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REVISITING UNIPOLAR MANIA: AN ENTITY FORGOTTEN?

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ABSTRACT

Unipolar mania, also referred as recurrent mania or unipolar recurrent mania, is an entity which position in bipolar disorder remains controversial. Notwithstanding, there are a considerable number of bipolar patients in clinical practice presenting only with recurrent episodes of mania or hypomania, without episodes of depression. Additionally, the existence of certain clinical, demographic and treatment peculiarities suggests that the categorization of unipolar mania as a subtype of bipolar disorder still to be useful for early detection and maximization of treatment response. In this review, the authors intend to provide a literature revision of unipolar mania throughout history, epidemiology and clinical features.

KEY-WORDS: UNIPOLAR MANIA, MANIA, RECURRENT, AFFECTIVE DISORDERS

REVISITANDO A MANIA UNIPOLAR: UMA ENTIDADE ESQUECIDA?

RESUMO

Mania Unipolar, também conhecida como mania recorrente ou mania unipolar recorrente, é uma entidade cuja posição na Perturbação Afectiva Bipolar ainda permanece controversa. No entanto, existe um número considerável de doentes bipolares na prática clínica com apresentação de apenas episódios de mania ou hipomania recorrentes, sem episódios de depressão. Além disso, a existência de certas particularidades clínicas, demográficas e de tratamento, sugerem que a categorização da Mania Unipolar como um subtipo de Perturbação Afectiva Bipolar poderá útil para a sua detecção precoce e optimização da resposta ao tratamento. Neste artigo, os autores pretendem realizar uma revisão da literatura existente de Mania Unipolar, incidindo sobre aspectos históricos, epidemiológicos e clínicos.

PALAVRAS-CHAVE: MANIA UNIPOLAR, MANIA, RECORRENTE, PERTURBAÇÕES DO HUMOR

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INTRODUCTION

Bipolar disorder is a severe chronic mood disorder characterized by episodes of mania or hypomania alternating with episodes of depression. The consideration of unipolar mania as a subtype of bipolar disorder is historically old but remains controversial and implies the absence of a mixed depressive subtype diagnosis.[1,2] According to Beigel and Murphy´s early descriptions, "Pure mania" is defined as a mental state having an expansive mood, thought pressure, and grandiose delusions.[3]

Systematical descriptions of mood disorders, as depressive (melancholia) and manic states were first made by Hippocrates, but the notion of mania and melancholia as two different images of a single disease having the same aetiology was proposed by Aretaeus, whose view was maintained up to the seventeenth and eighteenth centuries.[1] Thereafter, Falret described bipolar disorder as an individual entity named "folie circulaire", characterized by a continuous cycle of depression, mania and free intervals of varying length.[4] Also, E. Kraepelin classified endogenous psychoses into "manic-depressive insanity" and "dementia praecox", but he also described cases of manic irritability with no features of depression, which he termed as "periodic mania".[5]

The assumption that some patients suffering from affective illness revealed a pattern of recurrent episodes was stated by Kleist who suggested pure mania (monopolar) and melancholy as unipolar disorders, assuming that bipolar disorders were a combination of both forms with special affinity to one of them.[6] Then, it was Leonhard that proposed unipolar and bipolar disorders as separate entities.[7]

Although Angst and Perris demonstrated that unipolar mania as a different entity was an artefact,[8,9] evidence in the last years related to certain clinical, psychopathological and treatment features shows that sub-categorization of unipolar mania within bipolar affective disorder can still be useful.[2,10-16] Additionally, case reports on literature suggest the importance for viewing unipolar mania as a subtype for early detection and treatment optimization.[17]

THE CLASSIFICATION CHALLENGE

Unipolar mania position in both main actual diagnostic psychiatry classifications is not clearly defined, as they include it within the diagnostic entity of bipolar affective disorder but they do not admit the notion of a unipolar disorder to characterize the recurrence of the same type of episode.[18]

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR, 2000)[19] section of "bipolar disorders not otherwise specified", includes recurrent hypomanic episodes with no intercurrent depressive features, being this the nearest diagnostic category to unipolar mania.

On the other hand, in The International Classification of Diseases, 10th edition (ICD-10, 1992)[20] patients with two or more episodes of mania are understood as being bipolar and are included un-

der the category of bipolar others (F31.8), but the previous version (ICD-9) contemplated a separate category of unipolar mania.[21]

Additionally, there is lack of consensus on the definitional criteria to diagnose unipolar mania. The discussion concerns on the definition of the diagnostic criteria, such the number of manic/hypomanic episodes, the definition of a manic episode, and the inclusion/exclusion of the depressive symptoms in the intercurrent period and also the time frames. In fact, different authors have proposed distinct settings in clinical studies. Aghanwa considered 3 episodes of mania or hypomania[22] and Yazici *et al.* admitted at least 4 episodes of mania[15], both advocating a time frame of at least 4 years of follow-up without any depressive episode.[15,22] More recently, Perugi *et al.* considered the presence of at least three manic episodes with no depressive episodes in the last 10 years.[2]

The absence of depressive episodes can become an important practical issue, since the diagnosis is usually made retrospectively and because of that there always remains the scope of missing a mild depressive episode. Alternatively, it is necessary to ascertain the aetiology of depressive symptomatology, as it can be part of an adjustment or reactive disorder, and for that reason not considered an expression of bipolar disorder. A recent report using stringent criteria and prospective observations after up to 20 years of follow-up, found out that in twenty-seven patients that had the diagnosis of unipolar mania at the time they entered the study, seven did not suffer any episodes of major depression, supporting the diagnostic validity.[23]

The course and change in polarity of initially diagnosed unipolar mania are still an aim of actual debate and to a true unipolar manic course it is necessary that patients had only manic episodes. Interestingly, the duration limits are also arbitrary since a patient with bipolar disorder with only manic episodes initially, can go on to develop depressive episodes along with mania. Therefore the change from "unipolar" to "bipolar", is warranted due to a depressive episode occurring in the follow-up period.

