With regard to a case of unipolar mania

A propósito de um caso de mania unipolar

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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 maniac 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 episode[1]. It was Kleist, in 1953, who first suggested unipolar mania as a separate entity[2,3]. 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 artefact[4,5]. A possible change in polarity is feasible, and some patients had unipolar mania because the time for a depressive episode has not yet arrived, one study showing a variation from 5.9 to 27.7 years[5]. This can become an important practical issue since a mild depressive episode could not be ascertained or it can be part of an adjustment disorder. Although there is a lack of consensus on the definitional criteria for its diagnosis, the most accepted today is the presence of at least three manic episodes with no depressive episodes in the last 10 years.

Its prevalence in western countries varies from 5% to 28%, in all bipolar patients[6]. Recent data showed a significantly earlier age of onset (23 years) compared to bipolar patients (26 years)[7], but a similar mean age at first treatment or at first hospitalization[1,8]. Also, it seems to be more common in females, and there are no significant differences relatively to the marital status, level of education, occupational status and race[1]. It was also reported a lower severity scores in social, familial and work disability which can have prognostic implications[1].

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 studies[9].

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 stabilizer[10]. 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.

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