Address Comorbidities in Tourette Syndrome

BY BRUCE JANCIN

COLORADO SPRINGS — Most children with Tourette syndrome don't need tic suppression medication, according to Dr. Samuel H. Zinner.

"I tend to be a person who veers away from medications. I'm 1 of 15 physicians on the medical advisory board of the Tourette Syndrome Association, and very few of us think medication is the way to go. All of us recommend it, but we do so with a caveat: Education and anticipatory guidance for the family, the child, teachers, and peers is the critical intervention, and it's often sufficient," said Dr. Zinner, a developmental and behavioral pediatrician at Seattle Children's Hospital.

The psychiatric conditions often comorbid with Tourette syndrome are a very different matter. Anxiety disorders, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder, disruptive behavior disorders, and learning disabilities can have far-reaching, very destructive consequences in children with Tourette syndrome. Be alert for these disorders and treat them, he emphasized at the annual conference of the Colorado Academy of Family Physicians.

Obsessive-compulsive disorder (OCD) and Tourette syndrome are probably differing manifestations of the same underlying process involving defective sensory-motor filtering at the basal ganglion level. OCD can be diagnosed in about 30% of Tourette syndrome patients; however, varying degrees of OCD symptoms are present in 90%.

Studies indicate that ADHD is present in 40%-70% of patients with Tourette syndrome. Anxiety disorders are also extremely common. Learning disabilities—mostly restricted to nonverbal learning—are present in about one-quarter of children with Tourette syndrome, as is extremely poor sleep.

Dr. Zinner recommended considering tic suppression medication on a case-by-case basis depending on the tics' impact on daily activities, self-esteem, peer interactions, school, and the parent-child relationship.

The alpha-adrenergic agents clonidine and guanfacine have poor efficacy but

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are less likely to cause significant side effects, so that's usually where to start for mild to moderate tics. However, it can take up to 3 months for these drugs to show a tic-reducing effect.

The drugs that are effective for severe tic problems have side effects that make them unacceptable to most patients long term. The traditional neuroleptics pimozide (Orap), haloperidol (Haldol), and fluphenazine (Prolixin) are the only drugs with regulatory approval for Tourette syndrome. The atypical antipsychotic agents are under study; all show some efficacy but have significant side effects.

For very severe tics causing self-injury, such as lip biting or trichotillomania, injection of botulinum toxin into a targeted muscle provides 3 months of benefit.

Several good studies indicate stimulants have no impact on tics.

Cognitive-behavioral therapy can help patients learn to suppress tics by recognizing the hallmark premonitory sensory urges, but like medications, CBT should be employed selectively, in Dr. Zinner's view.

Deep brain stimulation, similar to the treatment developed for Parkinson's disease, has resulted in dramatic and compelling benefits in the limited number of treated patients with Tourette syndrome. As yet there are no guidelines as to when or how to use it, he continued.

Dr. Zinner's talk was sponsored by the Tourette Syndrome Association as part of an ongoing outreach partnership with the Centers for Disease Control and Prevention. Physicians interested in learning more will find the Tourette Syndrome Association (www.tsa-usa.org) to be a great resource, he said. ■