Case Report

Chronic Mania: An Underrecognized Clinical Entity

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ABSTRACT

Chronic mania (defined as the presence of manic symptoms for more than 2 years without remission) poses significant problems in diagnosis and management. Generally it denotes poor outcome, though contrary reports are available. We present a case of chronic mania and discuss the clinical features of chronic mania reported in the literature, which are useful in distinguishing chronic mania from acute mania.

Key words: *Bipolar disorder, chronic mania, course*

INTRODUCTION

Although chronic mania has been described in psychiatry literature for a century now,[1] it has not received the equivalent status as given to chronic depression by the current nosological systems.[2,3] One of the major limitations of this is the lack of systematic research on this entity.

In this report, we present a case of chronic mania and discuss the clinical features of chronic mania reported in the literature, which are helpful in distinguishing chronic mania from acute mania.

CASE REPORT

Mr A, 22-years-old, unemployed, and belonged to a nuclear family of lower socioeconomic status, presented with an insidious-onset illness of 5 years' duration, with a continuous course, characterized by dysphoric mood, grandiose ability, grandiose associations, grandiose identity, poor self-care, wandering, abusiveness, assultativeness, and aggressive behavior. He would claim that he is on a special mission of the army.

The patient had been using cannabis off and on for a few days, but use of or abstinence from cannabis did not have much influence on the nature of psychopathology. He also had a history of tobacco dependence syndrome since the age of 15 years. Over the period of 3 years, he frequently absconded from home; whenever found he would be in a disheveled state and when asked about his whereabouts, he would talk about his grandiose abilities, identity, and association and would say that he had been on his special mission of the army.

He was treated with some psychotropic medications after continuation of symptoms for a period of 3 years, with which family members perceived only 20% improvement in his psychopathology. Later, he was treated with tablets of olanzapine 20 mg/day, lithium 600 mg/day, and valproate 500 mg/day, and he showed a 25% improvement in his symptoms with the above combination. He had been kept in seclusion for few months before being brought to our center.

There was no family history of mental illness or any history of past episodes. Early developmental history did not reveal any abnormality, and there was no history

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of hyperthymic traits. There was no history suggestive of Schneider's first-rank symptoms, overfamiliarity, depressive features, head injury, and seizures.

On examination, he was found to have dysphoric mood and he expressed grandiose delusions of being a general in the army and ability to control people at remote areas. He also had secondary delusions that people are trying to harm him because of his special powers and abilities. His cognitive functions were preserved, but he lacked insight into his illness. With the available information, a diagnosis of chronic mania was considered.

His routine investigations and a computerized tomography scan of brain did not reveal any abnormality. He was managed with a course of 12 electroconvulsive therapy treatments along with olanzapine 30 mg and benzodiazepines. He showed only marginal improvement in his symptoms with the above combination. Following this, he was shifted to tablets of haloperidol 15 mg/day along with lithium 1050 mg/day (serum lithium level 0.7 meq/l). With this combination, over the period of 6 weeks, the patient showed improvement in his overall behavior, delusion of persecution subsided, but the grandiose delusions persisted. His family was asked to shift the patient to a long-stay mental health facility. However, his family decided to keep the patient at home. Over the period of next 1 year, he was continued on the combination of haloperidol 20 mg/day and lithium 1050 mg/day, during which he did not take up any work and continued to harbor the grandiose delusions and had elevated mood. However, he was better in the form of lack of abusiveness and running away behavior.

DISCUSSION

The current nosological systems define mania by a duration of 7 days,[2,3] and epidemiological studies suggest that untreated mania usually remits within 6 months, though in some cases it may last longer.[4] Classically, chronic mania has been defined as the presence of manic symptoms for more than 2 years without remission.[5] However, in recent years, other researchers have used different definitions such as lack of improvement by at least two points from baseline on the Clinical Global Impression-Bipolar Disorder Mania scale[6] at any observation during the 12 months after starting treatment for acute mania.[7] However in literature, chronic mania lasting for about 48 years has also been described.[8]

Studies that have evaluated patients with bipolar disorders have reported an incidence of 6–15% for chronic mania among all the patients with bipolar disorders.[4,5,7,9,10] With regard to symptomatology and associated clinical features, one of the recent studies that compared patients of acute mania and chronic mania suggested that chronic course usually arises in the background of hyperthymic temperament and recurrent mania, with a deteriorative pattern. Furthermore, the authors reported that compared to patients with acute mania, patients with chronic mania have significantly a high rate of almost constant euphoria, grandiose delusions, and related delusions and relatively low rates of sleep disturbance, psychomotor agitation, and hypersexuality. Another study suggested that compared with treatment responders, patients who do not respond and run a chronic course have a lower severity of mania symptoms at baseline but a higher prevalence of delusions/hallucinations, have a shorter duration of current episode prior to start of the treatment, are less socially active, and have a higher occupational impairment.[7]

However, despite the presence of clear diagnostic symptoms of mania, it is often difficult to diagnose a patient with chronic mania because of superimposed cyclothymic or hyperthymic temperament or overlap of symptoms between mania, schizophrenia, and schizoaffective disorders.[11] Some authors have propounded that 'chronicity' may include nonmanic symptomatology and even repeated manic episodes with interepisodic recovery.[5] In general, it is suggested that the grandiosity in chronic mania is associated with an elevated mood, compared to schizophrenia, in which patients exhibit grandiosity associated with the flat effect.[12]

With regard to management, it is generally suggested that chronicity denotes poor outcome; however, reports contrary to this belief also exist.[8,13]

The index case exhibited manic symptoms for 5 years prior to presentation to us, with minimum improvement with treatment. He has been under our care of about 1.5 years, with no change in the core manic symptoms despite good treatment compliance. This clinical picture fits with the clinical description of chronic mania and suggests that in rare patients, mania can run a chronic course.

In recent times, there have been a few reports of chronic mania from various other centers in India,[8,12,13] and this suggests that chronic mania does exist in clinic population and there is a need to study this clinical entity more meaningfully to understand its biological correlates and treatment outcome.

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