



## CHILDHOOD MANIA WITH ATYPICAL CLINICAL PRESENTATION

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**Abstract :** In the past decade, interest in and research on pediatric bipolar disorder (BD) has increased substantially. Prevalence rates of the disorder have doubled in outpatient settings, while twice as many research articles on pediatric BD were published in the past five years as in the prior decade. Assessment of BD presents numerous challenges, such as a fluctuating presentation, complicated diagnostic criteria, and high rates of co morbidity. Here, we are reporting a case of a 7 year old male child who presented with mania with psychotic symptoms.

**Keyword :** Bipolar disorder, mania, psychotic, suicidal.

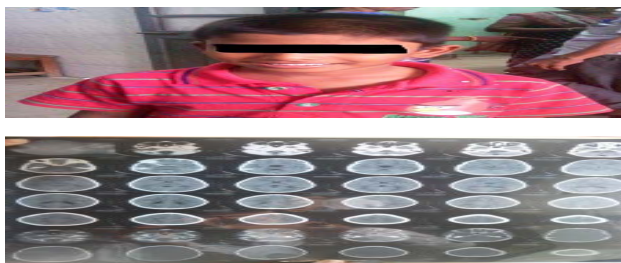
### INTRODUCTION :

Bipolar disorders are common, recurrent, frequently debilitating, and in many instances tragically fatal illnesses, characterized by oscillations in mood, energy and ability to function (Ketter 2010) [1]. Recognition of manic depression in child and adolescent psychiatry began with the dissemination of Kraepelin's monograph *Manic Depressive Insanity and Paranoia after 1921* [2]. Child psychiatrists searched for the same condition in their patients but found mostly adolescent depression which was highly familial. Mania was very rare, even in teens. Brief attempts to broaden the concept of manic depression for younger children were discouraged by literature review conducted by Anthony and Scott in 1960 that used very stringent criteria to identify manic depression in youth [2]. The tension between restricting the diagnosis to classical presentations versus altering the criteria to fit children continues to the present [5]. Paediatric patient may present with disruptive behaviour disorders that may have considerable symptom overlap with bipolar disorders [1] [5]. According to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* Manic episode include a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal directed activity or energy accompanied by at least three additional symptoms (four if the mood is only irritable) including inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased goal directed activity or psychomotor agitation, excessive involvement in activities that have high potential for painful consequences. To meet full criteria for mania symptoms must last at least 1 week. Episodes of depression must last at least 2 weeks and include five (or more) of the following symptoms of which at least one of the symptoms is either depressed mood or loss of interest or

pleasure and other symptoms include significant weight loss, insomnia or hypersomnia nearly every day, psychomotor agitation or retardation nearly every day, fatigue or loss of energy nearly every day, feeling of worthlessness nearly every day, diminished ability to think or concentrate and recurrent thoughts of death or recurrent suicidal ideation without a specific plan or suicide attempt or specific plan for committing suicide [3].

### CASE – REPORT :

Master A, 7 years old boy was brought by his grandmother to our tertiary care centre with complaints of talking and laughing to self, irrelevant talk, making boastful claims, seeing images of ghosts, abusing elders and sleep disturbance for the past 5 months. 5 months ago, his grandmother noticed him to be preoccupied and often talking to himself. When asked, he had said that there is a hidden treasure beneath the house and he has the power to unearth it. He also claimed that he could drive a car. He also started talking disrespectfully to elders and pacing around the house. The boy also exhibited odd behaviours like throwing his food on the ground, picking it up and then eating it. One day he threatened to jump from the top floor of his school building. He rarely slept and was found talking to himself throughout the day. The child is from rural background, his mother passed away when he was 13 days old. His father remarried and maternal grandmother is his primary caregiver. Mother's antenatal period was uneventful. His developmental milestones were normal. He is currently studying 2nd grade in a government school. There was no family history of any mental illness or suicide. No past history of jaundice, seizures or loss of consciousness. Child was temperamentally difficult. On examination, child was found to be hyperactive, pacing inside the room, fidgety while sitting on the chair. He had spontaneous talk and repeatedly asked whether he would get admitted today. He was over familiar with the interviewer and expressed his wish to unearth the treasure beneath his house. He said that he saw images of 4 to 5 unknown males in black cloth but could not elaborate on it. His mood was irritable, attention span was decreased. He was administered Young Mania Rating Scale (YMRS) and Positive and Negative Symptom Scale (PANSS). He had scored 32 on YMRS, on PANSS positive symptoms 23, negative symptoms 15 and general psychopathology 46. As the child was highly distractible Intelligence assessment could not be done. Child was diagnosed as Severe Mood Dysregulation Disorder and started on treatment



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with Tablet Olanzapine 5mg at night, Tablet Sodium Valproate 600mg in three divided doses and Tablet Clonazepam 0.5mg at night. Two weeks after follow up, the child showed reduced irritability, his sleep improved and his talkativeness reduced. His scores on YMRS were 14, PANSS scores were 11, 8 and 25. Intelligence assessment was done using Binet Kamat Test and IQ was found to be 92 which is average Intelligence. Child was advised regular follow up for treatment.

CT SCAN BRAIN of MASTER A was reported as Normal

#### **DISCUSSION :**

According to McClellan and colleagues, "outburst of mood lability, irritability, reckless behavior and aggression," which have come to represent the model presentation of very early onset bipolar disorder in the community, may represent a subtype of bipolar disorder or may characterize mood dysregulation that has no particular diagnostic specificity [1]. Leibenluft's group at the National Institute of Mental Health (NIMH) is attempting to explore the question of bipolar subtypes and distinguish between *narrow phenotype bipolar disorder* and a broad bipolar phenotype that they term *severe mood dysregulation* (SMD). SMD describes children exhibiting chronic irritability with extreme reactivity to negative stimuli and symptoms of hyperarousal. Children and adolescents meeting criteria for bipolar disorder nearly always present with co-occurring conditions. Symptoms of mania may overlap with those of concurrent Attention Deficit Hyperactivity Disorder (ADHD) and oppositional defiant/conduct disorder, depression and anxiety of which ADHD is the most common comorbid diagnosis among children with bipolar disorder.

#### **CONCLUSION :**

Elevated rates of bipolar disorder have been found among relatives of children with narrow phenotype bipolar disorder as compared to adult onset cases. On the other hand there does not appear to be an increased risk for bipolar disorder/severe mood dysregulation, suggesting that broad and narrow bipolar disorder may be etiologically distinct. Elevated rates of affective disorder (mainly depression), anxiety and behavioral disorders (especially ADHD) are consistently reported among offspring of parents with bipolar disorder and are considerably higher than rates of bipolar I disorder [4]. Pharmacological treatments have generally addressed "mania". Risperidone was recently approved for treatment of acute mania down to the age of 10 years. Use of more than one medication has increasingly become acceptable for treating mania/bipolar disorder in both adults and young people [4]. Treatment of bipolar depression in young people has received little attention, however Lithium monotherapy have been found to be effective. Psychosocial treatment include multifamily and individual family psychoeducation, family focused therapy, child and family focused cognitive behavior therapy (CBT) and collaborative problem solving.

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