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COMORBIDITY IN BIPOLAR DISORDER - CASE REPORT

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INTRODUCTION

Bipolar disorders (BD) are a group of brain disorders that cause extreme fluctuation in a person's mood, energy, and ability to function (American Psychiatric Association 2013). Psychiatric comorbidities are highly prevalent in BD including substance abuse or dependency, generalised anxiety disorder (GAD) and personality disorders (Gaudiano et al. 2005, Preti et al. 2016, Yerevanian et al. 2001). Physical comorbidities are also usually present, most commonly metabolic, cardiovascular, thyroid, and neurological (Krishnan 2005, Charles et al. 2016, Vancampfort et al. 2016, Ferreira et al. 2016). The aim of this paper is to highlight the importance of recognizing and timely treatment of comorbidity in BD.

CASE REPORT

Here we present the case of the femalepatient, aged 59, married, mother of one child. Early psychomotor development and growing up were normal and no psychiatric heredity were recorded. When she was 18 both of her parents died within a year. It was a very difficult period of her life and almost every night she felt restlessness in the body and pressure in the chest. At the age of 25 she got married and became a mother. After graduating she got a job and at the age of 33 started her own company.

In January, 2016. she visited psychiatrist for the first time due to symptoms of depression which had persisted for six months. She was then hospitalized and given medicament treatment which had subsided the symptoms. Later that year, she was hospitalized for the second time with acute mania symptoms. In the preceding period she had caused significant financial loss spending all of her family savings. During the second hospitalization elevated blood sugar and altered levels of thyroid hormones were noted and the patient was diagnosed with diabetes mellitus type 2 (DM) and hypothyroidism. Insulin therapy and thyroid hormones substitute were introduced. Symptoms of psychiatric disorder/mania were reduced with the mood stabilizer, antipsychotic, anxiolytic and hypnotic. After discharge from the hospital the patient noticed skin and nails changes and was diagnosed with psoriasis.

A year later (2017) she was re-hospitalized for the actualization of BD and GAD, and the clinical condition was further aggravated by changes in her physical appearance caused by psoriasis. Since her last hospitalization, the patient is in regular outpatient psychiatric, endocrinological and dermatological treatment and regularly takes prescribed medication. She is in a stable mood, functional in all spheres of life and is in state of solid symptom remission.

The patient described in this paper, during psychiatric treatment of BD, developed a series of medical and psychiatric comorbidities. The potential common origin of comorbidities most likely involves multifactorial etiology and numerous mechanisms. For DM and BD those mechanisms may include behavioural/psychological factors i.e. inactive lifestyle and excess carbohydrate ingestion, passive coping skills, treatment non-compliance; as well as biological factors such as sympathetic nervous system hyperactivity, HPA axis hyperactivity and pharmacological treatment for BD (Mcintyre et al. 2005). Thyroid abnormalities in patients with BD have been linked to lithium treatment, but other therapies also seem to be related to thyroid hormone imbalance (Lambert et al. 2016). This patient also developed psoriasis and skin and nail changes adversely affected her self-esteem, while diabetes and hypothyroidism further intensified anxiety and preoccupation with health problems. We can also assume that external stressors (as a consequence of the manic phase of the disease) and the early trauma associated with the death of both parents contributed to the development of stress-related comorbidities.A continuous period of stress exhausts the organism, interferes with body functioning and can be a trigger for different somatic disorders. It can be assumed that, in this case, the interactions of BD and physical/psychiatric comorbidities include abidirectional mechanisms in forming a complex clinical picture.

CONCLUSION

Treatment of BD with concomitant medical disorders requires a comprehensive approach. Comorbidities (psychiatric and physical) should be treated in parallel with basic psychopathology, as comorbidities can exacerbate the overall clinical picture, increase the risk of re-hospitalization, and be an aggravating factor in the treatment of patients with BD (Charles et al. 2016). It is necessary to recognize these conditions in a timely manner, especially because of the peculiar psychopathology of BD, comorbid conditions may sometimes be missed. Therefore, it is important to develop a personalized approach to the patient as much as possible and, when necessary, involve other specialists in diagnosis and treatment. In order to achieve optimal treatment outcomes, it is important to recognize comorbidities on time and treat them through an individualized interdisciplinary approach.

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Contribution of individual authors:

Tanja Grahovac Juretić - examination of the patient and taking a medical history, manuscript writing;

Klementina Ružić & Marina Letica Crepulja - literature searches, manuscript writing;

Ana Došen - examination of the patient and taking a medical history, manuscript writing;

Elizabeta Dadić-Hero - literature searches, manuscript writing.

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