



The Curious Case of Panic Disorder vs Hypomania (BPAD)

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Aims and Objective

To improve the detection of Bipolar Disorder through education and clinical awareness highlighting the subtlety of hypomanic symptoms, recognising the likely bipolar status of antidepressant associated hypomania and most importantly the significance of anxiety as a co morbidity with BPAD through a case report.

Case Report

This is a case report analysis of a 16 year old teenager with normal development who was referred to CAMHS for an urgent appointment due to acute deterioration of her mental state. She had previously attended CAMHS the year before for 6 months for CBT with a diagnosis of anxiety (moderate) with poor sleep and was successfully discharged due to marked improvement.

This presentation, Patient X presented to A & E in a distressed emotional state and panic attacks consisting of extreme anxiety, shaking and uncontrollable tremors in both her upper and lower limbs with difficulty breathing and swallowing. Epileptic seizures were ruled out and Patient X was deemed medically fit for discharge on the same day. Diazepam and Propranolol were given with positive effect reducing the emotional distress and 'shaking episodes.'

Upon assessment at CAMHS, Patient X described feeling constantly on edge and worrying about school, people and everyday tasks. A recent transition to a new school and doing public music performances appeared to trigger the 'Shaking Episodes.' Her sleep continued to be disturbed particularly prior to big school and music performances.

Patient X was commenced on Sertraline 25 mg and it was titrated up slowly to 150 mg OD. Promethazine 25 mg BD PRN was given for 'shaking episodes' to decrease the likelihood of dependency on Benzodiazepines. An initial improvement in anxiety was seen in Week 1, 2 and 3 and a reduction in the 'Shaking episodes.' Patient X was able to leave the house and re-engaged in social activities including attending her music lessons. Patient X's mood had improved slightly but sleep was still continually very poor. It was noted that a trigger for her anxiety was Sunday nights before school and the school week. Concentration was still extremely poor and school was becoming too difficult to attend as Patient X was in the nurse's office most of the day.

Week 3, 4, 5 there appeared to be very subtle changes in behaviour. Patient X energy levels increased and she slowly started increasing her activity level with a full social calendar and taking on more tasks and responsibilities. One appointment it was noticed she was subtly over familiar with medical professionals, slightly tangential in her speech and her concentration appeared limited. Other changes in behaviour included slight increased agitation, paranoia and hostility towards parents. Impulsivity increased with one incident where Patient X felt she could no longer cope and made plans to jump in front of the subway. There was subtle increased risk taking behaviour weekly with leaving the house in the middle of the night to meet up with male peers. A critical incident was described where Patient X had a vivid dream about a male attacking Patient X. Whilst in school the next day; Patient X was unsure if the dream was real or not and nearly attacked the male. Patient X was able to stop herself as the uncertainty had held her back. During the recent American elections, Patient X became extremely distressed on social media about the results and describes lashing out at the public verbally, and hearing Trumps voice in her head. Initially no psychosis was evident and insight didn't appear to be impaired but these incidents highlighted that she may be on the brink of a severe manic episode as there appeared to be a blurring of reality. The symptoms were subtle and each weak additive leading to a discussion at the MDT where it felt that she could easily have a psychotic break due to her family history, symptoms she was presenting with and the family dysfunction.

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Past psychiatric history

Patient X was given a diagnosis of anxiety/panic states the previous year and had psychological work (Cognitive Behavioural Therapy) for 15 sessions with a psychologist and discharged successful. The issues highlighted were continual and catastrophic worries about school, her becoming unwell, her family becoming unwell and doing poorly on school exams. Her sleep was poor with 2-3 hours of sleep a night. She presented with somatic symptoms including nausea, shaking, and perspiration. Concentration was an evident difficulty with Patient X being unable to focus on one task, carry out simple tasks and disorganisation. Patient X was very socially active and frequently doing many activities. Throughout the sessions it became evident there was systemic issues within the family with high expressed emotions, critical comments and unclear messages. Much of these difficulties were much the same but to a higher degree in her current presentation.

Family history

Patient X comes from an intact family with 2 other siblings. One sibling has a diagnosis of BPAD. Mom and Dad have their own mental health difficulties including anxiety and depression and a maternal uncle has a diagnosis of Schizophrenia. There have been ongoing systemic issues amongst the family with marital discord and relational difficulties amongst family members. Patient X describes a tumultuous relationship with mom with significant communication and boundary issues. Patient X describes not wanting to be at home and frequently staying with the partner or siblings for reprieve.

School history

Patient X had recently changed schools as it was felt by the parents it would be a better option academically. Patient X has always done extremely well at school and has extremely high expectations of herself with regards to academic success. Both siblings previously have attended university and have highly successful careers which have put increased pressure on Patient X to do the same.

Social history

Patient X has multiple stable friendships and frequently socialises. Patient X has multiple interests including arts and music where Patient X's talent is recognised at a national level to be very significant. Patient X's friendships started to deteriorate during the hypomanic episode due to negative thought pattern, paranoia and irritability alongside young people perceiving her actions as attention seeking.

