Angststoornissen

Deze richtlijn is tot stand gekomen op initiatief van Nederlandse Vereniging voor Psychiatrie

Inhoudsopgave

Angststoornissen

Waar gaat deze richtlijn over?

Deze richtlijn richt zich op wat volgens de huidige maatstaven de beste zorg is voor patiënten met angststoornissen. In de richtlijn komen de volgende onderwerpen aan de orde:

- De meetinstrumenten voor het vaststellen van het niveau en de vorm van een angststoornis en om de gevolgen hiervan voor het functioneren op verschillende levensgebieden te inventariseren.
- De behandelmogelijkheden van verschillende angststoornissen, zowel medicamenteuze als psychologische benaderingen, of combinaties hiervan.
  - Paniekstoornis
  - Sociale angststoornis
  - Obsessief-compulsieve stoornis (OCS)
  - Gegeneraliseerde angststoornis (GAS)
  - Posttraumatische stressstoornis (PTSS)
  - Specifieke fobieën
  - Hypochondrie

Voor wie is deze richtlijn bedoeld?

Deze richtlijn is bestemd voor alle zorgverleners die betrokken zijn bij de zorg voor patiënten met angststoornissen.

Voor patiënten

Bij een angststoornis voelt iemand zich zeer angstig in bepaalde situaties in het dagelijks leven, zonder dat daar een duidelijke aanleiding voor is. Deze heftige en vaak langdurig aanhoudende angstige gevoelens hebben een grote impact op het functioneren van de patiënt en hun naastbetrokkenen. Daarnaast gaat angst vaak gepaard met hinderlijke lichamelijke klachten zoals hartkloppingen, zweten, trillen, duizeligheid of benauwdheid. Een angststoornis komt bij ongeveer 8 procent van de mannen voor en bij 13 procent van de vrouwen. Er zijn vele verschillende angststoornissen te onderscheiden. Een psychiater of psycholoog stelt vast van welk type angststoornis sprake is.

Meer informatie over angststoornissen is te vinden op Thuisarts:
http://www.thuisarts.nl/angststoornis

Meer informatie over verschillende angststoornissen is ook te vinden op de website van de psychiaters:
http://www.nvvp.net/website/patienteninformatie

Hoe is de richtlijn tot stand gekomen?

Het initiatief voor deze richtlijn is afkomstig van de Nederlandse Vereniging voor Psychiatrie (NVvP).
De richtlijn is opgesteld door een multidisciplinaire commissie met vertegenwoordigers vanuit de psychiaters, psychotherapeuten, psychologen, huisartsen en verpleegkundigen in de ggz. Daarnaast namen ook patiënten, maatschappelijk werkers, bedrijfsartsen, verzekeringsartsen, ziekenhuisapothekers, sociaal pedagogisch hulpverleners en vaktherapeuten deel aan de werkgroep. In de laatste revisie van de richtlijn is in het bijzonder aandacht besteed aan het patiëntenperspectief door middel van de inbreng van patiëntenvertegenwoordigers.

Verantwoording

Laatst beoordeeld : 01-01-2013
Laatst geautoriseerd : 01-01-2013

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

Obsessief-compulsieve stoornis (OCS) bij volwassenen

In deze module worden achtereenvolgens besproken: (a) onderzoek naar de effectiviteit van farmacologische interventies, (b) onderzoek naar de effectiviteit van psychologische en psychotherapeutische interventies; en (c) vergelijkend onderzoek naar de relatieve effectiviteit van farmacologische en psychologische en psychotherapeutische interventies of de effectiviteit van de combinatie van beide interventies bij de obsessief-compulsieve stoornis. De module wordt afgesloten met adviezen over de farmacologische en/of psychologische en psychotherapeutische behandeling bij deze stoornis, waarbij deze adviezen eveneens beknopt in de vorm van een beslisboom zullen worden gepresenteerd.

Het onderwerp “Obsessief-compulsieve stoornis (OCS) bij volwassenen” wordt uitgewerkt in verschillende modules. Specifieke aanbevelingen, conclusies, onderbouwing en overwegingen kunt u vinden in deze (sub)modules.

Verantwoording

Laatst beoordeeld : 01-02-2010
Laatst geautoriseerd : 01-02-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Farmacotherapie bij obsessief-compulsieve stoornis bij volwassenen

Voor twee geneesmiddelengroepen is in dubbelblind placebogecontroleerd onderzoek vastgesteld dat ze effectief zijn bij de behandeling van de obsessief-compulsieve stoornis (OCS), te weten:
1. selectieve serotonine heropnameremmers (SSRI's),
2. Het tricyclische antidepressivum clomipramine.
Nieuwere antidepressiva zoals venlafaxine, mirtazapine en nefazodon, zijn nog niet of onvoldoende onderzocht en worden daarom niet besproken.

Verantwoording

Laatst beoordeeld : 01-02-2010
Laatst geautoriseerd : 01-02-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Gebruik van SSRI's bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Gebruik van SSRI's bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Effectiviteit
SSRI's zijn in de farmacotherapie van OCS goed te gebruiken middelen. I.v.m. de bijwerkingen wordt uitgebreide voorlichting hierover vooraf en tijdens de behandeling geadviseerd.

Dosering
De SSRI's worden gedurende 5 weken laag gedoseerd. Bij non-respons en goede tolerantie wordt de dosering daarna stapsgewijs verhoogd tot de maximale dosering. Het effect wordt 12 weken na starten met de medicatie geëvalueerd.

Lange termijn
Nadat SSRI's 12 weken na instellen effectief gebleken zijn, wordt de patiënt langdurig door behandeld. De dagdosering kan na deze 12 weken stapsgewijs worden verlaagd. Dit wordt langzaam, in stappen van drie maanden gedaan, waarbij eventuele terugval goed in de gaten gehouden moet worden. Ook dient de patiënt gewaarschuwd te worden voor onthoudingsverschijnselen. Deze dienen onderscheiden te worden van recidiefklachten van OCS. Bij onthoudingsverschijnselen is het beleid: uitleg geven en expectatief, zo nodig de afbouw iets vertragen maar wel continueren; bij recidiveren van OCS is het beleid: weer terug naar die dosering waarop er geen verschijnselen van OCS waren en langdurig doorbehandelen.

Additiemogeliikheden bij non-respons op SSRI's
Een aanzienlijk deel van de non-responders op een SSRI zal alsnog reageren wanneer een antipsychoticum wordt toegevoegd. Het verdient aanbeveling om eerst te kiezen voor een atypisch antipsychoticum en dit laag te doseren. Buspiron of lithium additie is niet effectief en moet niet worden toegepast.

Overwegingen

Effectiviteit
Ofschoon geen vergelijkende studies voorhanden zijn wordt aangenomen dat alle SSRI's even effectief zijn. In tegenstelling tot andere angststoornissen blijkt in de eerste weken van de behandeling met SSRI's geen toename van angst- en paniek te ontstaan. Wanneer er sprake is van een comorbide paniekstoornis of GAS kan deze angsttoename wel optreden. Aangezien bij OCS over het algemeen een hogere dagdosisering wordt nagestreefd, kunnen bijwerkingen toenemen en daarmee vroegtijdige uitval. Goede voorlichting vooraf en langzame opbouw van de medicatie kan de patiënt ondersteunen de behandeling vol te houden.

