With regard to a case of unipolar mania

A propósito de un caso de mania unipolar

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Received: 4/1/2012 – Accepted: 13/2/2012


MFS is a 52 years female patient, elementary school teacher, who went to emergency because of total insomnia, exaggerated self-confidence and engagement in multiple activities with duration of one week. She presented irritability, agitation, elation of mood, verbiage, sexual disinhibition, persecutory delusional activity, absence of insight. Three manic episodes earlier were noticed, being the first ten years ago, and she hadn’t previous depressive episodes. An optimal level of performance functioning between manic episodes was stated. She described herself as a very creative, friendly, sociable, responsible person. She hadn’t alterations on physical and neurologic examination. Basic blood investigations, cerebral TC, illicit drugs screen and EEG showed no relevant alterations. She was treated at an acute psychiatric care unit for 16 days, with risperidone 2 mg and 1000 mg of divalproex sodium, with remission of symptoms.

Our presumptive diagnosis is unipolar mania. As in this clinical vignette, there are a sizeable number of patients reported with a recurrent manic course without any depressive episode1. It was Kleist, in 1953, who first suggested unipolar mania as a separate entity2,3. But, Angst and Perris, years later, showed that it was clinically and genetically very strongly related to bipolar disorder, and that its distinction as a different entity, was an artefact4,5. A possible change in polarity is frequently very strongly related to bipolar disorder, and that its distinction as a different entity, can still be useful to an early detection and maximization of treatment response. Although initially there were no significant differences regarding treatment, recent evidence showed a relatively less response to lithium, and the need for an additional mood stabilizer6,7. Consequently, the consideration of unipolar mania as a subtype of bipolar disorder, can still be useful to a early detection and maximization of treatment response.

Also, comparing with bipolar patients, unipolar manic patients more commonly exhibit expansive mood, confusion, emotional lability, hyperthimic temperament, psychotic symptoms (especially persecutory delusions), and substance abuse, but have less auditory hallucinations, flight of ideas, suicidal rates, rapid cycling, hostility and anxiety. Lesser third ventricular widths as well as parieto-occipital cortical sulcal ratings, were found in neuroimaging studies8. Although initially there were no significant differences regarding treatment, recent evidence showed a relatively less response to lithium, and the need for an additional mood stabilizer9. Consequently, the consideration of unipolar mania as a subtype of bipolar disorder, can still be useful to an early detection and maximization of treatment response.

References