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AN UNCOMMON CASE OF INTELLECTUAL DISABILITY WITH MOOD DISORDER

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ABSTRACT
Intellectual disability (ID) is a developmental disorder affecting about 1% of the population and is often seen to exist with a number of co-morbidities, mainly mental and neuro-developmental disorders such as attention deficit hyperactivity disorder (ADHD), depressive and bipolar disorders, anxiety disorders and autism spectrum disorders. We present here an uncommon case of intellectual disability with comorbid bipolar disorder.

KEYWORDS: Intellectual disability, Comorbidity, Bipolar mood disorder.

INTRODUCTION

Intellectual disability (ID) is the term used to define a developmental disorder characterized by both intellectual and adaptive deficits. It affects nearly 1% of the population and is often seen to exist with a number of co-morbidities.[1] The most common co-occurring mental and neuro-developmental disorders are attention deficit hyperactivity disorder (ADHD), depressive and bipolar disorders, anxiety disorders, autism spectrum disorders etc. The prognosis and outcome of co-occurring diagnoses may be influenced by the presence of intellectual disability. Moreover, owing to intellectual and communication limitations, it is difficult to use the psychiatric diagnostic interview and apply standard diagnostic criteria to this population.[2] According to a review , individuals with mental retardation were found to manifest the full range of affective disorders but due to the influence of the developmentally impaired social functioning and intelligence on the clinical presentation, the diagnosis would be difficult.[3] There are several case reports of intellectual disability coexisting with ADHD and autism,[4] but very few cases of co-morbid mood disorder have been reported.[5] We present here a case of intellectual disability with comorbid bipolar disorder.

CASE REPORT

A 22-year old male was brought with the chief complaints of shouting, aggressive abusive behavior, increased talkativeness, increased physical activity and decreased sleep since last 8 months. Developmental history revealed delayed cry at birth, delayed motor and language milestones and patient still required assistance in his activities of daily living. The patient had never attended school or been employed. He was even unable to perform minor household chores. Patient's mother also revealed that he had developed two earlier similar episodes of increased talkativeness, increased physical activity, aggressive behaviour, abusing people and decreased sleep. The first episode was at 10 years of age. Initially family members thought it was a usual behavioural problem and did not seek help. But when it went on increasing and became problematic after a few months, some treatment was given, following which patient improved. But the treatment was discontinued due to financial difficulties. The next episode was about 2 years later when he again started having similar symptoms. At that time, the patient was brought to a tertiary care hospital in New Delhi and was admitted in psychiatry ward for a couple of weeks. Patient was started on sodium valproate 1000mg/day in divided doses and risperidone 6mg/day in divided doses. Later on, the dose was reduced and patient was well maintained on valproate 700mg/day and risperidone 3mg per day. Once the patient's mood symptoms were controlled, Intelligence Quotient assessment was done using Binet Kamat test and revealed a score of 52, suggestive of mild mental retardation.[6] The patient remained asymptomatic for another 2 years and thereafter, the family discontinued treatment due to financial reasons.

There was no history of any substance abuse. Family history for mental subnormality, mood disorder or any other mental illness was negative.

At the time of presentation in our department on physical examination, bilaterally there was a bent at the proximal interphalangeal joints. Systemic examination was within normal limits. Mental status examination revealed a young adult male with poor hygiene, ill-sustained eye to

eye contact, increased psychomotor activity, increased amount of speech with reduced reaction time, irritable affect and impaired cognitive abilities. Haemogram, serum electrolytes, liver and renal function tests did not reveal any abnormalities. Magnetic resonance imaging of brain did not report any significant abnormality. Electroencephalograhy revealed normal awake study.

A diagnosis of bipolar mood disorder current episode of mania without psychotic symptoms with mild intellectual disability was kept and patient restarted on the aforementioned treatment with dose of valproate being increased to 1000mg/day. The family was psychoeducated regarding the nature of the illness and the importance of compliance to treatment. Within a fortnight there was reduction in severity of the manic symptoms. At 6 months follow-up, the patient was well maintained on treatment.

DISCUSSION

Patients with mental subnormality are often under-diagnosed due to their lack of verbal expression, thus being unable to fulfil the diagnostic criteria. Besides that, another factor leading to delay in the diagnosis could be assuming the symptoms to be a part of retardation, as was the scenario in the current case also.[7] So far, only few such cases of bipolar mood disorder have been reported.[5]

Intellectual disability is associated with a number of co-morbidities like ADHD, autism etc. It is often difficult to distinguish between mood disorders and hyperactivity in intellectually disabled children because of the lack of ability to express properly. In such cases, the history and the chronology of the events become very important. Appearance of symptoms for the first time at the age of 10 years and sleep impairment with no past history were the main pointers towards bipolar disorder in this patient.

In our case, treatment was started with sodium valproate, low dose and titrated to 1000 mg/day. A follow-up study of Kastner et al. demonstrated efficacy of valproic acid on affective symptoms of individuals with mental retardation.[8]
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Lithium is another drug that has been used for the treatment of bipolar disorder with considerable success.[9] In unmanageable cases ECT can also be given.[10] Patients of mental retardation are more prone to the adverse effects of medication, hence the lowest possible dose should be started and increased slowly.

To conclude, due to the varied presentation of bipolar disorder in such patients, it is very important to take a very detailed history of the symptoms from the family members as such patients might not always be able to express the symptoms diagnosable of the disorders clearly.

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