Unipolar mania, an Unavoidable Diagnosis: Case report and Literature Review

Felipe Vergara T.[1] , Jennifer Green M.[2] , Antonia Cooper S.[2]

Introduction: *Unipolar mania (UM) is a disorder that behaves in a different manner than Bipolar Disorder-I (BP-I); however, it is not deemed as an independent entity by the current diagnosis manuals, but rather it is included in BP-I diagnosis.* ***Clinical case:*** *The patient is a 21-year-old man. He has a 3-month clinical picture, whose evolution has been characterized by over excited mood and psychotic symptoms matching his mood. The patient denies to have suffered previous depressive episodes. The treatment was started with lithium and aripiprazole which turned out to have good results. He did not have any recurrence after 5 years of follow-up.* ***Review of the Literature and Discussion:*** *Diagnostic manuals state that diagnosing BP-I it is not necessary to have a major depressive episode. This implies that UM patients fall into the same category diagnostic than BP-I patients. Differences between UM and BP-I have been proved in epidemiological/clinical/genetic studies; therefore, including heterogeneous patients within the same category could hinder studies interpretation and limit progress and knowledge of both disorders.* ***Conclusion:*** *Literature review suggests that UM must be recognized with an independent diagnosis. Despite its low prevalence, if validated as such, in the future we could have more and better quality of data about this disorder. In this way, we could define in a better way its distinctive characteristics; therefore, we could improve clinical approach of these patients.*

Key Words: *Unipolar mania, Bipolar Disorder, Classification.*

INTRODUCTION

The concept of bipolar disease, as it is currently known as a cyclic disease with periods of mania and melancholy was initially developed by French psychiatrists who named it as "folie circulaire" or else circular madness[(1)]. Later, it was Carl Wernicke (1848-1905) who defended the concept that single/recurrent unipolar episodes of mania or depression should be studied as independent disorders, thus conforming unipolar depression and unipolar mania (UM)[(1)]. From then on, increasing evidence in epidemiological/clinical/genetic studies have proved that UM does exist and it behaves in a different manner than bipolar disorder-I (BP-I) [(2)]; however, it is not considered as an independent entity by the current DSM 5 diagnostic manuals (Diagnostic and Statistical Manual of Mental Disorders (2013)[(3)] and CIE-10 (International Classification of Diseases, 1993)[(4)], but rather it is included in the BP-I diagnosis. Even more, the proposed version number 11 of the International Classification of Diseases (CIE-11) to be valid from 2022, would not make any nosologic distinction between both disorders[(5)].

The authors declare that they have no conflicts of interest with respect to this article.
Accepted: 2021/03/04
Received: 2020/07/20

[1] Medical Surgeon, Universidad Finis Terrae, Santiago, Chile.
[2] Intern Student 7th year of Medicine, Universidad Finis Terrae, Santiago, Chile

The objective of this review is to present, in an illustrative manner, one UM clinical case and to perform a bibliographic update on this topic, emphasizing on the need to recognize UM as an autonomic disorder. Such modification has not been done to date, despite the broad evidence to consider it as such. The discussion will be focused on the methodological limitations of UM study, potential reasons why it is not yet deemed as an independent nosologic entity, and some recommendations are aimed to increase recognition of this diagnosis.

Clinical Case

The patient is a 21-year-old- man. He has no morbid records, and has a three-month clinical picture of evolution characterized by over excited mood, tachypsychia, verbosity, insomnia, uncontrolled money expense and delusion of grandeur. He recognizes severe affectation of his functionality. When he was asked, he denied consumption substances or other drugs triggering this specific condition. He also denied prior depressive episodes and a family background of psychiatric diseases. Among the most important tests is his negative drugs profile.

Before his evident conduct aberration, one of his relatives took him to the ER. He was diagnosed with a manic episode describing psychotic features. He was hospitalized under antipsychotic treatment. Two weeks after, he was discharged, but he was hospitalized again, 10 days later, as he was not conscious about his disease and poor adherence to his treatment. He remained hospitalized for 2 weeks more. After his final discharge he was prescribed a treatment with Lithium, 1.600 mg a day, plus Aripiprazole, 15 mg a day. He had regular psychiatric controls with psychotherapy.

