Very-late Onset Mania Episode: Case Report and Review of Cases Over 75 Years of Age

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ABSTRACT

Introduction: Bipolar I disorder typically characterized by cycles of depression and mania. Onset after the age of 75 years is very rare and the reported incidence of mania is 2/100000, which most often occur due to secondary organic aetiology. Here we are presenting a review and an interesting case of late-onset first episode mania while evaluating and excluding all other secondary causes of mania.

Case Report: 79-year-old male presented with 2 weeks' duration of illness and symptoms was suggestive of a manic episode. The patient was thoroughly assessed with laboratory investigations and non-contrast computerised tomography (NCCT) brain to find any secondary causes of mania but nothing was significant. Finally, as per tenth revision of the International Statistical Classification of Diseases (ICD-10) diagnosis of first episode Mania without psychotic symptoms (F30.1) was made. He was started on Valproate which was gradually increased up to 750 mg/day and olanzapine 5mg. After 6 weeks, the YMRS score decreased from 32 to 8 and he achieved his premorbid functioning level.

Conclusion: This case highlights that primary psychiatry illness can occur at any age but in the geriatric population before finalizing the diagnosis all other secondary causes should be ruled out. There is a high need for systematic research in this area to formulate effective management guidelines in the geriatric population.

Keywords: Bipolar Disorder; Late Age Of Onset; First Episode Mania; Secondary Mania

INTRODUCTION

Lifetime prevalence of Bipolar I disorder is 2.1% with age of onset between 20-40 years.[1] Onset of first manic/ hypomanic episode after 50 years of age without any significant previous history is considered as late onset mania.[2] After 75 years of age reported incidence of mania is 2/100000, which is very rare and serious concern in view of assessment, diagnosis and management perspective.[3] In Geriatric population, it's very challenging to rule out secondary causal factors before making a primary psychiatry diagnosis like first episode mania. We are presenting an interesting case of late-onset first episode mania while evaluating and excluding all other secondary causes of mania.

CASE REPORT

79-year-old married male having no significant past or family history of psychiatric or medical illness was brought by family members to the psychiatric outpatient clinic. He presented with a continuous progressive illness of 2 weeks' duration characterizing by decreased need for sleep, over-talkativeness, over-spending, over-grooming, increased libido, irritability and abusive behavior towards family members. There was no past or recent history suggestive of any stressor, high-risk sexual behavior or any substance/ drug use. The patient had no history of fever, head injury, seizure, loss of consciousness or any prolonged hospital admission for any kind of medical illness in the recent past. His premorbid personality was well adjusted, there were no complaints suggestive of memory problems in particular of remembering recent events, confusion or reduced concentration.

Mental state examination revealed increased psychomotor activity, coherent speech, increased speech rate and tone, exalted affect, overfamiliarity, grandiose ideas, and demanding behavior. Patient's Young Mania Rating Scale (YMRS) score was 32, Mini-Mental Status Examination (MMSE) score was 25/30 and insight was absent, otherwise patient was cooperative for the examination and assessment. Considering the late age of onset, a complete physical and systemic examination was conducted which was normal. To rule out possibility of secondary mania, detailed blood investigations in the form of complete blood counts, kidney function test, liver function test, blood sugar, serum electrolytes, thyroid function test, vitamin B-12, folate, viral markers (Hepatitis B, C and HIV) and non-contrast computerized tomography (NCCT) brain was done. All the biochemical investigations were normal and NCCT brain was suggestive of mild age-related cerebral atrophy. As systemic examination, blood investigations and neuroimaging didn't reveal any significant abnormality so as per ICD-10 diagnosis of first episode Mania without psychotic symptoms (F30.1) was made.

