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Between Tics and Obsessions: Case Report and Review on OCD-Tic comorbidity

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Introduction: Tic disorder and Obsessive Compulsive Disorder (OCD) are neuropsychiatric conditions that can occur simultaneously and share a waxing and waning course. Both disorders involve dysfunction in cortico-striatal-thalamo-cortical (CSTC) circuits and share overlapping phenomenology, including repetitive, intrusive, and irresistible behaviors.
Objectives: To illustrate the clinical complexity of the OCD-Tic comorbidity by presenting a clinical case of a young male meeting both diseases' diagnostic criteria.
Methods: Single-case report and narrative review of relevant literature of the comorbidity of OCD-Tic disorder.
Results: A 20-year old male presented with simple motor tics and sexually themed-related obsessions and mental compulsions causing marked impairment in social and academic functioning since he was 8 years old. Pharmacological management was started with sertraline, titrated up to 150 mg/day, combined with risperidone up to 2 mg/day, leading to significant clinical improvement. The treatment was well tolerated, and both obsessive-compulsive symptoms and tics were notably and persistently reduced.
OCD comorbid with tic disorder enter a specific category in DSM classification since they have a worse prognosis and tend to be more frequent in male-individuals with OCD onset in childhood. Genetics and neuroinflammation may explain the occurrence of these disorders.
Conclusions: This case highlights the clinical relevance of recognizing and addressing comorbidity between tic disorders and OCD. Shared neurobiological substrates, particularly dysregulation in dopaminergic and serotonergic pathways within CSTC circuits, may explain the overlap. Combined pharmacological treatment with SSRI and atypical antipsychotics is clinically beneficial. Precocious identification and an integrated treatment approach are essential to address properly the OCD–Tic comorbidity.

Disclosure of Interest: None Declared

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Balancing Seizure Quality and Cardiovascular Safety in Anesthetic Selection During ECT

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Introduction: Electroconvulsive therapy (ECT) is a cornerstone of treatment for severe depression, suicidality, and catatonia. Anesthetic choice directly influences seizure threshold, seizure quality, hemodynamic stability, and ultimately therapeutic efficacy. Cardiovascular comorbidity amplifies these challenges. For psychiatrists, acquiring fluency in anesthetic principles contributes to safety, tolerability, and quality outcomes.
Objectives: To review anesthetic agents used in ECT and clarify how pharmacological selection intersects with treatment efficacy and patient safety.
Methods: Narrative educational review of psychiatric, anesthetic, pharmacologic literature (2010–2025), focus on four mainstay agents showcasing the effect on hemodynamics, cardiac function, and therapeutic seizure characteristics.
Results: ECT anesthetics differ substantially in both neuropsychiatric and cardiovascular profiles (Table 1):
Methohexital is the gold standard: it lowers seizure threshold, sustains adequate seizure duration, and provides remarkable hemodynamic stability in the majority of patients. However, its dose-dependent negative inotropy can become significant in patients with advanced heart failure.
Etomidate preserves cardiac output and reliably produces long seizure durations, often yielding higher efficacy in treatment-resistant depression. Downsides include temporary adrenal suppression, especially in the context of frequent treatments and limited availability outside North America.
Propofol blunts hypertensive surges and provides rapid emergence, though slower than methohexital. It raises seizure threshold and shortens seizure duration. Hemodynamic effects include vasodilation leading to lower systemic vascular resistance and some negative inotropy, making it less suitable in patients with heart failure.
Ketamine prolongs seizure duration and augments sympathetic tone, occasionally improving mood acutely. Yet its indirect sympathetic activation may be destabilizing in patients with arrhythmias or advanced coronary disease.

	Onset time (s) (IV)	Seizure Threshold	Context-sensitive half time 1 hour infusion (min)	Half-life (hours)	Effect on LVEF
Methohexital	~30	← → "Gold Standard"	Less than propofol	2-6	↓↓
Propofol	40-60	↑	10	4-7	↓
Ketamine	10-30	↑	~10	2.5-2.8	↔/↑
Etomidate	40-60	↓	8 (bolus dose)	2.9-5.3	↔/↑

Conclusions: Psychiatrists who understand anesthetic pharmacology can better anticipate treatment trajectories and maintain treatment efficacy and safety, especially in patients with cardiovascular comorbidities. Education in anesthetic-psychiatric intersections within the psychiatric curriculum would benefit safe ECT therapy in cardiac patients.

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Development of mental disorders after removal of pituitary tumors

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