IMPACT OF PSYCHOPATHOLOGY OF ADULT OBSESSIVE COMPULSIVE DISORDER ON QUALITY OF LIFE: A PATIENT CONTROLLED STUDY

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ABSTRACT

BACKGROUND

Obsessive-compulsive disorder (OCD) is the 10th leading cause of disability of all medical conditions in the industrialized world and the 'Quality of Life' has emerged as a valid parameter to measure the outcome of illness and effectiveness of treatment.

OBJECTIVE

To see the quality of life, functioning and clinical variables between the OCD patient and the 'Patient control' group

MATERIAL AND METHODS

A total of 120 probands were assessed, of which 60 subjects were OCD patients and 60 stable schizophrenia patients were used as patient control group. Yale-Brown Obsessive-Compulsive Rating Scale, Positive and Negative Symptom Scale for Schizophrenia, Hamilton Rating Scale for Depression, Hamilton Rating Scale for Anxiety, The Brown Assessment of Beliefs Scale, WHOQOL-BREF, Global Assessment of Functioning Scale were applied as per the protocol. The data was analysed using descriptive statistics with the help of SPSS version 16.0 for Windows.

RESULTS

The cost of medication was significantly higher in OCD group as compared to Schizophrenia Group. Depression and anxiety scores were significantly higher in OCD group. Global functioning was significantly better in schizophrenia group but quality of life better in OCD group on Physical Health domain and Environment domain of WHOQOL-BREF.

CONCLUSION

The Psychopathology of OCD spared satisfaction with sleep, ability to perform daily living activities, capacity to work, ability to get around, energy for everyday life, physical pain and need for any medical treatment to function in daily life, satisfaction with the conditions of your living places, access to health services, transport, opportunities for leisure activities, money to meet the needs, availability of the required information, and safety in daily life; when compared to stable schizophrenia patients

The Psychopathology of OCD had as severe an impact as Schizophrenia on 'enjoying life, finding it meaningful, level of negative feelings, satisfaction with self, evaluation of body appearance and ability to concentrate' 'satisfaction with personal relationships, sex life and support from friends'.

KEYWORDS

Obsessive Compulsive Disorder, Quality of Life, Functioning.

INTRODUCTION: OBSESSIVE COMPULSIVE DISORDER (OCD): OCD is a debilitating disorder marked by two distinct phenomena: recurrent, disturbing, intrusive thoughts (obsessions) and overt repetitive behaviours or mental acts (compulsions) that are performed to reduce distress caused by obsessions. The most common obsessions concern thoughts about contamination, pathological doubt, and order/symmetry.[1]

The most common compulsions include checking, washing, counting, need to ask or confess, symmetry and precision (e.g. ordering), and hoarding[1]. By definition, obsessions and compulsions in OCD must cause marked distress, be time consuming, and seriously interfere with daily functioning.

The most common age of onset of OCD is reported to be between 22 and 35, while affected patients spend an average of 17 years before receiving a correct diagnosis

and treatment, with most OCD and OCRDs often showing a waxing and waning course, frequently increasing in severity when left untreated.[2,3]

There is existence of a "poor insight" subtype of OCD, with studies reporting poor insight in between 15% and 36% of OCD patients.[4]

IMPACT OF OBSESSIVE-COMPULSIVE DISORDER ON QUALITY OF LIFE: Obsessive-compulsive disorder (OCD) is the 10th leading cause of disability of all medical conditions in the industrialized world.[5] Several studies have investigated impairment found in individuals with OCD using self-report measures.[6] All these studies reported substantial impairment in QOL in OCD. The instrumental role performance and social functioning of the patients with obsessive- compulsive disorder were worse than those of the general population and of diabetes patients.[7] Eisen et al.[8] demonstrated substantial impairment in QOL and psychosocial function in a large representative clinical sample of individuals with OCD studied to date using both self-reports and rater-administered measures of global QOL. One-third of the sample was unable to work because of psychopathology.

AIM: To study the quality of life in patients with Obsessive Compulsive Disorder (OCD).

OBJECTIVE: To see the quality of life, functioning and clinical variables between the OCD patient and the 'Patient control' group.

HYPOTHESIS: There will be no significant difference in the quality of life, functioning and clinical variables between the OCD probands and control group.

