First Onset Manic Episode in an 85 year Old Male: Whether Primary or Secondary Mania?

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Abstract

Significant scientific research has lead to greater understanding in areas of neurobiology, genetics, classification and treatment in bipolar disorder. However late onset Bipolar disorder, regarding "organic" risk factors and in areas of treatment, remains a less researched area. Whether late onset bipolar disorder is a distinct entity or an artificial boundary exists from bipolar disorder of adult onset is not clear yet. Vascular risk factors have been well studied and have attained etiological status for depressive disorders; the role of risk factors and possible etiological role for manic episodes and bipolar disorder remain unclear. A case of first episode mania at 85 years is presented in the background of vascular risk factors.

Keywords: Late onset bipolar disorder, Transient ischemic attack, vascular mania, vascular risk factors

Introduction

Bipolar Affective Disorder (BPAD) has been considered to be a condition mostly starting in late adolescence and early adulthood. The usual age of onset has been considered to be 18-22 years.1 However, it has been reported that late onset manic episodes contribute to seven percent of psychogeriatric hospitalizations in a five-year period.2 Although manic episodes in older adults are not rare, little-published data exist on late-life manic episodes. Resistance to treatment and concomitant neurological lesions are frequent correlates of elderly mania. The mean mood disorder onset age amongst older adults has been found to be around 50 years of age.2, 3 Late onset mood disorders, including mania, have been reported to be associated with vascular risk factors.4 The incidence of mania at age >75 years has been reported to be around only 2 per 100000 persons.5 We report the case of an 85-year old male who presented with the first manic episode and had vascular risk factors.

Case Report

The present case report is about 85 years male with vascular risk factors of Transient Ischemic Attacks presenting with a first manic episode. The patient was brought to psychiatry outpatient department with fifteen days history of irritable mood, increased goal-directed activity, increased self-esteem, aggressive behavior, decreased the need for sleep, and ideas of grandiose ability. The patient was admitted for detailed clinical and laboratory investigation along with clinical management of his condition. There was no history of recent substance abuse, head trauma, confusion, and memory impairment, impairment of cognitive function, recent fever, or recent CNS localizing sign. On further historical clarification history of two attacks of Transient ischemic attacks was found. Magnetic resonance imaging was done in both the episodes and no finding was recorded in either.
These two vascular events had occurred six years and two years before the psychiatric presentation. The patient was a diagnosed case of hypertension and was receiving Telmisarten 20 mg for past 6 years and the Blood Pressure was under control till the last recording done a day before psychiatric hospitalization. No family history of psychiatric disorder was found on detailed history taking.

On general physical examination, the current blood pressure was found to be 128/84 mm of Hg, and all other vital parameters were within normal limits. Detailed neurological and cognitive assessment was done and no abnormality was detected in the examination carried out. The mental status examination carried out serially revealed signs of increased grooming, increased psychomotor activity, increased rate, tone and volume of speech with reduced reaction time. The affect of the patient was found to be irritable along with increased self-esteem and ideas of grandiose ability were established on serial mental status examinations. His mini mental status examination revealed a score of 26 out of 30. He scored 21 out of 59 on Young’s Mania Rating Scale with high scores on items like elevated mood, speech, and content.

His detailed systemic examination, including neurological examination, was done and was found to be normal. His fundus examination was also normal. His investigations including complete blood counts, kidney function tests, liver function tests, blood sugar, serum electrolytes, thyroid function tests, serum vitamin B12, and serum folic acid were all normal. Magnetic resonance imaging of the brain was done, which showed non-specific ischemic changes in the bilateral peri trigonal region, periventricular ischemic changes, and age-related cortical atrophy.

Discussion

The index case presented to us with the first onset manic episode without psychotic symptoms at the age of 85 years. The current psychiatric disorder was present in the background of vascular risk factors of Transient Ischemic Attacks, Hypertension and MRI findings of non-specific ischemic changes in the bilateral peri trigonal region, periventricular ischemic changes. The clinical presentation was a typical manic episode, and no atypical features were found. Hence differentiation from usual manic episodes could not be done by clinical presentation. The above clinical interpretation is in keeping with the findings of previously done studies which have reported that clinical differentiation may not be possible in late onset manic episodes from usual presentations. The presence of vascular risk factors in our case presentation is also reflected in prior clinical research done in this area. Depression with underlying vascular pathology has been widely studied, and the correlation has been established, mania has been associated with stroke in a frequency of one case per 100 stroke admissions. As compared to vascular dementia and vascular depression the concept of vascular mania is still an under-recognized condition. It broadly encompasses a manic syndrome associated with evidence of cerebrovascular disease, including the history of stroke or transient ischemic attack, focal neurologic signs, radiological changes on neuroimaging, or cognitive deficits, although there is no universally accepted definition or criteria for diagnosing vascular mania.

Silent cerebral infarcts were found to be more frequent in older adults with late onset Bipolar Disorder than in older adults without Bipolar Disorder. However the pathogenic role of the vascular lesion could not be determined. Delayed onset of manic symptoms following silent cerebral infarctions is more common than acute onset immediately after a stroke. Late-onset mania is associated with greater vascular risk factors, making some authors hypothesize that late-onset mania may be a distinct subtype of mania. Late onset manic episodes have been considered to be a spectrum, which consists of it being a secondary disorder, as an expression of lower vulnerability to the disease, as the subform of pseudodementia, as the risk factor for developing dementia, or as Bipolar type VI. Klauthamer and Klerman gave the concept of secondary mania to describe a subform of Bipolar Disorder which is associated with a wide variety of organic factors involved in the development of the disorder. Lack of family predisposition and prior psychiatric history were considered to be defining characteristics of secondary mania. Neurological illness and most specifically cerebrovascular disorders were found to be twice as common in secondary mania than primary disorder.

To summarize, most findings in this case point towards the manic episode being secondary mania, but the MRI findings were non-specific, and it was hence difficult to differentiate between primary and secondary mania. However, this case highlights the fact that primary psychiatric illnesses can occur at a late age, should be investigated in detail given multiple medical and neurological etiologies and should be managed as they are being managed in young patients.
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References


