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Chronic unipolar mania. A case report

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Introduction. 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.

Clinical case. A middle-age man, with no prior history of depressive episodes, began to suffer a picture of manic characteristics as an adolescent that has lasted for 18 years. Despite the numerous drug treatments prescribed, there has been no improvement, and the disorder has followed a torpid and chronic course.

Conclusions. 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:
Chronic unipolar mania, bipolar disorder, eletroconvulsive therapy.

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Manía unipolar crónica. A propósito de un caso

Introducción. El trastorno bipolar es una patología mental de naturaleza fásica, caracterizada por la presencia de episodios (hipo)maníacos, depresivos y/o mixtos que se suceden a lo largo del curso de la enfermedad.

Caso clínico. Se expone el caso de un varón de mediana edad, sin antecedentes de episodios depresivos, que inició en la adolescencia un cuadro de características maniformes de 18 años de evolución. A pesar de los numerosos tratamientos farmacológicos prescritos, no se apreció mejoría alguna, presentando un curso tórpido, tendente a la cronicidad.

Conclusiones. La manía unipolar crónica es una entidad clínica representada de una manera residual en la nosología psiquiátrica actual. Su ínfima prevalencia dificulta la investigación orientada a dilucidar su naturaleza subordinada o independiente del trastorno bipolar. Se hace necesaria una evaluación sistematizada de la efectividad de la terapia electroconvulsiva con estos pacientes.

Palabras clave:
Manía unipolar crónica, trastorno bipolar, terapia electroconvulsiva.

INTRODUCTION

Bipolar disorder is a serious mental condition characterized by the presence of (hypo) manic, depressive and/or mixed episodes that occur during the course of the disease. Therefore, two of its most outstanding traits are its phasic nature (frequently with residual interepisodic symptoms)[1] and its bimodal distribution, whether towards the depressive or manic pole. In spite of this scientific consensus, the clinical evidence sometimes challenges the suppositions on which this condition is based in the current psychiatric nosology, "chronic unipolar mania" being one of the most paradigmatic examples.

REASON FOR CONSULTATION

A case report of a 36-year-old man who was admitted to the Long Stay Unit (LSU) of Betera due to the impossibility of outpatient treatment in the reference Addictive Behavior Unit (ABU) is presented. He was referred due to a maniform type picture of 14 years of evolution, which was refractory to all treatments prescribed up to that time.

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BACKGROUND OF THE PROBLEM

The manic picture began at 18 years of age, the presence of verbose ideas with flight of ideas and predominance of megalomanic delusions with mystic-religious and genealogical content standing out.

Persistent insomnia and psychomotor restlessness were also observed. This debut occurred parallel to a recreative use of cannabis and opiates (orally) and excessive costs in type B recreative machines, all this motivating behavioral disturbances in his setting. During the decade of out-patient follow-up in the ABU, complete remission was obtained of the toxic usage (5 last years). However, the mentioned maniform psychopathy persisted. In some periods, the psychotic symptoms remained encapsulated, although the verborreic speech, tachypsychic thinking and psychomotor restlessness that followed a course tending towards chronicity, inconsistent with the premorbid personality of the patient. Treatment was prescribed with many psychotropic agents, with partial pharmacological compliance. Even when there was regular compliance to treatment, the picture continued to be refractory, including some prolonged admissions to the Psychiatric Hospitalization Unit of the health care area in these lapses. All the medical tests conducted ruled out an organic cause. As a whole, the psychotic decompensations motivated 25 hospitalizations, and the advisability of admission in a LSU was finally proposed.

PSYCHOBIOGRAPHY

He was born prematurely (eight months). Without psychomotor problems, although he had "some delay" in speech acquisition. No adverse drug reaction or known allergies. Described since childhood as a child with hyperthymic temperament, without evidence of hyperactivity, distractibility or lack of attention. He generally cut classes at school and his academic performance was low, although he finally obtained his high school degree. Good social support network, being a member of a large family of a specific ethnic origin with integration in the community. No (neuro) psychiatric background among these relatives. He even collaborated in the family work.

CLINICAL EXAMINATION

During the LSU admission interview, he was conscious and alert. Frank loss of interpersonal distance. Oriented in time, place and person. Absence of cognitive deterioration. Tachypsychia, with distractibility and verbosity and flight of ideas. The content stood out for its megalomanic delusional ideas of genealogical and mystic-religious nature. On the affective level, hyperthymic mood on expansive background. Psychomotor restlessness. No disease awareness.

DIAGNOSIS

Bipolar disorder, single manic episode F.296.0

TREATMENT AND COURSE

During the 4 years he has been admitted to the LSU, the maniform picture has persisted in spite of the modifications introduced into the treatments prescribed. Currently, he is being treated with Plenur (lithium) 400 1-1-1, Leponex (clozapine) 100 2-2-2, Sinogan (levomepromazinr) 100 1/2-1/2-1, Trileptal (oxcarbazepam) 300 1-1-1 and Risperdal Consta 50 (risperidone) (fortnightly).