VENUE: The index study was conducted in the Central Institute of Psychiatry, Kanke, and Ranchi. The study subjects included both inpatients and the patients coming for follow up in the Out Patient Department of the Institute.

STUDY DESIGN: The study was a cross sectional hospital based study. The subjects were recruited for the study by the purposive sampling technique. Ethical approval was taken from the institutional ethics committee.

Sample: Two groups of 60 patients each.

1. **Obsessive Compulsive Disorder Probands** consisted of 60 probands of both the sexes who were of 18 years of age and above. Probands were diagnosed with Obsessive Compulsive Disorder according to ICD 10, DCR.[9]
2. **Schizophrenia Probands** included 60 probands of both the sexes, with schizophrenia who were of 18 years of age and above. Probands were diagnosed with schizophrenia as per ICD 10, DCR.[9] They were evaluated during the stabilization phase, defined as a

clinically stable period lasting at least 1 month, where each item on the positive subscale of the Positive and Negative Syndrome Scale (PANSS) scored less than 4.

Inclusion Criteria

1. **OCD Group:**
   1. Patients of both the genders meeting the ICD 10, DCR[9] criteria for Obsessive Compulsive Disorder.
   2. Patients aged 18 years and above.

2. **Schizophrenia Group:**
   1. Patients of both the genders meeting the ICD 10, DCR[9] criteria for Schizophrenia.
   2. Patients aged 18 years and above.
   3. Patients in the stabilization phase, defined as a clinically stable period lasting at least 1 month, where each item on the positive subscale of the Positive and Negative Syndrome Scale (PANSS) scored less than 4.

Exclusion Criteria:

1. **OCD Group:**
   1. Not giving informed consent.
   2. Patients with any co morbid psychiatric condition including substance dependence (except nicotine abuse and depression).
   3. Depression of more than moderate level as per HAM-D (score≥19).
   4. History of any head injury, seizure disorder or mental retardation.
   5. Serious medical disorder, neurological condition as assessed by history and examination.

2. **Schizophrenia Group:**
   1. Not giving informed consent.
   2. Patients with any co morbid psychiatric condition including substance dependence (except nicotine abuse).
   3. History of any head injury, seizure disorder or mental retardation.
   4. Serious medical disorder, neurological condition as assessed by history and examination.

Tools for Assessment:

1. **Socio-Demographic and Clinical Data Sheet:** Separate demographic and clinical profile for the probands and the first degree relatives of the probands which included information such as name, age, sex, religion, education, employment-status, income, marital status, residence, family-type, residence, income, treatment history, personal history, past history and current physical examination.

2. **Yale-Brown Obsessive-Compulsive Rating Scale:[10]** In order to determine the severity of OCD symptoms, the Yale-Brown Obsessive-Compulsive Rating Scale (YBOCS) was administered.

3. **Positive and Negative Symptom Scale for Schizophrenia:[11]** The scale was applied on the schizophrenia probands to assess the positive symptoms in the stabilization phase of illness and served as a screening tool.

4. **Hamilton Rating Scale for Depression:[12]** The HAM-D was developed to monitor the severity of major depression. Scores of 7 or less may be considered normal; 8 to 13, mild; 14 to 18, moderate; 19 to 22, severe; and 23 and above, very severe.

5. **Hamilton Rating Scale for Anxiety:[13]** The HAM-A was used to assess anxiety symptoms, both somatic and cognitive.

6. **The Brown Assessment of Beliefs Scale:[14]** It is a seven item clinician-administered semi structured scale designed to assess delusionality of beliefs in a broad range of psychiatric disorders.

7. **WHOQOL-BREF:[15]** WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment. WHOQOL-BREF has been shown to display good discriminant validity, content validity and test-retest reliability. Domain scores produced by the WHOQOL-BREF have been shown to correlate at around 0.9 with The WHOQOL-100 domain scores. The WHOQOL-BREF contains two items from the Overall Quality of Life and General Health, and one item from each of the 24 facets included in The WHOQOL-100. Recent analysis of The WHOQOL-100 structure has suggested the possibility of merging domains 1 and 3,

and also merging domains 2 and 6, thereby creating four domains of quality of life. In our current approach to scoring the WHOQOL-BREF, these domains have been merged therefore and four major domains are assessed: physical, psychological, social relationships and environment.

