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Case Report

Mania in a Ten-Year-Old Child

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Abstract

Once thought rare in pre-adolescents, paediatric bipolar disorder is now increasingly diagnosed in children, including preschoolers. The drugs used to treat it include mood stabilizers and antipsychotics, which carry the risk of significant side effects. But still the controversies regarding the diagnosis and treatment issues are present resulting in misdiagnosis and management of the child. Here forth is presented a case of bipolar affective disorder first episode mania in a ten-year-old boy (German J Psychiatry 2012; 15 (2): 63-65).

Keywords: Bipolar disorder, mania, children

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Introduction

In the past decade, interest in and research on paediatric bipolar disorder (BD) has increased substantially. Prevalence rates of the disorder have doubled in outpatient settings, while twice as many research articles on paediatric BD were published in the past five years as in the prior decade (Leibenluft & Rich, 2008).Those who are not alarmed by the increase suggest that in the past, clinicians missed cases of BD because they did not understand that it can affect children and because BD symptoms can look different in children and adults. A manic episode consists of a distinct period of persistently elevated, expansive or irritable mood lasting for more than one week or more than 4 days for hypomanic episode and the presence of neurovegetative symptoms such as grandiose thinking or inflated self-esteem, decreased need for sleep, pressured speech or increased verbalizations, racing thoughts or flight of ideas, distractibility, increase in goal-directed activities or ideation and helplessness, which seems to be equally likely at any age according to DSM-IV. Here we are reporting a 10 year old boy with features of bipolar disorder first episode mania.

Case History

A 10 year old boy of 6th class from rural Haryana was brought to psychiatry outpatient clinic of Postgraduate Institute of Medical Sciences, Rohtak, Haryana, India with symptoms of sleep disturbances, running away from school, increased talkativeness and talks of big things for the past 20 days. He would refuse to go to school or to do school homework. He would run away from school or would not listen to teachers and even make fun of other students. He would talk more and keep roaming in the house as well as outside. Sometimes he would even go out without informing anyone at home. He would not be able to sit at one place and keep shifting positions or moving things of house from here to there. He started saying that he has been given special powers by God through which he can do anything. He would say "I am a rich man, I have lots of money". Only when family members contradicted him he would get aggressive and abusive and even hit them. He would specially get angry towards his family members saying they did not believe in what he was saying. He would order family members

to bring new clothes and eatables for him. He would get angry on trivial things when spoken to but otherwise he would keep talking about his grandiose powers and his ability. He would sleep for two to three hours at night and would keep roaming or waking everyone rest of the night. Throughout the illness patient's mood used to remain irritable. He did not manifest hallucinations or thought alienation, thought broadcasting, passivity or depersonalization. He had no inappropriate or precocious sexual behaviour. There was no history of delinquent behaviour, bed-wetting, sleep talking, seizure, substance abuse and head trauma. Birth and development were normal with no significant past history. Significant family history was reported as patient's mother as well as grandfather was reported to have bipolar affective disorder. Prior to the onset of illness, he was a quiet boy, shy, responsible and would listen to family members. He would go to his school regularly and was average in studies.

General physical examination was within normal limits. Mental state examination revealed an average built boy, uncooperative, increased psychomotor activity with decrease reaction time, easily distractible as he was not able to sit at one place and all through the interview he kept on changing postures or trying to go from the room and when made to sit he would get angry, spontaneous speech, inflated self-esteem and delusion of grandiosity. He was found to be irritable throughout the interview.

The neurological examination, routine laboratory test, thyroid, visual examination and CT scan head were normal. He was submitted for psychometric investigation with the Binet-Kamat test of mental ability, the Wechsler Intelligence Scale for Children, and the Rorschach inkblot test. There were no schizophrenic indicators in the inkblot test. His IQ was 92, with average intelligence. Based on the clinical and psychometric assessment, a diagnosis of paediatric bipolar disorder (PBD) was made. Patient was started on olanzapine 5 mg and later increased to 7.5 mg with significant improvement.