Dosering
Eerder onderzoek, dat uitging van hoge doseringen clomipramine bij OCS, heeft in eerste instantie geleid tot onderzoek met hoge doseringen van de SSRI's. Fluvoxamine, waarbij geen dosis-effect onderzoek is verricht, blijkt steeds onderzocht te zijn in doseringen tot 300 mg per dag. Uit klinische ervaring was al gebleken dat

patiënten soms baat kunnen hebben bij lagere doseringen. Deze observatie wordt gesteund door de genoemde dosis-respons studies. Hieruit kan worden afgeleid dat gestart moet worden met de laagste dosering. Deze dosering wordt 5 weken gegeven. Wanneer geen effect bemerkt wordt, en het middel goed verdragen, wordt de dosering stapsgewijs opgehoogd tot uiteindelijk de maximale dosis is bereikt. De effectiviteit wordt 12 weken nadat de patiënt met de SSRI is gestart geëvalueerd. Aangezien er een trend wordt gevonden dat non-responders die behandeld werden met lage doseringen bij dosisverhoging alsnog kunnen reageren op de medicatie, heeft het dus zin om bij non-respons de dagdosering te verhogen.
De start-, en maximale doseringen per dag voor de SSRI's zijn bij OCS:

Citalopram	20 mg	60 mg
Fluoxetine	20 mg	60 - 80 mg
Fluvoxamine	50 mg	300 mg
Paroxetine	20 mg	60 mg
Sertraline	50 mg	200 mg

Lange termijn
In de klinische praktijk blijken alle SSRI's bij langdurig gebruik effectief. Een minimaal effectieve dosering wordt bepaald door de dagdosering van de SSRI's stapsgewijs te verlagen, en het effect van deze verlaging na 12 weken te evalueren. Wanneer de klachten van de patiënt niet zijn toegenomen na deze verlaging, kan de dagdosering na 12 weken opnieuw een stap verminderd worden. Waarschijnlijk zullen SSRI's bij OCS als monotherapie zeer langdurig, en mogelijk levenslang, gebruikt moeten worden.
Bij afbouwen van een SSRI kunnen onthoudingsverschijnselen optreden zoals angst, gespannenheid, duizeligheid en tremoren, paresthesieën, prikkelbaarheid, slaapstoornissen en gastro-intestinale verschijnselen. Deze onthoudingsverschijnselen dienen onderscheiden te worden van die van een recidief OCS. Bij een recidief treden weer dwangverschijnselen op. Bij het eerste is het beleid: uitleg geven en expectatief, zonodig de afbouw iets vertragen; bij recidiveren van OCS is het beleid: weer terug naar die dosering waarop er geen verschijnselen van OCS waren en langer doorbehandelen.
Ondanks het optreden van SSRI-onthoudingsverschijnselen bij te snel afbouwen spreekt men bij de SSRI's niet van gewenning en verslaving, omdat in tegenstelling tot bijvoorbeeld de benzodiazepinen, bij de SSRI's geen sprake is van psychische afhankelijkheid.

Additiemogeliikheden bij non-respons op SSRI's
Er zijn aanwijzingen dat andere atypische antipsychotica dan de bovengenoemde ook effectief zijn (olanzapine, quetiapine). Aangezien er waarschijnlijk langdurig zal moeten worden behandeld en van de klassieke antipsychotica bekend is dat zij op de lange termijn tardieve dyskinesie kunnen veroorzaken, hebben de moderne atypische middelen bij OCS de voorkeur. Omdat er casusbeschrijvingen gepubliceerd zijn van patiënten die een verergering van de dwangklachten kregen nadat ze op een atypisch antipsychoticum waren ingesteld, is er enige tijd toch voor klassieke antipsychotica gekozen. Het blijkt echter dat dwangklachten op een atypisch antipsychoticum alleen verergeren bij patiënten met een psychotische stoornis als hoofddiagnose en daarbij een comorbide OCS.

Inleiding

Voor twee geneesmiddelengroepen is in dubbelblind placebogecontroleerd onderzoek vastgesteld dat ze effectief zijn bij de behandeling van de obsessief-compulsieve stoornis (OCS), te weten:
1. selectieve serotonine heropnameremmers (SSRI's),
2. Het tricyclische antidepressivum clomipramine.
Nieuwere antidepressiva zoals venlafaxine, mirtazapine en nefazodon, zijn nog niet of onvoldoende onderzocht en worden daarom niet besproken.

Conclusies

Effectiviteit

Niveau 1	SSRI's zijn veilig en effectief bij de behandeling van OCS. Hoewel goed getolereerd, valt door bijwerkingen ongeveer 20% van de behandelde patiënten voortijdig uit. De effectiviteit van de diverse SSRI's verschilt klinisch weinig. *A2 Montgomery et al; A2 Tollefson et al; A2 Goodman et al; A2 Zohar et al; A2 Kronig et al; A1 Greist et allü ; A1 Piccinelli et al; A1 van Balkom et al.*

Dosering

Niveau 1	Effectieve doseringen voor de SSRI's zijn als volgt: citalopram, fluoxetine en paroxetine: 20, 40 of 60 mg per dag en sertraline: 50, 100 of 200 mg per dag. Bij fluvoxamine is geen dosis-effect studie verricht. *A2 Montgomery et al; A2 Tollefsen et al; A2 Data on file Glaxo SmithKline; A2 Greist et al.*

Lange termijn

Niveau 1	De SSRI's fluvoxamine, fluoxetine, en sertraline blijven effectief op lange termijn. Het is zinvol om naar een minimaal effectieve dosering te zoeken. Staken van de medicatie laat frequent terugval zien. *A2 Tollefson et al; A2 Romano et al; A2 Mundo et al; A2 Ravizza et al; A2 Greist et al; A2 Rasmussen et al.*

Additiemogeliikheden bii non-respons op SSRI's

Niveau 1	Wanneer OCS niet reageert op een behandeling met SSRI's kan symptoomreductie worden verkregen door de SSRI te combineren met een antipsychoticum als haloperdol (5-10 mg) of risperidon (2-3 mg). Dit geldt waarschijnlijk voor alle patiënten met OCS, en niet, zoals eerder gevonden alleen voor een subgroep met comorbide tics. Additie van buspiron of lithiumcarbonaat aan een SSRI heeft geen meerwaarde. *A2 McDougle et al (1994); A2 McDougle et al (2000); A2 McDougle et al (1991); A2 McDougle et al (1993).*

Samenvatting literatuur

Effectiviteit

De vijf SSRI's citalopram, fluoxetine, fluvoxamine, paroxetine en sertraline zijn voor de behandeling van de obessieve compulsieve stoornis (OCS) effectiever bevonden dan placebo. Met een behandeling met SSRI's verbetert 50% van de patiënten klinisch relevant. Het effect is te evalueren na 12 weken behandeling. Onder invloed van SSRI's verbeteren dwanggedachten, dwanghandelingen, angsten en eventueel aanwezige depressieve klachten. SSRI's worden over het algemeen goed verdragen en zijn veilig in het gebruik. Desondanks valt ongeveer 20% van de patiënten voortijdig uit vanwege bijwerkingen. Frequent (tot 30%) voorkomende voorbijgaande bijwerkingen zijn: misselijkheid, hoofdpijn, slaperigheid of slapeloosheid, angsttoename. Ook kunnen seksuele functiestoornissen optreden. Deze zijn dosis afhankelijk en volledig reversibel na staken van de middelen. Gewichtstoename is eveneens een bekende bijwerking op termijn. In dubbelblinde placebogecontroleerde studies is de werkzaamheid van citalopram, fluoxetine, fluvoxamine, paroxetine en sertraline ondubbelzinnig aangetoond.
In meta-analyses blijkt de effectiviteit van de SSRI's afnemend te zijn in de volgende volgorde: fluoxetine, fluvoxamine, sertraline. Citalopram en paroxetine waren ten tijde van deze reviews nog niet op effectiviteit onderzocht en hebben dus geen plaatsbepaling gekregen. Er zijn tot op heden geen directe vergelijkingen tussen de SSRI's voorhanden. De verschillen die blijken uit de meta-analyses lijken niet klinisch relevant.

