Turkish Medical Journal, 2026; 11(1),31-34.

Olgu Sunumu / Case Report
https://doi.org/10.70852/tmj.1780012

CASE REPORT: FLUOXETINE TREATMENT IN PRESCHOOL-ONSET OCD

Vaka Sunumu: Okul Öncesi Dönemde Başlayan Okb Tanili Bir Olguda Fluoksetin Tedavisi

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Geliş / Received: 09.09.2025
Kabul / Accepted: 31.10.2025

Cite as:
Soyugür, H.S. & Kapan, O.G. (2026). Case Report: Fluoxetine Treatment in Preschool-Onset Ocd. Turkish Medical Journal, 11(1),31-34. https://doi.org/10.70852/tmj.1780012

ABSTRACT

Obsessive-compulsive disorder (OCD) is a psychiatric condition characterized by the presence of obsessions and compulsions, which significantly impair functioning. Although OCD was previously thought not to manifest in early childhood, recent studies have demonstrated that it can be diagnosed during the preschool period. Preschool-onset OCD is more frequently observed in males and is associated with a higher prevalence of familial loading and comorbidity. Diagnosis during this period is challenging due to the potential overlap with normative ritualistic behaviors of childhood and the presence of multiple differential diagnoses, and treatment options are limited. Here, we present the case of a 46-month-old male patient presenting with obsessional doubts and symmetry concerns who was diagnosed with OCD and treated with fluoxetine. This case highlights the potential benefits of pharmacological interventions in preschool-onset OCD.

Keywords: Child, Differential diagnosis, Fluoxetine, Obsessive-compulsive disorder, Preschool onset OCD, Treatment

ÖZET

Obsesif kompulsif bozukluk (OKB) obsesyon ve kompulsiyonların varlığıyla seyreden ve işlevselliği büyük ölçüde etkileyen bir psikiyatrik bozukluktur. Daha önceleri OKB'nin küçük yaşlarda gözlenmeyeceği düşüncesi olmasına rağmen yapılan son çalışmalarda OKB'ye okul öncesi dönemde de tanı konabildiği saptanmıştır. Okul öncesi başlangıçlı OKB erkek cinsiyette daha sık gözlenir, ailesel yüklülük ve komorbidite sıklığı daha fazladır. Bu dönemde tanı koymak çocukluk çağının ritüelistik davranışlarıyla karışma ihtimali ve birçok ayırıcı tanı seçeneğinin olması nedeniyle zordur ve tedavi seçenekleri kısıtlıdır. Bu olguda, şüphe ve simetri obsesyonları ile başvuran ve OKB tanısı alan 46 aylık bir erkek hastada fluoksetin tedavisi ve sonuçları sunulmaktadır. Olgumuz okul öncesi başlangıçlı OKB'de farmakolojik müdahalelerin faydasını vurgulamaktadır.

Anahtar kelimeler: Ayırıcı tanı, Çocuk, Fluoksetin, Obsesif kompulsif bozukluk, Okul öncesi başlangıçlı OKB, Tedavi

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is a psychiatric disorder characterized by repetitive behaviors and mental acts (compulsions) performed in response to repetitive and persistent thoughts, impulses and images (obsessions) that cause significant anxiety in the individual and greatly affect functionality (American Psychiatric Association, 2013). Lifetime prevalence rates for childhood-onset OCD range from 0.7% to 2.9%, which is similar to adults. Although the mean age of onset is found to be 10.3 years, many studies show that the disorder may occur at earlier ages. Although childhood-onset OCD is more common in the male gender, it has been reported that the frequency is equalized between the sexes during adolescence. A high familial risk is also observed in relatives of people with childhood-onset OCD (Brezinka et al., 2020). In preschool children, ritualistic behaviors, magical thoughts and superstitions may be part of normal development (Siddeswara et al., 2021). At the same time, given the difficulties in identifying and transferring thought content, low level of insight and characteristics of the developmental period, it is difficult and rare to diagnose OCD in preschool children (Brezinka et al., 2020). In these patients, the duration of illness is longer, the frequency of comorbidity is higher and there is usually a family history of OCD (Coskun, Zoroglu, & Ozturk, 2012; Sharma et al., 2021). It is important to understand the phenomenology of OCD in preschool children because both early age of onset and longer duration of illness have been associated with increased persistence of OCD (Brezinka et al., 2020). Although there are different methods that have been shown to be effective in treatment, there is no consensus among experts. In this case report, we aimed to discuss the diagnosis and treatment process in a 46-month-old boy diagnosed with OCD in preschool period.