Discussion

Debates about diagnosis of BD in children can be traced back to the 1950s(Carlson & Glovinsky, 2009) due to presentation, especially in younger children which can vary from the classic description of bipolar disorder in adults. In mid-1990s, Biederman et al. (2004) and Geller et al. (2010) re-described the syndrome of mania in children. As a result, children who exhibit, in the case of Geller et al. (2000) primarily rapidly cycling elevated/expansive and/or grandiose mood, or in the case of Biederman et al. (2004), primarily chronic irritable mood, have received a diagnosis of BD. Younger persons can have difficulty in noticing and describing symptoms and providing accurate accounts of time of onset and duration of symptoms (although children always have a secondary informant). Further, given how rapidly children's brains develop, even practitioners can and do disagree about whether a given behaviour or mood is developmentally appropriate or a symptom of disorder. Moreover, identifying symptoms and making a diagnosis can be harder in children than in adults. Primarily two reasons are identified for difficulty to diagnose in children. Psychiatric disorders are predictable clusters of emotional, behavioural and sometimes somatic symptoms that cause impairment and emerge on a spectrum. Bright lines do not separate individuals whose emotions and behaviours are not disordered enough to receive a BD diagnosis. Second, because different diagnoses, some of which are themselves contested (e.g., conduct disorder, oppositional defiant disorder, pervasive developmental disorder, attention-deficit/hyperactivity disorder and PBD) can share some of the same symptoms, deciding which diagnostic label(s) to apply to a particular patient can be challenging (Parens & Johnston, 2010).

Adolescent presentation may be bizarre, mood incongruent and/or paranoid. Schneiderian first-rank symptoms occur in 20% of cases, early-onset bipolar disorder may be missed in 50% (James & Javaloyes, 2001; Giedd 2000). Mania in children is seldom characterized by euphoric mood. Rather, the most common mood disturbance in manic children is severe irritability, with "affective storms" or prolonged and aggressive temper outbursts (Davis 1979). The type of irritability observed in manic children is very severe, persistent, and often violent (Wozniak et al., 1995).

The incidence and prevalence of the disorder and the associated comorbidities vary according to study setting and criteria used. The overall rate of bipolar disorder was 1.8% (95% CI, 1.1%–3.0%). There was no significant difference in the mean rates between US and non-US studies, but the US studies had a wider range of rates (Anna et al., 2011). One community study showed a lifetime prevalence of bipolar disorder of 1% in youths aged 14 to 18 years, using the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Mani et al., 2005). However, Brotman et al. (2006) found the lifetime prevalence of severe mood dysregulation to be 3.3% in children aged 9 to 19 years from an epidemiological study sample. These findings indicate that a high percentage of the population may experience symptoms consistent with the broad phenotype of PBDbut it remains unclear, how symptoms in childhood relate to adult-onset bipolar disorder, as well as whether there is continuity between the childhood-onset presentation and the more classic presentation of adult bipolar disorder.

Twin and family studies report that the disorder has 59–87% heritability, and first-degree relatives of probands with BD are at very high risk of BD (Smoller & Finn, 2003).Concordance rates among identical twins average 57%, and among dizygotic twins, 14% (Alda 1997). Averaging across studies, and using the narrow DSM-IV criteria for bipolar I or II disorder, the morbid risk of major affective disorder to first degree relatives if an individual has bipolar disorder is about 23% (about 9% bipolar and 14% major depressive disorder) (Smoller & Finn, 2003).Familial rates are higher when one includes the spectrum conditions. Notably, the risk of bipolar spectrum disorders in the offspring of parents with BD I or II disorder ranges from 14% to 50% across studies, and the risk of major depressive disorder ranges from 7% to 43% (Chang et al., 2003).

The psychopharmacological interventions for childhood mania include lithium, valproate and/or atypical antipsychotics. All mood stabilizers and antipsychotic agents are commonly used for early-onset bipolar disorder in clinical set-

tings. There have been few prospective studies on the efficacy and safety of psychotropic medications in the treatment of paediatric BD. With one exception, i.e., lithium, no psychotropic medications have been approved for paediatric BD by the U.S. Food and Drug Administration. In the majority of the trials, rescue medications were needed in addition to the primary mood stabilizer to treat concomitant symptoms such as aggression, psychosis, and sleep disturbance. Retrospective chart reviews, although not rigorous in methodology, led to the observation that antidepressants may worsen or precipitate mania. Such switching to mania was not noted in psychotic depression, however (Mani et al., 2005).

Children with BD may be relatively uncommon in outpatient settings, but clinical experience suggests that they may account for a substantial number of child psychiatric hospitalizations and that they are plagued with chronic psychiatric and psychosocial disability (Kovacs & Pollock, 1995; West et al., 1995).

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