The expansive background, psychomotor restlessness, verbose speech and flight of ideas continue to be irreducible, while the psychotic psychopathology has been impregnating the spontaneous speech of the patient based on the exacerbation or not of the disease. At some times, psychotic symptoms incongruent with the mood state have been observed as delusional ideas of control. No cognitive deterioration has been observed. He has null disease awareness, preventing psychoeducation approach. On the behavioral level, the patient performs basic activities of daily functioning with full independence, although with perseverance of behavior that does not adapt to the social scripts (hyperfamiliarity). However, these behaviors can be redirected when the limits are indicated to the patient. Therefore, it has been possible to include the patient in community tasks supervised by occupational monitors.

CONCLUSIONS

"Chronic unipolar mania" is a diagnosis included residually in the current psychiatric nosology. In the DSM-IV, the clinician has to decide on making a diagnosis of "bipolar disorder, single manic episode,"[2] thus paradoxically obviating that the inherent nature of the "circular psychosis" is a recurrent and/or bimodal nature, a fact that is not verifiable in our case. On the other hand, the ICD-10 differentiates those single manic episodes of the bipolar disorder per se,[3] in which "recurrent unipolar mania" would be integrated a similar but not identical construct to that of "chronic unipolar mania." Also in this case, the adequacy of using "single episode" for the persistent course presented in our patient is questionable. Thus, it would be preferable to also incorporate the "chronic" label to this type of manic syndromes, in equivalence to the depressive episodes of more than 2 years duration included in the DSM-IV.[4] In

conclusion, at presently there is really no diagnostic category in the current reference manuals that integrate "chronic unipolar mania" with its most distinctive traits (validity of content), that is, persistent course and maniform psychopathology.

Even though "chronic unipolar mania" has enjoyed an apparent or clinically recognized validity for more than one century,[5] one of the reasons why it has gone unnoticed in the current nosology is its low prevalence.[6] This is especially true when broad criteria are used in the epidemiological studies that do not incorporate the cases included under the construct "recurrent unipolar mania," these being more common if we consider that most of the manic episodes are self-limited to a period of 4 to 8 months.[7] Its testimonial presence has also been potentiated in recent decades by the incorporation of effective psychopharmaceuticals in most of the potentially prolonged episodes.[8] This adds even more notoriety, if possible, to cases such as that of this patient, whose torpid course is the longest (18 months) found in the scientific literature consulted within the psychopharmacologic era.

In regards to the differential diagnosis, the clinician should consider several longitudinal and cross-sectional factors. On the one hand, there are the limitations of the retrospective reports when ruling out previous depressive episodes, while from a prospective approach, it cannot be assured that no changes will occur in the polarity in subsequent years in some manic patients (pseudo)unipolar,[9] even more so when the bipolar disorder, as a whole, makes up one of the mental disorders with more diagnostic errors in the long term follow-up,[10] especially if it begins at an early age.[11] Another error is found in the possible confusion between personality and mood. This is understandable if it is taken into consideration that a greater presence of hyperthymic temperament has been found in unipolar (versus bipolar) manics.[12] These episodes promote more euphoric than irritable manics in line with a continuum or spectrum model between character and mood state disorders. On a more cross-sectional level, a chronic maniform picture and with psychotic symptoms should lead to suspicion, in the first place, of a possible organic etiology, choosing an "idiopathic causality" after having principally ruled out toxic abuse, above all if we are dealing with a young patient. Additionally, some clinicians may be reluctant to make a diagnosis of "chronic mania" on the basis of a first range symptom incongruous with the moon state that leads to the proposal of a diagnosis of schizoaffective disorder, obviating with it the prevalence of the affection component in its longitudinal course.

In regards to the treatment, there is evidence that supports the greater refractariety of the unipolar (versus bipolar) manic pictures.[13] In spite of this greater resistance to mood stabilizer drugs combined with neuroleptics, some case studies[14] indicate that the relative benefit of adding an atypical antipsychotic, for example, clozapine, in a patient with "chronic unipolar mania" could derive from a dose-dependent effect. Regarding the application of ECT in subjects with "unipolar mania," casuistic reports show their efficacy in "recurrent unipolar mania,"[15] these having been sterile in a case of "chronic unipolar mania.[16] This research deficit around the implementation of ECT makes it necessary to carry out a more systematized analysis of the results that could occur in persons with both chronic and recurrent "unipolar mania."

In summary, given its rare character,[17] there are no experimental studies that contribute to determine whether "chronic mania" has an independent nature from the rest of the conditions collected under the category of "bipolar disorder." Thus, not only would it be necessary to take into account the premorbid personality, the evolutive course or the differential response to a same treatment (it could be a "bipolar subtype" of poor prognosis or torpid evolution), but also other factors such as onset age, sociodemographic variables, biological markers, family backgrounds and its clinical characteristics per se.[18]

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