During his 5 years of follow-up he had neither manic recurrence nor depressive episodes. Currently the patient is found euthymic, with a good social/functional adjustment. As an academic tool he was applied the version translated into Spanish of the TEMPS-A Self Applied Temper Scale (Temperament Evaluation of Memphis, Pisa, Paris, and San Diego)[6], which concludes the patient has a hyperthymic temper. He does not have concomitant anxiety disorders. He has never had a suicide conduct.

Literature Review and Discussion

The Prevalence estimated of UM as a subtype of BP-I is 1.7% in western countries[1], and increasing in non-western countries and developing countries[7]. Although UM is relatively infrequent, there is significant evidence proving it behaves in a different manner than BP-I. Among other differences we can mention:

Sociodemographic Characteristics:

Most studies agree that BP-I Prevalence is higher than UM. In a study of Stokes et al. (2019), the percentage of UM patients included in BP-I diagnosis, in a British/French cohort is 1.2% and 3.3% respectively[7]. A similar frequency is reported in a study in USA, with a frequency of 5%[8]. However, these data challenge the observations made in non-western countries, such as India, Tunisia, Nigeria, South Africa and Hong Kong, where UM reports 40% in people diagnosed with BP-I[1][7]. This distinction is supported with another finding made in the study of Stokes et al. (2019), where a higher UM frequency was reported in African ethnicity versus non-African[7]. Differences in the prevalence among cultures are hard to be interpreted, and studies with intercultural scenarios are required to clarify this phenomenon.

Clinical characteristics

Regarding the review made by Angst et al. (2019), the average age and onset age of manic episodes is similar for both groups; however, there is a difference, regarding predominant sex between both groups, where UM patients are mostly males and for BP-I patients are mostly females[9]. There is also a higher prevalence of hyperthymic temper, a higher rate of remission, and better functionality and prognosis in the long term, among UM patients[9]. Another difference is that UM has a higher incidence of manic episodes and psychotic symptoms matching the mood, ranging from 1.7 to 2.5 times more than in BP-I[7].

Comorbid Diseases

UM, both in adults as well as in adolescents is less correlated with generalized anxiety disorder, with panic disorder, with eating disorders and disorders due to substances abuse, compared with BP-I[9]. Regarding suicidal attempts, it

is lower in UM versus BP-I, with a prevalence of 19.3% versus 38.3%, in adults; and 5.6% versus 22%, in adolescents, respectively[9].

Family Background and Genetic Characteristics

UM infrequently reports a family background of major depressive disorders, compared with BP-I[1]. On the other hand, studies in monozygotic/dizygotic twins report that mania is more inheritable than depression[1].

A study made by Merikangas et al. (2014) confirms that mania and major depression are transmitted --to a great extent in an independent manner-- among families, thus suggesting these big components of bipolar disorders may be caused by different underlying ways, instead of even more severe manifestations of an underlying diathesis in common[10].

Pharmacological treatment

UM prophylactic treatment is less complex, compared with that of BP-I, as we must only focus on the mania and not on episodes of both polarities, where it is necessary the association of more than one drugs[9]. A prior study of Angst et al. (2015), reported that UM patients are frequently treated with antipsychotic drugs and probably have a lower response to the treatment with lithium, compared with BP-I[1].

Diagnostic manuals state that for diagnosing BP-I the presence of a major depressive episode is not required, thus implying that UM patients remain within the same category diagnostic than BP-I patients[11]. Including heterogeneous patients within the same category could hinder the interpretation of studies and limit progress in the knowledge of both disorders. Just as we consider that unipolar depression is different from bipolar disorder, we should do the same thing with UM.

One of the main methodologic problems on the study of this pathology is the lack of consensus regarding the final criteria for making a diagnosis. The main discrepancies deal with the minimum number of manic episodes, minimum follow-up duration and exclusion criteria. Follow-up time is highlighted, as from manic onset we cannot predict if the patient will have a depressive episode in the future or not. Therefore, UM diagnostic stability would increase, the longer the periods with no depressive episodes. A study made by Yacizi (2014) reviewed the various criteria of diagnostic inclusion in 20 MU studies and proposed the following consensus for a final diagnosis of UM: "Presence of --at least-- 3 manic episodes, with no depressive episodes, with a minimum follow-up period of 4 years"[12].

