

## MORNING REPORT

**Shave and Repeat: New Onset Obsessive Behavior in a Nonagenarian**

Janelle L. Weaver, PhD (presenter), Seki A. Balogun, MBBS, FACP, AGSF (discussant)

*Dr. Weaver (JRL3C@virginia.edu) is a fourth-year medical student at the University of Virginia. Dr. Balogun (sab2s@virginia.edu) is the director of the Geriatric Fellowship Program and associate professor of medicine, University of Virginia, Charlottesville, VA.*

*(The texts in italics below are comments from the discussant.)*

**M**r. A is a 96-year-old male with a medical history of dementia, uncomplicated type 2 diabetes mellitus, hypertension, benign prostatic hyperplasia, hypercholesterolemia, and hearing loss, who lives in a nursing home. He ambulates with a walker, is dependent on others for all of his instrumental activities of daily living and some of his basic activities of daily living, such as bathing. During a physician visit, his nurse reports an ongoing issue of the patient repeatedly shaving his face and neck throughout the day. This behavior was first noticed several weeks prior, continuing to worsen, and now resulting in skin irritation and abrasions. His current medications include aspirin, hydrochlorothiazide, simvastatin, losartan, melatonin, and donepezil. Physical exam is notable for erythematous, dry, irritated skin over bilateral jaw and neck. He is alert and oriented to person and place but not to time, and has 1+ bilateral pitting edema in the lower extremities.

*Based on the information so far, it is important to think of the differential diagnoses for this behavioral change. A broad differential for the new onset of obsessive-compulsive behaviors in this individual would include a mood disorder, worsening dementia, a structural brain lesion or new onset obsessive-compulsive disorder (OCD). Geriatric aged patients, particularly those with co-morbid memory dysfunction, can exhibit differing manifestations of depression as compared to younger individuals. Older depressed adults with memory impairment can present with increased agitation or somatic*

*symptoms instead of the typical symptoms of depression.<sup>1</sup> In addition, mood disorders are common in the setting of cognitive impairment with an estimated prevalence of up to 40%.<sup>2</sup> New onset OCD after age 50 is rare and, in the majority of cases, is related to structural cerebral damage or lesions.<sup>3</sup>*

About six weeks prior to this evaluation, his wife of 60+ years died. When asked how he felt about his wife's death, he smiled and pointed to her picture above his bed saying "I am the luckiest man alive... I am grateful to have spent so long with such a lovely woman". He denies depressed or anxious mood, though he became tearful when talking about his wife and could not recall the exact date of her death. Otherwise, he does not display any acute changes in cognitive function, sleep or appetite.

*With this additional information, one should consider bereavement as a possible factor in his presentation. There is very little data on the impact of grief and bereavement in older adults with memory impairment or dementia. However, several studies link bereavement to adverse health outcomes such as depression, anxiety, and even death.<sup>4</sup> Older adults with dementia may be unable to verbalize their grief or lack the cognitive ability to process and appropriately develop an acceptance of the death of their loved one. There are also several reports of grief related distress presenting in varying forms in older adults with dementia such as perseveration, psychosis, and increased anxiety. In our patient, while he maintains an awareness of*

*his wife's death, he does not recall when it occurred and he may be unable to completely process the event. Alternatively, there may be a decline in cognitive function, such that he forgets that he shaved and is misinterpreting his abrasions from prior repetitive shaving as stubble. However, it is important to note that he did not exhibit this behavior before his wife died.*

*While OCD symptoms may increase in the setting of acute distress, these are overall generally thought to decrease with age and are usually preceded by past OCD symptoms, in addition to other associated areas of neurological impairment.<sup>5,6</sup> Some intracerebral lesions, particularly in the frontal or caudate nuclei, can produce OCD symptoms in older adults.<sup>3</sup> In this case, imaging would not be indicated in the absence of other neurological findings and likely not be beneficial for the patient, given his co-morbidities and goals of care.*

Behavioral modification strategies were instituted to help with this symptom, which included frequent discussions with the patient about the need to minimize his shaving activities, and taking pictures of the facial abrasions to show him. He continued to insist that he required additional daily shaves. Ultimately, his access to the electric razor was limited to once per day and gentle reorientation was provided if he requested repeat shaves throughout the day. A geriatric psychiatry consultation was also sought with recommendations for continued behavioral modifica-

continued on page 2

## MORNING REPORT

continued from page 1

tion. Over time, he continued to exhibit the same behavioral issues and was eventually started on escitalopram, a selective serotonin reuptake inhibitor (SSRI) with some improvement in his symptoms.

*In this case, a simple behavioral intervention was initially chosen given the ease of implementation, the patient's advanced age and comorbidities, and the lack of clear evidence for a mood disorder. This approach proved to not be effective for this patient and he was ultimately started on an antidepressant (SSRI), to treat possible bereavement-related depression. It is not clear how effective antidepressants are in treating complicated bereavement in older adults with cognitive impairment, though in this patient, it led to improvement in his symptoms. SSRIs are also the suggested first-line medical treatment for OCD in older adults.<sup>5</sup>*

*Overall, it is important to remem-*

*ber that symptoms of bereavement in older adults with cognitive impairment can be atypical and assessment for bereavement-related depression is indicated in these patients. Behavioral modification intervention should be considered first in the management of bereavement-related obsessive behaviors in older adults with cognitive impairment. While new onset OCD is possible in geriatric aged patients, it is rare in individuals who have not experienced OCD symptoms before.*

### References

1. Hegeman JM, Kok RM, van der Mast RC, et al. Phenomenology of depression in older compared with younger adults: Meta-analysis. *Br J Psychiatry*. 2012;200(4):275-281.
2. Ismail Z, Elbayoumi H, Fischer CE, et al. Prevalence of depression in patients with mild cognitive impairment: A systematic review and meta-analysis. *JAMA Psychiatry*. 2017;74(1):58-67.
3. Weiss AP, Jenike MA. Late-onset obsessive-compulsive disorder: A case series. *J Neuropsychiatry Clin Neurosci*. 2000;12(2):265-268.
4. Grief CJ, Myran DD. Bereavement in cognitively impaired older adults: Case series and clinical considerations. *J Geriatr Psychiatry Neurol*. 2006;19(4):209-215.
5. Calamari JE, Faber SD, Hitsman BL, et al. Treatment of obsessive compulsive disorder in the elderly: A review and case example. *J Behav Ther Exp Psychiatry*. 1994;25(2):95-104.
6. Skoog G, Skoog I. A 40-year follow-up of patients with obsessive-compulsive disorder. *Arch Gen Psychiatry*. 1999;56(2):121-127.

SGIM