8. **Global Assessment of Functioning Scale:[16]** GAF was used for global assessment of functioning.

Procedure for Data Collection: Patients were selected according to above mentioned inclusion and exclusion criteria. Informed consent was taken. The case record files were also reviewed to confirm the diagnosis and to know the necessary variables. The above mentioned tools were applied as per the protocol.

Statistical Analysis: The data was analysed using descriptive statistics with the help of SPSS version 16.0 for Windows. Quantitative data are presented as mean (+S.D). For the categorical variables Chi-square test was used to analyse differences between the groups, Yates continuity correction was computed for a 2x2 contingency table where appropriate. Quantitative data that were normally distributed were analysed using Independent samples t-test. We used two-tailed statistics set at a significant p value at < 0.05.

RESULTS:
SAMPLE CHARACTERISTICS:
Socio-Demographic Characteristics: The study included a total of 120 probands, of which 60 subjects were Obsessive Compulsive Disorder patients which composed the patient group, 60 schizophrenia patients serving as patient control group.

The socio-demographic characteristics of the proband group are displayed in Table 1a and 1b.

VARIABLE		OCD (N=60) n(%)	SCHIZ (N = 60) n(%)	$\chi 2$	df	p
SEX	Male	40(66.7)	49(81.7)	3.53	1	0.094
	Female	20(33.3)	11(18.3)			
Marital status	Unmarried^	30(50)	27(45)	.301	1	.583
	Married	30(50)	33(55)			
Religion	Hindu	53(88.3)	53(88.3)	0	1	1.000
	Others	7(11.7)	7(11.7)			
Socio-economic Status	Upper + Middle U	20(33.3)	11(18.3)	3.564	2	.168
	Middle L	22(36.7)	28(46.7)			
	Lower U + Lower L	18(30.0)	21(35.0)			
Background	Rural	32(53.3)	49(81.7)	10.987	1	.001*
	Urban	28(46.7)	11(18.3)			
Table 1a: Distribution of socio-demographic-clinical variables in OCD and schizophrenia probands. (Categorical data)						

^Unmarried= Single+ Widow, Widower + Divorced, p< 0.05*

The patient group was composed of 40(66.7%) males and 20(33.3%) females with a mean age of 29.35+ 8.12 years. 30(50%) of participants in patient group were married, and other 30(50%) were either unmarried, widow/widower, or divorced. With respect to religion 53(88.3%) were Hindus; while Muslims, Christians and Sikh comprised the rest 7(11.7%). On assessing for socioeconomic status as per Kuppuswamy's revised classification (which includes Income, Education and Employment status), 20(33.3%) were Upper+Middle (Upper) status, 22(36.7%) were of Middle (Lower) status, and 18(30.0%) were of Lower economic status. The patient control group was comparable with the patient group with respect to above parameters.

With respect to background, 28(46.7%) were from urban background in OCD group, which was significantly more than patient control group 11(18.3 %); and 32(53.3%) were from rural background in OCD group as compared to 49(81.7%) in patient control group.

Variable	OCD M±SD	Schizophrenia M±SD	p
Age (in Years)	29.35±8.122	31.8±78.767	.106
Education (in Years)	11.68±3.133	9.22±4.872	.001*

Table 1b: Comparison of socio-demographic variables in OCD and schizophrenia probands. (Continuous data)

p< 0.05*

There was significant difference in years of education as the patient group had 11.68±3.13 years which was more than 9.22±4.87 years in the patient control group.

Clinical Characteristics: As shown in Table 1c, out of the 60 OCD probands, 11(20.8%) had poor compliance, 34(64.2%) had fair compliance and 8(15.1%) had good compliance, while in schizophrenia group 11(18.3%) had good compliance, 38(63.3%) had fair compliance and 11(18.3%) had poor compliance; which was comparable across two groups. There was past history of medical disorders in 6(10.0%) of OCD group, and in 3(5%) in Schizophrenia Group, premorbid personality traits in 8(13.3%) of OCD group, and in 5(8.3%) in Schizophrenia Group which were comparable across two groups.