Dosering

Er zijn gecontroleerde dosis-effect studies verricht bij de SSRI's citalopram, fluoxetine, paroxetine en sertraline. Uit deze studies blijkt dat zowel lage als hogere doseringen significant effectiever zijn dan placebo. Tussen de groepen met lage en hoge doseringen worden geen significante verschillen gevonden. Er bestaat wel een niet significante tendens dat hogere doseringen leiden tot een hoger percentage reponders. De bijwerkingen nemen toe met de hoogte van de dagdosis.

Lange termijn

De volgende SSRI's zijn op lange termijn onderzocht: fluoxetine, fluvoxamine en sertraline.
In de onderzoeksperiode blijven de SSRI's effectief en worden geen nieuwe bijwerkingen gevonden. Er zijn aanwijzingen dat de dagdosering van responders verlaagd kan worden met gelijkblijvend effect. Na staken met monotherapie SSRI werd significant vaker terugval gezien dan bij het voortzetten van de behandeling. Fluoxetine werd gedurende 1 jaar dubbelblind onderzocht. De responders van een kortetermijn studie werden dubbelblind vervolgd in hun oorspronkelijke doseringen: 20mg, 40mg, 60mg of placebo. De behaalde korte-termijn resultaten bleven behouden. Non-responders uit de korte termijnfase werden open doorbehandeld, waarbij de fluoxetine doseringen verhoogd werden tot maximaal 80 mg als de patiënt het middel goed verdroeg. Tweederde van de non-responders reageerde alsnog op de dosisverhoging. Fluvoxamine (en clomipramine) werden gedurende 4 maanden onderzocht met de vraag of de oorspronkelijke dagdosering gereduceerd kon worden met eenderde of tweederde. Een andere onderzoeksgroep bleef de oorspronkelijke dagdosering behouden. Er werden geen significante verschillen gevonden tussen de drie condities. Hieruit volgt dat getracht kan worden de dagdosering van responders te verminderen met het oog op instellen op een ‘minimaal effectieve dosering'. Een alternatieve verklaring is dat de onderzoekspatiënten in eerste instantie op een te hoge dosering waren ingesteld (zie onder dosering). In een zelfde soort studie met fluvoxamine, fluoxetine (en clomipramine) werd gevonden dat halvering van de dagdosis gedurende 2 jaar geen nadelige gevolgen had vergeleken met de continueren van de oorspronkelijke dagdosering.

Responders uit een korte termijn vergelijking van sertraline en placebo werden dubbelblind vervolgd gedurende 1 jaar. Sertraline, dat in de oorspronkelijk doseringen (50mg, 100mg, of 200mg) werd doorgebruikt, bleef effectief.

Additiemogelijkheden bij non-respons op SSRI's
Bij OCS met een comorbide tic stoornis of M. Gilles de la Tourette blijkt de effectiviteit van antidepressiva toe te nemen door ze te combineren met antipsychotica. Dit is in een placebogecontroleerde studie aangetoond voor 5 tot 10 mg haloperidol dat toegevoegd werd aan patiënten die behandeld waren met fluvoxamine en tot dan toe niet op de medicatie gereageerd hadden.
Recent werd het atypische antipsychoticum risperidon in een dosering van 2 tot 3 mg per dag dubbelblind toegevoegd aan patiënten die met verschillende SSRI's waren behandeld zonder resultaat. Het bleek dat 50% van de non-responders op de additie met risperidon alsnog responders werden. Een verschil met de studie van McDougle was echter dat nu ook patiënten zonder comorbide ticstoornis op de additie reageerden.
Ander additieonderzoek heeft tot nu toe niet veel opgeleverd. Net zoals bij de farmaco-therapeutische behandeling van de depressieve stoornis is er placebo gecontroleerd onderzoek gedaan naar de meerwaarde van het toevoegen van buspiron en lithiumcarbonaat aan fluvoxamine. Helaas blijken deze combinaties niet effectiever te zijn dan de combinatie met placebo.

Zoeken en selecteren

Voor de onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in Medline op combinaties met de volgende trefwoorden: obsessive compulsive disorder, meta-analysis, pharmacotherapy, antidepressants, dose, SSRI, TCA, MAOI. Gezien de grote hoeveelheid literatuur werd in eerste instantie gebruik gemaakt van meta-analyses. Wanneer deze niet beschikbaar waren, werd per psychofarmacon steeds één kwalitatief goede (beoordeeld op kwaliteit van opzet en uitvoering van het onderzoek, voldoende duur van behandeling, geen tegenstrijdige uitkomsten) en recente Randomized Controlled Trial (RCT) geselecteerd.

Verantwoording

Laatst beoordeeld : 01-02-2010
Laatst geautoriseerd : 01-02-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Gebruik van TCA Clomipramine bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Gebruik van TCA Clomipramine bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Effectiviteit
Clomipramine is effectief in de farmacotherapie van OCS. Aangezien clomipramine in vergelijking met SSRI's minder goed verdragen worden, zal er vermoedelijk meer uitval zijn door bijwerkingen. Clomipramine is minder veilig en even effectief als SSRI's. Hieruit volgt dat eerst behandeld wordt met een middel uit groep van de SSRI's. Pas bij gebleken ineffectiviteit of intolerantie van de SSRI's wordt clomipramine voorgeschreven.

Dosering
Clomipramine wordt langzaam ingeslopen om bijwerkingen te beperken. Getracht wordt de patiënt in twee weken op een streefdosis van 150 mg in te stellen, en na 5 weken behandeling het effect te evalueren. I.v.m. de bijwerkingen wordt uitgebreide voorlichting hierover vooraf en tijdens de behandeling geadviseerd.

Lange termijn
Nadat clomipramine na 12 weken effectief gebleken is, wordt de patiënt langdurig doorbehandeld. De dagdosering kan daarna stapsgewijs worden verlaagd. Dit wordt langzaam, in stappen van drie maanden gedaan, waarbij eventuele terugval goed in de gaten gehouden moet worden. Ook dient de patiënt gewaarschuwd te worden voor onthoudingsverschijnselen. Deze dienen onderscheiden te worden van recidiefklachten van OCS. Bij onthoudingsverschijnselen is het beleid: uitleg geven en expectatief, zo nodig de afbouw iets vertragen maar wel continueren; bij recidiveren van OCS is het beleid: weer terug naar die dosering waarop er geen verschijnselen van OCS waren en langer doorbehandelen.

Additiemogeliikheden bij non-respons op clomipramine
Een deel van de nonresponders op clomipramine zal alsnog reageren wanneer een antipsychoticum wordt toegevoegd. Het verdient aanbeveling om eerst te kiezen voor een atypisch antipsychoticum en dit laag te doseren. Buspiron- en lithiumadditie is niet effectief en moet niet worden toegepast.

Overwegingen

Effectiviteit
Clomipramine lijkt even effectief als de SSRI's fluoxetine, fluvoxamine en paroxetine. Naar alle waarschijnlijkheid zal dit ook gelden voor citalopram en sertraline.
In tegenstelling tot andere angststoornissen blijkt in de eerste weken van een behandeling met clomipramine geen toename van angst- en paniek te ontstaan. Wanneer er sprake is van een co-morbide paniekstoornis of GAS kan deze angsttoename wel optreden. Aangezien bij OCS een hogere dagdosisering wordt nagestreefd (zie aldaar), kunnen bijwerkingen toenemen en daarmee vroegtijdige uitval. Goede voorlichting vooraf en langzame opbouw van de medicatie kan de patiënt ondersteunen de behandeling vol te houden.

