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Case Report Open Access

Recurrent Mania: Rare or Common!

Anil Kumar[1]*, Shyamanta Das[1], Mythili Hazarika[2], Sangeeta Datta[3], Simanta Talukdar[2], Amal Baishya[2] and Dipesh Bhagabati[2]

[1]*Department of Psychiatry, Fakhruddin Ali Ahmed Medical College Hospital, Barpeta, Assam, India,*
[2]*Department of Psychiatry, Gauhati Medical College Hospital, Assam, India*
[3]*NEMCARE Hospital, Assam India*

Abstract

Traditionally we diagnose bipolar disorder if a patient has maniac or hypomaniac episode along with depressive episode. Again there is a diagnostic entity called recurrent depressive disorder in the classification system. But we don't have a diagnostic entity called recurrent mania although in clinical practice many patients present only with episodes of mania and no depressive episode. Thus cases of recurrent mania might have phenomenological differences with rest of the cases of bipolar disorder. Thus, a 30 years old man patient's atypical case history has been discussed in the context of bipolar disorder and having the possibility of a new subtype of recurrent mania.

Keywords: Recurrent mania; Bipolar; Phenomenology

Introduction

Klerman classified bipolar disorder into six types [1]. Type VI is mania without depression, also called unipolar mania [1]. The tenth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) [2] states, As patients who suffer only from repeated episodes of mania are comparatively rare, and resemble (in their family history, premorbid personality, age of onset, and long-term prognosis) those who also have at least occasional episodes of depression, such patients are classified as bipolar."

Although, recurrent manic episodes have been reported to be rare, but in clinical practices, it was found that recurrent mania is much more common [3].

Case

A 30 years old man's presenting symptoms were talkativeness, less sleep, boastfulness, assertiveness, and not listening to family members for four months; as well as arguing with seniors and colleagues, increased intake of alcohol, someone had done black magic over him and family members, colleagues were conspiring against him, and suspicious towards family members for one and half months. Precipitating factor was stopping of salary, five months back.

There were past histories of four episodes. In 2001, he was suspicious and heard voices. In 2003, he was suspicious and fearful. Both these two episodes were preceded by a few days of withdrawn behavior and brooding. After an asymptomatic period of eight years, patient again became suspicious and irritable for three months in 2011. In 2013, for a brief period of one week, he was sad and there was lack of initiative for work.

There was family history of alcohol use by brothers. In personal history, patient was educated up to 10+2+3. He was employed, unmarried, and smoked tobacco and used alcohol. Premorbidly, he was a 'slow to warm up' child. Mental state examination revealed mesomorphic built, elated mood, grandiosity and delusion of persecution, not sustained attention, and level one insight.

Discussion

Regarding diagnosis, several possibilities came to the picture. Talking in reverse order, can it be paranoid personality disorder, taking into consideration the prominent symptom of suspiciousness in the first two episodes. But, they were episodic instead of being continuous. Then comes the possibility of delusional disorder. Here again, along with delusion, there were prominent hallucination and affective symptoms. When there are a mix of symptoms like suspiciousness, fearfulness on one hand, and affective symptoms on the other, diagnosis of schizoaffective disorder seems to be a safe bet. But, in this patient, these symptoms didn't occur simultaneously. Then can it be schizophrenia? Past history of schizophrenia, and now mania, is a possibility. Though, considering all the possibilities, the weight is more towards a provisional diagnosis of bipolar disorder.

The third episode of this patient was of low mood and a lack of initiative for work. But, it does not qualify to be called a depressive episode either in terms of symptoms or severity. Ghosh et al. [3] aimed to study recurrent mania, and its relation with body build and family history of mood disorder. Fifty recurrent mania patients and equal number of bipolar disorder patients were taken for the study [3]. Mean age for recurrent mania was 36.4 years and for bipolar patients was 41.1 years. Amongst the recurrent mania group, eight per cent (n=four) had endomorphic build, 28% (n=14) mesomorphic build, and 64% (n=32) ectomorphic build. Whereas in bipolar group of patients, 78% (n=39) had endomorphic build, ten per cent (n=five) mesomorphic build, and 12% (n=six) ectomorphic build. This difference in body build was found to be statistically significant (P<0.0001). When family history of mood disorder was compared between the groups, amongst recurrent mania group, ten per cent (n=five) had positive family history, whereas in bipolar disorder group, 28% (n=14) had family history of mood disorder. An attempt was made to compare different body build of both groups with family history. This finding was statistically considered to be very significant (P=0.0061).

In conclusion of the study [3], it was found 64% (n=32) with ectomorphic body build amongst 50 cases of recurrent mania group,

***Corresponding author:** Anil Kumar, MD, Registrar, Department of Psychiatry, Fakhruddin Ali Ahmed Medical College Hospital, Barpeta, 781 301, Assam, India, Tel: 9613180189; E-mail: anil2005kumar5@gmail.com

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and 78% (n=39) had endomorphic body build amongst 50 cases of bipolar disorder group. Next, family history was found more in bipolar disorder group than recurrent mania group. Our patient had mesomorphic build and there was no family history of mood disorder. In our clinical practice, we often come across patients whose symptoms together do not constitute a syndrome within the diagnostic confines of the currently available systems. Do we entertain a possibility of having mood disorder patients only with manic episodes, and without depressive episodes?

Ghosh et al. [3] studied recurrent mania patients in relation to the body build and family history of mood disorders, and found differences from those bipolar patients having both manic and depressive episodes. Thus, phenomenological studies in our cultural background of this group of patients may throw more light on the topic. The areas highlighted by ICD-10 [2], i.e. premorbid personality, age of onset, and long-term prognosis may be the other parameters to be included in future studies. This study being a case report has limited role in generalization of its findings but opens new doors for further studies. Future studies should incorporate a large number of patients and should try to see the phenomenological differences between recurrent mania and other bipolar disorders. This will enhance better understanding of bipolar disorders in terms of etiopathogenesis and treatment.

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