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Chronic Mania-A Case Report

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Abstract

Bipolar disorder is a phasic mental disorder characterized by the presence of (hypo) maniac, depressive and/or mixed episodes during the course of the disease. A 70 year man, with no prior history of depressive episodes, began to suffer a picture of manic characteristics as an adolescent. Despite the numerous drug treatments prescribed, there has been no improvement, and the disorder has followed a torpid and chronic course. Chronic unipolar mania is a clinical entity appearing as a residual characteristic in the current psychiatric nosology. Its low prevalence makes it difficult to carry out research aimed at elucidating whether it has a subordinate or independent relationship with the bipolar disorder. A systematic assessment of the effectiveness of electroconvulsive therapy is needed in these patients.

Keywords: bipolar disorder, mania , depression , electroconvulsive therapy.

Introduction

That concept of Chronic Mania as a diagnostic clinical entity does exist. In the second half of nineteenth century every professor of psychiatry had his own system of diagnostic formulation. It was **Emil Kraepelin** through his clinical descriptions of observations brought order in psychiatric diagnosis and also gave his classification which was the basis of later development of diagnostic system. He also given clinical description of chronic mania and this idea got strength by corroborating case reports of various researchers, though DSM-4 TR had categorized criteria of chronic specifier for major depressive episodes but omitted for manic episode. We have tried to report one case which fulfills the ICD-10 criteria of mania. Classically chronic mania has been defined ascontinuouspresence of manic symptoms for more than two years without remission (Goodwin FK, Jamison KR).[1]Other researchers have used different criteria such as improvement in symptoms and treatment resistant or treatment responders also in their research work.In this case report we present a case of chronic mania with classical symptoms found in bipolar mania or manic episode.

Case Report

Mr A, 70 years male of middle socioeconomic status, was referred to our referral centre by his family physician. His son who is IT Engineer came to his native place during lockdown and has been

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staying with his father while working from home, accompanied him because he was not willing to consult a psychiatrist.He had been kept in seclusion for few months before being brought to our centre. He denied having psychotic illness but displayed diminished insight, claiming that he was well but took medication for forgetfulness and disturbed sleep. History reveals that his disorder commenced when he was 65 years of age, presented with an insidious-onset of 5 years' duration, with a continuous course with above mention symptoms.

He also had a history of tobacco abuse since the age of 40 years. In the last 5 years, he frequently absconded from home; when asked about his whereabouts, he would talk about his grandiose abilities, identity, and association and would say ''**I m the king of city and I can go anywhere I want**'' .Before coming to our facility about one year back he had been treated with some psychotropic medications.With which family members reported only 20% improvement in his symptoms.

There was no family history of mental illness or any history of past episodes. Early developmental history did not reveal any abnormality, and there was no history of hyperthymic traits. There was no history suggestive of Schneider's first-rank symptoms, overfamiliarity, depressive features, head injury, and seizures.

On examination, he was found to have expensive and dysphoric mood he was having grandiose ideas. His cognitive functions were preserved. He was having pressure of speech and he giggled inappropriately. He readily became distracted and, on occasion he showed overfamiliarity. With the available information, a diagnosis of chronic mania was considered.

His routine investigations did not reveal any abnormality,and computerized tomography scan of brain show age related cortical changes. Earlier he was managed with Quetiapine 200 mg/day . He showed only marginal improvement in his symptoms with the above combination. Following this, he was shifted to tablets of Olanzapine 30 mg/day along with Sodium Valproate 1000 mg/day, with this combination, over the period of 8 weeks, the patient showed improvement in his overall behaviour, delusion of grandiosity subsided, sleep was improved. His family was advised to shift the patient to a long-stay mental health facility. However, his family decided to keep the patient at home. Over the period of next 6 month, he was continued on the combination of Olanzapine 30 mg/day along with Sodium Valproate 1000 mg/day during which he did not take up any work and continued to harbour delusion of grandiosity and had elevated mood. However, he was better in the form of lack of abusiveness and running away behaviour.

Discussion

According to DSM –5 and ICD 10 mania can be of duration of 7 days[1,2,3] and epidemiological studies suggest that untreated mania usually remits within 6 months, though in some cases it may last longer.[4] Classically, chronic mania has been defined as the presence of manic symptoms for more than 2 years without remission.[5] However, in recent years, other researchers have used different definitions such as lack of improvement by at least two points from baseline on the Clinical Global Impression-Bipolar Disorder Mania scale[6] at any observation during the 12 months after starting treatment for acute mania.[7] However in literature, chronic mania lasting for about 48 years has also been described.[8]

Studies that have evaluated patients with bipolar disorders have reported an incidence of 6–15% for chronic mania among all the patients with bipolar disorders. With regard to symptomatology and associated clinical features, one of the recent studies that compared patients of acute mania and chronic mania suggested that chronic course usually arises in the background of hyperthymic temperament and recurrent mania, with a deteriorative pattern. It also noticed that compared to patients with acute mania, patients with chronic mania have significantly a high rate of almost constant euphoria, grandiose delusions, and related delusions and relatively low rates of sleep disturbance, psychomotor agitation, and hyper sexuality. Another study by Van Reil et all suggested that compared with treatment responders, patients who do not respond and run a chronic course have a lower severity of mania symptoms at baseline but a higher prevalence of delusions/hallucinations, have a shorter duration of current episode prior to start of the treatment, are less socially active, and have a higher occupational impairment.

Conclusion

Present case illustrates unremitting treatment-resistant chronic mania that posed a diagnostic and management challenge. The Iowa study [9], which

examined the natural history of 525 mentally ill patients in the era predating modern psychotropic agents, found that the majority of the 122 patients with bipolar disorder recovered within 3 years, and that almost all eventually experienced some period of recovery. Hare [10], in reviewing the concept of mania, commented on the notable 20 century decline in interest in chronic mania, and suggested that it was more prevalent at the beginning of the last century than it is now, due presumably to the implementation of efficacious treatments. The index case exhibited manic symptoms for 5 years prior to presentation to us, with minimum improvement with treatment. He has been under our care of about 1.5 years, with no change in the core manic symptoms despite good treatment compliance. This clinical picture fits with the clinical description of chronic mania and suggests that in rare patients, mania can run a chronic course.

In recent times, there have been a few reports of chronic mania from various other canters in India, and this suggests that chronic mania does exist in clinic population and there is a need to study this clinical entity more meaningfully to understand its biological correlates and treatment outcome.

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Conflict of Interest - Nil

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