Dosering

De aanbevolen dosering van clomipramine is afgeleid uit aanwezig placebogecontroleerd onderzoek en klinische ervaring. Bij individuele patiënten kan een lagere dosering dan de aanbevolen dagdosering al effectief zijn. Reden dat er in studies steeds gewerkt is met een hogere dosering werd waarschijnlijk veroorzaakt door de relatief lange duur voordat het effect beoordeeld kan worden, waardoor artsen geneigd waren de dosering te vroeg te verhogen. Bij SSRI's blijkt dat lagere doseringen even effectief zijn als hogere, hoewel non-responders op lage doseringen alsnog bij dosisverhoging kunnen reageren. Het is mogelijk dat ook voor clomipramine geen dosis-respons relatie bestaat. Het lijkt zinvol in de klinische praktijk de medicatie langzaam in te sluipen om bijwerkingen te voorkomen. Het lukt meestal de patiënt in 2 weken op een streefdosering in te stellen. Afgeleid uit het onderzoek met SSRI's is dit voor clomipramine 150 mg per dag. Net als bij de SSRI's wordt de effectiviteit na 5 weken behandeling geëvalueerd. Wanneer het middel goed wordt verdragen, maar onvoldoende effectief is, wordt de dosering verhoogd tot de maximale dosis, ontleend aan de klische praktijk.

De start-, streef-, en maximale doseringen per dag voor clomipramine bij OCS:

Clomipramine	25 mg	150 mg	250 mg

Lange termijn

Een minimaal effectieve dosering wordt in de klinische praktijk bepaald door de dagdosering van clomipramine stapsgewijs te verlagen, en het effect van deze verlaging na 12 weken te evalueren. Wanneer de klachten van de patiënt in remissie zijn gebleven na deze verlaging, kan de dagdosering opnieuw een stap verminderd worden. Waarschijnlijk zal clomipramine bij OCS als monotherapie zeer langdurig, en mogelijk levenslang, gebruikt moeten worden.
Bij afbouwen van clomipramine kunnen onthoudingsverschijnselen optreden, zoals angst, gespannenheid, duizeligheid en tremoren, paresthesieën, prikkelbaarheid, slaapstoornissen en gastro-intestinale verschijnselen. Deze onthoudingsverschijnselen dienen onderscheiden te worden van die van een recidief OCS. Bij het eerste is het beleid: uitleg geven en expectatief, zonodig de afbouw iets vertragen; bij recidiveren van OCS is het beleid: weer terug naar die dosering waarop er geen verschijnselen van OCS waren en langer doorbehandelen.

Additiemogeliikheden bij non-respons op clomipramine

In de klinische praktijk zijn er aanwijzingen, analoog aan additie onderzoek bij de SSRI's, dat atypische antipsychotica (risperidon, olanzapine, quetiapine) en klassieke antipsychotica (haloperidol) toegevoegd aan clomipramine alsnog verbetering teweegbrengen bij non-responders op clomipramine alleen. Aangezien er waar-schijnlijk langdurig zal moeten worden behandeld en van de klassieke antipsychotica bekend is dat zij op de lange termijn tardieve dyskinesie kunnen veroorzaken, hebben de moderne atypische middelen bij OCS de voorkeur.

Inleiding

Voor twee geneesmiddelengroepen is in dubbelblind placebogecontroleerd onderzoek vastgesteld dat ze effectief zijn bij de behandeling van de obsessief-compulsieve stoornis (OCS), te weten:
1. selectieve serotonine heropnameremmers (SSRI's),
2. Het tricyclische antidepressivum clomipramine.

Nieuwere antidepressiva zoals venlafaxine, mirtazapine en nefazodon, zijn nog niet of onvoldoende onderzocht en worden daarom niet besproken.

Conclusies

Effectiviteit

Niveau 1	Clomipramine is effectief bij de behandeling van OCS. De effectiviteit van de SSRI's, SSRI's fluoxetine, fluvoxamine en paroxetine verschilt klinisch weinig van clomipramine. *A1 Greist et al; A1 Piccinelli et al; A1 van Balkom et al; A2 Pigott et al; A2 Koran et al; A2 Zohar et al.*

Dosering

Niveau 4	Bij clomipramine zijn geen dosis-effect studies verricht. De mening van de werkgroep is dat ook lagere doseringen dan 300 mg per dag in individuele gevallen effectief kunnen zijn.

Lange termijn

Niveau 1	Clomipramine blijft effectief op lange termijn. Het is zinvol om naar een minimaal effectieve dosering te zoeken. Volledig staken van de medicatie laat frequent terugval zien. *A2 Mundo et al254 ; A2 Ravizza et al.*

Additiemogeliikheden bii non-respons op SSRI's

Niveau 3	Additie van buspiron en lithiumcarbonaat aan clomipramine heeft geen meerwaarde. *A2 Pigott et al; A2 Pigott et al.*

Samenvatting literatuur

Effectiviteit

In dubbelblinde placebogecontroleerde studies is de werkzaamheid van de TCA clomipramine bij OCS ondubbelzinnig aangetoond. Andere TCA's zijn onvol-doen-de onderzocht (bijvoorbeeld imipramine) of onwerkzaam bevonden (bijvoorbeeld desipramine). De werkzaamheid lijkt vooral afhankelijk van de serotonerge activiteit.

Op een behandeling met clomipramine verbetert ongeveer 50% van de patiënten. Het effect is te evalueren na 12 weken behandeling. Onder invloed van clomipramine verbeteren dwanggedachten, dwanghandelingen, angsten en eventueel aanwezige depressieve klachten.

TCA's worden over het algemeen minder goed verdragen dan SSRI's en zijn onveilig bij overdosering. Frequent voorkomende bijwerkingen zijn: sufheid, droge mond, transpireren, hartkloppingen, obstipatie, urine retentie en reactietijdvertraging. Een deel hiervan, zoals de sufheid en de hartkloppingen, is voorbijgaand. Ook kunnen seksuele functiestoornissen optreden. Deze zijn dosis afhankelijk en volledig reversibel na staken van de middelen. Gewichtstoename is eveneens een bekende bijwerking op termijn.

Hoewel in de drie meta-analysen clomipramine vergeleken met de SSRI's het meest effectieve middel is, blijkt in RCT's waarin de effectiviteit van de SSRI's fluoxetine, fluvoxamine en paroxetine vergeleken werd met die van clomipramine geen significant verschil in effectiviteit.

Dosering
Er is bij clomipramine geen dosis-effect studie verricht. Al het onderzoek gaat uit van hogere doseringen vergeleken met die bij de depressieve stoornis. In het placebo-gecontroleerde onderzoek worden doseringen gebruikt tot 300 mg clomipramine per dag. Lagere doseringen kunnen echter ook al effectief zijn.

Lange termijn
Er is gecontroleerd onderzoek verricht bij clomipramine tot 2 jaar. In deze studies werd deels de oorspronkelijke dosering aangehouden, deels werd de dosering verlaagd. Clomipramine (vergeleken met fluvoxamine) werd gedurende 4 maanden onderzocht met de vraag of de oorspronkelijke dagdosering gereduceerd kon worden met eenderde of tweederde. Een andere onderzoeksgroep bleef de oorspronkelijke dagdosering behouden. Er werden geen significante verschillen gevonden tussen de drie condities. Hieruit volgt dat getracht kan worden de dagdosering van responders te verminderen met het oog op instellen op een 'minimaal effectieve dosering'. Een alternatieve verklaring is dat de onderzoekspatiënten in eerste instantie op een te hoge dosering waren ingesteld (zie onder dosering). In eenzelfde soort studie met clomipramine, fluvoxamine en fluoxetine werd gevonden dat halvering van de dagdosis gedurende 2 jaar geen nadelige gevolgen had vergeleken met de continueren van de oorspronkelijke dagdosering. Volledig staken van clomipramine als monotherapie geeft zeer frequent terugval.

