First-rank symptoms in Bipolar disorder: A case report

Despite their description as characteristic symptoms of schizophrenia, first-rank symptoms (FRS) are also seen in other conditions.[1] The prevalence of FRS was 70% in schizophrenia, 29% in psychotic bipolar disorder, and 18% in psychotic depression.[2] Manic hyperactivity may at times be confused with psychotic agitation and excitement. Amidst debate on the diagnostic utility of FRS, they continue to be relevant from prognostication and treatment planning point of view.[3] The presence of FRS in bipolar affective disorder (BPAD) may be predictor of poor short-term outcome and decompensating the course of illness.[4] BPAD patients with mania or mixed episodes are more likely to be females. Younger patients had a higher prevalence of FRS.[5] The presence of FRS in psychiatric illness is associated with poor long-term residential status and poorer psychosocial functioning.[6] We present a case of bipolar affective disorder who at presentation had florid psychotic symptoms with FRS.

A 19-year-old female, BA LLB student, with no family history of psychiatric illness, premeditated stable extrovert with past history of an insidious onset gradually progressive persistent and pervasive depressed mood, loss of interest and enjoyment, reduced concentration and attention, reduced self-esteem and self-confidence, disturbed sleep and diminished appetite in September 2019 remitted gradually without treatment over 3–4 months. She manifested in November 2020 with acute onset and progressive elevated and expansive mood, increased physical restlessness, and over-talkativeness. She was suspicious as she was unable to upload video on Instagram and believed that unknown people are jealous of her celebrity status and has hacking her mobile and network. General physical and systemic examinations were within normal limits. Mental status examination revealed her to be well-groomed, wearing colorful clothes with matching mask, and nail polish. She entered the chamber without seeking permission with air of confidence around her. She briskly shook the hand with examiner and sat on chair without asking as if in casual conversation. She was suspicious that the wall clock had monitoring device and there was someone behind the curtain. She was easily distractible by people entering the room. She was over-familiar, jocular, distractible, and had increased motor activity. She had elated affect, flight of ideas, delusion of grandiosity and persecution, intermittent auditory hallucination giving a running commentary on her action, ill sustained concentration, impaired judgment and insight, and decreased need for sleep and increased energy. Her hematological, biochemical parameters (including thyroid profile), and NCCT head were within normal limits. Young Mania Rating Scale score was 32/60, suggestive of moderate mania. Rorschach psychodiagnostic test revealed an increased number of responses, decreased initial and total reaction time, high number of color, sexual, and movement responses. New and additional responses in inquiry were suggestive of mania. She was provisionally diagnosed as a case of bipolar affective disorder, current episode manic with psychotic symptoms. She was started on tablet risperidone 2 mg/day and tablet lithium 900 mg/day. Psychoeducation about the illness and relapse prevention was taught to which she responded well.

Schizophrenia is often difficult to diagnose, and it is important not to give a label of Schizophrenia to those who do not suffer from it.[7] In the index case, there was a diagnostic dilemma in view of the initial presentation with widespread persecutory delusions obscuring the disturbance of affect. The presence of FRS further complicated the clinical picture. However, history suggestive of a depressive episode which remitted without medications over 4 months compelled us to consider a diagnosis of BPAD with psychotic symptoms as more likely. She responded well to antipsychotic and mood stabilizer and supportive psychotherapy with improvement in mood, social and academic functioning. The index case underscores the importance of being aware of overlapping nature of symptoms in various psychiatric disorders, the need for close serial monitoring of patients for evolution of new symptoms of changing psychopathology and the utility of Rorschach psychodiagnostic test in difficult cases.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the legal guardian has given his consent for images and other clinical information to be reported in the journal. The guardian understands that names and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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There are no conflicts of interest.

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