



A case report on very late onset mania

Abstract

Diagnosing primary psychiatric disorder in elderly is a challenge considering the high prevalence of neurological and other medical diseases presenting with psychiatric manifestation. The first episode of mania occurring after the age of 80 years is extremely rare. We report a case of an 88-year-old married Hindu male educated up to fifth standard from rural background and lower socioeconomic status presenting with first episode mania, diagnosed using the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) criteria. Secondary causes were ruled out and successfully treated with low dose olanzapine.

Keywords: Elderly. Olanzapine. Zolpidem.

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Received: 8 November 2016

Revised: 14 December 2016

Accepted: 18 December 2016

Epub: 28 December 2016

DOI: 10.5958/2394-2061.2017.00004.0

Introduction

The manic episode in elderly is a serious clinical problem which requires careful evaluation and management. Unfortunately, the clinical data and research in this area are inadequate. This is especially significant considering the fact the elderly population is on a steady rise with increasing life expectancy and improved healthcare facilities. The incidence of mania in the population aged more than 75 years is around two per 100000.[1] The main challenge in late-onset cases of mania is to exclude secondary causes like vascular mania, multiple sclerosis, Parkinson's disease, temporal lobe epilepsy, acquired immunodeficiency syndrome (AIDS), dementia, and traumatic brain injury[2] before considering primary psychiatric diagnosis like unipolar mania. A number of studies have consistently reported that the prevalence of bipolar disorder has an inverse relationship with age, with a decline in prevalence with increasing age.[3] We report a case of an 88-year-old man who was diagnosed with the first episode of mania after detailed evaluation.

Case report

An 88-year-old married male presented to the Geriatric Mental Health outpatient department (OPD), with three months' history of unduly cheerful mood, over-talkativeness, increased activity level- doing excessive worship of God, restlessness, and decreased need for sleep. No significant past or family history of any medical or psychiatric illness was present. Onset of illness was acute with no treatment received

for current illness. No history of substance use, head trauma, cognitive decline, or altered consciousness was obtained. He was well-adjusted pre-morbidly.

Mental status examination at the time of presentation in OPD revealed a playful elderly male with preserved higher mental functions, increased psychomotor activity, elated affect, ideas of grandiosity, and insight Grade I/V. Physical examination was within normal limits except bilateral cataract (immature). His Young Mania Rating Scale (YMRS) score was 23 and Mini Mental Status Examination (MMSE) score was 27/30.

The possibility of a manic episode was kept and the patient was admitted in Department of Geriatric Mental Health for further evaluation and management. In view of late onset of symptoms, his detailed systemic examination was carried out 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, the Venereal Disease Research Laboratory (VDRL) test, Elisa for human immunodeficiency virus (HIV), and serum vitamin B12 were done and were all normal. Magnetic resonance imaging (MRI) of the brain showed mild atrophy consistent with his age. After considering the laboratory results and normal imaging results, the diagnosis was set as the first manic episode as per the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) criteria and the patient was started with olanzapine 5 mg per day

along with sustained release zolpidem 6.25 mg for sleep. The dosage of olanzapine was increased to 7.5 mg and sustained release zolpidem to 12.5 mg after two days. The patient initially showed improvement in his sleep followed by other symptoms over a period of next seven days and his YMRS score reduced to eight, and was subsequently discharged. He had been followed up in OPD after two weeks and was maintaining well on same medications (tab olanzapine 7.5 mg, tab zolpidem 12.5 mg per day).

Discussion

Our patient presented with symptoms suggestive of a manic episode but considering the very late onset of illness and lack previous episodes in the past it is imperative to rule out the possible secondary causes before confirming the diagnosis of mania. His extensive evaluation failed to reveal any secondary causes and his symptoms responded positively to treatment. And patient was diagnosed mania without psychotic symptoms using the ICD-10 diagnostic criteria.

There are significant variations in the reported incidence of bipolar disorder in the elderly and no clear consensus on mania/hypomania. A one-year incidence rate of 0.1% among adults over 65 years which is lower compared to younger age groups.[4] There are a few studies in late-onset manic episodes which suggest an average age of onset be around 56 years.[4]

Our patient had an age of onset of mania at 88 years which is much higher than reported by any studies. This case signifies the very fact that it is not extremely uncommon to have cases of first episode of mania even at a late age. It also underlines the importance of ruling out secondary causes by detailed evaluation and investigations before confirming the diagnosis.

Our case shows that the drug dosage requirement in controlling manic symptoms in elderly is much lesser compared to younger age and as far as possible the general principle of geriatric psychopharmacology should be followed giving minimum medications at minimum effective concentration.[5]

Conclusion

This case highlights the fact that primary psychiatric disorder can actually occur at any age but requires a detailed evaluation to rule out secondary causes before finalising the diagnosis. Once confirmed the patient can be managed in the same lines that of the younger population but psychotropic dosage should be kept at minimum effective dosage. Scientific and systematic research in this area is highly required to formulate effective management strategy in elderly population.

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Muraleedharan M, Suthar S, Singh B. A case report on very late onset mania. *Open J Psychiatry Allied Sci.* 2017;8:169-70. doi: 10.5958/2394-2061.2017.00004.0. Epub 2016 Dec 28.

Source of support: Nil. Declaration of interest: None.