CASE

A 46-month-old male patient was brought to our outpatient clinic with the complaint of "wanting to touch objects to the armpit" accompanied by his parents. He had been touching some objects and his parents' hand to his armpit for about 1 year. It was learned that after touching, he asked his parents to confirm the situation because he was not sure. (Mom, I must have touched him, right?) The family reported that they usually confirmed it when he asked, and when they did not confirm it, the patient had tantrums in the form of hitting his head on the floor and shouting. When obsessions other than touching were questioned, they stated that he wanted things to be symmetrical at home and that he would immediately correct his shoes when they were turned upside down. No other obsessions or compulsion-like behaviors were described. It was also learned that the patient had a rocking behavior while standing for 1 year. The patient's CGI-S (Clinical Global Impression – Severity) score was assessed as 5 during this period. When the family was asked about daily routines, no continuous behavior was defined. It was learned that he had tics in the form of blinking which increased and decreased for approximately 2 months. No recent history of infection or vaccination was reported. In the examination of the patient this time, it was observed that he made eye contact, looked when his name was called, followed the commands, had good joint attention, and his social communication was compatible with the expected level. His cognitive development was thought to be compatible with his peers. His speech was slower than expected for his age. He was still forming 2-word sentences and had articulation problems. When the psychiatric admissions of the patient were examined, it was found that he was first brought with the complaint of speech delay when he was 3 years old and was examined in detail in terms of autism spectrum disorder (ASD). In the developmental test, no significant delay was found in any of the developmental areas. The patient was clinically evaluated in the council (by many child psychiatrists) and ASD and intellectual disability were not considered. When information about his family history was obtained, it was learned that he was born by cesarean section at 38 weeks of gestation, walked at 18 months of age, started saying words at 18 months of age and formed sentences at the age of 3.5 years. It was learned that his mother was the primary caregiver since his birth. He did not have any medical disease. No pathologic findings were found in the neurologic and dermatologic examinations and blood tests. It was learned from

his parents that there was no psychiatric disease in the family except speech delay in the father in the past. Fluoxetine 2.5 mg/day was started as treatment. It was increased to 5 mg/day upon lack of benefit and psychotherapy was recommended. However, due to factors such as the child's age, developmental limitations in fully adapting to psychotherapy, the family's limited financial resources, and difficulties in accessing treatment, psychotherapy could not be implemented. The dose of fluoxetine was increased to 10 mg/day after the patient's symptoms did not decrease during follow-up. At the end of one month, the patient's CGI-S was assessed as 2. It was recommended that the patient continue his treatment in this way and be supported with psychotherapy. Informed consent for the case report was obtained from the patient's family.

