



**AN INTERESTING PRESENTATION OF EARLY ONSET BIPOLAR DISORDER
A CASE REPORT**

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Abstract:

Bipolar disorder can occur in children and adolescents. Prevalence of early onset bipolar disorder is rather rare. Studies have reported an incidence of 0.1%.

In this case report, we present a case of early onset bipolar disorder where dissociative (conversion) symptoms were associated with mania. The presence of dissociative symptoms in bipolar disorder has been reported in the literature.

Introduction:

Although there is a general agreement that bipolar disorder can occur in children and adolescents, there remain several unanswered questions regarding the frequency with which it manifests, the best ways to measure and define it.¹

The prevalence of early onset bipolar disorder is rare, based on studies using diagnostic criteria within the DSM – IV- TR.² Epidemiological studies in adolescents have reported prevalence rates of bipolar disorders to be ranging from 0.06 percent to 0.1 percent.³

Diagnosing early onset bipolar disorder is difficult and often delayed due to the atypical presentation, more commonly in prepubertal age group, resulting in considerable chronicity and impairment.⁴

Among adolescents, the evolution of a manic episode and clinical features is almost similar to that in adult bipolar disorder and its presentation is less atypical than the prepubertal age group.²

In this case report, we present a case of early onset bipolar disorder where dissociative (conversion) symptoms were associated with mania. The presence of dissociative symptoms in bipolar disorder has been reported in the literature.^{5,6,7}

Case studies have shown how the co morbidity of bipolar disorder and dissociation increases a patient's lethality risk and how both disorders may contribute to the volatile destabilization of the other.⁸

CASE REPORT

A 16 year old male was referred to us from department of neurology with history of recurrent fainting episodes followed by involuntary movements for past 2 weeks. He had presented with history of three similar episodes in the past² weeks. He had no focal neurological deficit and his EEG and MRI was normal. He was referred to us as a case of non epileptic seizures for opinion.

He lived with his parents and younger sister in a rural lower middle class family. He had discontinued schooling and was working in a mechanic shop as an assistant. In the past 1 month his employer had scolded him several times for not doing work properly and this had upset the patient. Detailed history obtained from his father revealed, he had H/O sleep disturbance, excessive worry, crying spells and involuntary movements for past 2 weeks.

Physical examination revealed no abnormality.

There was a family history of completed suicide in his maternal aunt. There was no family history of seizures, or abnormal involuntary movements.

On MSE, he was depressed, with lack of confidence, ideas of worthlessness and ideas not worth living. There were no active suicidal intentions.

He was started on pharmacotherapy with fluoxetine 20 mg/day and diazepam 5 mg/day and supportive therapy. In a period of 1 week of onset of treatment, patient became irritable and abusive. His appetite increased and need for sleep decreased. He began to sing songs, and had become adamant, demanding special food from restaurants everyday which was beyond his family's economic limitations. He had inflated self esteem, increased psychomotor activity, pressure of talk, abusive and aggressive behavior, and his mood was irritable. He had auditory hallucinations characterized by voices of Gods talking to him.

Detailed evaluation of patient's past history, revealed history of similar episodes of changes in his behavior and mood, and these episodes were every time associated with episodes of fainting followed by jerky movements of all 4 limbs. The first episode was in July 2011, when the behavioral and mood changes had lasted for 1 week and the involuntary movements had occurred 2- 3 times a day, every day during that week. The second episode was in April 2012 with features similar to the first episode.

The third episode was in October 2012, lasting for 2 weeks, which was when he was referred to us. The family had every time consulted a private neurologist during his previous episodes, concerned about the jerky movements alone. EEG and MRI taken during those times were also normal. He had been treated with sodium valproate 800 mg/day and diazepam 5mg/day, which the parents had discontinued once patient became asymptomatic. There was no history of substance use.

INVESTIGATIONS

EEG, CT and MRI of the brain, blood biochemistry and serum ceruloplasmin levels were normal.

