity
32 - 40	Extreme
24 - 31	Severe
16 - 23	Moderate
8 - 15	Mild

In controlled treatment trials, response is typically classified as improvement on $\geq 35\%$ on the Y-BOCS. A partial response is a 25-35% improvement. These same criteria were used.

Outcomes were examined at three time-points:

- 1) Baseline;
- 2) Discharge from hospital;
- 3) 12 months after treatment.

Results

Demographics for the two groups are shown below:

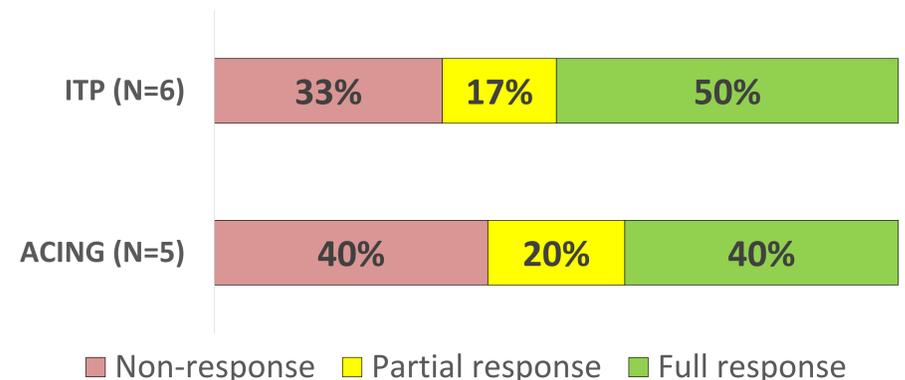
	ITP (N=6)	ACING (N=5)
Males:Females	3:3	4:1
Mean age \pm SD	36.5 \pm 13.4	46.6 \pm 11.8
Age of onset of OCD (yrs)	23.9 \pm 8.5	19.2 \pm 6.6
Duration of OCD (yrs)	14.5 \pm 5.1	28.5 \pm 12.1
Baseline Y-BOCS score	30.3 \pm 5.4	32.4 \pm 5.7

There were some differences between the two groups. The ACING group were generally older and had a longer duration of illness. This is to be expected since those undergoing surgery will be at a later stage of illness and will have had more extensive treatment.

There was no significant difference between the baseline severity of the two groups, suggesting that decisions about surgery more commonly reflect chronicity and treatment non-response than severity of symptoms.

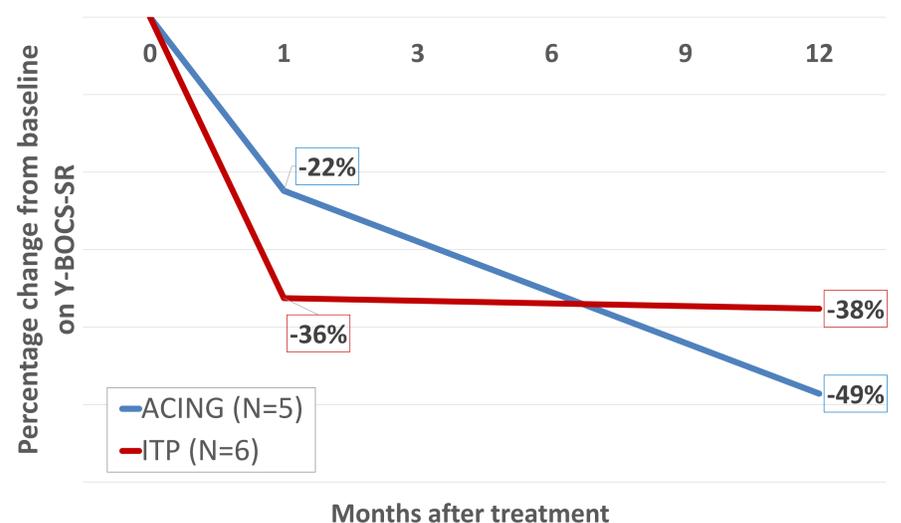
Response rates at 12 months

The following chart shows the percentage in each group meeting criteria for response / partial response / non-response:



Percentage change over time

The percentage change for each group is shown below:



Whilst the proportions of response between groups are not markedly different, there is some evidence that improvements from intensive treatment are less sustained. Those who experienced a response to ACING continued to show symptom improvement over time.

Conclusions

It should be noted that the two groups differ in terms of their treatment pathways, with those in the ACING group having failed to respond to *all* previous treatments (including intensive/ inpatient treatment).

However, intensive treatment is clearly beneficial for some individuals, and 50% of patients have demonstrated an improvement of $\geq 35\%$ at 12 month follow-up.

For those that do not respond to intensive treatment, ablative neurosurgery in the form of anterior cingulotomy offers a treatment alternative. Although overall response rates aren't any better than intensive treatment, the population undergoing ACING are more chronic and more treatment-refractory.

However, 40% of patients undergoing ACING meet criteria for response at 12 months.

For those considering ACING, an intensive treatment programme should be an essential step before neurosurgery. There is evidence to suggest that non-responders to intensive treatment may still benefit from ACING.