VARIABLE		OCD (N=60) n(%)	SCHIZ (N=60) n(%)	χ2	df	p
Compliance	Poor	11(20.8)	11(18.3)	0.263	2	0.877
	Fair	34(64.2)	38(63.3)			
	Good	8(15.1)	11(18.3)			
Past Medical History#	Absent	54(90.0)	57(92.5)	.480	1	.488
	Present	6(10.0)	3(5)			
Past Psychiatric History#	Absent	58(96.7)	59(97.5)	.000	1	1.000
	Present	2(3.3)	1(2.5)			
Premorbid Personality Traits	Absent	52(86.7)	55(91.7)	.776	1	.378
	Present	8(13.3)	5(8.3)			

Table 1c: Distribution of clinical variables in OCD and schizophrenia probands (Categorical variables)

Yates Continuity Correction

As shown in Table 1d, the illness duration was 68.13±53.59 months in OCD group, and 88.55±78.80 months in Schizophrenia Group which were comparable, as were age of onset 23.13±7.49 years and 25.75±12.13 years respectively, and also the duration of treatment which was 24.05±27.49 months in OCD group, and 38.32±51.11 months in Schizophrenia Group. The cost of medication was significantly higher in OCD group at Rs 719.55±674.47 per month as compared to Rs 454.92±292.50 per month in Schizophrenia Group.

Variable	OCD M±SD	Schizophrenia M±SD	t	df	p
Age of onset of illness (in years)	23.13±7.49	25.75± 12.13	-1.421	118	.158
Illness Duration (in Months)	68.13±53.594	88.55±78.806	-1.659	118	.100
Treatment Duration (in Months)	24.05±27.490	38.32±51.116	-1.904	118	.059
Cost Drugs (Rs per month)	719.55±674.472	454.92±292.507	2.788	118	.006*

Table 1 d: Comparison of clinical variables in OCD and schizophrenia probands (Continuous data)

p< 0.05*

COMPARISON OF THE PATIENT GROUP VS PATIENT CONTROL GROUP ACROSS SCORES OF Y-BOCS, BABS, HDRS, HAMA, GAF, WHO-QOL: Table 2 shows comparison of scores of Yale-Brown Obsessive-Compulsive Rating Scale, Brown Assessment of Beliefs Scale, Hamilton Rating Scale for Depression, Hamilton Rating Scale for Anxiety, and WHO Quality of life-BREF scores. Obsessions and compulsions were significantly higher in OCD group as compared to Schizophrenia group. The score on HDRS and HAMA was significantly higher in OCD group (4.87±3.56 and 4.87±3.568 respectively) as compared to schizophrenia group (2.58±1.89 and 2.12±1.76

respectively). The GAF scores were higher in schizophrenia group (67.00±11.83) as compared to OCD group (61.23±12.31). OCD group scored more on Physical Health domain (13.13±1.82) and Environment domain (12.63±1.36), as compared to schizophrenia group (12.02±1.72 and 11.71±1.42 respectively) of WHOQOL-BREF.

There was no significant difference in both groups on Brown Assessment of Beliefs Scale, Psychological Health domain and Social Relationships domain of WHOQOL-BREF.

Variable	OCD M±SD	Schizophrenia M±SD	t	df	p
YBOCS obsessions	10.67±5.458	0.23±1.212	14.456	118	.000*
YBOCS compulsions	8.03±6.128	.07±.362	10.052	118	.000*
YBOCS total	18.72±10.551	.28±1.354	13.423	118	.000*
BABS	0.40±1.278	1.15±1.903	-2.534	118	.013
HDRS	4.87±3.568	2.58±1.898	4.377	118	.000*
HAMA	4.87±3.568	2.12±1.767	5.351	118	.000*
GAF	61.23±12.313	67.00±11.832	-2.616	118	.010*
qol1	13.133±1.82376	12.0286±1.72691	3.407	118	.001*
qol2	12.1778±2.04605	12.0222±1.54757	.470	118	.639
qol3	11.9111±2.35292	11.1556±2.52704	1.695	118	.093
qol4	12.633±1.36812	11.7167±1.42129	3.599	118	.000*
Table 2: Comparison of scores of Y-BOCS, BABS, HDRS, HAMA, GAF, WHO-QOL Bref in OCD and Schizophrenia groups (Probands)					

p<0.05*,

Y-BOCS=Yale-Brown Obsessive-Compulsive Rating Scale, BABS=Brown Assessment of Beliefs Scale, HDRS=Hamilton Rating Scale for Depression, HAMA=Hamilton Rating Scale for Anxiety, qol1=WHOQOL-BREF-Physical Health domain, qol2=WHOQOL-BREF-Psychological Health domain, qol3=WHOQOL-BREF-Social Relationships domain, qol4=WHOQOL-BREF-Environment domain.

