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STUCK IN THE CYCLE: CHRONIC & RESISTANT MANIA IN BIPOLAR DISORDER: A CASE REPORT

Psychiatry

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ABSTRACT

Chronic mania has been described in psychiatric literature for many years, yet it has not been accorded the same formal recognition as chronic depression in diagnostic systems. Traditionally, chronic mania is defined as the persistence of manic symptoms for a prolonged period—typically more than two years—without achieving full remission. Patients with this condition continue to exhibit elevated or irritable mood, increased energy, grandiosity, reduced need for sleep, and other characteristic features of mania over an extended duration, often leading to significant functional impairment. When such manic symptoms fail to respond adequately to standard treatment approaches, the condition may be further classified as treatment-resistant mania. Treatment resistance is usually considered when there is an insufficient clinical response after an adequate therapeutic trial, commonly around three weeks, of combination therapy involving a mood stabilizer and an antipsychotic medication. Chronic and treatment-resistant mania present major challenges in clinical management and are associated with poorer outcomes, emphasizing the need for early identification, comprehensive treatment strategies, and further research into effective interventions

KEYWORDS

Chronic Mania; Resistant Mania; Bipolar Disorder

INTRODUCTION

Although chronic mania has been discussed in psychiatric literature for over a century, it has not been recognized with the same significance as chronic depression in current diagnostic systems (1). According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders, a manic episode is characterized by an elevated, expansive, or irritable mood, accompanied by increased goal-directed activity or energy, lasting for at least one week (or any duration if hospitalization is required) (2). Most epidemiological studies have found that in the course of bipolar disorder, a manic episode typically lasts between 4 and 6 months (3). Although it is uncommon, a manic episode can sometimes last far beyond the typical duration, sometimes extending for several years, which is referred to as chronic mania. Chronic mania is currently defined as the persistence of manic symptoms for more than two years without remission, and it has a prevalence rate of 6%–12% (4). Most patients show a response to treatment within two weeks, usually to first-line medications. However, if mood stabilizers and antipsychotics do not work, the condition is considered treatment-resistant mania. This is defined by ongoing manic episodes despite at least three weeks of treatment with one mood stabilizer and one antipsychotic (5).

OBJECTIVE

To discuss the clinical recognition, diagnostic challenges, and treatment implications of chronic mania and treatment-resistant mania

CASE DETAILS

A 32-year-old married male from a lower socioeconomic background presented with complaints of decreased sleep, excessive talking, loud singing, increased energy, overfamiliarity, delusions of grandiosity, and heightened religiosity for the past 5 days. He has a 12-year history of psychiatric illness with similar episodes, including 7 past exacerbations that required admissions to a private psychiatric hospital. The patient underwent multiple ECT sessions during each admission, followed by oral medications (mainly mood stabilizers and antipsychotics), resulting in partial remission but with some persistent symptoms. The patient has no family history of psychiatric illness, no medical or surgical comorbidities, and no history of substance use. Radiological and general physical examinations were unremarkable. Mental status examination revealed a less cooperative male with increased psychomotor activity, attention that was aroused but not sustained, and initial ease in rapport-building. His mood was described as "khush" with an elated affect, increased volume and tone of speech, decreased reaction time, delusions of grandiosity, flight of ideas, impaired judgment, and no insight.

Psychometeric Test:

Scale	Score
Young Mania Rating Scale (On Admission)	40
Young Mania Rating Scale (On Discharge)	28

Management

Upon admission under Psychiatry ward in Pravara Rural Hospital, the patient's YMRS score was 40. After treatment with T. Clozapine 350mg, T. Divalproex Sodium 1000mg, T. Olanzapine 20mg, and 8 ECT sessions, the score decreased to 30, with partial improvement upon discharge. When symptoms worsened during follow-ups, medications were adjusted to T. Clozapine 450mg, T. Lithium 900mg, T. Oxcarbazepine 900mg, T. Aripiprazole 5mg, T. Promethazine 50mg, and T. Endoxifen 8mg, resulting in partial improvement. After 3 months, symptoms worsened again, and the medication was changed to T. Clozapine 500mg, T. Lithium 900mg, T. Oxcarbazepine 900mg, T. Trifluoperazine 10mg, T. Trihexyphenidyl 4mg, T. Ziprasidone 40mg, and T. Lorazepam 4mg, with 6 ECTs administered again and on follow up partial improvement was perceived.

DISCUSSION

Current diagnostic systems define mania as lasting for at least 7 days. Epidemiological studies indicate that untreated mania typically resolves within 6 months, although it can sometimes persist longer. Chronic mania is traditionally defined as the presence of manic symptoms for over 2 years without remission (6). Studies have shown that, compared to individuals with acute mania, those with chronic mania experience significantly higher rates of nearly constant euphoria, grandiose delusions, and related delusions. They also exhibit relatively lower rates of sleep disturbances, psychomotor agitation, and hypersexuality (7). Diagnosing chronic mania can be challenging due to the influence of cyclothymic or hyperthymic temperaments, as well as overlapping symptoms with mania, schizophrenia, and schizoaffective disorders. Some authors suggest that 'chronicity' may encompass non-manic symptoms or repeated manic episodes with periods of recovery in between (8). The patient exhibited manic symptoms for approximately 12 years before seeking care, with minimal improvement despite treatment. Under our care for 1.5 years, he showed partial remission of core manic symptoms, despite good treatment adherence, high-dose medications, and ECTs. This case aligns with chronic mania and suggests that, in rare cases, mania can follow a chronic course. It highlights the existence of chronic, treatment-resistant mania in clinical practice, underscoring the need for further study into its biological causes and treatment outcomes.

CONCLUSION

Chronic and treatment-resistant mania is relatively rare and often misdiagnosed or underrecognized. Patients with chronic mania tend to have more severe illness, co-occurring psychotic symptoms, and significant socio-occupational impairment. Various treatment approaches, including antipsychotics, mood stabilizers, benzodiazepines, and ECT, have been explored in small studies, but results have been mixed. The limited literature on the chronicity of mania presents challenges in understanding and managing such cases. In our case, partial remission was achieved with a combination of antipsychotics, mood stabilizers, benzodiazepines, and other

supportive measures. Further follow-up is necessary to assess the role of newer antipsychotics in treating chronic and resistant mania.

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