DISCUSSION

When the data in the literature are examined, the views that OCD cannot be diagnosed in preschool children have recently changed and studies in this direction have become more frequent. OCD has started to be defined in preschool children aged 2-3 years (Sharma et al., 2021). The lifetime prevalence of childhood-onset OCD varies between 0.7% and 2.9% (Siddeswara et al., 2021). Unlike adult-onset OCD, preschool-onset OCD appears to be predominant in the male gender (Coskun, Zoroglu, & Ozturk, 2012; Sharma et al., 2021; Siddeswara et al., 2021). Similarly, the present case report describes OCD symptoms in a 46-month-old boy. Although the rates of OCD in older children and adults are similar, it is difficult and rare to diagnose at a very early age (Siddeswara et al., 2021). Difficulties in diagnosis include the differentiating normative and ritualistic behaviors in young children from compulsions in OCD, expressing existing OCD findings because language development is incomplete in young children, lack of many areas where functionality and adaptation skills can be evaluated and determining differential diagnoses. In a study, the mean age at onset of OCD was shown to be 4.95 years and the mean age at presentation was shown to be 6.72 years, and this data supports the difficulty in making the diagnosis of OCD in the preschool period (Coskun, Zoroglu, & Ozturk, 2012). Preschool-onset OCD has been described to represent a familial form of the disorder. However, in this case, there was no history of OCD or related disorders in the psychiatric family history. In the literature, it has been suggested that there is a comorbidity rate of up to 62% in preschool-onset OCD (Sharma et al., 2021). In a study, it was reported that anxiety disorders, attention deficit and hyperactivity disorder, oppositional defiant disorder (ODD) and tic disorder were the most common comorbidities (Coskun, Zoroglu, & Ozturk, 2012). In our case, OCD was accompanied by tic disorder. It was learned from the patient's history that he had irritability and temper tantrum when his parents did not touch his armpit. The temper tantrums were thought to be related to his increased anxiety when he could not perform the compulsions, and were not evaluated within the scope of ODD and other behavioral problems. Before making a diagnosis of preschool-onset OCD, differential diagnoses such as normal ritualistic behaviors, ASD, stereotypic movement disorders, Tourette syndrome, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) should be excluded (Siddeswara et al., 2021). In this case, according to the information obtained from the family and clinical evaluation ASD was excluded. In addition, there was no history of infection and vaccination. When these findings and the results of blood tests were evaluated, PANDAS was not considered. Developmentally normal ritualistic behaviors may be similar to the compulsive behaviors observed in OCD. Normal ritualistic behaviors increase the child's communication with other people, help socialization and tend to decrease with age (Coskun, Zoroglu, & Ozturk, 2012). OCD findings, on the other hand, negatively affect the child's social life, impair functionality and may lead to aggressive behaviors. In this case, temper tantrums were evaluated in favor of OCD due to the lack of a tangible outcome, the behaviors significantly affecting the functionality of the family and disrupting the child's social interaction with peers. Children with preschool-onset OCD have been found to be associated with poor prognosis and severe symptoms, despite studies showing that good results can be achieved with appropriate intervention. Some studies have also reported that there is no significant relationship between age of onset and

prognosis (Miyawaki et al., 2018). Considering the fact that preschool-onset OCD is not frequently observed in clinical samples and the difficulties in diagnosis and limited treatment options, there is no consensus on treatment options. In the literature, family-based Cognitive Behavioural Therapy (CBT), pharmacologic agents such as aripiprazole, fluvoxamine, fluoxetine and sertraline have been used (Coskun & Zoroglu, 2009; Çolak Sivri & Bilgiç, 2016; Inci Izmir & Ercan, 2023; Miyawaki et al., 2018; 9). In the use of fluoxetine, behavioral disinhibition has been shown to affect drug compliance with improvement in follow-up (Coskun & Zoroglu, 2009). In this case, pharmacotherapy was preferred because the family's functionality was significantly affected and the family's access to psychotherapy was limited, and for this purpose, fluoxetine was used with a gradual dose increase to reach 10 mg/day. During the follow-up, the patient showed clinical improvement and an increase in functionality, as well as a decrease in CGI-S scores (7/4). Although these data show that fluoxetine can be considered as an option in preschool-onset OCD, further studies are needed.

CONCLUSION

When diagnosing preschool-onset OCD, it is very important to consider differential diagnosis and conditions. There is no consensus on the treatment of patients yet. Existing information is limited to case reports. In this case, fluoxetine treatment was tried in preschool-onset OCD and found to be effective. Further studies are needed to elucidate this issue.

Conflict of Interest: There is no conflict of interest between the authors.

Financial Support: The authors received no financial support for the research and/or authorship of this article.

Authors Contributions: H.S.S collected the clinical data related to the case, drafted the case report, and conducted the literature review. O.G.K evaluated the case, contributed to the preparation of the discussion section, and critically reviewed the manuscript for scientific accuracy. Both authors read and approved the final version of the manuscript and share responsibility for all aspects of the work.

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