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Brief report

Preschool Bipolar Disorder: Brazilian children case reports ☆

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Abstract

Objective: This study describes the clinical phenomenology and family history of preschool age onset Bipolar Disorder (BD).
Methods: Eight children and adolescents out of 118 cases (6.78%), both genders, meeting current DSM-IV criteria diagnosis of BD were described. The clinical assessment, CBCL, DICA-IV and CGAS were performed directly with each patient and their parents.
Results: Most (87.5%) presented classical symptoms of mania: euphoria, grandiosity, irritability, psychomotor agitation and agitated sleep or, in the same proportion, sleeplessness. Hyperactivity and increase of energy were found in all eight cases. The clinical course varied from a rapid, ultra-rapid, ultradian cycle to a continued pattern. Five out of eight children (62.5%) presented aggressiveness toward others and one deliberate self-harm. Most (87.5%) had psychiatric family history. The average number of medications used during their life was 4.5 drugs.
Limitation: The small sample and retrospective reports of the first manic symptoms in three of the cases (cases V, VI and VII).
Conclusion: An important incidence of classical manic features was found in very young children. The clinical course tended to be continuous, and preschool BD seems to have a strong association with affective disorder family history.

Keywords: Preschool bipolar disorder; Bipolar disorder; Brazillian children

1. Introduction

Early onset Bipolar Disorder (BD) has increasingly attracted clinical and scientific interest, demonstrated by a large number of publications (Leibenluft et al., 2003; Faedda et al., 2004), including manic and hippomanic symptom in preschool children (Poznanski et al., 1984; Wozniak et al., 1995; Findling et al., 2001; Wilens et al., 2003; Scheffer and Niskala Apps, 2004; Pavuluri et al., 2006). For instance, Tumuluru et al. (2003) described 6 hospitalized patients diagnosed with BD, with an average age of four and a half years and a family history of BD, and 5 of whom responded well to lithium treatment. Another example is a paper by Dilsaver and Akiskal (2004) that described eleven cases of preschool children with BD, emphasizing the high incidence of manic symptoms and a family history of affective disorders in these children.

It is well established that a child's age and psychological development are determinant factors in clinical manifestations of psychiatric diseases. During preschool, children may not verbally express their feelings adequately. As there

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is a lack of instruments for diagnosing BD mania in preschool children, the diagnosis definition essentially depends on a detailed description of clinical phenomenology, family history, and global functioning evaluation (Tumuluru et al., 2003; Fu-I, 2004; Scheffer and Niskala Apps, 2004; Dilsaver and Akiskal, 2004).

Further investigation is necessary for improving early identification and treatment for these children, thus contributing to a better quality of life for the entire family, in both social and educational spheres, and possibly, in the development of the disease. Our present study describes 8 patients who developed BD in preschool ages and their family history.

2. Methods

This study was carried out in the Child and Adolescent Affective Disorder Clinic (ATA-SEPIA) of the Institute of Psychiatry of School of Medicine at the University of Sao Paulo. All patients, who attended regularly ATA throughout 2005, with a current diagnosis of BD type-I, according to the DSM-IV and manic symptoms or hippomanic symptoms with first onset before age 6, were included. The parents or legal guardians were required to sign informed consent forms before entering the study. Subjects presenting chronic medical illness or mental and/or physical handicaps, diagnosis of Pervasive Development Disorder, possible Schizophrenia or psychosis and subjects with IQ = 70 or less were excluded.

Eight subjects out of 118 cases (6.78%), of both gender, age ranged from 4 to 12 constituted the sample of this study. As expected, the ratio of boys was predominant: seven boys (87.5%) and one girl (12.5%). The BD symptoms onset was between 2 and 5 years of age (average: 3 years and 6 months). Consistent with similar studies, there were more white children than other race group (Scheffer and Niskala Apps, 2004). Five were white (62.5%) and three black (37.5%).

The data for all diagnoses was based on: (1) a review of the routine clinical records completed by the attending psychiatrist, and scored global functioning by Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983); (2) data collected during the authors direct interviews with the parent and child when they carefully reviewed the medical history and obtained available collateral information, as well as relying on a meticulous clinical description; (3) Child Behavior Check List (CBCL) (Bordin et al., 1995), Diagnostic Interview for Children and Adolescents — DSM-IV Version (DICA-IV) (Reich et al., 1995) for children up to six years of age performed by trained researchers. Afterwards, an independent consensus conference was held to establish clinical assessment and final diagnoses of all subjects. When there was any divergence of opinion between investigators, the disagreement was settled by recalling patients and their parents for additional interviews, until unanimity was reached.

The case reports are as follows:

2.1. Case report — I

L.G.A.S. is a 6 year-old black boy. From his first years of life he was disturbed and agitated with only one or two hours of sleep per night. The first symptoms included detachment, low frustration tolerance, inability to finish homework and frequent complaints of headaches. These symptoms worsened throughout the subsequent three years. At age 3, he went to an attention deficit and hyperactivity disorder (ADHD) clinic, and was misdiagnosed and treated subsequently with methylphenidate, periciazine, amitriptyline and imipramine with no improvements, and occasionally his headaches, hyperactivity, anger and sleeplessness worsened. He always awoke very talkative, energized, laughing without reason and with a progressive worsening of his hyperactivity. By afternoon he was found moving slowly, bored, wishing to die and sounding quite sorrowful. He would then finish the day, irritated, destructive and hostile. During one of his euphoric moments, he took out everything in the freezer, urinated in butter containers and continued playing in the middle of the mess. When he first came to ATA-SEPIA at age 6, he already had very severe global dysfunction (CGAS = 20), and had no euthymic periods lasting more than 30 consecutives days. His subsequent treatment attempts include haloperidol 5 mg/d, risperidone 6 mg/d, ziprasidone 40 mg/d, carbamazepine 800 mg/d (9.4 ug/L), valproic acid 1 g/d and lithium 900 mg/d (0.7 mEq/L) in monotherapy or combined, but certain medications had no positive effect, and lithium should have been discontinued because of severe nightly and daily enuresis. Mood oscillations improved and the medications were well tolerated when treated with combination of valproic acid 1 g/d and quetiapine 400 mg/d. He has a four year-old BD type-I sister (case VIII), and his father was diagnosed with BD type-I and committed suicide in October of 2005.

2.2. Case report — II

G.M.H. is a 6 year-old white boy. He was a quiet boy until age 5; suddenly his behavior changed to a pattern never seen before. For instance, he began to run away from school, refused to do his homework, was physically