

Rapid cycling bipolar-II disorder presenting as hypomanic episodes associated with menstruation: a case report

Sayanti Ghosh

Summary

Studies show an association between the menstrual cycle and bipolar disorder and an increased risk of affective disturbances during the premenstrual phase. These symptoms are usually depressive and can create diagnostic problems due to symptom overlap with premenstrual dysphoric disorder (PMDD). This case report describes an unusual history of recurrent

hypomanic episodes associated with all menstrual cycles since menarche, in an 18 year old girl. These episodes were followed by a major depressive episode. This case highlights the importance of inquiring about premenstrual affective disturbances in patients with mood disturbances.

SL J Psychiatry 2013; 4 (2):47-48

Introduction

It is known that bipolar-II disorder which is associated with chronic depressive symptoms is more frequent in women. It shows a tendency for rapid cycling (1). Studies also indicate that patients with mood disorder have an increased risk of affective disturbances during menarche and menstruation (2). Premenstrual syndrome (PMS) or its severe form premenstrual dysphoric disorder (PMDD) also presents with a constellation of emotional, behavioral and physical symptoms that typically begin premenstrually and abate with menses. Diagnostic overlap between these disorders and mood disorders is not surprising, considering commonalities in the emotional symptoms such as depression, irritability and mood swings. The differentiation usually lies in the timing of symptoms in relation to menses, meaningful change between post and pre-menstrual symptom severity and a clinically significant severity of symptoms (3). Mood disorders are usually not confined to the premenstrual phase and may persist beyond it. This case report describes a patient with bipolar disorder with a history of recurrent hypomanic episodes associated with all menstrual cycles since menarche.

Case report

An 18 year old female from a rural area in West Bengal was brought to the Psychiatry OPD of R.G.Kar Medical College, Kolkata by her mother. She had low mood, decreased appetite, sleep disturbance, lethargy, recurrent suicidal thoughts and self harm behavior during the last three months. The apparent precipitating event was an altercation during the patient's marriage ceremony three months ago after which the patient was sent back home. She first developed anorexia and insomnia followed by other depressive features which gradually increased in intensity. She attempted deliberate self-harm 10 days prior to presentation by consuming pesticides and required hospitalization for two days.

The symptoms first developed 12 years ago which was approximately six months after menarche. Since

then, she had been experiencing cyclical mood changes which commence just before the menses and persist during the period of menstruation. This pattern had persisted for the last six years. These changes occurred during all menstrual cycles. About a week prior to menses the patient becomes irritable, there is increased talkativeness, argumentativeness, grandiosity, increased goal-directed activity, excess spending sprees and excessive grooming. The symptoms persist throughout the menstrual phase (which lasts an average of five days) and about a week after. The total duration of symptoms is about 12 to 14 days. After this period, the condition improves spontaneously and she remains well until a week prior to the next period. Social and occupational activities become normal when the symptoms subside. The patient got married three months ago and during this time she was in the premenstrual phase and the mood was irritable. Since then, the depressed mood has persisted and there have been no fluctuations of mood. There was no history of major physical illness or psychoactive substance use. Physical examination was normal except for mild pallor.

On mental status examination, the patient was well groomed, alert and conscious. Eye contact was poor and there was psychomotor retardation. Speech was relevant and goal-directed, of low volume and there was lack of spontaneous speech. Mood was severely depressed and there was suicidal ideation. Perceptual disturbances, psychotic features or formal thought disorder were not present. The cognitive functions were normal. Routine haematological tests, biochemical and hormonal investigations including thyroid function tests were normal.

The patient was diagnosed with bipolar II disorder currently depressed with rapid cycling according to DSM-IV-TR criteria.

The patient was diagnosed with PMS by a physician two years ago and was prescribed clonazepam 0.5 mg at bedtime. Although she was referred to a psychiatrist she did not attend the appointment. The mother stated that the patient took clonazepam 0.5 mg/day for 2 or

3 cycles with some improvement. The patient was commenced on quetiapine 200mg nocte at bedtime and the dose was increased to 300mg in the third week. Clonazepam 0.5 mg was given as required during the last six weeks. On her first follow-up visit after three weeks, she showed partial improvement of biological functions though the mood was low. After six weeks the mood and socio-occupational functioning improved. She currently continues the same treatment regime.