DISCUSSION:
Methodological Considerations: The index study undertook identification of Quality of life and Clinical Variables in patients with Obsessive Compulsive disorder and used schizophrenia patients serving as patient control group.

Use of Patient Controls: Previous studies[17,18] used normal individuals free from psychopathology as controls. We made the between group comparison more stringent by taking schizophrenia patients as controls. Since we were studying psychiatric morbidity in patients, a group of patients would be more suitable to serve as controls rather than normal individuals as this increased the homogeneity of comparison with regards to morbidity. The patient control increased the robustness of our study. The expression of significant difference between two groups means excess morbidity from a baseline of some degree of morbidity in both groups.

Tools Used: Yale-Brown Obsessive-Compulsive Rating Scale, Brown Assessment of Beliefs Scale, Hamilton Rating

Scale for Depression, Hamilton Rating Scale for Anxiety, WHO Quality of life, and Global assessment of Function were used. This is an improvement over past studies[18,19,20] which have been lacking in such a comprehensive approach to the topic. Depression of more than moderate level as per HAM-D(score≥19), was excluded thus making the sample more homogenous and free of confounding effect of severe depression. Mild to moderate depression was included making it more naturalistic and applicable to real world settings.

Socio-Demographic and Clinical Characteristics: Our OCD probands had a mean age of 29.35+ 8.12 years. This is comparable to the average age of 35.7+13.3;[21] mean age of 35.5 yrs. as per du Toit et al.,[20] 33.6 +12.1 years as per Pauls et al.[17] and even closer to 26.27+10.14 years for males and 31.92+11.46 years for females in Jaisoorya et al[22] and to 27.9+10.8 years age as per Jaisoorya et al [19] which are Indian studies.

Our sample was composed of 40(66.7%) males and 20 (33.3%) females. This reflects the general pattern of referral in our setup. In other Indian studies also[19,22] males

were overrepresented. This could be reflection of our social milieu where males are the bread earners and so are seek treatment early. In western studies both sexes were almost equally represented e.g. 48.57% males in Lochner et al;[21] 44.7% in du Toit et al;[20] 51.28% in Pauls et al/[17]

In our study 30(50%) of participants in patient group were married, and other 30(50%) were either unmarried, widow/widower, or divorced. 36% were married in Jaisoorya et al 2003,[19] 24.09% of males and 64.6% of females were married in Jaisoorya et al 2009.[22]

With respect to religion 53(88.3%) were Hindus; while Muslims, Christians and Sikh comprised the rest 7(11.7%). This simply reflects the Hindus being the religious majority population being in the catchment area of our centre. In other Indian studies also same pattern was reflected- 80.12% of males were Hindus and 84.61% were females in Jaisoorya et al[22] and 81% males in Jaisoorya et al.[19]

On assessing for socioeconomic status as per Kuppuswamy's revised classification (which includes Income, Education and Employment status), 20(33.3 %) were Upper+Middle (Upper) status, 22(36.7 %) were of Middle (Lower) status, and 18(30.0 %) were of Lower economic status. Only one patient was from Upper status in 'Upper+Middle (Upper) status'. Most of the patients were from middle socioeconomic status.

With respect to background, 28(46.7%) were from urban background in OCD group, which was significantly more (p≤0.05) than patient control group 11(18.3%); and 32(53.3%) were from rural background in OCD group as compared to 49(81.7%) in patient control group. In the study by Jaisoorya et al. 2003[19] the urban population was 23%; and 77.10% males and 75.38% females were from urban background in Jaisoorya et al 2009.[22] Both the studies had over representation of either rural or urban and our study had a relatively equal representation of both backgrounds. Urban overrepresentation in OCD group, despite the catchment area being more rural than urban, may be a reflection of increased awareness of OCD being a disorder, and avenues of better outcome with treatment in urban areas. Whilst in schizophrenia group rural referral was more reflecting the true representation of catchment area, as it a more severe illness needing referral as causes much disruption in the life of patient and family.