Psychometry revealed an IQ of 80 using Binet Kamat test and adaptive skills age equivalent of 15 years 8 months using Vineland Social Maturity Scale.

Initially on admission, Beck depression inventory had showed evidence of moderate depression. Children's Apperception Test revealed perception of environment to be stressful, poor self confidence and inadequate coping ability. YMRS score during the manic phase was 18.

TREATMENT

Once he started presenting with manic features, antidepressants were gradually tapered and stopped, and simultaneously was started on valproic acid 25 mg/kg/day, diazepam 5 mg/day. Patient and his parents were psycho educated on nature of his illness and the significance of strict medication compliance.

OUTCOME AND FOLLOW-UP

He showed significant improvement in his behavior with treatment. His irritability, abusiveness, demanding and adamant attitudes, inflated self esteem gradually reduced. Frequency of episodes of fainting and involuntary movements reduced and at the end of 2 week of treatment, he was symptom free and almost attained his premorbid status.

Patient is under regular follow up. There have been no episodes of pseudo seizures or significant behavioral abnormalities so far and patient is going to work regularly. He is still continuing valproic acid which we plan to taper.

DISCUSSION

Our patient was an adolescent who presented with conversion symptoms which was elicitable with suggestion. He went on to develop manic episode after receiving antidepressants. Our patient switched over to mania with antidepressants which suggests bipolarity as evidence is now compelling that mania or hypomania in association with antidepressant treatment requires the presence of a bipolar diathesis.⁹

Dissociative symptoms and dissociative disorders in children are being increasingly described in child psychiatry literature. Even in the absence of a syndromal diagnosis, dissociative symptoms may occur in a number of juvenile psychiatric conditions with bipolar disorder being one of them.⁶

As pseudo seizures occurred only during the episodes of mood change, and not during periods of remission, it can be more seen as a presenting symptomatology, than a co morbidity.

References:

1. Carlson GA, Meyer SE: Diagnosis of bipolar disorder across the lifespan: complexities and developmental issues. *Dev Psychopathology* 2006; 18:939–969
2. Sadock BJ, Sadock VA, editors. , eds. synopsis of psychiatry. 10th edn: Philadelphia Lippincott Williams Wilkins, 2007: 1266-9
3. Sadock BJ, Sadock VA, editors. , eds. Comprehensive Textbook of Psychiatry, 9th edn : Philadelphia ,Lippincott Williams Wilkins, 2009: 3663–9.
4. Souminen K, Mantere O, Valtonen H, et al. Early age at onset of bipolar disorder is associated with more severe clinical features but delayed treatment seeking. *Bipolar Disorder* 2008; 10: 56. [PubMed]
5. Oedegaard KJ, Neckelmann FB, Benazzi F, et al. Dissociative experiences differentiate bipolar-II from unipolar depressed patients: The mediating role of cyclothymia and the Type A behaviour speed and impatience subscale. *J Affect Disorder* 2008; 108: 207–16
6. Wyllie, Elaine, Glazer, John, Benbadis, Selim, Kotagal, Prakash, Wolgamuth, Barbara A. Psychiatric Features of Children and Adolescents With Pseudoseizures. *Archives of Pediatrics & Adolescent Medicine* March 1999; 153(3): 244–248. [PubMed]
7. Unusual presentation of more common disease/injury-Conversion (dissociative) symptoms as a presenting feature in early onset bipolar disorder: a case series Malay Kumar Ghosal et al, *BMJ Case Rep.* 2009; 2009: bcr01.2009.1448.
8. Hanstock TL. Bipolar affective disorder and dissociation. A potentially lethal combination. *Clinical Case Studies* 2007; 6: 131–42.
9. Hagop S Akiskal. The emergence of the bipolar spectrum: validation along clinical-epidemiologic and familial-genetic lines. *Psychopharmacol Bull* 2007; 40: 99– 115. [PubMed]