Is Chronic Mania a Distinct Clinical Entity?

Sirs,

Sometimes, chronic mania poses a great diagnostic and management challenge in day to day clinical practice. Chronic mania is defined as presence of manic symptoms for more than two years without remission.[1] Clinician face difficulty in such patients in differential diagnosis from clinical conditions like cyclothymia, bipolar disorder (mixed), and borderline personality disorder.

Due to this overlapping of clinical manifestations, diagnosis of chronic mania is difficult to make in these patients. Here the authors present a case of a young woman with a persistent mood disorder.

A 35-year old female presented to our clinic with features of irritability, hostile feelings, marked reactivity, increased psychomotor activity with decreased sleep and appetite for the last 21 years. She had poor interpersonal relations with her close family members. Over trivial issues, she used to become irritable and suspicious and thus not allow her husband to go out of home. Patient developed dysphoric mood, delusions of infidelity, distortion of reality but had no perceptual disturbances. Her husband developed negative feelings against her and developed suicidal wishes. Her family members visited many medical practitioners and mental health professionals. She was given antipsychotics, ECTs, antidepressants, and anxiolytics but response with medications was variable. Her husband and family members were distressed with her clinical condition and her husband on one occasion left her home.

During their visit to our clinic, patient’s detailed examination and investigations ruled out any organic etiology for the symptoms. There was no past or family history of any medical or psychiatric illness. She was primarily diagnosed as chronic mania and was subsequently started on lithium carbonate 800 mg/day and sodium valproate 1500 mg/day. She recovered well with treatment. She has been followed up in OPD for the last six months and has been maintained well on lithium carbonate 450 mg/day. Her other medication sodium valproate was tapered off and stopped over a period of two months after remission.

Renewed interest has been generated in clinical entity chronic mania in the last decade of third new millennium.[2-4] Even with current therapies a significant number of patients with persistent mood disorder particularly chronic mania have a poor outcome. This clinical entity of chronic mania deserves a better attention of health professionals. In the above case report, patient was prescribed many medications in the past but she did not improve. No mood stabilizer was prescribed in last so many years and patient was treated on the line of major depression, agitated depression, personality disorder. In the past, patient received a misdiagnosis and subsequent poor management of psychotic symptoms. More research work on persistent mood disorders especially chronic mania is suggested to better understand the phenomenology of this subgroup of patients.

In a recent European cohort study (EMBLEM), 15% of patients fulfilled criteria for chronic mania and this clinical entity was associated with lower severity of mania symptoms, less socially active and greater occupational impairment in such patients.[4] Khanna et al.[5] found that in India chronic and recurrent manic pattern is more prevalent than the typical bipolarity. Our case highlights that primary persistent mood disorders like chronic mania can occur at young age and should be managed with mood stabilizers. It has a definite place as a separate clinical entity.

Gurvinder Pal Singh, K. C. Jindal
Department of Psychiatry, G.G.S. Medical College and Hospital, Faridkot, Punjab, India

Address for correspondence: Dr. Gurvinder Pal Singh, H. No. 76, Medical Campus, Sadiq Road, G.G.S. Medical College and Hospital, Faridkot, Punjab - 151 203, India.
E-mail: gpsluthra@gmail.com

REFERENCES

1. Perugi G, Akiskal HS, Rossi L, Paiano A, Quilici C, Madaro D, et al. Chronic mania. Family history, prior course, clinical picture and social consequences. Br J Psychiatry 1998;173:5148.
2. Malhi GS, Mitchell PB, Parker GB. Rediscovering chronic mania. Acta Psychiatr Scand 2001;104:153-6.
3. Mendhelkar DN, Srivastav PK, Jiloha RC, Awana S. Chronic but not resistant mania: A case report. Acta Psychiatr Scand 2004;109:147-9.

4. Van Riel WG, Vieta E, Martinez-Aran A, Haro JM, Bertsch J, Reed C, et al. Chronic mania revisited: Factors associated with treatment non-response during prospective follow-up of a large European cohort (EMBLEM). World J Biol Psychiatry 2008;9:313-20.

5. Khanna R, Gupta N, Shanker S. Course of bipolar disorder in eastern India. J Affect Disord 1992;24:35-41.

Sir,

In addition to selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT), alternative monotherapies, augmentation strategies and biological therapies have shown results in individual cases of treatment resistant obsessive compulsive disorder (OCD), but no conclusive evidence has been found in placebo-controlled trials.

Severe neurological symptoms have been reported after sudden discontinuation of SSRI.

Currently there are insufficient data and inconsistent results about use of repetitive transcranial magnetic stimulation (rTMS) in OCD.

Transcranial magnetic stimulation (TMS) is a noninvasive technique that delivers magnetic pulses to the cortex by means of a stimulating coil applied directly to the head. One-single pulse produces an intense magnetic field that causes depolarization of lower neurons. Its use has been widely studied with depression and lately been approved for use. Several studies have been published that it has promising role in treatment of treatment resistant OCD.

We report a therapeutic effect of extended rTMS to a case of treatment resistant OCD who responded poorly to various combinations of pharmacological and cognitive behavioral therapies and in the course, developed persistent and intractable symptoms of sudden SSRI discontinuation.

Ms. L.D., a 52-year-old woman, was on regular treatment for 25 years for her incapacitating ego-dystonic obsessions of causing harm to children in the family by throwing them. There were intermittent depressive symptoms but always secondary to her obsessive thoughts. She never met any other diagnoses according to DSM-IV-TR.

L.D. received subsequent adequate trials of clomipramine, imipramine, trazodone, and citalopram augmented with CBT. None of therapy proved effective for her. Her last treatment regimen consisted of citalopram 80 mg/day, clomipramine 150 mg/day, buspirone 30 mg/day, lithium 300 mg/day and clonazepam 2 mg/day, which was augmented by subsequent adequate trial of CBT and then Electroconvulsive therapy without any success.

Patient changed her psychiatrist without disclosing her past treatment history. Due to sudden discontinuation of her treatment, she developed withdrawal symptoms of gait disturbance, tremors, rigidity, and a generalized tonic-clonic seizure. Radio-imaging and neurologist opinion suggested no neurological abnormalities. Upon discharge from the medical facility, symptom of gait disturbance persisted. The patient worsened in terms of her obsessive symptoms (Yale-Brown obsessive compulsive scale score (Y-BOCS) = 32).

Sertraline 200 mg/day was given as monotherapy for 6 weeks with no change in score and then rTMS (right dorso-lateral prefrontal cortex at intensity 100% of motor threshold) therapy added as an augmenting agent after patient consented for the same. She was given first 30 sessions over 6 weeks with Monday to Friday schedule and reported significant improvement in her obsessions (Y-BOCS=15) as well as gait problem. She was given next 30 treatment sessions once per week rTMS and on completing total 60 sessions, Y-BOCS score was 5 and patient had no problem with her gait. She was able to move on plain surface as well as on stairs without any assistance. The improvement has