CLASSIC ULTRA - RAPID CYCLER BIPOLAR DISORDER: A CASE REPORT

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ABSTRACT

A 44 year old man presented with classical pattern of bipolar disorder with a fortnightly cycle of mania and depression for last many years. The patient was not responding to chronic lithium therapy but responded to a combination of carbamazepine and nifedipine.

Key Words: Bipolar disorder, rapid cycler, lithium, carbamazepine, nifedipine

Rapid cycling has been defined by Dunner and Fieve (1994) as four or more episodes of mood disorder per year and represent about 15-20% of bipolar patients. The same has been revalidated by Bauer et al. (1994). American Psychiatric Association in DSM IV (1994) has also included rapid cycling as a course specifier for Bipolar I and Bipolar II disorder, the essential feature of rapid cycling being the occurrence of four or more mood episodes during the previous 12 months. These mood episodes may be of mania, hypomania or major depression. 70 to 90% of rapid cyclers are women. Ultra rapid and ultradian mood alterations are also increasingly being recognised which are lithium resistant (Kramlinger & Post, 1996).

CASE REPORT

A 44 years old male reported to the psychiatry outpatient about one year back with the classical symptoms of mania alternating with depression, 7 days each, for the last 10 years. He has been taking inadequate dose of lithium carbonate for the same duration. During the depressive phase there was marked psychomotor retardation and sadness of mood. On closer communication he told that he had multiple obsessions while depressed. The obsessions were mainly of counting and washing. After a week of depression he would spontaneously switch into manic phase. During this phase he would be dysphoric and had irritable mood. He would often quarrel with his wife and neighbours and colleagues at place of work. In manic phase mild degree of BP elevation used to be noticed. He fulfilled the criteria for bipolar disorder type I with rapid cycling. There was no family history of mental illness in first degree relatives and he was not used to any drugs of dependence. In the first phase of treatment initially adequate dose of lithium (1200 mg/day) were instituted along with clomipramine (150 mg/day) but this did not help much except he would have control over his obsessions. Addition of haloperidol for control of mania along with lithium would make him too much depressed and lethargic therefore haloperidol had to be discontinued. In the second phase of treatment EEG and thyroid functions were assessed and were found to be normal. He was instituted on carbamazepine 800 mg/day and lithium 1200 mg/day but this also did not help in preventing the depressive phase although manic phases were controlled. After that lithium was discontinued and patient was put on a combination of carbamazepine 800 mg/day and nifedipine
30 mg/day. After four weeks of treatment the patient was stable and is reported to be stable since then for the last nine months.

DISCUSSION

There are numerous reports in the literature about rapid cycling about bipolar patients in which lithium and antidepressant drugs (TCAs and MAOIs) are reported to induce rapid cycling (Wehr and Goodwin, 1979). Rapid cycling has also been seen in head injury, mental retardation, multiple sclerosis and due to oestrogens in women. The present case also is associated with chronic lithium therapy. But there are certain other features in this patient which need to be highlighted.

There is spontaneous, classic switching from one phase to other without any period of euthymia in between. This has been described in literature as spontaneous classic, rapid cycling (Cowdrey et al., 1983; Patkar et al., 1990). There is weekly regularity of mood alteration which could be explained as a manifestation of seizure disorder whereby bipolar illness is based on an animal model known as kindling (repeated subthreshold stimuli in summation ultimately leading to development of seizure activity) (Albright & Burnham, 1980).

Another feature in this case is lithium non response. 4 controlled and 10 uncontrolled studies have reported antimanic response of lithium to be 80%. Rapid cyclers are notoriously unlikely to respond to lithium monotherapy (Post et al., 1997). Calabrese and Woyshille (1995) reported that lithium nonresponders are those with mixed states and variants of rapid cycling e.g. ultra rapid and ultradian mood alterations which are increasingly being recognised (Kramlinger & Post, 1996). Frye and Altshuler (1997) report that rapid cycling, dysphoric mania and negative family history of mood disorders are predictors of poor response to lithium and predictors of good response to carbamazepine and valproic acid. However for carbamazepine most recently it has been reported to be better for prophylaxis in non rapid cyclers than rapid cyclers (Post et al., 1997). Frye and Altshuler (1997) also report that many of rapid cyclers may respond to dihydropyridine Ca. channel blockers e.g. nifedipine, nimodipine and isradipine.

In the present case there is no response to combination of lithium and carbamazepine but ultimately patient responded to a combination of carbamazepine and nifedipine. We therefore observe that there might be existing a subgroup of rapid cycling bipolar patients which are hereto called as ultra rapid cyclers. May be that they deserve a separate nosological status and further work needs to be done in this regard. These ultra rapid cyclers are characterized by frequent dysphoric mania, obsessional depression, negative family history, poor response to lithium and good response to a combination of carbamazepine and calcium channel blockers. An early identification of such cases may be helpful in preventing psychiatric morbidity and mortality in the long run.

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