Additiemogeliikheden bij non-respons op clomipramine
Gecontroleerd additie onderzoek bij clomipramine heeft tot nu toe niet veel opgeleverd. Net zoals bij de farmacotherapeutische behandeling van de depressieve stoornis is er placebo gecontroleerd onderzoek gedaan naar de meerwaarde van het toevoegen van buspiron en lithiumcarbonaat aan het antidepressivum. Helaas blijken deze combinaties niet effectiever te zijn dan de combinatie met placebo.

Zoeken en selecteren

Voor de onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in Medline op combinaties met de volgende trefwoorden: obsessive compulsive disorder, meta-analysis, pharmacotherapy, antidepressants, dose, SSRI, TCA, MAOI. Gezien de grote hoeveelheid literatuur werd in eerste instantie gebruik gemaakt van meta-analyses. Wanneer deze niet beschikbaar waren, werd per psychofarmacon steeds één kwalitatief goede (beoordeeld op kwaliteit van opzet en uitvoering van het onderzoek, voldoende duur van behandeling, geen tegenstrijdige uitkomsten) en recente Randomized Controlled Trial (RCT) geselecteerd.

Verantwoording

Laatst beoordeeld : 01-02-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Psychologische interventies bij obsessief-compulsieve stoornis bij volwassenen

Bij de behandeling van obsessief-compulsieve stoornis (OCS) zijn verschillende psychotherapeutische interventies onderzocht. Uit het onderzoek komt naar voren dat met name twee behandelmethoden effectief zijn:
a. exposure in vivo met respons-preventie en
b. cognitieve therapie.
Hierbij is exposure in vivo met responspreventie eerste keus behandeling, vanwege de grote hoeveelheid positieve onderzoeksresultaten en de positieve lange termijn effecten. Bij cognitieve therapie zijn deze lange termijn effecten nog niet onderzocht. Andere psychotherapeutische behandelmethoden blijken niet of minder effectief, of zijn onvoldoende onderzocht. Er zijn geen randomized controlled trials waarin de effectiviteit van andere psychotherapeutische methoden is geëvalueerd.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Exposure in vivo met responspreventie bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Exposure in vivo met responspreventie bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Effectiviteit
Exposure in vivo in combinatie met responspreventie dient standaard psychotherapeutische behandeling te zijn bij OCS.

Wijze en duur van toepassing
Neem voor de sessies waarin exposure en responspreventie wordt toegepast voldoende tijd zodat de angst van patiënt tot een aanvaardbaar niveau is gereduceerd. Zorg ervoor dat patiënt daarbij geheel afziet van zijn dwangrituelen.
Pas indien mogelijk graduele exposure in vivo toe en doe dat bij voorkeur in groepsverband om vervolgens huiswerkopdrachten mee te geven betreffende exposure en responspreventie door de individuele patiënten zelf thuis uit te voeren.
Maak bij cognitieve dwang onderscheid tussen angst-verwekkende en angst-reducerende gedachten. Stel bloot aan de eerste en voorkom de tweede.

Duurzaamheid
Ook nadat aanvankelijke resultaten beperkt blijven dient de behandeling met exposure en responspreventie te worden voortgezet. Speciale aandacht dient te worden besteed aan het motiveren van patiënten voor de behandeling en een behandeling dient te worden afgesloten met een terugvalpreventie programma.

Overwegingen

Effectiviteit
Exposure met responspreventie is een gemakkelijk toe te passen methode die door de patiënt doorgaans gemakkelijk wordt begrepen en door deze goed kan worden uitgevoerd.

Wijze en duur van toepassing
In de gevallen waarin niet alleen de obsessies maar ook de compulsies van cognitieve aard zijn is het van belang functioneel onderscheid te maken tussen de angst-verwekkende en angst-reducerende gedachten en beelden: aan de eerste dient patiënt te worden blootgesteld, de tweede dienen te worden verhinderd. Bij de blootstelling zal in dit geval vaker sprake zijn van exposure in vitro. Ook in een aantal andere gevallen zal exposure in vitro aangewezen zijn of de voorkeur verdienen al was het maar om praktische redenen.
Omdat graduele exposure in vivo even effectief is als flooding in vivo zal de voorkeur van patiënt voor de eerste variant over het algemeen gehonoreerd kunnen worden. Graduele exposure heeft als voordeel dat het minder spanning voor de patiënt met zich meebrengt en ook gemakkelijker tussen de sessies door zelfstandig thuis uitgevoerd kan worden. Blijven oefenen tussen de sessies is immers van belang.

Vooral vanuit het oogpunt van kosteneffectiviteit verdient het overweging exposure met responspreventie eventueel toe te passen in een groepsformat.

Duurzaamheid
Om patiënten te motiveren voor de toch vaak als belastend ervaren behandeling kan niet alleen gebruik gemaakt worden van motiveringstechnieken maar ook van de hierna te bespreken cognitieve therapie die drempelverlagend kan werken ten aanzien van de bereidheid om tot blootstelling over te gaan en om de subjectief ervaren risico's te dragen die een gevolg zijn van het niet uitvoeren van de dwangrespons. Toevoeging van een aantal sessies bij uitblijvend resultaat alsmede van een terugval-preventieprogramma verdienen overweging ook al leidt dit tot verlenging van de behandeling.

Inleiding

Bij de behandeling van obsessief-compulsieve stoornis (OCS) zijn verschillende psychotherapeutische interventies onderzocht. Uit het onderzoek komt naar voren dat met name twee behandelmethoden effectief zijn:
a. exposure in vivo met respons-preventie en
b. cognitieve therapie.
Hierbij is exposure in vivo met responspreventie eerste keus behandeling, vanwege de grote hoeveelheid positieve onderzoeksresultaten en de positieve lange termijn effecten. Bij cognitieve therapie zijn deze lange termijn effecten nog niet onderzocht. Andere psychotherapeutische behandelmethoden blijken niet of minder effectief, of zijn onvoldoende onderzocht. Er zijn geen randomized controlled trials waarin de effectiviteit van andere psychotherapeutische methoden is geëvalueerd.

Conclusies

Effectiviteit

Niveau 1	Het is aangetoond dat exposure in vivo (met responspreventie) een effectieve behandeling is voor de obsessief-compulsieve stoornis. *A1 Cox et al.,1993; Van Balkom et al., 1994; Kobak et al., 1998; Abramowitz, 1998; Franklin et al., 2000; O'Sullivan & Marks, 1990.*

Wijze en duur van toepassing

Niveau 1	Exposure met responspreventie heeft het meeste effect als de sessies liefst in aanwezigheid van de therapeut voldoende lang duren om de angst te laten afnemen. De wijze van presentatie van de stimuli alsook de daarbij gekozen strategie zijn naar keuze en kunnen worden afgestemd op de individuele problematiek van de patiënt. *A1 Abramowitz, 1997; Abramowitz, 1996;* *A2 De Araujo et al 1995; Fals-Stewart et al, 1993.*

Duurzaamheid

Niveau 1	Effect en duurzaamheid van de behandeling met exposure en responspreventie kunnen nog worden vergroot indien voldoende aandacht wordt besteed aan patiënts motivatie en aan terugvalpreventie. Naarmate de klachten ernstiger zijn is het noodzakelijk de behandeling langer voort te zetten ook bij aanvankelijk gering resultaat. *A1 O'Sullivan & Marks, 1990; Emmelkamp, 2001; Marks 1997.*

Samenvatting literatuur

Effectiviteit

Gedragstherapeutische behandeling van OCS (doorgaans bestaande uit een combi-natie van exposure in vivo met responspreventie) is effectiever bevonden dan placebo. Met een dergelijke behandeling worden klinisch significante reducties bereikt in obsessief-compulsieve klachten. Dit geldt met name de reductie in klachten zoals door de patiënten zelf gerapporteerd. Gemelde drop-out percentages variëren van 6% tot 8%.
Aan het einde van de behandeling blijken patiënten eerder vergelijkbaar met de normale populatie dan met onbehandelde OCS-patiënten en de positieve resultaten blijven niet beperkt tot deelnemers aan experimentele studies, maar zijn ook generaliseerbaar naar de doorsnee polikliniek populatie met OCS. Van de patiënten die deze behandeling ondergaan verbetert over het algemeen 70 tot 80%, een resultaat dat bij follow-up in ieder geval tot 2 jaar aanhoudt.