Drug/alcohol history

Alcohol use is infrequent due to poor access but Patient X states that when there is availability Patient X finds it takes the edge of the anxiety and helps with reducing the worries and improving relaxation.

Past medical history

Migraines

No Allergies

Current Treatment Plan

Medical/psychiatry input

Patient X after 2 months of being treated with Sertraline 150mg OD for Panic Disorder without Agoraphobia was stopped. Her diagnosis after discussion at MDT and with Consultant CAMHS psychiatrists was changed to Hypomanic Episode/ BPAD.

Patient X was commenced on Quetiapine XL titrated weekly from 50 mg up to 200 mg OD. With each week there was an improvement with her sleep initially which resulted in a marked improvement in her mood and anxiety. There was slow improvement in her racing thoughts, concentration and energy levels but with weekly titration there was a noticeable improvement. No side effects were noted with the Quetiapine XL but patient was very aware of the possible weight increase and hesitant at times for dosage increase. Quetiapine XL was the medication Patient X's sibling was commenced on with good effect and was the initial medication of choice for CAMHS.

Currently her medication remains at Quetiapine XL 200 mg with good effect and her mental state is stable with no racing thoughts, reduction in energy levels, no psychosis and mild anxiety. No further panic attacks have ensued. Her mood is described as good with significant sleep improvement (8 hours). Current medication dose.

Family therapy input

A family therapist was involved due to the extent of high expressed emotion and interpersonal difficulties amongst family members. Structural family therapy techniques were used with boundaries being realigned between the parents. Increased and improved relationship amongst the parents has been a significant factor in improving familial relationships as both mom and dad are taking responsibility in parenting. There was an onus of increased responsibility on Patient X in managing her emotions, anxiety and medication. Previously, patient X found blame in her parents for the way she felt. After 6 sessions in family therapy and with notable improvement in relationships and communication amongst the family they were discharged.

Psychology input

Psychology input was required due level of anxiety and interpersonal/relationship difficulties within the family. The psychologist used a CBT approach but the work largely focused on self-triggers/monitoring, personal management plan and psycho-education surrounding BPAD/Hypomania. Patient X engaged extremely well with therapy and as patients mental state improved with medication her ability to engage and show insight improved substantially. The psychologist takes note that one of Patient X's struggles was not being able to see faults or difficult behaviours within her when it came to parental boundaries. Patient was successfully discharged from Psychology Services due to success in self-monitoring, recognising triggers and using personal management plan during periods of escalation.

Discussion

As in the case of Patient X, Anxiety and particularly panic attacks were significant prior to diagnosis of BPAD and anxiety still is present following treatment of BPAD. Current research indicates that bipolar disorder significantly co occurs with anxiety disorders at rates that are higher than those in the general population in adults [1]. The neurobiological mechanism that is thought to contribute to this is the various neurotransmitter systems interplay including GABA, serotonin, dopamine and Nora epinephrine [1]. It is thought that high levels of anxiety may be associated with poor outcomes. Studies in the past have shown that high anxiety scores in those with BPAD are related to more suicide attempts, increased abuse of alcohol, and tended to be less likely to respond to lithium. Others studies have indicated that BPD plus Axis I disorders suffer with earlier age at onset of affective symptoms, syndromal BPD, a history of cycle

acceleration and more severe episodes [2].

It's interesting to note that research indicates that the lifetime prevalence of panic disorder was 21% in those with a diagnosis of BPAD. Conversely patients with a diagnosis of panic disorder have a rate of BPAD at 23%. Some research papers have made a strong argument that panic disorder with bipolar is a genetic subtype of BPD [3].

Studies with paediatric populations have indicated similar results that bipolar disorder in youth is associated with a significantly increased risk for most DSM-IV anxiety disorders. Studies also show that those diagnosed with having an anxiety disorder as an adolescent increases the risk of developing BPAD as well [2].

In cases of treatment of anxiety and BPAD, further research and trials is required. The use of antidepressant medication can worsen the outcome for patients with BPAD as was the case for Patient X. Secondly when antidepressants can result in drug interactions with mood stabilisers. Very little data exists regarding the use of CBT in those with co morbid anxiety and BPAD [1].

Conclusion

Cases like Patient X, highlights the need for clinicians to consider anxiety symptoms when diagnosing and treating patients for Bipolar disorder. A clear diagnosis is required due to the increased negative

outcomes for patients who have this co morbidity. It's also equally important to screen for BPAD in those with anxiety, as BPAD is under diagnosed significantly and this can result in poor outcomes for the patient if left untreated. Co morbidity between any anxiety disorder and BPAD would require more aggressive and comprehensive interventions compared to children without such co morbidity. The research pertaining to pharmaceutical treatment in individual with co morbidity of this nature is limited but managing the mood takes precedence over the anxiety initially but managing the anxiety is essential as its significant contributory factor to their mental state and outcome.

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