The duration of illness has varied from 5.9 years to 27.7 years, but inconsistency is found across studies, as the majority are retrospective, with small size number of samples and short period of follow-up. This may predispose to bias of recall of patients or its siblings. Solomon *et al.* in their prospective study of 15-20 years found that unipolar mania was not necessarily recurrent.[23] Perris concluded that in the majority of cases, change in polarity from mania to depression occurred by the 3rd episode after the onset of the illness and rarely, it may occur even after the 8th episode. It is possible that many patients had unipolar mania because the time for a depressive episode has not yet arrived.[8]

EPIDEMIOLOGY

In descriptions of psychiatry textbooks, unipolar mania as a form of bipolarity expression, arises as being 10-20% of all bipolar affective disorders.[24] Interestingly, the prevalence of unipolar mania in western countries varies from 5% to 28%[25] but it seems to be quite common in some non-Western countries such as India (44%)[26] and Nigeria (53%).[27] These data however must be interpreted considering the variations of different diagnostic criteria used in the studies, such as time frame or number of manic episodes. In fact, earlier retrospective studies required one single manic episode in absence of depressive episodes, which yielded to a prevalence of up to 28%[10] in contrast to studies considering the more actual diagnostic criteria of three or four episodes in a 4 to 10 years of follow-up.[2,15,22]

Recent data showed a significantly earlier age of onset (23 years) for patients with unipolar mania compared to bipolar patients (26 years),[28] but a similar mean age at first treatment or at first hospitalization.[2,29] Taylor and Abrams reported that late onset mania (≥ 30 years) run a course of unipolar mania in half of the patients whereas early onset mania (< 30 years) tends to run a typical bipolar course.[30]

Recent evidence have showed that unipolar mania is more common in females,[2,23] although previous studies documented for a slightly more prevalence in males.[31,32] There are no significant differences between unipolar and bipolar manic patients relatively to the marital status,[2,15,22,23] level of education,[2,14,15,26] occupational status,[2] and race.[22] Unipolar mania patients showed lower severity scores in social, familial and work disability characteristics that might be considered of clinical and prognostic interest.[2]

Interestingly, recent family studies have demonstrated that first-degree relatives of unipolar manic patients comparing to those of bipolar manic patients, have an equal morbid risk for psychiatric illness such bipolar affective disorder, schizophrenia,[13,22,29,33,34] alcoholism,[2] but lesser risk for suicide.[15]

CLINICAL FEATURES

Clinical features of unipolar manic patients differ from bipolar manic patients, probably resulting for

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different phenomenology aspects. The majority of studies found that unipolar manic patients more commonly exhibit euphoria, expansive mood, grandiosity, confusion, emotional lability,[10] hyperthimic temperament,[2,15] psychotic symptoms (especially persecutory delusions),[10,11,13] and substance abuse such as cannabis and amphetamines.[13] In contrast they exhibit less auditory hallucinations, flight of ideas,[10] suicidal rates, rapid cycling,[13,15] hostility and anxiety symptoms[2] and comorbidities.[11] It seems that they had more manic and less hypomanic episodes and a complete absence of depressive temperament.[2] The number and duration of the illness episodes showed a tendency to have lower total mean number of affective episodes[2] but more hospitalizations and medications.[11]

There is evidence in neuroimaging studies of lesser third ventricular widths as well as parieto-occipital cortical sulcal ratings compared to bipolar manic patients.[12] A study also reported that patients with unipolar mania secondary to a brain injury sustained significantly large cortical lesions, primarily in right orbitofrontal and right basotemporal cortices but less of subcortical lesions.[14] The laboratory findings are scarce, one study showing absence of thyroid autoimmunity.[13]

TREATMENT

There is limited data concerning treatment. Although older studies did not find any significant differences in treatment response compared to bipolar manic patients,[31] a recent study performed by Yazici et al., showed a relatively poorer response to lithium (20% versus 36%).[15] This apparent poorer response to lithium was also documented in a study performed by Palha and Arrojo in which half of ten patients with unipolar mania required treatment with a second mood stabilizer (carbamazepine or sodium valproate) along with lithium carbonate and an antipsychotic.[35] These differences may be related to the fact that depressive predominance in bipolar patients has been associated with better response to lithium prophylaxis.[28]

CONCLUSIONS

The conceptualization of unipolar mania as a subtype of bipolar affective disorder has received very less attention compared to others bipolar disorders subtypes or even to unipolar depression. Although the overlap of sociodemographic and clinical variables, there does seem to be recent evidence concerning clinical, psychopathological and treatment features indicating a nosological separation of unipolar mania from bipolar mania.

Notwithstanding, some unipolar manic patients require a change in the diagnosis, probably because of underestimation of previous depressive episodes, particularly if their intensity was low. Further, there remains a lack of standardized criteria for the establishment of unipolar mania diagnosis concerning the number of manic episodes and also time frames.

Future prospective studies with larger sample sizes and follow-up are needed for the establishment of a better consensus on the definition criteria of this particular entity.

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