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Original Research Paper

Psychiatry

A CASE REPORT-ORGANIC MANIC

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ABSTRACT Manic Syndromes are generally a part of affective disorder in psychiatry, but can also be a part of neurological, metabolic or toxic origin. The clinician needs to distinguish idiopathic bipolar mania from the rest of organic disorders. The cardinal symptom of mania is an abnormally and persistently elevated, expansive or irritable mood with persistently raised goal directed activity. In patients with the first episode of mania, a thorough information about current symptoms, past, medical and addiction with decision of the appropriate laboratory and radiological investigations be made.[1]

KEYWORDS : subdural hematoma, secondary mania, organic mania, oldage

CASE VIGNETTE:

Mr. A is a 59 year old, male married, Muslim, resident of Gujarat was seen 7-8 months back in psychiatry outpatient department , with complains of hyperactivity, talkativeness, sleep impairment, anger irritability, hyper charitable behavior and psychotic features as self talking , gesturing, hearing of voices. His mental status examination showed pressure of speech, psychomotor agitation and irritable mood. The patient was started with low dose antipsychotics and benzodiazepine.

The patient was again reviewed for treatment for worsening after stopping his psychiatric medications for last 2 months. The relatives denied for complete recovery in the treatment period. His sleep had been disturbed with describe his need only 1-2 hours of rest all day. He would remain away from home all night, roam nearby alleys, and leave the doors of his house open at day. He would stare at open spaces, continue to speak in indecipherable words, and get angry if interrupted. He would easily get irritable, throw plates of food, push, strangle and even claw his wife at times. The patient was started treatment on outpatient basis but failed to improve leading to his admission.

His medical history showed history of percutaneous coronary intervention at right coronary artery after angiography 3 years back, with controlled hypertension and his regular medications included adequate doses of ant platelet, antihypertensive and statins regularly. He had no significant contributory past and family history of any psychiatric illness. He used to smoke tobacco since last 10 years, with 10-12 bidis per day. The relatives were not aware for any history of head trauma.

EXAMINATION:

The patient was vitally stable with pulse and blood pressure within normal ranges. The patient was well groomed with clear consciousness but raised psychomotor activity, attention difficult to hold, with euphoric mood, impaired judgement and no insight of his illness. There were significant hyper charitable thoughts for the society, but no grandiosity, suicidality or perceptual abnormality. Memory, intelligence, attention / concentration and abstract thinking were normal. The neurological examination was too unremarkable.

LABORATORY / RADIOLOGICAL INVESTIGATIONS:

The serum chemistry was within normal limits.
The chest X ray and ECG were unremarkable.

The patient was diagnosed as manic without psychotic features based on the history presented. Treatment was included as anti epileptic, antipsychotic and benzodiazepine. Being the first manic episode in his life, an MRI recording was suggested which presented with the changes showing chronic subdural hemorrhage noted involving bilateral fronto- parieto- temporal convexity measuring 10 mm on right side and 7.7 mm on left side. A referral was made to the neurosurgical department and started on a low tapered dosing of steroid for a fortnight with no operative management advice. The patient was discharged with mild improvement in manic symptoms with continuation of neuro surgical line of management.

DISCUSSION:

Bipolar mania is always considered a part of nonorganic Affective Disorders, with epidemiological studies suggesting a lifetime prevalence of around 1% for bipolar type I in the general population and seems to decrease with age. Only 10 % of all patients with bipolar disorder present with a first episode after the age of 50 [2,3]. A subdural hematoma presents with diagnostic difficulty especially in elderly population. A subdural hematoma usually precipitated after repeated anticoagulant use in elderly from atrophied parasagittal veins in elderly than young making them more predisposed to bleed[4] .The symptoms develop more gradually in elderly, which can come into notice at a later phase with symptoms of dementia, affective and psychotic disorders .[5]

PATHO PHYSIOLOGY :

Organic lesions associated with manic syndromes involve the areas of the brain that modulate neuro vegetative functions and emotion.[5] Right-sided lesions have been reported more frequently in patients with organic mania, but left-sided and diffuse lesions have also been reported.[6]Any focal or diffuse degenerative or irritative lesion in these areas could conceivably precipitate a manic episode.

DISTINCTION BETWEEN IDIOPATHIC AND SECONDARY MANIA

Idiopathic bipolar disorder should be diagnosed only after all organic causes have been ruled out with careful medical and neurological assessment made. Organic mania generally develops in patients who are older than 35 years of age.[7]Irritability and assaultive behavior were more common than euphoria in a group of patients with posttraumatic mania[7]. The family history of affective disorders is less common in organic mania in comparison with idiopathic mania.[6,7]

CONCLUSION:

1st manic episode in elderly should have extensive differential diagnosis and is rarely a first manifestation of Bipolar manic episode. Unless proven on the contrary after detailed evaluation, a first manic episode in elderly should always be considered a secondary mania. A preliminary screen should include (1) a careful history, including drug ingestion, medications, and recent infection, (2) neurological examination, looking especially for focal signs, (3) EEG, (4) skull x-ray films, CT or MRI , and (5) toxic screening. Any abnormality should be followed by more elaborate studies.[7] Pharmacological treatment of the acute condition is largely the same as for primary mania in elderly but with doses lower than for younger adults because slower metabolism and sensitivity to side effects[8]

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