Atypical Symptoms Before the First Episode in Bipolar Children and Adolescents

Bipolar Bozukluğu Olan Çocuk ve Ergenlerde İlk Ataktan Önce Atipik Belirtiler

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ABSTRACT
In this study, atypical symptomatology and difficulties concerning the differential diagnosis of bipolar disorder (BPD) in children and adolescents before the first episode are discussed through 4 cases aged 5, 13, 14 and 16 years. Although all cases were treated and followed for months/years with diagnoses such as conduct disorder, attention deficit hyperactivity disorder, borderline disorder, dissociation, and psychosis, their diagnoses were considered as BPD after months or years. Misdiagnosis and/or delayed diagnosis of BPD are common among children and adolescents. Use of stimulant or antidepressant agents provoked manic symptoms, while antipsychotics (risperidone and aripiprazole) and mood stabilizers (valproic acid and lithium) were useful as combined and/or mono therapy for these cases. BPD should be considered in the differential diagnosis in child and adolescent cases with atypical symptomatology and treatment resistance. (Archives of Neuropsychiatry 2009; 46: 34-6)

Key words: Bipolar disorder, differential diagnosis, child, adolescent

INTRODUCTION
According to studies in large community samples, pediatric BPD prevalence was found to be 0.1 - 2% (1). Additionally, 50 - 60% of bipolar adults recalled the initial onset of mania or depression at 19 years or younger (2,3) and one-third of subjects with BPD had early onset (4). Pediatric bipolar disorder (BPD) is characterized by the early age of onset of mood disturbance; long duration; fluctuating course; high familial loading for mood and other psychiatric disorders; high rates of co-morbid psychiatric disorders particularly attention deficit/ hyperactivity disorder (ADHD), disruptive behavior, anxiety disorders, and psychosis; and prevailing mixed/ rapid cycling episodes (2,5,6). Early recognition and treatment of BPD in children and adolescents is important to ameliorate ongoing symptoms and to reduce or prevent serious psychosocial morbidity (6,7,8). In 74% of individuals with BPD, psychopathology is recognizable before age 3, usually as mood and sleep disturbances, hyperactivity, aggression, and anxiety but pediatric BPD is often mis-or undiagnosed (9).

Comorbid psychiatric disorders are common in BPD. However, it is not well known whether individuals with bipolar disorder are at risk for future psychiatric disorders or whether individuals with other psychiatric disorders are at risk for bipolar disorder. In this study, atypical symptomatology before the first episode and diagnostic difficulties of BPD among children and adolescents are discussed through the description of 4 cases.
Case Reports

Case 1: A 5 year old girl with symptoms of hyperactivity, impulsivity, acting outs, oppositional behavior, aggression to other children and her mother. Methylphenidate 10 mg/day was started with a diagnosis of (ADHD) in another psychiatry clinic through 8 months. After initiation of this treatment, her hyperactivity improved slightly, while other symptoms were aggravated, with prominent mood lability and irritability. Her mother had reported that her symptoms were episodic with a duration of one or two days, these episodes were more frequent and severe through the 8 months of methylphenidate treatment. This treatment was stopped for 4 months, and her symptoms moderated to the level of pretreatment with methylphenidate. Diagnostic reevaluation of the case put BPD in the differential diagnoses because of mood lability, severe irritability as a cardinal symptom, lacking efficacy of methylphenidate, and increased frequency of episodes with stimulant treatment, Valproic acid 20 mg/kg/day was started. Her symptoms markedly improved after the second month of this treatment; and this might also support the BPD diagnosis.

Case 2: A 13 year old girl presented with audio-visual hallucinations, disorganized behaviors, insomnia, bizarre outfit and secondary diurnal enuresis. Risperidone 2 mg/day was given with a diagnosis of atypical psychosis. This treatment was maintained through 18 months with a moderate improvement but full remission was not seen. Because of side effects, including galactorrhea and extrapyramidal symptoms (EPS), this treatment was changed to aripiprazole 10 mg/day. Her symptoms improved dramatically in the first few months of medical treatment. She stopped taking her drugs herself at the end of 6 months of this treatment, then insomnia, grandiosity, seductive behaviors, increased sexual behavior and irritability symptoms emerged. Therefore her first clinical presentation was evaluated in detail. Her mother reported mood lability with depressive and euphoric states more than once in a day, so BPD was considered in the differential diagnosis because of the labile mood, beneficial effects of antipsychotic and manic excitation just after stopping antipsychotic drugs. Aripiprazole resulted in successful mood regulation and she is now in remission for two years.