Wijze en duur van toepassing

Bij een exposure behandeling is het de bedoeling dat de patiënt wordt blootgesteld (exposure) aan de (doorgaans door hem vermeden) stimuli die zijn obsessies triggeren alsmede zijn neiging tot het uitvoeren van neutraliserende dwanghandelingen en rituelen. Hierbij wordt hij tegelijkertijd verhinderd om deze uit te voeren (responspreventie). Zo zal bijvoorbeeld iemand met smetvrees een deurknop of een trapleuning moeten aanraken (exposure), zonder vervolgens zijn handen te wassen (responspreventie). De patiënt leert ervaren dat de spanning en angst op den duur dalen zonder dat hij zijn dwanghandelingen en rituelen hoeft uit te voeren.
Exposure en responspreventie kunnen op verschillende wijzen worden toegepast. Men kan de intensiteit, de duur, de wijze (in vivo/in vitro) en de gehanteerde strategie (gradueel/flooding) bij blootstelling variëren, de responspreventie geheel, gradueel of gedeeltelijk doen plaatsvinden, de controle van het een zowel als van het ander bij de therapeut leggen of bij de patiënt zelf en tenslotte de gehanteerde variant individueel of in een groepsverband toepassen en al dan niet de partner/familie in de behandeling betrekken.
Er zijn voldoende aanwijzingen in de literatuur waaruit blijkt dat beide componenten (exposure en responspreventie) in ieder geval gezamenlijk moeten worden toegepast. Exposure alleen leidt tot meer angstreductie en minder verbetering op het gebied van de uitvoer van dwanghandelingen en rituelen terwijl het omgekeerde geldt voor responspreventie.
Het effect in de zin van een reductie in dwangklachten wordt groter naarmate de sessies langer duren en neemt toe als de patiënt afziet van zijn dwangrituelen tijdens de behandeling. Er zijn ook aanwijzingen gevonden in een meta-analyse dat exposure met responspreventie uitgevoerd in aanwezigheid van de therapeut een groter effect heeft dan wanneer de patiënt alleen oefent. Hierover is echter nog enige discussie mogelijk omdat in enkele gecontroleerde effectstudies die beide condities direct vergeleken geen verschillen werden gevonden. De reductie in dwangklachten hangt in ieder geval niet samen met de wijze van presentatie van de stimuli (in vivo/in vitro) of met de gehanteerde strategie (gradueel/flooding).

Er lijkt geen evidentie te zijn dat het betrekken van de partner in de behandeling meer effect heeft dan het behandelen van de patiënt alleen (Emmelkamp, de Haan & Hoogduin,1990).
Hoewel exposure in vivo en responspreventie met succes zijn toegepast in een groepssetting zijn er aanwijzingen dat individuele gedragstherapie tot een snellere reductie leidt van obsessief-compulsieve klachten dan groepstherapie.

Duurzaamheid
Over het algemeen blijft de verbetering na exposure en responspreventie over jaren bestaan (273 189 368). Dit effect en de duurzaamheid ervan kunnen nog worden vergroot door het opzetten en uitvoeren van een terugvalpreventie programma aan het einde van de behandeling (166). Langduriger voortzetting van de behandeling na gering resultaat bij aanvang lijkt zinnig omdat alsnog resultaat kan worden behaald. De noodzaak hiervan lijkt meer aanwezig naarmate de klachten ernstiger zijn.
Overigens worden over het algemeen weinig consistente aanwijzingen gevonden waar het predictoren van het behandelresultaat betreft. Het meest robuust lijkt nog de motivatie van patiënten voor de behandeling en de mate van compliance

Zoeken en selecteren

Voor onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in MedLine en PsycINFO met de volgende trefwoorden: obsessive compulsive disorder, behavior therapy, cognitive therapy en psychotherapeutic techniques. Gezien de grote hoeveelheid literatuur werd in eerste instantie gebruik gemaakt van meta-analyses en reviews, in tweede instantie van randomized controlled trials. Waar nodig is gebruik gemaakt van aanvullende niet systematisch gezochte literatuur.

Verantwoording

Laatst beoordeeld : 01-02-2010
Laatst geautoriseerd : 01-02-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Cognitieve therapie met responspreventie bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Cognitieve therapie met responspreventie bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Effectiviteit
Gezien het feit dat de resultaten van cognitieve therapie veelbelovend zijn verdient het aanbeveling cognitief therapeutische elementen toe te voegen aan de standaardbehandeling van OCS. Interventies gericht op het doen afnemen van de overschatting van risico's en gevaren kunnen de patiënt over de drempel helpen bij de behandeling met exposure en responspreventie en aldus motiverend werken.
Bij de groep patiënten met uitsluitend obsessies en/of mentale rituelen betekent de cognitieve therapie een welkome aanvulling op het standaard pakket. De effecten ervan zijn echter nog onvoldoende onderzocht.

Wijze en duur van toepassing
Cognitieve therapie bij OCS kan worden gegeven in betrekkelijk kortdurende behandelingen van tien tot vijftien zittingen, waarbij overwogen kan worden om de behandelingen een groepsformat te geven.

Duurzaamheid
Het gebrek aan gegevens over de lange termijn effecten van cognitieve therapie is vooralsnog geen reden om de interventie niet toe te passen bij OCS. Het is wel een extra reden om grote zorgvuldigheid te betrachten bij afspraken met betrekking tot het voorkómen van terugval en met betrekking tot maatregelen indien terugval zich heeft voorgedaan.

Overwegingen

Effectiviteit
De eerste studies die de effecten van cognitieve therapie vergeleken met die van exposure en responspreventie maakten gebruik van een traditionele vorm van cognitieve therapie (RET). Hierbij blijven gedragsinstructies achterwege. In latere studies wordt binnen de cognitieve behandeling expliciet het gedragsexperiment inbegrepen (CBT). Een gedragsexperiment nu heeft een aantal overeenkomsten met exposure in vivo, waardoor het onderscheid tussen beide interventies minder gemakkelijk valt te maken.
Een speciale groep waarvan men mag veronderstellen dat deze baat heeft bij cognitieve therapie wordt gevormd door patiënten met uitsluitend obsessies zonder uitwendige dwanghandelingen en rituelen. Deze groep is zeer beperkt alsmede het onderzoek naar de behandeling ervan. Er is slechts één gecontroleerde studie waaruit blijkt dat cognitieve therapie effectief is bij de behandeling van obsessies. Ook bij obsessies zijn de lange termijn effecten van cognitieve therapie nog niet onderzocht.