Limitations on literature interpretation are given by the low disorder prevalence and the absence of definition and defined diagnostic criteria. In this line, scientific evidence on UM is still scarce and is characterized by a poor sampling size and study designs are too heterogeneous among them.

CONCLUSION

After literature review UM is suggested to be deemed as an independent diagnosis. Despite its low Prevalence, when validates as such, in the future we could have more and better quality of data about this topic. In this way, we will be able to better define its distinctive characteristics and, therefore, improve its clinical approach for these patients. This practice would be boosted by the introduction of UM as an independent diagnosis in the next version of the Classification Manuals. UM and BP-I inclusion within the same diagnostic code, as described in the proposal for the next CIE -11 should be considered as a loss, in clinical/research terms.
Despite the foregoing methodological limitations, data allow us to summarize differences between UM and BP-I: UM is more common in male patients. It has a higher incidence of psychotic symptoms matching hyperthymic mood/temper. It would have a lower suicidal risk, and it would be less associated to anxiety disorders and abuse of concomitant substances. Regarding treatment, a lower response to lithium has been reported. It would also be associated to a higher rate of remission, and better functionality in the long term. Regarding the foregoing clinical case, it calls our attention that it has most of aforementioned UM distinctive characteristics. Despite he is only one patient, his clinical characteristics support UM as an autonomic disorder.

¿How could we transfer this knowledge into clinical internship? Before patients with BP-I

diagnosis, who have no record of depression episodes, with --at least-- 4 years of follow-up, we could classify them as UM, in order to address them with the foregoing distinctive characteristics. For patients with mania onset, diagnosis must be done after years of follow-up, with no depressive episodes, as currently there are no clear characteristics aimed to differentiate both disorders, from the beginning.

More studies with similar methodologies and well defined diagnostic criteria are necessary, in order to be more certain about the differences between both nosological entities and to better characterize UM.

REFERENCES

1. Angst J, Grobler C. Unipolar mania: a necessary diagnostic concept. Eur Arch Psychiatry Clin Neurosci. 2015; 265: 273-280.
2. Angst J, Ajdacic-Gross V, Rossler W. Bipolar disorders in ICD-11: current status and strenghts. Int J Bipolar Disord. 2020; 8: 3.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Fifth edition. Washington, DC: American Psychiatric Association; 2013.
4. Organización Mundial of the Health. CIE-10. Mental disorders and of the conduct. Décima version of the International Classification of Diseases . Descripciones clinical and pautas for the diagnosis. Ginebra, Suiza: Organización Mundial of the Health; 1993.
5. Reed GM, First MB, Kogan CS, Hyman SE, Gureje OR, Gaebel W, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019; 18: 3-19.
6. Jimenez AND, Bonnín C, Solé B, Sanchez-Moreno J, Reinares M, Torrent C, et al. Spanish validation of the Barcelona TEMPS-A questionnaire in patients with bipolar disorder and general population. J Affect Disord. 2019; 249: 199-207
7. Stokes P, Yalin N, Mantingh T, Colasanti A, Patel R, Bellivier F, et al. Unipolar mania: Identification and characterization of cases in France and the United Kingdom. J Affect Disord. 2020; 263: 228-235.
8. Baek J.H, Eisner L.R, Nierenberg A.A. Epidemiology and course of unipolar mania: results from the national epidemiologic survey on alcohol and related conditions (NESARC). Depress Anxiety. 2014; 31, 746–755.
9. Angst J, Rossler W, Ajdacic-Gross V, Angst F, Wittchen H.OR, Lieb, R, et al. Differences between unipolar mania and bipolar-I disorder: evidence from nine epidemiological studies. Bipolar Disord. 2019; 21, 437–448.
10. Merikangas KR, Cui L, Heaton L, Nakamura AND, Roca C, Ding J, et al.
11. spectrum disorders. Mol Psychiatry. 2014; 19: 214-9
12. Angst J, Ajdacic-Gross V, Rossler W. Classification of mood disorders. Psychiatr. Pol. 2015; 49 (4): 663-671.
13. Yazici OR. Unipolar mania: A distinct entity? J Affect Disord. 2014; 152-154: 52-56

Correspondence to:
Felipe Vergara Tike
Camino el Alba Avenue 11494, Las Condes, Santiago
e-mail: felipevtike@gmail.com
Telephone: +56976224630