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Author	Age of onset (years)/Sex	Diagnosis	Investigations	MMSE	Management
Aggarwal A. et.al., 2010	75/Male	FEM (1 week)	CBC, LFT, KFT, Blood sugar, TFT, HIV ELISA, Serum B-12, MRI Brain, EEG	26/30	Divalproex and Olanzapine
Dhonju G et.al., 2014	78/Male	FEM with Psychotic symptoms (2 weeks)	CBC, LFT, KFT, Blood sugar, TFT, HIV ELISA, VDRL, Serum B-12, Calcium and Phosphorus, CT Brain (Age related cerebral atrophy and maxillary sinusitis)	Not assessed	Haloperidol
Muraleedharan M. et. al., 2017	88/Male	FEM (3 months)	CBC, LFT, KFT, Blood sugar, TFT, HIV ELISA, VDRL, Serum B-12, MRI Brain (Showed mild age related atrophy)	27/30	Olanzapine
* MMSE- Mini mental status examination, FEM- First episode mania, CBC- Complete blood counts, KFT- Kidney function tests, LFT- Liver function tests, TFT- Thyroid function tests, VDRL–Venereal Disease Research Laboratory, ELISA-Enzyme-linked immunosorbent assay, HIV–Human immunodeficiency virus, CT-Computed tomography, MRI- Magnetic resonance imaging					

Table-1: Review of case reports over 75 Years of Age (Total 3 reports)

The patient was started on 250 mg of sodium valproate twice a day and 5 mg of olanzapine. Subsequently over the next one-week patient started to gradually improve and at the end of two weeks, his YMRS score decreased to 22. In further follow-up visits, the daily dose of valproate was increased up to 750 mg/day, attaining a serum valproate level of 66 µg/ml with no adverse effects. At the end of 6 weeks, further YMRS score decreased to 8 and he almost achieved his premorbid functioning level.

DISCUSSION

Late-onset psychiatric disorders are most often secondary to an organic aetiology which could be metabolic or neurological. The index case as per ICD 10 guidelines fulfilled the criteria of the first episode of mania without psychotic symptoms (F30.1), as detailed assessment and investigations failed to establish any organic cause.

The prevalence rate of most psychiatric disorders is increasing in elderly population, but there is significant variation in incidence of bipolar disorder. The concept of secondary mania was first introduced by Krauthammer and Klerman.[4] They suggested that unlike primary mania, secondary mania might be characterized by late onset and negative family history arising secondary to precipitants, such as drugs, infections, metabolic disturbances, neoplasm, epilepsy, infections, and toxins. A comprehensive review suggests the average age of late onset mania 56 years, this also highlights association between late-onset bipolar disorder with neurologic illness and white matter hyper intensities (WMH).[5] An onset over the age of 75 years could thus serve as a case with very-late onset mania.

After conducting a thorough literature review on the Medline, PubMed and Google Scholar databases using combinations of the keywords "Late onset mania" "very late onset mania" and "First Episode Mania". We included English-language reports and excluded all cases with secondary cause and past history of depressive/manic episode. Finally, we have only 3 case reports with primary psychiatric diagnosis of first episode mania with age of onset at 75, 78 and 88 years as illustrated in Table 1.[6,7,8] The current case and previous similar case reports highlight the importance of recognizing late-onset primary psychiatric diagnosis. Since majority of late onset psychiatric disorders are secondary to comorbidity so in elderly before making final diagnosis clinician should emphasize on ruling out possible secondary causes like vascular mania, multiple sclerosis, Parkinson's disease, temporal lobe epilepsy, acquired immunodeficiency syndrome (AIDS), dementia, and traumatic brain injury.[9] As geriatric population is more likely to experience adverse effects, so clinician should be more vigilant during assessment, diagnosis and making management plans.[4] This compel the researchers to make separate guidelines for management of psychiatric illness in geriatric patients, because adult treatment guidelines cannot be directly extrapolated to the older age groups.

CONCLUSION

This case highlights that primary psychiatry illness can occur at any age of lifespan specifically extreme older age. Although it is rare in the current scenario but as geriatric population is increasing so before finalizing the diagnosis all other secondary causes should be ruled out. It also necessitates the need for systematic research in this area to formulate effective management guidelines in elderly population.

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