CASE REPORT

CHRONIC MANIA: AN UNEXPECTEDLY LONG EPISODE?

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ABSTRACT

Mood disorders (unipolar and bipolar disorders) are one of the most distressing and disabling disorders known to man kind. Mood disorders may present as either a depressive phase or manic phase. Chronic mania by definition means presence of manic symptoms in excess of 2 yrs without remission. Chronic mania differs in its psychopathological presentation from the acute mania. Chronic mania also poses a diagnostic and management challenge. Along with the poor response to the treatment these patients are also likely to suffer from severe impairment in the social, familial, interpersonal and occupational functioning. These disturbances may add to the chronicity of the condition. This case underlines the significance of keeping possibility of chronic mania which has been overlooked in the recent literature.

Key words: Chronic mania, mood, bipolar disorder.

INTRODUCTION

Mood disorders (unipolar and bipolar disorders) are currently the 4th leading contributor to the global burden of disease (DALY's) in 2000. Mood disorders may present as bipolar disorder with a depressive phase at one pole. The other pole, called as mania is characterized by euphoric mood, irritability, hostility, dysphoria, reactivity, agitation, aggressiveness, destructiveness, increased psychomotor activity, sexual indiscretions and decreased need for sleep lasting for a minimum period of one week. The usual duration of a manic episode is around 4 to 6 months. Chronic mania by definition means presence of manic symptoms in excess of 2 yrs without remission.[1] Hereby, we are presenting a case of chronic mania along with review of literature.

CASE REPORT

A 63 yrs old male, a known case of bipolar affective disorder, came to psychiatry department with exacerbation to a manic episode for last 10 days. He was taking lithium (1200 mg/ day) with adequate blood levels and chlorpromazine (100 mg/day). Detailed evaluation revealed patient had acute episode with psychotic features, which lasted for 8 months around 22 years back. Since then, he continued to have multiple episodes (around 5 episodes, each lasting for 7-10 months) till date, last episode being in 1999. He was hospitalized for each episode, since he would be unmanageable by family members. During interepisodic period, all his manic symptoms would remit except for the grandiose delusion. The patient would harbor the belief that he was the king of the world and was ruling it. He would also claim to have special powers that could decide the fate of the others. The patient would continue to harbor this delusion although it would not seem to hamper his day to day functioning. There was no depressive episode during his illness. During each manic episode, the dose of antipsychotic would be increased and his exacerbation would resolve. The patient over the years was tried on sodium valproate and carbamazepine in adequate therapeutic doses along with olanzapine (up to 20 mg), risperidone (up to 8 mg/ day) and haloperidol (up to 15 mg/day). In spite of these combinations the patient continued to have the false unshakable belief.

Routine investigations and physical examination have always been normal, while electroencephalography and computed tomography revealed no pathology. There was no significant family history of psychiatric/neurological illness and his premorbid personality was devoid of any hyperthymic traits.

DISCUSSION

The prevalence of chronic mania is estimated to be around 6-12%, due to the variable criterions chosen to describe the condition.[2] Although, it remains to be underreported in the literature.

Description of this condition dates back to the 19th century when Kraepelin routinely described such cases in his presentations.[3] In a study carried by Perugh et al in 1998, studied 155 patients with DSM III criteria for mania, 13% of the patients showed a chronic course (more than six months without remission).

Chronic mania differs in its psychopathological presentation from the acute mania. The disturbances in the biological functions in the form of sleep disturbances and appetite are hallmark of an acute episode. Chronic mania, on the other hand, is devoid off the psychomotor and vegetative symptoms seen in the acute episode. The possibility of schizophrenia is also unlikely because of the absence of the flattening of affect and the gross thought abnormality. At times, it becomes very difficult to diagnose a case of mania because of personality style of the patient superimposed on a cyclothymic or hyperthymic temperament.[4] This patient had a well adjusted premorbid personality.

These individuals are poor responders to the conventional treatment for the mood disorders namely, the mood stabilizers and neuroleptics. The persistence of psychotic symptoms, despite the remission of other acute psychiatric symptoms, is a poor

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prognostic factor in many psychiatric disorders, not only in chronic mania. Actually, the long-term persistence of delusions seems to induce a cognitive adaptation in patients. The content of delusions may be integrated in a long-lasting or even definitive patients’ point of view which becomes independent of the phases of illness and unresponsive to treatment.

This may account for the persistence of “psychotic symptoms” in the absence of other symptoms typical of the acute phase of the illness.

Not surprisingly, chronic delusions are often unresponsive to all treatments. The possible interventions include a step wise introduction of these medications, a combination of mood stabilizers and neuroleptics.

There is a need to look into the neurobiological basis of the condition and to find out what makes a subgroup of patients with bipolar affective disorder to follow this chronic course. These findings would have far reaching consequences in the proper management of such cases.

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REFERENCES