Wijze en duur van toepassing

Exposure met responspreventie kan bij OCS doorgaans goed in groepsverband worden gegeven. Diverse vormen van cognitieve therapie kunnen ook goed in groepsverband worden gegeven. Er zijn dus geen overwegende argumenten om cognitieve therapie bij OCS niet in een groepsformat te geven.

Duurzaamheid
Bij diverse andere angststoornissen blijken de lange termijn effecten van cognitieve therapie goed te zijn. Er is vooralsnog geen reden om aan te nemen dat dit anders zal zijn bij cognitieve therapie voor OCS.
'Good clinical practice' suggereert dat met de patiënt afspraken moeten worden gemaakt over wat hem te doen staat bij mogelijke terugval. Afspraken om bij terugval snel te kunnen worden gezien voor één of enkele afspraken moeten met de patiënt en de huisarts worden gemaakt.

Inleiding

Bij de behandeling van obsessief-compulsieve stoornis (OCS) zijn verschillende psychotherapeutische interventies onderzocht. Uit het onderzoek komt naar voren dat met name twee behandelmethoden effectief zijn:
a. exposure in vivo met respons-preventie en
b. cognitieve therapie.
Hierbij is exposure in vivo met responspreventie eerste keus behandeling, vanwege de grote hoeveelheid positieve onderzoeksresultaten en de positieve lange termijn effecten. Bij cognitieve therapie zijn deze lange termijn effecten nog niet onderzocht. Andere psychotherapeutische behandelmethoden blijken niet of minder effectief, of zijn onvoldoende onderzocht. Er zijn geen randomized controlled trials waarin de effectiviteit van andere psychotherapeutische methoden is geëvalueerd.

Conclusies

Effectiviteit

Niveau 1	Cognitieve therapie is een effectieve behandelmethode bij OCS. *A1 Abramowitz; Van Oppen et al; Van Balkom et al; Freeston et al; McLean et al.*

Wijze en duur van toepassing

Niveau 1	Cognitieve therapie bij OCS kan in een betrekkelijk kortdurend format van tien tot vijftien zittingen worden gegeven. *A1 Abramowitz; Van Oppen et al; Van Balkom et al;* *Freeston et al; McLean et al.*

Duurzaamheid

Niveau 4	De lange termijn effecten van cognitieve therapie bij OCS zijn nog niet bekend.

Samenvatting literatuur

Effectiviteit

Cognitieve therapie bij OCS is minder onderzocht dan exposure in vivo met respons-preventie. In een overzichtsstudie en een aantal gerandomiseerde gecontroleerde studies wordt cognitieve therapie vergeleken met exposure in vivo en responspreventie. De resultaten van beide behandelmethoden blijken daarbij ongeveer overeen te komen.

Wijze en duur van toepassing
In een cognitieve behandeling worden de interpretaties van de patiënt geregistreerd, uitgedaagd en vervangen door meer rationele en functionele interpretaties. Hierbij komen de interpretaties over de obsessies aan bod en ook de verschillende denkfouten die op het gebied van kansschattingen en verantwoordelijkheden worden gemaakt. In veel gevallen worden binnen de cognitieve behandeling de interpretaties getoetst in de werkelijkheid in de vorm van gedragsexperimenten.
Met betrekking tot de wijze van toepassing en de optimale duur van cognitieve therapie zijn nog geen vergelijkende gecontroleerde studies voorhanden. Doorgaans wordt uitgegaan van behandelingen tussen de tien en vijftien zittingen.

Duurzaamheid
De lange termijn effecten van cognitieve therapie bij OCS zijn nog niet onderzocht.

Zoeken en selecteren

Voor onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in MedLine en PsycINFO met de volgende trefwoorden: obsessive compulsive disorder, behavior therapy, cognitive therapy en psychotherapeutic techniques. Gezien de grote hoeveelheid literatuur werd in eerste instantie gebruik gemaakt van meta-analyses en reviews, in tweede instantie van randomized controlled trials. Waar nodig is gebruik gemaakt van aanvullende niet systematisch gezochte literatuur.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Combinatietherapie bij obsessief-compulsieve stoornis bij volwassenen

Voor de onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in Medline op combinaties met de volgende trefwoorden: obsessive compulsive disorder en treatment. Er zijn tot op heden geen studies verricht waarin antidepressiva direct met cognitieve gedragstherapie zijn vergeleken. Er werden zes combinatiestudies gevonden: vijfmaal de combinatie van een antidepressivum met exposure in vivo en eenmaal de combinatie met cognitieve therapie. Eén studie is verricht met het bij OCS onwerkzame imipramine, en werd daarom niet geïncludeerd. De overige studies zijn verricht met clomipramine (2x) en fluvoxamine (3x).

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Effectiviteit antidepressiva versus CGT (combinatietherapie) bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Effectiviteit antidepressiva versus CGT (combinatietherapie) bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Aangezien het dropoutpercentage gedurende en terugvalpercentage na het staken van een behandeling met antidepressiva groter is dan met cognitieve gedragstherapie, lijkt het zinvol om eerst te starten met een behandeling met cognitieve gedragstherapie, met name wanneer de voorkeur van de patiënt uitgaat naar een niet-medicamenteuze behandeling, Dit geldt niet voor patiënten met een comorbide depressieve stoornis. Deze kunnen waarschijnlijk beter eerst ingesteld worden op een antidepressivum (zie ook onder combinatie).

Conclusies

Niveau 1	Het is aannemelijk dat cognitieve gedragstherapie superieur is aan antidepressiva bij OCS. *A1 van Balkom et al; Cox et al; Kobak et al.*

Samenvatting literatuur

Er zijn tot op heden geen studies verricht waarin antidepressiva direct met cognitieve gedragstherapie zijn vergeleken. Er zijn wel enige meta-analysen gepubliceerd waarin beide behandelingen met elkaar vergeleken zijn. Een probleem bij de interpretatie van de resultaten is dat onderzoek bij verschillende studiepopulaties met elkaar vergeleken worden. Met deze restrictie kan voorlopig uit de meta-analysen worden afgeleid dat cognitieve gedragstherapie minimaal even effectief is als antidepressiva en mogelijk zelfs superieur. Verder blijkt het drop-outpercentage bij een behandeling met antidepressiva groter te zijn dan met cognitieve gedragstherapie. Het terugvalpercentage na staken van een behandeling met antidepressiva is groter dan na staken van een behandeling met cognitieve gedragstherapie (CGT).

Zoeken en selecteren

Voor de onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in Medline op combinaties met de volgende trefwoorden: obsessive compulsive disorder en treatment. Er zijn tot op heden geen studies verricht waarin antidepressiva direct met cognitieve gedragstherapie zijn vergeleken. Er werden zes combinatiestudies gevonden: vijfmaal de combinatie van een antidepressivum met exposure in vivo en eenmaal de combinatie met cognitieve therapie. Eén studie is verricht met het bij OCS onwerkzame imipramine, en werd daarom niet geïncludeerd. De overige studies zijn verricht met clomipramine (2x) en fluvoxamine (3x).

Verantwoording

Laatst beoordeeld : 01-02-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Combinatie antidepressiva met CGT (combinatietherapie) bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Combinatie antidepressiva met CGT (combinatietherapie) bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Effectiviteit
Bij patiënten met OCS bestaande uit dwanghandelingen, die tevens licht of matig depressief zijn en weinig of geen overige comorbiditeit hebben, wordt een behandeling gestart met cognitieve gedragstherapie. Bij depressieve patiënten met OCS heeft het zin om te starten met een serotonerge antidepressivum. Bij onvoldoende effect kan hieraan een behandeling met exposure in vivo met respons preventie of cognitieve therapie toe worden gevoegd. Wanneer men bij patiënten met OCS, die met een antidepressivum behandeld worden, denkt aan het staken van de medicatie, wordt exposure in vivo met responspreventie toegevoegd om recidieven te voorkómen.