There was also significant difference in years of education (p≤0.05) as the patient group had 11.68±3.13 years which was more than 9.22±4.87 years in the patient control group. This can be explained by overrepresentation of urban background in OCD group, as there is more emphasis of being educated in urban areas, while not so in rural areas. Also a psychotic presentation is more likely to cause disruption of functioning.

The illness duration was 68.13±53.59 months in OCD group which is comparable to Median duration of 72 months in Jaisoorya et al,[19] 95.29±83.9 months in Jaisoorya et al.[22]

The cost of medication was significantly higher in OCD group (p≤0.05) at Rs.719.55±674.47 per month as compared to Rs 454.92±292.50 per month in Schizophrenia Group. The reason might be that our schizophrenia group was in remission as chosen by the selection criteria, whereas OCD cases were not necessarily in remission, many in active phase and thus higher treatment cost may reflect the increased burden of treatment.

Comparison of Obsessive Compulsive Disorder and Schizophrenia across Scores OF Y-BOCS, BABS, HDRS, HAM-A, GAF, WHO-QOL: YBOCS obsessions score was 10.67±5.45, compulsions score 8.03±6.128, total being 18.72±10.551.

The score on HDRS and HAM-A was significantly higher (p≤0.05) in OCD group (4.87±3.56 and 4.87±3.568 respectively) as compared to schizophrenia group (2.58±1.89 and 2.12±1.76 respectively). This could be a reflection of symptomatic presentation in OCD, and it being a non-psychotic illness leading to more depression and anxiety due to intact contact with reality.

The GAF scores were higher (p≤0.05) in schizophrenia group (67.00±11.83) as compared to OCD group (61.23±12.31) which may have arisen from the fact that the Schizophrenia probands were in remission by the selection criteria. The OCD having a poorer functioning than patient control group emphasises the need to identify and treat it, and not to be taken lightly.

Despite poor overall functioning the OCD group scored more on Physical Health domain (13.13±1.82) and Environment domain (12.63±1.36), as compared to schizophrenia group (12.02±1.72 and 11.71±1.42 respectively) of WHOQOL-BREF[15] (p≤0.05).

The physical domain reflects satisfaction with sleep, ability to perform daily living activities, capacity to work, ability to get around, energy for everyday life, physical pain and need for any medical treatment to function in daily life. Better outcome on this measures may be an indicator of OCD being less severe than Schizophrenic illness, intact insight and more treatment seeking attitude-as despite overall worse overall functioning there still was more satisfaction on these domains when seen in isolation.

The environment domain reflects satisfaction with the conditions of your living places, access to health services, transport, opportunities for leisure activities, money to meet the needs, availability of the required information, and safety in daily life which are better in urban background and may be a reflection of more OCD probands being from this background and also the higher level of education in OCD group.

There was no significant difference in both groups on Psychological Health domain which reflects 'enjoying life, finding it meaningful, level of negative feelings, satisfaction with self, evaluation of body appearance and ability to concentrate' and Social Relationships domain of WHOQOL-BREF which considers 'satisfaction with personal relationships, sex life and support from friends'. This suggests both groups were equally impaired on these domains.

CONCLUSIONS: The treatment cost is more in OCD than in stable schizophrenia. Depression and anxiety are more common in OCD.

The Psychopathology of OCD spared satisfaction with sleep, ability to perform daily living activities, capacity to work, ability to get around, energy for everyday life, physical pain and need for any medical treatment to function in daily life, satisfaction with the conditions of your living places, access to health services, transport, opportunities for leisure activities, money to meet the needs, availability of the required information, and safety in daily life; when compared to stable schizophrenia patients.

The Psychopathology of OCD had as severe an impact as Schizophrenia on 'enjoying life, finding it meaningful, level of negative feelings, satisfaction with self, evaluation of body appearance and ability to concentrate' 'satisfaction with personal relationships, sex life and support from friends'.

Despite worse global functioning, OCD had a partial sparing effect on quality of life when compared with Schizophrenia.

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