Discussion

Premenstrual psychological disturbances are usually attributed to PMS or its severe form PMDD. Mood disorders such as Major Depressive Disorder (MDD) or bipolar disorder (BD) may also show premenstrual exacerbations which can create diagnostic confusion (1). Females with PMDD have a high risk of eventually developing MDD which raises the possibility that premenstrual symptoms are an expression of vulnerability traits to depression (4).

The relationship between the menstrual cycle and bipolar disorder has been described mostly in case-reports with few systematic studies. High rates (60%) of pre-menstrual mood changes have been reported retrospectively in patients with rapid-cycling mood disorders (5). An increased rate of premenstrual emergency hospital admission in bipolar patients and high prevalence of suicidal ideation and intent have also been reported (6,7). There is a similar case report of a patient with recurrent menstrual hypomanic episodes without a history of depression. The authors have postulated this to be a case of bipolar-II disorder (8). Repeated pre-menstrual manic episodes have been reported as an unusual manifestation of premenstrual syndrome (8). In contrast, other studies have reported a lack of relationship between bipolar disorder and menstruation (10).

In our patient, there was initial difficulty in differentiating from PMDD because at that time the patient's symptoms were solely confined to the menstrual phase and there was no history of a depressive episode. Symptoms such as irritability and lability of mood rather than typical elated mood were more suggestive of PMDD. Such mixed symptoms are commonly seen female patients with rapid cycling female bipolar disorder. Efficacy of quetiapine as a mood stabilizer in bipolar depression is well established and our patient continues to be well on quetiapine.

Because retrospective assessment can lead to over attribution of symptoms to the menstrual cycle, prospective daily rating and careful evaluation for other psychiatric disorders are essential. As bipolar disorder in women is more likely to be undiagnosed and therefore untreated or inappropriately treated, recognizing that premenstrual psychiatric symptoms, especially unusual presentations could be due to mood disorders will aid effective treatment and better outcome (11).

The patient provided informed consent for publication of the case report.

Acknowledgement

Department of Psychiatry, R.G.Kar Medical College, Kolkata. West Bengal, India

Declaration of interest

None declared

Sayanti Ghosh,

Department of Psychiatry, R.G. Kar Medical College, Kolkata, West Bengal, India.

Corresponding author: Sayanti Ghosh

E mail: dr_sayanti@rediffmail.com

References

1. Liebenluft, E. Women with bipolar illness: clinical and research issues. *Am J Psychiatry*. 1996; 153:163-173.
2. Freeman, M.P., Smith, K.W., Freeman, S.A. et al. The impact of reproductive events on the course of bipolar disorder in women. *J. Clin. Psychiat*. 2002; 63:284-287.
3. Freeman W Ellen. Premenstrual syndrome and premenstrual dysphoric disorder: definitions and diagnosis. *Psychoneuroendocrinology*. 2003; 28: 25-37.
4. Halbreich U. 'Premenstrual dysphoric disorders: a diversified cluster of vulnerability traits to depression'. *Acta. Psychiatr. Scand*. 1997; 95:169-76.
5. Price W.A. and DiMarzio L. 'Premenstrual tension in rapid-cycling bipolar affective disorders'. *J. Clin. Psychiatry*. 1986; 47:415-17.
6. Diamond S.B., Rubinstein A. A., Dunner D.L. et al. 'Menstrual problems in women with primary affective illness'. *Compr. Psychiatry*. 1976; 17: 541-48.
7. Chaturvedi S.K., Chandra P.S., Gururaj G. et al. 'Suicidal ideas during the premenstrual phase'. *J. Affective Discord*. 1995; 34: 193-9.
8. Rachid Aalouane, Ismail Rammouz Fatima Elghazouani Chadya Aarab, Lisa Blecha. Hypomanic episodes during menstrual periods: Bipolar II disorder? *Psychiatry and Clinical Neurosciences*. February 2011; 65(1): 112-113.
9. Hsiao MC, Liu CY. Unusual manifestations of premenstrual syndrome. *Psychiatry Clin. Neurosci*. 2007; 61:120-123.
10. Shivakumar G, Bernstein IH, Suppes T et al.; Are bipolar mood symptoms affected by the phase of the menstrual cycle? *J Womens Health (Larchmt)*. 2008 Apr; 17(3):473-8.
11. McElroy, SL. Bipolar disorders: special diagnostic and treatment considerations in women. *CNS Spectrums*. 2004; 9(8 Suppl): 5-18.