Overwegingen

Effectiviteit
Om onderzoekstechnische redenen zijn aan de patiënten die met deze studies meededen extra voorwaarden gesteld. Dit bemoeilijkt een generalisatie tot de groep patiënten met OCS in de klinische praktijk. Allereerst geldt dat al deze studies zijn verricht met patiënten met OCS die last hadden van dwanghandelingen. Dit extra inclusiecriterium is meestal gesteld omdat de gedragstherapeutische behandeling bestond uit exposure in vivo met responspreventie, en deze techniek moeilijk toe te passen is bij patiënten met alleen dwanggedachten. Voor patiënten die alleen lijden aan obsessies en coverte compulsies kunnen cognitieve therapie of een antidepressivum uitkomst bieden. Voorts is een beperking dat slechts relatief zuivere groepen patiënten met OCS in dergelijke effectstudies worden geïncludeerd. Dat wil zeggen dat ernstig depressieve patiënten om ethische redenen als het voorkómen van suïcidaliteit gedurende een placebobehandeling vaak niet in de onderzoeksgroep vertegenwoordigd zijn. Voor deze groep lijkt een behandeling met een antidepressivum primair geïndiceerd. Eventueel kan dan later nog cognitieve gedragstherapie worden toegevoegd om resterende dwangklachten aan te pakken.
Vanuit het oogpunt van gezondheidszorgkosten lijkt een combinatiebehandeling in eerste instantie niet op zijn plaats bij ongecompliceerde OCS, gezien de beperkte toegevoegde waarde op het gebied van effectiviteit. Wanneer er geen mogelijkheid is voor cognitieve gedragstherapie op korte termijn, bijvoorbeeld vanwege een bestaande wachtlijst, kan de behandeling worden gestart met een antidepressivum en eventueel later gecombineerd met cognitieve gedragstherapie.

Conclusies

Effectiviteit

Niveau 1	Het combineren van clomipramine of fluvoxamine met exposure in vivo met respons preventie of cognitieve therapie bij OCS geeft slechts beperkt toegevoegd effect vergeleken met een behandeling met exposure of cognitieve therapie alleen. Er zijn enige aanwijzingen dat het effect van antidepressiva versterkt wordt door het toevoegen van cognitieve gedragstherapie. De combinatiebehandeling lijkt het meest effectief bij comorbide depressieve patiënten. *A1 van Balkom et al, 1994;* *A2 Marks et al, 1980; Marks et al, 1988; Cottraux et al, 1990; van Balkom et al, 1998; Hohagen et al, 1998.*

Samenvatting literatuur

Effectiviteit
In deze studies werden de onderzochte antidepressiva clomipramine en fluvoxamine in doseringen gegeven zoals bij OCS gebruikelijk. Gedragstherapie is onderzocht in verschillende varianten van exposure in vivo gecombineerd met responspreventie. Cognitieve therapie werd gegeven volgens de methode van Beck, Salkovskis en Van Oppen.
In drie studies en één meta-analyse werd geen significant verschil gevonden tussen de combinatiebehandeling en exposure in vivo of cognitieve therapie alleen. In één van deze studies liet de combinatiebehandeling na enige weken een grotere verbetering zien dan na placebo plus exposure in vivo. Deze verbetering werd echter na 4 maanden weer teniet gedaan. In twee studies gaf de combinatie een significant sterkere verbetering van dwangsymptomen dan een behandeling met exposure in vivo met responspreventie alleen. Het bleek in één studie vooral te gaan om patiënten die naast OCS depressief waren. In slechts één studie is adequaat onderzocht of de combinatiebehandeling effectiever is dan medicatie alleen. Dit bleek inderdaad zo te zijn. In een andere studie met een conditie medicatie alleen bleken de patiënten zich niet goed aan het protocol gehouden te hebben. Uit deze studie is dus geen goede conclusie te trekken.
Een superieur effect van de combinatiebehandeling boven cognitieve gedragstherapie alleen op middellange (6 maanden tot 2 jaar) en lange termijn (6 jaar) is niet aangetoond: er werd geen verschil meer gevonden tussen de groep patiënten die met de combinatie behandeld waren en zij die alleen met cognitieve gedragstherapie behandeld waren. Een vergelijking op lange termijn tussen de combinatiebehandeling en medicatie alleen is niet gemaakt.
Een cognitieve gedragstherapie toegevoegd aan een behandeling met antidepressiva lijkt recidieven na staken van de medicamenteuze behandeling te kunnen voorkomen.

Zoeken en selecteren

Voor de onderstaande tekst is gebruik gemaakt van literatuur die gevonden is door middel van een gecomputeriseerd literatuuronderzoek in Medline op combinaties met de volgende trefwoorden: obsessive compulsive disorder en treatment. Er zijn tot op heden geen studies verricht waarin antidepressiva direct met cognitieve gedragstherapie zijn vergeleken. Er werden zes combinatiestudies gevonden: vijfmaal de combinatie van een antidepressivum met exposure in vivo en eenmaal de combinatie met cognitieve therapie. Eén studie is verricht met het bij OCS onwerkzame imipramine, en werd daarom niet geïncludeerd. De overige studies zijn verricht met clomipramine (2x) en fluvoxamine (3x).

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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Niet-farmacologische biologische behandelmogelijkheden bij obsessief-compulsieve stoornis bij volwassenen

Uitgangsvraag

Niet-farmacologische biologische behandelmogelijkheden bij obsessief-compulsieve stoornis bij volwassenen.

Aanbeveling

Het is de mening van de werkgroep dat bij zeer ernstige therapieresistente OCS verwijzing naar de Werkgroep Psychocirurgie overwogen moet worden.

Overwegingen

Er zijn bij deze module geen overwegingen geformuleerd.

Conclusies

Bij deze module zijn geen conclusies geformuleerd.

Samenvatting literatuur

Psychochirurgie
Ondanks de negatieve lading van neurochirurgische (psychochirurgische) interventies bij psychiatrische aandoeningen in het verleden, zoals frontale lobotomie, zijn moderne stereotactische neurochirurgische procedures reële behandelopties bij OCS. Met name cingulotomie en capsulotomie blijken bij een deel van de patiënten met ernstige therapieresistente OCS vermindering van symtomen te geven. De complicaties van de ingreep, zoals postoperatieve infecties, neurologische uitval, postoperatieve epilepsie en persoonlijkheidsveranderingen, blijken bij een zorgvuldige uitvoering van de procedure zeldzaam. Bij follow-up blijkt ongeveer eenderde deel van deze ernstige patiënten door de ingreep duidelijk te verbeteren.
In Nederland is deze behandeling gereserveerd voor zeer ernstige en therapieresistente patiënten met OCS. De beoordeling of een patiënt voor deze behandeling in aanmerking komt vindt plaats door de Werkgroep Psychochirurgie en de ingreep wordt in een gespecialiseerd centrum uitgevoerd.
Andere niet-farmacologische biologische behandelopties bij OCS, zoals rTMS (Transcraniele Magnetische Stimulatie) en Deep Brain Stimulation, bevinden zich momenteel nog in een experimentele fase en zijn nog onvoldoende onderzocht om in deze richtlijn te worden opgenomen.

ECT
Wat betreft ECT (elektroconvulsie therapie) geldt dat een positief effect hiervan bij OCS onvoldoende is aangetoond.

Verantwoording

Laatst beoordeeld : 01-02-2010
Laatst geautoriseerd : 01-02-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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