Case 3: A 16 year old girl. had audio-visual hallucinations, conversion attacks such as syncope and fugue, bizarre anxiety attacks including self-mutilation and amnesia. Risperidone 1 mg/day was started with a diagnosis of dissociative disorder. This treatment helped symptom reduction. However, one year later she had one mixed (insomnia, depressive mood, suicide ideas, impulsivity, seductive behaviors, increased sexual behaviors and irritability) and one manic episode (grandiosity, impulsivity, excessive talkativeness, seductive behaviors, increased sexual behaviors and irritability) while she was still using the drug. BPD was considered as the differential diagnosis because of the observed typical mixed and manic excitations despite regular antipsychotic using. Valproic acid 20 mg/kg/day was added to the regimen after which her symptoms were significantly improved for two years.

Case 4: A 14 year old girl had symptoms of agitation, impulsivity, acting outs, important conflicts with other family members, seductive behaviors and self-mutilation. Risperidone 1 mg/day and valproic acid 20 mg/kg/day were given with a diagnosis of conduct disorder (CD) and/or borderline personality disorder. Moderate improvement of symptoms was observed as from the second month of this treatment. A manic episode including grandiosity, insomnia, excessive talkativeness, seductive behaviors, increased sexual behaviors, excessive spending and severe irritability was observed a year later while she was under this treatment. Her diagnosis was considered as BPD due to the observed typical manic excitation despite regular antipsychotic using. Her symptoms improved with a combination of risperidone 2 mg/day and lithium 900 mg/day so the diagnosis of BPD was supported.

Discussion

It is thought that one-third of subjects with BPD had an early onset characterized with an onset before 18 years old (10). Early onset BPD is associated with; female gender, more lifetime psychotic symptoms, greater overall co-morbidity, and a greater length of time from first episode to treatment (4). Similarly, all cases in this study were female, although the symptoms of all cases were atypical in the first presentation and follow-up.

Psychotic symptoms are more common among children and adolescents with BPD than in adults, and dysphoria is more likely than euphoric or depressive moods. Asymptomatic intervals rarely exist, whereas rapid cycling is frequent (11). Similarly, case 2 and 3 had psychotiatric symptoms such as hallucinations and disorganized behaviors. When psychotic symptoms are seen, clinicians may diagnose the condition as “psychosis” because of their daily routine practices. However, psychotic symptoms can be present in many conditions apart from psychosis in children and adolescents. It was reported that none of the subjects reporting atypical psychotic symptoms went on to develop a classic psychotic illness by the second year follow-up (12), and 24% had bipolar disorder, 41% had major depression, 21% had sub-syndromic depression, and 14% had schizophrenia spectrum disorders (13).

Children with BPD and comorbid ADHD have higher initial rates of other comorbidities, more symptoms of ADHD, worse scores on checklists, and a greater family history of mood disorder (14). This comorbidity is common but diagnostic errors are also frequent in these cases. Children who presumably have ADHD often have an unrecognized affective illness. There is a widely accepted view that modified criteria of BPD should be used for children because of atypical symptomatology and course of BPD through childhood so many children and adolescents with BPD are misdiagnosed as ADHD because of the similar diagnostic criteria for both diagnoses (15). The clinical future of childhood BPD is unlike the adult cases, and reconsideration of diagnostic criteria is an important need. Stimulants may be useful for some symptoms especially inattention and hyperactivity in the children with ADHD-BPD comorbidity (16,17). It is well documented that antidepressants have a greater risk of manic switch (18,19). Stimulants seem...
safer than antidepressants but it should be kept in mind that manic symptoms may be aggravated by stimulants, also (20,17). This was illustrated in case 1 where irritability and aggression symptoms were aggravated by methylphenidate despite limited beneficial effects.

Irritability as a symptom of mania is an important finding when manic symptoms in pediatric bipolar disorder present episodically (21). Irritability in ADHD, oppositional defiant disorder (ODD) and childhood BPD must be differentiated. There are certain features helping the clinician in making this distinction; irritability in BPD includes more severe insomnia, agitation, distractibility, racing thoughts, flight ideas, pressured speech, intrusiveness, temper tantrums triggered by negative emotional stimuli and frustration (21). All cases in this study had irritability and two of four cases were also diagnosed as destructive behavior disorders at first. Consistent with the literature, their behavioral and emotional problems were more severe than expected for children with ADHD, ODD or CD (21,22).

Mood stabilizers such as lithium, divalproex and carbamazepine are suggested for treatment of children and adolescents with BPD which are known to have acute anti-manic effects and provide relapse prevention (11,16,23,24). In addition, atypical antipsychotics have recently gained more importance in the treatment of manic states in children and adolescents, (11,13,23,24,25). However, more information is needed about the long-term treatment of mania, treatment of bipolar depression, and treatment of co-morbid psychiatric conditions. Mono therapy or combination therapy of atypical antipsychotic and mood stabilizers were both useful and well tolerated in the treatment of all cases in this study.

In summary, BPD in children and adolescents can commonly be mis- and/or undiagnosed. Clinicians should consider BPD in child and adolescent cases who have atypical symptomatology, and treatment resistance.

References